

# The rights of vulnerable groups to health care



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## 9.1 Introduction

Not all users of the health system are in a position to be able to exercise their health rights easily. Certain vulnerabilities, such as having a disability or being an undocumented migrant, place additional barriers in the way of accessing health care services. Thus one of the aims of the National Health Act is to protect, respect, promote and fulfil the rights of vulnerable groups such as women, children, older people and people with disabilities. The Patients' Rights Charter, in addition, says there must be provision for the special needs of vulnerable groups, such as infants, children, pregnant women, the aged, people with disabilities and people living with HIV/AIDS.

This part of the chapter considers specific policies and laws affecting some of these vulnerable groups, with a focus on children:

- people with disabilities, including people with impaired decision-making capacity;
- older persons;
- refugees, asylum seekers and undocumented immigrants;
- prisoners and detainees; and
- children.

The specific health rights of women are considered in chapter 12. The rights of people living with HIV/AIDS are considered in detail in the AIDS Law Project's *HIV/AIDS and the Law: a resource manual*, in particular in chapter 6 dealing with health rights.

## 9.2 People with disabilities

Disabled People International defines disability as the "loss or limitation of opportunities to take part in the normal life of the community on an equal level due to physical and social barriers". There is however no consensus on the definition of disability and definitions vary between the medical model that considers disability an individual medical problem and the social model that views disability as a system of social restrictions placed on people with impairments.

### Disability in general

As part of the right to equality, both the Constitution and the Equality Act prohibit unfair discrimination on the ground of disability. This includes denying or removing any person who has a disability from any facility that

supports or helps them function in society. While this is important, the right to substantive equality demands more than the mere removal of obstacles that unfairly limit or restrict people with disabilities from enjoying equal opportunities. People with disabilities are often subject to unfair discrimination through omission. The right to equality therefore includes the taking of reasonable steps to accommodate the needs of people with disabilities. In this respect, the Equality Act also specifically prohibits unfairly denying or refusing any person access to health care facilities or failing to make health care facilities accessible to any person.

In 1997 the government released its Integrated National Disability Strategy White Paper advocating for an approach to disability which focuses on the social barriers leading to disability and flowing from it. The approach recognises the need for people with disabilities to participate in policy and legislative developments on issues that affect them. The White Paper noted that 5 to 12% of South Africans are moderately to severely disabled and that people with disabilities who are women, children, elderly or living in rural areas are particularly vulnerable. The White Paper further noted that not only are poor people at greater risk of impairment or disability, but also that disability places an additional burden on families thrusting them into deeper poverty. In relation to health care, the White Paper's policy objective is the development of a comprehensive universal health care system, at primary, secondary and tertiary level, that is sensitive to the general and specific health care needs of people with disabilities. Strategies to achieve this should include:

- measures aimed at the elimination of discrimination on the basis of disability in the health sector, with special attention given to women with disabilities;
- the development of national norms and minimum standards for the building of health facilities to ensure barrier-free access;
- appropriate communication strategies at service-delivery points which must ensure equal access for people with communication disabilities; and
- the development of training programmes for health care workers in line with the ideas expressed in the White Paper.

#### Example: Medical schemes and disability

People with disabilities may need additional assistance from their medical scheme to be able to enjoy benefits to the same extent as members who do

not have disabilities. A person who is blind, for instance, may need benefit information to be supplied in Braille. Schemes should also be aware of rules which could indirectly affect members with disabilities. Medical schemes are required to reasonably accommodate members with disabilities.

#### CASE STUDY: *ELDRIDGE* AND SIGN LANGUAGE TRANSLATION

In the Canadian Supreme Court case of *Eldridge and two others against British Columbia (Attorney General) and the Medical Services Commission*, the appellants were born deaf and used sign language to communicate. They argued that the failure of government-funded health services to provide sign language interpreters impaired their ability to communicate with health care providers and increased the risk of misdiagnosis and ineffective treatment. The court held that where sign language interpreters are necessary for effective communication in the delivery of medical services, the failure to provide them constitutes a denial of the right to be treated equally before the law and not to be discriminated against.

The court noted that although government will rarely single out disabled persons for discriminatory treatment, many laws of general application have a disparate impact on the disabled. It is this failure to take into account the adverse effects of generally applicable laws that result in discrimination. The prohibition of discrimination on grounds such as disability is aimed both at eliminating discrimination based on untrue stereotypes and at taking into account the true characteristics of this group and to reasonably accommodate them. The failure of the Medical Services Commission and hospitals to provide sign language interpretation where it is necessary for effective communication constitutes a *prima facie* violation of the rights of deaf persons. This failure denies them the equal benefit of the law and discriminates against them in comparison with hearing persons. The government has not made a “reasonable accommodation” of the appellants’ disability.

In analysing the rights in the South African Bill of Rights, our courts have often followed the interpretation by Canadian courts of similar sections in the Canadian Charter of Rights. This case is a good example of how people with disabilities can use their right to equality to improve the health services available to them.

Although our law is relatively undeveloped in the area of disability, there are a number of key statutes and policies that deal expressly and progressively with the issue, including the National Health Act (NHA) and various codes of good practice. The NHA, for example, requires the Minister of Health to consider the needs of people with disabilities when deciding which people qualify for free public health services. All people with disabilities are already able to access free primary health care services. Those who receive disability grants – meaning poor people who are unable to work because of their disabilities – qualify for full subsidisation of public hospital fees. The same applies to people in receipt of pensions for the blind, care dependency grants and single care grants for mental illness.

A number of codes of good practice regulate the rights of people with disabilities. Those that are relevant to the provision of health care services include:

- the Department of Health document entitled *Core Norms and Standards for Health Clinics* requires clinics to be easily accessible for people with disabilities; and
- the Department of Labour's *Code of Good Practice on Disability and Human Resources Code of Good Practice* (drafted in terms of the Employment Equity Act 55 of 1998) place duties on employers to look after the needs of people with disabilities in the workplace.

#### PRIMARY HEALTH CARE CLINICS AND DISABILITY

According to the Department of Health's (2005) *User's Guide to Primary Health Care Services*, clinics should:

- have a ramp for wheelchair access;
- have toilet facilities for people with disabilities;
- assess people with disabilities and help them apply for a Disability Grant or Care Dependency Grant if needed; and
- provide equipment for people with disabilities or order it for them.

### People with impaired decision-making capacity

While people with impaired decision-making capacity (including those with mental illness) have all the rights of people with disabilities, many of their specific concerns are addressed in greater detail in the Mental Health Care Act 17 of 2002 (MHCA). The statute, which provides for the treatment, rehabilitation and care of persons who are mentally ill, is based on a human rights-based approach to mental health and replaces the outdated 1973 law. In particular, it:

- sets out requirements for admission to health establishments, including various procedures, safeguards and time-frames dealing with the admission of voluntary and involuntary mental health users to mental health facilities
- provides for the establishment of Mental Health Review Boards for each health establishment which reviews the decisions of the head of the health establishment and makes decisions regarding the treatment or transfer of assisted or involuntary health care users and mentally ill prisoners;

- recognises the need to improve the provision of mental health care services that promote the maximum mental well being of users; and
- requires mental health services to be provided at all health care levels, including – but not limited to – psychiatric hospitals and care and rehabilitation centres.

#### PSYCHIATRIC ILLNESSES IN SOUTH AFRICA:

- 14% of diseases worldwide are psychiatric and it accordingly ranks with heart disease and cancer as a major cause of illness.
- Ten of the top 20 chronic disabling conditions are psychiatric, including six of the top 10.
- 58% of visits to general medical practitioners are due to conditions caused or exacerbated by mental or emotional problems.
- 18 to 25% of senior citizens are in need of mental health care for anxiety, depression, psychosis or dementia.
- 1% of the population suffer from schizophrenia. Another 1% suffers from bipolar disorder.
- One in 10 people will suffer from disabling anxiety and one in four will develop depression.
- In South Africa it is estimated that the same number of people commit suicide that are killed in motor vehicle accidents every year.
- One in 33 children and one in eight adolescents may suffer from depression.
- The World Bank and the World Health Organisation predict that by the year 2020, psychiatric illness will be the leading cause of disability in the world.

Despite the prevalence of psychiatric illness, many medical schemes limit psychiatric benefits. Similarly the public sector provides insufficient psychiatric services. For example:

- there are few psychiatrists employed in the public health sector;
- not all primary care clinics treat psychiatric illnesses and access to clinics that do is limited;
- specialist psychiatric clinics have been closed;
- access to medicines is limited in terms of the Essential Drugs List; and
- there is a lack of adolescent psychiatric facilities.

#### Health care rights in the Mental Health Care Act

The MHCA applies to voluntary, assisted and involuntary mental health care users, state patients (classified as such by a court in terms of the Criminal Procedure Act 51 of 1977) and mentally ill prisoners (who are incarcerated in terms of the Correctional Services Act 111 of 1998). In addition to the broad mental health care framework that it sets up, the MHCA sets out a range of health care rights that may be claimed by all mental health care users, including the following:

- the human dignity and privacy of every user must be respected;
- all mental health care users must be provided with care, treatment and rehabilitation services that improve their mental capacity in order to develop to full potential and to facilitate integration into community life;
- services must be appropriate to the user's mental health status and must be the least intrusive of the user's rights, including the right to dignity and privacy; and
- before administering care, treatment and rehabilitation services, health care providers must inform a mental health care user of his or her rights and do so in an appropriate way.

#### KEY DEFINITIONS IN THE MENTAL HEALTH CARE ACT

Mental health status refers to the level of mental well-being of an individual as affected by physical, social and psychological factors and which may result in a psychiatric diagnosis. A mental illness is a positive diagnosis of a mental health related illness in terms of accepted diagnostic criteria made by a mental health care practitioner who is authorised to make such diagnosis.

"Voluntary mental health care users" are people who are able to consent to mental health interventions.

"Assisted mental health care users" are people who are incapable of making informed decisions owing to their mental health status and who do not refuse mental health interventions.

"Involuntary mental health care users" are people who are incapable of making informed decisions owing to their mental health status and refuse mental health intervention but require such services for their own protection and/or the protection of others.

#### Rights necessary for accessing health care rights

The MHCA also deals expressly with a range of other rights – such as unfair discrimination and protection against abuse – that are necessary for ensuring that mental health care users access their health care rights. For example:

- no user may be the subject of unfair discrimination on the basis of his or her mental health status, meaning that – in general – all mental health care users must receive the same standard of care provided to any other user;
- no decision on a person's mental health status may be based on factors such as socio-economic or socio-political status, cultural or religious background or close relationships; and
- any person or health establishment that provides care, treatment and/or rehabilitation services to a mental health user, must take steps to ensure that users are protected from exploitation, abuse and degrading treatment, and are not subjected to forced labour.

### DUTIES OF CLINIC STAFF IN DEALING WITH MENTAL HEALTH

The Department of Health's *Norms and Standards for the Provision of Primary Health Care* make it the duty of clinic staff to:

- consider risk factors for mental health in their area, such as poverty, unemployment, ill health, homelessness and migrancy;
- identify and provide appropriate interventions in cases of depression, anxiety, stress-related problems, domestic violence and substance abuse;
- ensure that time is allocated for home visits of patients who have returned from a mental hospital; and
- guard against segregation and stigmatisation of users.

While all mental health care users have the same rights to confidentiality as any other user, the MHCA deals expressly with a number of confidentiality issues that are specific to mental health. For example, the head of a health establishment may disclose a mental health care user's information if failure to do this will prejudice the health of the mental health care user or other people. In addition, a mental health care user can also temporarily be denied access to medical information if disclosure is likely to seriously prejudice him or her, or cause him or her to act in a way that may prejudice others.

These rights may have little meaning if mental health care users have no access to courts or other bodies where allegations of violations of their rights may be adjudicated. In recognising this problem, the MHCA provides that all mental health care users have the right to a representative (including a legal representative) to submit applications, lodge an appeal or appear before a court or Review Board. Indigent mental health care users are entitled to state-provided legal aid.

### EXAMPLE: DISCRIMINATION IN MEDICAL SCHEME BENEFITS AVAILABLE TO MENTAL HEALTH CARE USERS

The Department of Psychiatry at the University of Stellenbosch conducted a study which compared medical scheme benefits in 2001 and 2002 for major depressive disorder and ischemic heart disease. Their survey of 57 schemes and 130 options in South Africa revealed a 20-fold difference in in-hospital benefits, favouring members with heart disorder. The study showed that 73.8% of schemes had no limits on in-hospital benefits for the treatment of the heart disorder, while only 8.5% had no limits on in-hospital treatment of major depressive disorder. 7.7% offered unlimited out-of-hospital benefits for the heart disorder, but only 2.3% did so for the psychiatric disorder.

### Future developments in the law

In 2004, the South African Law Reform Commission (SALRC) released a Discussion Paper on assisted decision-making for people with impaired capacity. In its investigation prior to the release of the paper, the SALRC considered the lack of appropriate legislation to deal with adults who cannot make decisions for themselves because of diminished capacity (as a result of mental illness, intellectual disability, physical disability or an incapacity relating to ageing). This relates particularly to decisions regarding their personal welfare, financial affairs or medical treatment, opening them up to abuse and exploitation. The Discussion Paper noted the problems related to curatorships and the absence of a formal assisted decision-making mechanism to provide for cases of mild, fluctuating or temporary impairment. It is expected that this investigation will result in law reform that is necessary to protect the rights of persons with impaired decision-making capacity.

## 9.3 Older people

Both the Constitution and the Equality Act prohibit unfair discrimination on the basis of age. While these are important protections, they are insufficient – in and of themselves – to ensure that older people are able to access appropriate health care services. Consider, for example, the *South African Demographic and Health Survey* (1998), which indicated that:

- only 13% of people over 65 years of age had access to private medical scheme coverage;
- 50% of people over 65 years were taking two or more prescribed medications for chronic conditions; and
- 61% of all aged persons were women.

Added to this is the frequent need of many older people to use tertiary health establishments, primarily because of the nature of their illness. This adds to transport and treatment costs, which are often unaffordable. These ancillary costs are a significant barrier to access in a context where old age pensions are almost entirely used to support extended families in the context of high unemployment. In the last decade HIV/AIDS has further diverted the spending patterns in poor households to cover costs related to the care of family members infected by HIV/AIDS, burial costs, care of orphaned grandchildren etc.

In some important ways, our law has started to address these and other problems through a range of statutes and policies, including:

- the National Health Act;
- the Older Persons Act (originally Bill B68B-2003); and
- a series of guidelines issued by the Department of Health.

## National Health Act

As already discussed in this chapter, one of the key aims of the National Health Act (NHA) is to protect, respect, promote and fulfil the rights of vulnerable groups, including older people. It does this in a number of ways, such as by providing that when determining what categories of people qualify for free health services at public health establishments, the Minister must consider the needs of vulnerable groups such as older people.

In practice, all older people are already entitled to access free primary health care services at clinics, with those older people accessing old age pensions being entitled to access free secondary and tertiary health care services at public hospitals. Specialised tertiary care services for older people are available at tertiary academic hospital complexes but these are not easily accessible despite older people's particular need for such services. In general, dedicated geriatric services at secondary and tertiary levels have been marginalised.

## Older Persons Act

In recognition of the many challenges facing older people, the Older Persons Act which was passed by parliament in 2006, but which (at the time of writing) has yet to become law – aims to:

- maintain, increase and promote the status, well being, safety and security of older people;
- maintain and protect the rights of older people as recipients of services;
- regulate the registration of facilities for older people; and
- prevent the abuse of older people.

The Act defines an older person as any man who is 65 years or older, and any woman who is 60 years or older. It also defines a number of other terms, including:

- a frail person – an older person whose physical or mental condition requires 24-hour continuous care; and
- a facility – a building managed for the purposes of providing accommodation, housing and community-based care and support services to older people.

#### Express protections in the Act

The Act sets out the rights of older people at facilities, which include:

- access to basic care defined as “physical, psychological, social or material assistance to an older person” including “services aimed at promoting the quality of life and general well-being of the older person”;
- reasonable access to assistance and visits; and
- access to their own health care provider where they can afford it.

In addition, it states that no person may unfairly discriminate directly or indirectly against a person applying for admission to a facility on any of the prohibited grounds. It also makes the abuse by any person of an older person an offence, which it defines as a single or repeated act or lack of action that causes harm or distress to an older person, including physical, psychological, financial or material harm or neglect, or sexual harm and includes the violation of an older person’s constitutional rights.

Finally, the Act prohibits the operation of unregistered facilities that provide services to older people. If more than 10 older people reside in a facility, a residents’ committee – representing the interests of residents – must be established to ensure that the facility manager deals with allegations of abuse and establishes a complaints procedure for residents and staff.

## Department of Health Guidelines

As people get older, they are at increased risk of chronic diseases. The Department of Health’s Directorate for Chronic Diseases, Disabilities and Geriatrics is responsible for the development of national policy guidelines on the control of disease and conditions of older people. Some guidelines, which set the standard approach to be followed by health care personnel and assist users to determine what level of services they can expect from service providers, include:

- the National Guideline on the Prevention of Falls in Older Persons;
  - the Guideline for the Promotion of Active Ageing in Older Adults at Primary Level;
  - the National Guideline on the Management of Osteoporosis at Hospital Level and Preventative Measures at Primary Level; and
  - the National Guideline on the Prevention of Blindness in South Africa.
- These guidelines can be accessed at [www.doh.gov.za/docs/facts-f.html](http://www.doh.gov.za/docs/facts-f.html).

## 9.4 Refugees, asylum seekers and undocumented migrants

South Africa's Constitution says that "everyone" has a right of access to health care services. This is important to bear in mind when we consider that millions of people who live here are refugees from countries like Zimbabwe. In addition there are many undocumented migrants who have come to South Africa to escape poverty on other parts of the Continent.

The Refugees Act, 130 of 1998 refers to refugees as people who have been granted asylum in South Africa in terms of the Act. A person qualifies for refugee status if that person, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality and is unable to or, owing to such fear, unwilling to avail him or herself to the protection of that country. Such person's dependants would also qualify for refugee status. A person also qualifies for refugee status if compelled to leave his or her country of origin due to war or events which seriously disturb public order in the country or part of it. Once granted refugee status, this status is regularly reviewed and a person's refugee status ceases if the circumstances which gave rise to the recognition of refugee status ceases to exist and no other circumstances justify continued recognition as a refugee.

An asylum seeker is someone who is seeking recognition as a refugee. Once a person has applied for asylum, he or she is a recognised asylum seeker and issued with a temporary asylum seeker permit. Pending the determination of the application and until the temporary permit expires, such person may not be prosecuted for unlawful entry or presence in South Africa.

Undocumented migrants refer to people who are unlawfully in South Africa because of illegal entry, expiry of legally acquired work, study or visitor's permits or because they have not yet applied for asylum seeker status.

In terms of the South African Citizenship Act, 88 of 1995, a person can obtain citizenship through birth, descent or naturalisation. People who have legally resided in South Africa for a substantial period of time, may apply for permanent resident status.

Except for those rights that are expressly granted to citizens, such as the right to vote, all people in South Africa are entitled to enjoy the rights in the Constitution. This includes (but is not limited to) rights to equality, dignity and privacy, as well access to health care services. However, all rights may be limited by law, provided the limitation is reasonable and can be justified. The test for determining the constitutionality of any limiting law is set out in section 36(1) of the Constitution.

#### CASE STUDY: SOCIAL SECURITY FOR PERMANENT RESIDENTS

In the 2004 cases of *Khosa v Minister of Social Development; Mahlaule v Minister of Social Development* 2004 (6) SA 505 (CC), the Constitutional Court considered whether the law could exclude permanent residents from accessing certain forms of social security. In terms of the Social Assistance Act, only South African citizens were entitled to access old age pensions, child support grants and care dependency grants. But in terms of the Constitution, everyone has a right of access to social security, including social assistance where necessary.

The Constitutional Court found that it is unconstitutional to deny permanent residents access to social grants, in cases where they would otherwise qualify. The Court made the following crucial distinction between permanent residents and temporary (including illegal) residents:

*“The exclusion of all non-citizens who are destitute, however, irrespective of their immigration status, fails to distinguish between those who have become part of our society and have made their homes in South Africa, and those who have not.”*

The Court did not consider whether other non-citizens other than permanent residents should be entitled to access social security (as the applicants before the Court were all permanent residents), nor did it consider whether access to public health care services should be treated in the same way as access to social security (as the issue was not before them).

Human rights arguments in favour of access to health care services for all, whether citizens, permanent residents, refugees, asylum seekers or undocumented migrants, are supported by public health concerns. Consider, for example, the HIV/AIDS epidemic. If we exclude poor non-citizens from accessing HIV prevention services, we not only place their lives in danger but also those of citizens. And if we exclude poor non-citizens from accessing antiretroviral (ARV) treatment for HIV-infection, we create significant disincentives for such people to access HIV testing services.

## Refugees and asylum seekers

The rights of refugees and asylum seekers are – in large part – set out in the Refugees Act 130 of 1998, which expressly states that all refugees enjoy full legal protection, including all the rights set out in the Bill of Rights. In relation to health care, the Act provides that refugees are entitled to the same basic health services that citizens receive.

In practice, however, the Department of Health's policy on the classification of patients for the determination of fees says that non-citizens should be full paying patients, but excludes the following people from this provision:

- permanent residents;
- non-South Africans with temporary residence or work permits; and
- persons from SADC states who enter South Africa illegally.

People who access grants qualify for full subsidisation.

The policy on fees also specifically states that pregnant women and children under six years who are non-citizens are entitled to free health services. But only South African citizens are entitled to free primary health care services.

### ARV TREATMENT FOR HIV-INFECTION

Only the following categories of persons are currently eligible for accessing free ARV treatment in the public sector:

- South African citizens;
- permanent residents; and
- registered refugees.

Asylum seekers (people seeking to be recognised as refugees) are not entitled to access ARV treatment. This is most likely unconstitutional. By the time an HIV-positive asylum seeker's application has been processed, it may very well be too late for him or her get the full benefits of ARV treatment, assuming that he or she is still alive. One solution may be to fast-track asylum applications, although this will not help in cases where applications are initially refused but later granted on appeal.

## Undocumented migrants

Like refugees and asylum seekers, undocumented migrants enjoy the same constitutional protections in respect of the rights to equality, dignity, privacy, freedom and security of person, access to health care services and just administrative action. But, as has already been mentioned, rights may be limited. To date, we have very little (if any) direction from our courts – in particular the Constitutional Court – indicating the circumstances within which the socio-economic rights (including health rights) of undocumented migrants may be limited.

Interestingly, the National Health Act provides that all persons are entitled to free primary health care services although, as stated above, the policy on fees excludes non-citizens from such services. In addition, the NHA provision allowing all pregnant women and children under the age of six access to free public health services, should include the children of undocumented migrants. Similarly, the constitutional right of children to basic health care services should include the children of undocumented migrants, although their parents may be unaware of this right and scared of accessing public health institutions for fear of deportation and the prejudice that is often experienced, especially by people from other African countries.

In its preamble, the Immigration Amendment Bill, B11B-2004, endeavours to promote the rights of refugees by expressing the need to educate civil society on the rights of foreigners and refugees.

### CASE STUDY: RIGHTS OF ILLEGAL IMMIGRANTS

In the 2004 case of *Lawyers for Human Rights v Minister of Home Affairs* 2004 (4) SA 125 (CC), the Constitutional Court considered the rights of illegal immigrants who are detained at ports of entry pending their removal from the country. In its judgment, the Court rejected the state's argument that illegal foreigners have no right to claim constitutional protection. However, the Court held that it is reasonable and justifiable to limit the rights of illegal foreigners to freedom and security, thereby upholding the arrest and detention sections of the Immigration Act 13 of 2002.

### CASE STUDY: BIKO'S DEATH IN DETENTION

Steve Bantu Biko, a prominent leader of the Black Consciousness Movement, died in September 1977, just six days after being detained and interrogated by police. After an inquest found that the likely cause of death was complications following a head injury, the South African Council of Churches lodged a complaint in 1978 with the South African Medical and Dental Council (now the Health Professions Council of South Africa), alleging indifferent and irresponsible medical care on the part of the doctors who had attended to Biko after his assault but before his death.

Scandalously, the Council's committee of inquiry found no evidence of improper conduct. Thereafter, several concerned doctors took their decision on review to the then Supreme Court (now the High Court). In setting the Council's decision aside, the Court ruled that it must institute new disciplinary hearings against the two doctors who had attended to Biko. In 1985, some seven years after his death, the Council decided that the doctors who had treated Biko were guilty of improper behaviour. One of them was thereafter stripped of his medical qualifications.

#### MEDICAL PAROLE

Section 79 of the Correctional Services Act states that any person serving any sentence in a prison and who, based on the written evidence of the medical practitioner treating that person, is diagnosed as being in the final phase of any terminal disease or condition, may be considered for placement under correctional supervision or on parole to die a consolatory and dignified death. Such decision may be made by the Commissioner, Correctional Supervision and Parole Board or the court.

In terms of the prison standing orders, various factors should be "seriously kept in mind when considering a prisoner for placement/release on medical grounds" including "(v) in all cases where there is no doubt as to the nature of the illness and the life expectancy it is advisable that the placement/release on medial grounds be considered on a conditional basis". Another guideline states that injudicious placement or release on parole may foil the real objectives of the sentencing authority.

In practice, however, early release on medical grounds is a bureaucratic and often lengthy process; the condition of many prisoners worsens and some die before their release is approved. Many factors contribute to the delays:

- There is sometimes a reluctance by family members to receive the released person back, especially if he or she is terminally ill. This may be worse if HIV status is known and officials fail to make adequate arrangements for other placements for such prisoners.

- Where the DCS health staff believe that a prisoner should be released, the prisoner must be seen by the district surgeon, specialist, social worker and the parole board, which can take several weeks and can even stretch out for months.
- Parole Board members may not be skilled in assessing complex medical circumstances. Applications are often rejected based upon an incorrect consideration of current and/or previous criminal records and other irrelevant factors, without due consideration of the prisoner's medical needs.

### **Adequate medical treatment in prison**

In 2003 in a report to Parliament on behalf of the Judicial Inspectorate of Prisons, Judge Fagan warned that:

*“There has been a rapid escalation in the number of natural deaths in prison. During 1995 the natural death rate among prisoners was 1.65 deaths per 1 000 prisoners, last year it was 7.75 deaths per 1 000 prisoners. The continued escalation in natural deaths at the current rate of 34% per annum will mean that about 15 000 prisoners could die in the next 5 years.”*

As already explained, in practice, responsibility for the health of prisoners lies with the DCS, rather than the Department of Health (DoH). For many years organisations like the AIDS Law Project argued that this prejudices health care for prisoners because it means that they do not benefit from the same standards of care that exist in the public sector. Greater co-ordination between the DCS and the DoH is necessary. Section 21(2)(b)(vi) enjoins the Director-General of Health to “issue, and promote adherence to norms and standards on health matters, including ... health services for convicted persons and persons awaiting trial”.

This has recently been proved to be the case, as the number of prisoners dying because of HIV has increased dramatically, and the DCS has failed to implement properly an anti-retroviral treatment programme in prisons.

Fortunately, however, the specific rights of prisoners, which are set out in section 35(2)(e) of the Constitution, include an express right to adequate medical treatment. In addition, section 35(2)(f) entitles a detained person to be visited by his or her chosen medical practitioner.

But what exactly is “adequate” medical treatment? This matter has received some attention from the courts. In the 1997 decision in *Van Biljon v Minister of Correctional Services* 1997 (4) SA 441 (C), the Cape High Court held that:

- In deciding what is “adequate”, there must be regard for “what the State can afford”. Prison authorities cannot simply plead poverty – they have to make out a case that they “cannot afford a particular form of medical treatment or that the provision of such medical treatment would place an unwarranted burden on the State”.
- If it is proved that “anything less than a particular form of medical treatment would not be adequate, the prisoner has a constitutional right to that form of medical treatment”, subject to the consideration of available resources.

Interestingly, what is “adequate” medical treatment in prison may include services that are not ordinarily provided in the public sector. This is because prison conditions may place the health of detainees at significantly higher risk of infectious diseases like tuberculosis than that of people outside of prison.

In the *Van Biljon* case four sentenced prisoners living with HIV/AIDS approached the Cape High Court for an order compelling the relevant authorities to provide antiretroviral (ARV) treatment, at state expense, to prisoners in need of such treatment. At that time, both the state’s and the prisoners’ medical experts recognised that ARV treatment was the “state of the art’ medical treatment”

#### CASE STUDY: *DP V MINISTER OF CORRECTIONAL SERVICES*

(Unreported judgment, case number 6399/04, TPD, judgment delivered by Patel J on 15 March 2004.)

In this case, the applicant had committed armed robbery and was sentenced to 15 years’ imprisonment. He was admitted to the prison hospital at an early stage of his imprisonment with leukemia and an estimated life expectancy of one to two years. At the time of the application for parole on medical grounds, this life expectancy had dropped to one to three months. The Parole Board refused the application for parole and this decision was approved by the Head of the Prison. The prisoner made an application to review the decision to refuse his release on medical grounds.

The court set aside the initial decision and ruled that the prisoner should be placed on parole subject to the following conditions:

- That he be monitored by the Department of Community Corrections in accordance with the statutes and regulations pertaining to Correctional Services.
- That he continued to be under the supervision of his doctor at the local hospital.
- In the event of his being discharged from the hospital, that he be placed under the care of his wife at their home.
- That he be under house arrest except for being allowed to undergo any medical treatment at any hospital, clinic, doctors consulting rooms or hospice.

The judge commented that there is a tension between the necessity of imprisonment and the need to be compassionate towards someone suffering from a terminal illness.

for HIV infection that was generally unavailable in the public health system. Of the four applicants, only the first two were already in possession of prescriptions for ARV medicines.

Despite the medicines being unavailable in the public sector, the Court nevertheless directed the state “to supply first and second applicants with the ... [ARV] medication which had been prescribed for them ... for as long as this medication is prescribed for them on medical grounds”. But the Court refused to make a general order regarding the provision of ARV treatment to other similarly situated prisoners. Its decision was restricted to the particular facts before it, one of which was the state’s failure to show why it was unable to afford to treat those particular prisoners.

However, by 2006, the situation had changed completely. In 2003 the government adopted a policy to make antiretroviral medicines available to people living with HIV/AIDS and the Department of Health released its *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*. With regard to the DCS the Operational Plan remarked that:

*“Tight linkages with the public health system will be needed, so that patients requiring evaluation for antiretroviral therapy can be appropriately assessed and started on ARVs by skilled clinicians. The health care team will refer prisoners back to Correctional Services for ongoing primary care follow-up for HIV, with referrals for specialized care in public facilities according to national*

The applicant’s treating doctor noted that prison conditions were not conducive to his medical treatment:

- it was difficult to administer medication;
- he was exposed to opportunistic infections from other sick prisoners;
- his state of health required daily palliative care and regular hospice intervention but there are no DCS doctors skilled in providing such care; and
- prison officials did not provide him with the specific food prescribed for his condition, ostensibly as a result of budget constraints.

Significantly, the judge equated the refusal to place the applicant on medical parole with an infringement of his inherent right to dignity. The judge held that the refusal further violated his rights under:

- section 12(1)(e) of the Constitution not to be treated or punished in a cruel, inhuman or degrading way;
- section 27(1)(a) to have access to health care services;
- section 35(2)(e) to be detained in conditions consistent with human dignity, including nutrition and medical treatment;
- section 32(1)(a) and (b) to access to information; and
- section 33(1) and (2) to just administrative action.

*treatment guidelines. Upon discharge from Correctional Services, clear referral to ongoing care is to be formalised to ensure continuation of therapies and reinforcement of prevention counselling and support” (page 77).*

Unfortunately, between 2004 and 2006 the DoH and DCS did not work together to ensure either that prison hospitals were accredited to provide ARVs or that prisoners received ARVs at the nearest accredited public hospital. In the absence of ARV provision, many prisoners have died of AIDS when such deaths could have been prevented.

### GOVERNMENT ORDERED TO PROVIDE ARV TREATMENT TO PRISONERS

Westville Correctional Centre is situated in Durban, KwaZulu-Natal, one of the regions worst affected by the HIV/AIDS epidemic in the world. Many of the prisoners held at Westville have HIV or AIDS and more than 110 prisoners died of AIDS in 2005. Prisoners have untreated opportunistic diseases such as TB and thrush. Some of them cannot walk, wash or eat food by themselves.

Unfortunately the DCS did little to help and in late 2005, the AIDS Law Project and TAC began to assist inmates to access HIV/AIDS treatment. In early 2006, fifteen prisoners and TAC represented by the ALP took government, including the Departments of Health and Correctional Services, to court. On 26 June 2006, Judge Pillay of the Durban High Court ordered the government to:

*“remove the restrictions that prevent... the applicants and all other similarly situated prisoners at Westville Correctional Centre, who meet the criteria as set out in the National Department of Health’s Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, from accessing anti-retroviral treatment at an accredited public health facility... and that [government] is ordered with immediate effect to provide anti-retroviral treatment to the applicants and all other prisoners at Westville... at an accredited public health facility”.*

The state appealed this judgment first on the grounds that the judge should have recused himself because his daughter was a correspondent attorney in the case, and then on the grounds that they were already doing enough for inmates with HIV. The Judge granted them leave to appeal but ordered that they must immediately begin the treatment for those prisoners who needed it, and that government must produce a plan for the court about how they would do this. The deadline for this order was 14 August. Government refused to produce a plan and disobeyed a direct order from the court. Instead they again appealed.

During this time, one of the applicants, known as “MM”, died of an AIDS-related illness.

The government was subsequently ordered to produce their plan on 8 September 2006. They did so, and the applicants filed a responding document which commented on the plan. As at October 2006, the matter was still pending before the Court. The Court may hear argument on the reasonableness of the plan and whether the government should provide any further information.

## COMPLAINTS

The Act permits prisoners to make complaints or requests to the Head of the Prison and, if not happy with the response, to the Area Manager. In addition, it provides for several other complaint mechanisms:

- The Judicial Inspectorate of Prisons, an independent office under the control of the Inspecting Judge, must facilitate the inspection of prisons in order to report on the treatment of prisoners and prison conditions and deal with any complaints about prisons.
- Independent Prison Visitors (IPVs) are appointed by the Inspecting Judge for each prison and must conduct regular prison visits, interview prisoners, record complaints in an official diary and discuss complaints with the Head of the Prison with a view to resolve it.
- The Visitors’ Committee is established by the Inspecting Judge and consists of the IPVs of the prisons in a particular area. The Committee considers unresolved complaints and organise visits to prisons.

Prisoners can therefore refer complaints to the Independent Prison Visitor, who is required to report all unresolved complaints to the Visitors’ Committee. If there is no committee or the case is urgent, the report must be to the Inspecting Judge of Prisons.

## 9.6 Children

There are nearly 20 million children in South Africa.

Children are one of the most vulnerable groups in society – their age and comparative lack of maturity make it difficult for them to influence and participate in decisions about their lives. They must rely on adults to protect and promote their rights and assist them when their rights have been violated.

Health and access to health care services are major challenges for children. According to UNICEF of every 100 children in the world who were born in 2000:

- 30 are likely to be malnourished in their first five years of life.
- 26 will not be immunised against basic childhood illnesses.
- 19 will lack access to safe drinking water.
- 40 will lack access to proper sanitation.
- 17 will never go to school.

The state of children in South Africa is no different. Here an estimated 14 million children live in poverty and extremely difficult circumstances that threaten their survival, undermine their development and prevent meaningful participation in society.

In addition, the HIV epidemic has a dramatic impact on the lives and health of children. In 2005, according to the HSRC:

- 3.2% of males and 3.5% of females between the ages of two and 14 have HIV.
- This figure increases dramatically for females in the 15-19 age group to 9.4%, while the figure for males in this age group remains constant.

The high levels of HIV amongst children raise concerns about the increasing numbers of children who will be living with a chronic illness, and thus need ongoing care and support from an already overburdened public health system.

Also significant, particularly in a discussion on health law and policy, is the fact that South African children experience very high levels of violence. In 2000, about 72 000 crimes against children were reported, with common and aggravated assault being the most common crimes. Rape is the second most common crime against children, with children with disabilities being particularly vulnerable to sexual abuse and rape.

Children who are victims of sexual abuse and exploitation are at higher risk of contracting HIV and other sexually transmitted infections (STIs).

In view of this, internationally there has been a growing focus on child health. For example, the Millennium Development Goals, which were adopted by the UN, include:

- Reducing child mortality by two-thirds among children below the age of five by 2015.
- Stopping and beginning to reverse the spread of HIV, malaria and other major diseases.

In a similar vein, following the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2002, the Government committed itself to creating "a world fit for children" and adopted these Millennium Development Goals:

- Reducing infant and under-five mortality rates by one-third by 2010 and two-thirds by 2015.
- Reducing child malnutrition among children under the age of five by at least one-third by 2010, with special attention to children below the age of two.
- Reducing the proportion of infants infected with HIV by 20% by 2005 and by 50% by 2010.
- Ensuring that the reduction of maternal and natal disease and mortality is a health sector priority.
- Reducing child injuries due to accidents or other causes.
- Developing policies and programmes aimed at children to prevent substance abuse, and for the reduction of violence and suicide.
- Protecting children from all forms of violence, abuse, neglect and exploitation.

Below we examine key legal and rights issues related to providing health care services to children. We set out the steps taken by government to realise the right of children to "basic health care and social services", and examine some of the challenges that must still be resolved.

## The legal framework

### International obligations

Section 39(2) of the Constitution says that international law must be considered when the Constitution is being interpreted by a court, tribunal or forum. The most important international convention dealing directly with children's right to health is the *Convention on the Rights of the Child* (CRC). Other relevant declarations include:

- *The African Charter on the Rights and Welfare of the Child.*
- *The Universal Declaration of Human Rights.*
- *The International Covenant on Economic, Social and Cultural Rights.*
- *The African Charter on Human and Peoples' Rights.*
- *The Convention on the Elimination of All Forms of Discrimination Against Women.*

For more information on international law and health rights, see Chapter 5.

### Convention on the Rights of the Child (CRC)

In June 1995, the CRC was the first international instrument to be ratified by the post-*apartheid* Government. The government therefore has a duty to ensure that all its laws, policies and programmes are consistent with the provisions of the CRC.

Several CRC provisions relate directly to health:

- Article 23 deals with the rights of children with disabilities, and includes their rights to effective access to “education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities”. Where possible, these services should be provided free of charge.
- Article 24 recognises “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. The state must ensure that no child is deprived of access to health care services.

Other rights indirectly impact on the health of children, such as the rights to:

- Equality (article 2).
- Life (article 6).
- Be protected from performing any work that is hazardous (article 32).
- Be protected from sexual abuse and exploitation (article 34).
- Not to be subjected to torture or other cruel, inhuman or degrading punishment (article 37).

Each country that accepts the CRC, including South Africa, must submit an initial country report on progress in implementing the CRC. This must be done two years after ratifying the CRC, and again every five years, to the Committee on the Rights of the Child.

This Committee monitors the implementation of the CRC. It also makes recommendations on further steps to be taken in the form of “concluding observations” and issues its interpretations of human rights as “general comments”.

#### Examples: General comments

- “HIV/AIDS and the rights of the child”, *General Comment 3 (2003)*.  
In this comment, the Committee emphasised the vulnerability of children to HIV infection and advocated a holistic child rights-based approach as the most appropriate mechanism for protecting children.
- “Adolescent health and development in the context of the Convention on the Rights of the Child”, *General Comment 4 (2003)*. In this comment the Committee:

- ▶ Expressed concerns about the failure of states that have ratified the CRC to give sufficient attention “to the specific concerns of adolescents as rights holders and to promoting their health and development” (paragraph 3).
- ▶ Expressly said that “state parties must take all appropriate legislative, administrative and other measures for the realisation and monitoring of the rights of adolescents to health and development...” (paragraph 39).
- ▶ Identified a range of measures and strategies that state parties should adopt to ensure that they meet their duties to adolescents.

#### THE SOUTH AFRICAN CONSTITUTION

Section 28 of the Constitution provides children with an unqualified right to basic shelter, basic health services, nutrition and social services. However, almost all aspects of life can impact on a child’s health and therefore it is worth quoting the section in full. It says:

#### “28 CHILDREN

1. Every child has the right –
  - a) to a name and a nationality from birth;
  - b) to family care or parental care, or to appropriate alternative care when removed from the family environment;
  - c) to basic nutrition, shelter, basic health care services and social services;
  - d) to be protected from maltreatment, neglect, abuse or degradation;
  - e) to be protected from exploitative labour practices;
  - f) not to be required to or permitted to work or provide services that –
    - (i) are inappropriate for a person of that child’s age; or
    - (ii) place at risk the child’s well-being, education, physical or mental health or spiritual, moral or social development;
  - g) not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time and has the right to be –
    - (i) kept separately from detained persons over the age of 18 years; and
    - (ii) treated in a manner, and kept in conditions that take account of the child’s age.
  - h) to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and
  - i) not to be used directly in armed conflict, and to be protected in times of armed conflict.
2. A child’s best interests are of paramount importance in every matter concerning the child.
3. In this section, ‘child’ means a person under the age of 18 years.”

Children also have the rights set out in sections 26 and 27 of the Constitution, including the right of access to housing, health care services, food, water and social security. However, unlike section 28, these sections are qualified by saying that the state must take “reasonable legislative and other measures within its available resources” to achieve their progressive realisation. For a discussion on the qualification of rights in the Bill of Rights, see Chapter 2.

### Children’s rights to health care services

All children have the right to basic health care services. However, the Constitution does not define what “basic” health care services mean. Several pieces of new legislation, including the National Health Act 61 of 2003 and the Children’s Act 38 of 2005, have also not used the opportunity to include a definition of *basic health services*. The concept is also not defined in any government policy.

Because the law does not define what “basic” health care services are, policy-makers, law-makers and service providers are often not clear about what health services should be provided to adults and children to meet this constitutional standard.

The problem is further confounded by the fact that children’s health rights are scattered throughout a number of different pieces of legislation, leading to fragmentation and gaps, both in policy formulation and service delivery. Government has not taken the opportunity to ensure a comprehensive and holistic approach to children’s health through the National Health Act or the Children’s Act.

### Who has the primary responsibility to care for children?

The Constitutional Court decided in *Government of the Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC) (the Grootboom case) that parents, and not the state, had the primary responsibility to care for their children in the context of providing shelter and other “care entitlements” that are set out in section 28.

But in *Minister of Health and others v The Treatment Action Campaign and others* (No 2) 2002 (5) SA 721 (CC) (the TAC case), the Constitutional Court explained further:

- While the main duty to provide for the basic needs of children rests with their parents, “this does not mean... that the state incurs no obligation in relation to children who are being cared for by their parents or families”.
- The rights set out in section 28 would include situations where children were in the care of their families, who were unable to provide for them. In the context of medical care, these children included those born to poor mothers, who gave birth in public hospitals and clinics where nevirapine (an anti-retroviral medicine that reduces the risk of mother to child HIV transmission) was not being provided.
- These children were therefore dependent on the state to make the basic health services, including the provision of nevirapine, available. The state had a duty to fulfil this obligation.

For a fuller discussion of the *Grootboom* case and the *TAC* case, see Chapter 2.

### The best interests of the child

The “best interests of the child” standard is set out in the Constitution and other laws relating to children. This standard is also recognised in international law as the test to be used in all decisions affecting children.

While the Children’s Act now sets out criteria to be considered when applying the test, courts have tended to apply the test on a case-by-case basis. They have recognised that the standard “should be flexible as individual circumstances will determine which factors secure the best interests of a particular child”.

Source: *Minister of Welfare and Population Development v Fitzpatrick* 2000 (3) SA 422 (CC)

#### CHILDREN’S ACT: FACTORS TO CONSIDER IN DECIDING THE BEST INTERESTS OF A CHILD

- 7. (1)** “Whenever a provision of this Act requires the best interest of the child standard to be applied, the following factors must be taken into consideration where relevant:
- a) The nature of the personal relationship between—
    - (i) the child and the parents, or any specific parent; and
    - (ii) the child and any other care-giver or person relevant in those circumstances;

- b) the attitude of the parents, or any specific parent, towards—
    - (i) the child; and
    - (ii) the exercise of parental responsibilities or rights in respect of the child;
  - c) the capacity of the parents, or any specific parent, or of any other care-giver or person, to provide for the needs of the child, including emotional and intellectual needs;
  - d) the likely effect on the child of any change in the child's circumstances, including the likely effect on the child of any separation from—
    - (i) both or either of the parents; or
    - (ii) any brother or sister or other child, or any other care-giver or person, with whom the child has been living;
  - e) the practical difficulty and expense of a child having contact with the parents, or any specific parent, and whether that difficulty or expense will substantially affect the child's right to maintain personal relations and direct contact with the parents, or any specific parent, on a regular basis;
  - f) the need for the child
    - (i) to remain in the care of his or her parent, family and extended family; and
    - (ii) to maintain a connection with his or her family, extended family, tribe, culture or tradition;
  - g) the child's —
    - (i) age, maturity and stage of development;
    - (ii) gender; and
    - (iii) background and any other relevant characteristics of the child;
  - h) the child's physical and emotional security and his or her intellectual, emotional, social and cultural development;
  - i) the need for a child to be brought up within a stable family environment and, where this is not possible, in an environment resembling as closely as possible a caring family environment;
  - j) the need to protect the child from any physical or psychological harm that may be caused by
    - (i) subjecting the child to maltreatment, abuse, neglect, exploitation or degradation or exposing the child to violence or exploitation or other harmful behaviour; or
    - (ii) exposing the child to maltreatment, abuse, degradation, ill-treatment, violence or harmful behaviour towards another person;
  - k) any family violence involving the child or a family member of the child; and
  - l) which action or decision would avoid or minimise further legal or administrative proceedings in relation to the child.
- (2) In this section 'parent' includes any person who has parental responsibilities and rights in respect of a child."

This section of the Act seems to focus more on issues of custody and access, thus limiting its ambit. Other areas that may be relevant to a child's best interests include the issue of access to medical treatment or surgery.

### The National Health Act

The National Health Act (NHA) refers to the constitutional right to health care for children and other vulnerable groups in section 1 of the Act.

It also gives legal force to the government policy on providing free health care services to children under the age of six. Section 4 states that "the state and clinics and community health centres funded by the state" must provide free health services to children below the age of six who are not "members or beneficiaries" of medical aid schemes.

However, the NHA makes the provision of free health care to young children over six dependent on the discretion of the Minister of Health. It says this decision must be taken in consultation with the Minister of Finance and must take into account a number of factors, including:

- The range of free health services currently available.
- The categories of persons already receiving free health services.
- The impact of any such condition (in this case being a child) on access to health services.
- The needs of vulnerable groups such as women, children, older persons and persons with disabilities.

It is arguable that the inclusion of this section about the Minister's discretion means that the right of young children of six and older to free health care is not adequately safeguarded.

The definition of *health services* in the NHA says it includes "basic nutrition and basic health care services contemplated in section 28(1)(c) of the Constitution". This reference to 'health services' rather than 'primary health services' implies that *all* services, not just primary or basic health care services, must be provided free of charge to children under 6.

One of the key criticisms of the NHA is that it does not recognise children as a special group with specific needs. As a result, the Act contains very little that addresses the needs of children specifically.

## The Children's Act

### Key Point: Children's Act and Child Care Act

In January 2003 the South African Law Reform Commission presented a draft Children's Bill, intended to replace the Child Care Act, to the Department of Social Development. However, the department split the draft Bill into two separate Bills, so that national and provincial issues could be addressed separately. These became known as:

- the section 75 Bill – which dealt with Provincial issues
- the section 76 Bill – which dealt with national issues.

### KEY ASPECTS OF THE CHILDREN'S ACT THAT RELATE TO HEALTH

- The age of majority is now 18.
- The Bill has a special focus on children with disabilities and chronic illnesses (section 11).
- Virginity testing is prohibited for girls under the age of 16. For girls older than 16, strict regulations have to be followed (section 12.4-12.7).
- Female genital mutilation or circumcision is prohibited.
- Male circumcision of children under 16 is prohibited "except in accordance with the practices of the religion concerned and in the manner prescribed"; or "for medical reasons on the recommendation of a medical practitioner". (sections 12.3, 12.8-12.10).
- The act of forcing a child into marriage or engagement without their consent or below the minimum age for marriage, is now an offence (section 12.2).
- Trafficking of children has been made a criminal offence (section 284).
- Age for consent to medical treatment and HIV testing has been changed from 14 to 12 provided they are mature enough to understand the consequences of their decision (sections 129 and 130).
- Children of 12 or above may also access contraceptives without parental consent (section 134).

The Act now gives legal recognition to the role of care-givers in providing care and support to children whose parents or legally appointed guardians are absent. Importantly, *care-givers* are defined as people who are not necessarily parents, but who voluntarily care for children either permanently or temporarily. These care-givers have a legal obligation to safeguard the child's health, and well-being, including exercising:

*"any parental responsibilities and rights reasonably necessary... including the right to consent to any medical examination or treatment of the child if such consent cannot reasonably be obtained from the parent or primary care-giver of the child"* (section 32).

- Every child has the right to access information on health promotion, including sexuality and reproduction (section 13). This can promote the right to reproductive health care for adolescents, who often mention a lack of accessible information and fears about confidentiality as reasons for not finding the care they need. In the context of the HIV/AIDS epidemic, this is a key issue for sexually active youth.

In June 2006 President Mbeki signed the section 76 Bill. It is now known as the Children's Act 38 of 2005. However, this Act will take effect only on a future date to be fixed by the President by proclamation in the *Government Gazette*. Therefore, the Children's Amendment Bill (discussed below) must first be passed by Parliament, whereafter the Children's Act and the Amendment Bill will become a single comprehensive Act. This means that the Children's Act is not yet ready for implementation and the Child Care Act 74 of 1983 is still in operation.

For more information on how legislation is passed, see Chapter 4.

We now consider some of these key features of the Children's Act in more detail.

### **Age and access to health care**

The various inconsistencies in the law around the legal age when children are allowed to act, particularly around access to health care services, appear to have been resolved in the Children's Act. Before this legislation, the age of majority was 21, while various other Acts specified different ages after which children could make autonomous decisions.

The Children's Act will address these problems by incorporating all the differing age considerations into a single Act.

### **Age of consent to medical treatment**

The Children's Act lowers the age of consent to medical treatment to 12, provided that the child has the maturity to understand the "benefits, risks, social and other implications" of the treatment and surgery. This includes consenting to HIV testing and surgery.

A medical superintendent is still allowed to consent in urgent cases and the High Court still keeps its status as the 'upper guardian of all children'. The provisions on care-givers and consent should ensure that appropriate consent can be obtained in good time, either from the child or from an accessible adult.

### HIV testing

The Act exemplifies a rights-based approach to HIV testing of children. It requires that:

- All HIV testing must be conducted in the best interests of the child and with *informed consent*.
- An “appropriately trained person” must give *pre-test counselling* and *post-test counselling*.
- A range of stakeholders, including the child, their parents, legal guardians and designated child protection agencies, are authorised to consent to HIV testing.
- Children have a right to confidentiality. Disclosure is only allowed with the informed consent of the child or in certain specified circumstances.

There is one exception to the requirement that HIV testing must be conducted in the best interests of the child and with informed consent. Health care workers, who may have risked contracting HIV as a result of contact with the bodily fluids of a child in the course of a medical procedure, may have the child tested without consent if the test is necessary to establish the child’s HIV status.

### Access to contraception

Children who are 12 or older may buy condoms and have access to free condoms. The Children’s Act says that no person may refuse to sell or distribute condoms to children of 12 or older.

Children of 12 or older may access other forms of contraceptives without the permission of their parents or care-givers, provided that:

- they have received proper medical information; and
- they have had a medical examination to ensure that there are no medical reasons why the child should not receive a specific contraceptive.

This provision is inconsistent with the other provisions relating to the age of consent in the Act, because it does not require an assessment of the maturity of the child before the child receives contraception.

### Confidentiality

The Children’s Act also protects the right of the child to confidentiality when getting access to contraceptives and advice about contraception. However, there is a legal duty to inform the authorities, including the South African Police Services (SAPS), if there is a suspicion of abuse, sexual abuse or deliberate neglect.

There is a similar provision for any terminations of pregnancy performed under the *Choice on Termination of Pregnancy Act*. Any health care worker who performs a termination on a child must report this to a designated child protection agency, the SAPS or the clerk of any Children's Court, if they believe that the pregnancy may be as a result of sexual abuse.

The inclusion of a statutory right to confidentiality on access to contraceptives and termination of pregnancy is important to adolescents, particularly young women who bear the burden of unwanted teenage pregnancies. In public hearings by the Joint Committee on the Improvement of the Quality of Life and Status of Women on the Choice on Termination of Pregnancy Act, many teenagers talked about the attitude of health care workers. They said that worries about confidentiality were a barrier to accessing any service relating to their reproductive health. The newly entrenched rights may encourage them to seek information and health services relating to their reproductive health.

### **The Children's Amendment Bill (the 'section 75 Bill')**

The Amendment Bill addresses those public services whose administration the Constitution stipulates fall under provincial and local government, in this instance child care facilities. The Bill requires that any institution providing these services must be registered.

The Bill further provides a mechanism for the reporting of children in need of care and protection (section 105). The Bill identifies a range of people, including teachers, those in the health professions, religious leaders and staff at partial care facilities who have the responsibility of reporting cases where the abuse of children is suspected.

### **CHILD-HEADED HOUSEHOLDS**

In 2005 a report by the Human Sciences Research Council showed the prevalence of children who are orphans to be 14.4% with 2.6% being maternal orphans, 10% paternal orphans and 2% double orphans. Overall it was estimated that there were 2 531 810 orphans in South Africa.

Among children aged between 2-18, 2.6% identified themselves as heading households, making up a total of 180 433 child-headed households. Among those orphaned, 2.8% were heads of their households.

Child-headed households face many challenges, particularly around health, including:

- Difficulty in getting food, shelter, access to health care treatment and social security.
- A higher risk of being sexually abused by neighbours and relatives.
- Vulnerability to child prostitution and child labour.

In this regard it is important that section 136 of the Bill recognises the existence of child-headed households, defining them as households where:

- The parent or primary care-giver of the household is terminally ill or has died.
- No adult family member is available to provide care for the children in the household.
- A child has assumed the role of primary care-giver for a child or children in the household.

The Bill says that the provincial head of social development will recognise such a household, but it must function under the general supervision of an adult designated by a Children's Court, an organ of state or an NGO. The function of these adults will be to collect and administer any social security or other grant to which the household is entitled, and may place the household in a cluster foster-care scheme. However, the child heading the household will take all day-to-day decisions relating to the household and the children in it.

### What has the government done to give effect to children's right to health care?

The Department of Health (DoH) has a directorate responsible for children's health. The Maternal, Child and Women's Health and Nutrition sub-directorate is part of the Health Programme cluster and includes a sub-directorate of Child and Youth Health.

One of the first interventions targeting child health was made in 1994, when President Mandela introduced a policy that provided free health care to pregnant women and children under the age of six. Since then, the Government has developed a wide-ranging set of policies and programmes that target young children in particular and attempt to address their health needs. Some of these are described below. However, as with many aspects of health care the implementation of these policies has been poor.

### A primary health care approach

Child health is a key component in the primary health care (PHC) package of services, and includes preventative, curative and rehabilitative services.

According to government policy PHC clinics must:

- Provide services to children in accordance with the Integrated Management of Childhood Illnesses protocols whenever the clinic is open. This is the key national strategy for reducing morbidity and mortality from common childhood illnesses that affect children under the age of five years.
- Provide immunisation services at all times. The Expanded Programme of Immunisation (EPI) aims to decrease childhood morbidity and mortality from vaccine-preventable diseases.
- Monitor growth and provide advice and education on nutrition. The Integrated Nutrition Programme gives special attention to children under two and pregnant women.

But although the PHC package of services deals with adolescents, it is less comprehensive than the services offered to younger children.

In 2002 the DoH launched a policy on youth and adolescent health. The policy addresses sexual and reproductive health, mental health, substance abuse, violence, injuries, birth defects and inherited disorders, nutrition and oral health. But, as with many other policies, its implementation has been poor.

### National Programme of Action for Children

In April 1996, Cabinet approved the National Programme of Action (NPA) for Children - this followed the Government's ratification of the CRC in June 1995.

The NPA included a section on health services and committed government to achieving certain targets, including:

- Eradicating polio by 1998. In October 2006, the world polio virus certification body declared SA polio free.
- Reducing measles cases.
- Expanding the programme of immunisation of young children.
- Reducing maternal mortality and deaths of children below five owing to diarrhoea.

The NPA also included a range of strategies that were to be adopted to achieve these targets. But whilst progress has been made to meet some of the targets identified in the NPA, such as expanding immunisation, the HIV epidemic has had a negative impact on the health of both children and mothers.

Although the DoH has developed a range of child-specific policies and programmes, it has not still not determined the content of a basic package of health services for children. In addition, the focus of the DoH has been biased in favour of younger children, with the health needs of older children and adolescents receiving less attention.

Although the Constitution says that everyone has a right “to make decisions concerning reproduction” there remains a lack of dedicated health services available to adolescents, particularly around reproductive health care. This is despite our knowledge of high rates of teenage pregnancy and HIV infection among women and girls, and low rates of knowledge about sexual and reproductive health. For example, pregnant adolescents are treated as adults by the public health system, and are unable to access services that specifically deal with their needs.

### 9.7 Conclusion: Some specific challenges

- Despite the availability of services, many parents and care-givers are unable to access them because of problems of transport or cost. Others have to queue for hours to make appointments to see paediatricians and other child specialists.
- A lack of information and education may lead to parents accessing available services very late.
- Research conducted by the Children’s Institute reports that children who are not accompanied by a parent or adult care-giver are often unable to access services from public facilities. This has particularly severe consequences for children living in child-headed households.
- There is also a lack of appropriate services for vulnerable groups of children, such as children with disabilities who require specialised services. Although the Children’s Act addresses children with disabilities specifically and the DoH has taken steps to identify the key issues for these children, there are still serious gaps in both policy and service delivery.

Key Points: What needs to be done?

- Parents and care-givers must be adequately supported to enable them to care for children with disabilities.
- Health services and workers must be sensitive to issues around communication for children with disabilities, as many are unable to communicate with health care workers.
- Sign language and Braille must be made more widely available.
- Health facilities that offer antenatal care should ensure that youth-specific services during pregnancy are available to young women.