

Age or maturity? African children's right to participate in medical decision-making processes

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Summary: *This article advocates an approach to children's participation in medical decision-making processes guided by the rationality of the best interests' principle, a child's evolving capacity and a child's age. Using a human rights-based approach, rooted in the UN Convention on the Rights of the Child and the African Children's Charter, it seeks to elucidate the contested three-way partnership between the child, its parent(s) and the assigned physician(s), which plays out in relation to most medical procedures involving children. In analysing legislation and case law, the article further aims to clarify the complex relationship between age and maturity in child participation; to facilitate a child's involvement in the three-way partnership; and to suggest the statutory recognition of an age indicator in domestic African law in relation to medical procedures.*

Keywords: *children's autonomy; children's right to participate; medical decision-making process; child's evolving capacity; best interests of the child; age and maturity*

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1 Introduction

The right to participate was first presented as a legally-binding right in article 25 of the International Covenant on Civil and Political Rights (ICCPR)¹ to secure (adult) citizens' participation in the politics of a member state.² Conventionally, this right was not fashioned for the benefit of children.³ However, after the adoption of the United Nations (UN) Convention on the Rights of the Child (CRC)⁴ and the African Charter on the Rights and Welfare of the Child (African Children's Charter),⁵ it is broadly accepted that children also have a right to participate, albeit in different contexts. The analysis in this article specifically focuses on the position of children and their ability to meaningfully participate in medical decision-making processes involving them.

For African children, the right to participate is contained both in article 12 of CRC and in articles 4(2) and 7 of the African Children's Charter.⁶ As indicated above, children's right to participate differs from adult participation. A child's right to participate under international human rights law may be distinguished from (adult) citizens' participation under, for example, article 25 of ICCPR, in that article 12 of CRC and articles 4(2) and 7 of the African Children's Charter do not guarantee a specific outcome such as, for example, casting a vote, or the free expression of political opinion. Despite the fact that international human rights law and medical practice encourage patients' involvement in medical decision-making processes, children often are not involved. This is so because decisions of parents and/or physicians, often argued to be based on the best interests of the child, make the opinion of the child redundant.⁷

To prevent the exclusion of the child in this regard, this article adopts a human rights-based approach to children's participation in medical decision-making processes, rooted in CRC and the African

1 Adopted 16 December 1966, entered into force 23 March 1976, 999 UNTS 171.

2 Other examples include arts 21 and 27 of the Universal Declaration of Human Rights 1948; art 13 of the African Charter on Human and Peoples' Rights 1981; and art 9 of the African Women's Protocol.

3 G van Bueren *The international law on the rights of the child* (1998) 131.

4 Adopted 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3.

5 Adopted 11 July 1990, entered into force 29 November 1999, CAB/LEG/24.9/49 (1990).

6 L Ehlers & C Frank 'Child participation in African context' in J Sloth-Nielsen (ed) *Children's rights in Africa: A legal perspective* (2008) 116-122.

7 W Wadlington 'Medical decision making for and by children: Tensions between parent, state, and Child' (1994) 2 *University of Illinois Law Review* 311.

Children's Charter.⁸ Under international children's law, a child's right to participate crucially demands the recognition, respect and meaningful engagement of children during decision-making processes relating to all matters concerning them, both in private and in public. Furthermore, children's right to participate stresses the role of adults in enabling such participation. For instance, adults, especially those with the legal responsibility to care for a child, have an underlying mandate to continuously assess a child's evolving capacity based on the child's age, maturity and ability to contribute substantively in a decision-making process. The importance of this responsibility relates to the fact that the right to participation, unlike any other right, requires a child to be meaningfully engaged in a decision-making process. It is the meaningful engagement (or lack thereof), enabled by the relevant adult(s), which constitutes the enjoyment or abjuration of this right.

Against this background the objective of the article is to argue the need in domestic African law to incorporate a specific age indicator to protect children's right to participate in a medical decision-making process. The method of the article is to examine the three-way partnership between the child, its parent(s) and the assigned physician(s), to explain why it is important to identify an age indicator against which a child's general level of maturity can be measured under domestic law. This contribution further highlights the composition of the three-way partnership and how African states have defined and applied age in relation to legislation to ascertain the level of a child's maturity and ability to participate in a medical decision-making process. This objective and further discussion should be viewed from the perspective that the article ultimately suggests that the African human rights system, specifically the African Committee of Experts on the Rights and Welfare of the Child (African Children's Committee), should adopt an age indicator that will further guide all African jurisdictions to properly implement child participation in a medical decision-making process.

The article is divided into five parts. These include the introduction; the nexus between the best interests of the child and a child's right to participate in a medical decision-making process; an analysis of the power imbalance relating to the three-way partnership in a child's medical decision-making process; an in-depth discussion around the

8 According to the Office of the High Commissioner for Human Rights, a human rights-based research approach must be guided by a systematic understanding of the context and the challenges that contribute to a human rights problem. See United Nations Human Rights Office of the High Commissioner (OHCHR) *Manual on human rights monitoring*, <https://www.ohchr.org/Documents/Publications/Chapter08-44pp.pdf> (accessed 8 June 2020).

interlinked caveats of age and maturity identified under international children's law as crucial to children's right to participate; and the conclusion.

2 Nexus between the best interests of the child and child participation

In most cases a medical decision-making process, which concerns a child, requires a three-way partnership, involving the child, its parent(s) and the assigned physician(s). Notwithstanding the fact that children's participation is essential for the fulfilment of all children's rights, as mentioned above, it is important to recognise its practical implications, especially in the context of a medical decision-making process. This right could, for example, assign children with the daunting task of making sense of a complex medical procedure involving the child.

For obvious reasons the three-way partnership usually evokes negotiation, compromise and the unwavering necessity to protect the best interests of the child. However, as is further discussed in part 3, parents and physicians involved in this partnership have (clear) mandates, while in most cases, and especially during severe and life-threatening episodes in a child's life, the role or mandate of the child is ill-defined and sometimes non-existent.

The best interests of the child and child participation are two of four⁹ key aspects of international children's law identified as guiding principles in children's rights jurisprudence.¹⁰ A proper definition and method of application of these principles is not clearly provided under international children's law.¹¹ However, according to the United Nations Children's Fund (UNICEF), these principles 'form nothing less than a new attitude toward children [as] they give an ethical and ideological dimension to the convention'.¹² According

9 The four general principles also include non-discrimination(equality) and survival and development.

10 See, eg, T Morag 'The principles of the UN Convention on the Rights of the Child and their influence on Israeli law' (2014) 22 *Michigan State International Law Review* 531.

11 L Lundy & B Byrne 'The four general principles of the United Nations Convention on the Rights of the Child: The potential value of the approach in other areas of human rights law' in E Brems et al (eds) *Children's rights law in the global human rights landscape* (2017) 52.

12 See <https://www.unicef.org/armenia/en/stories/four-principles-convention-rights-child> (accessed 8 June 2020).

to the CRC Committee, to underpin the protection of a particular child's right a combination of these principles is possible.¹³

Relating to child participation, the CRC Committee further provides that the best interests principle fortifies the functionality of a child's right to participate.¹⁴ This means that the decision, or lack thereof, to involve a child in a medical decision-making process must be motivated by the best interests of the child concerned.¹⁵ Rodriguez argues that even though the best interests principle is inherently dependent on the specific situation of a particular child, the principle is ideologically unclear on a method of application.¹⁶ For instance, as discussed in part 3, there hardly is uniform agreement on who, in the three-way partnership, is to make the final decision to include or exclude a child from a medical decision-making process. Here, the CRC Committee argues that to determine what is in the best interests of the child, one should start with the assessment of the child's evolving capacity.¹⁷ As argued in parts 3 and 4, the evolving capacity of a child usually matures with age.¹⁸ Indeed, while it is generally accepted that physicians should lead in relation to medical questions, it is uncertain as to whether they are better placed to permit child participation in relation to, for instance; abortion, contraception or sterilisation which may also involve moral, ethical and religious considerations. In *Gillick v West Norfolk*,¹⁹ Lord Fraser states that parental rights exist for the benefit of the child and the child's best interests requires the physician to advise or to treat the child-patient. In *Christian Lawyers Association v Minister of Health*²⁰ it was equally established that, in relation to the termination of pregnancy, the best interests of the pregnant girl allows for a flexible criterion for capacity to consent irrespective of the opinion of the girl's parents.²¹ Based on the best interests principle, both cases arguably advocate an approach which first and foremost supports child participation in the three-way partnership. This is because the

13 CRC Committee General Comment 12 CRC/C/GC/12 (2009), <https://digital.library.un.org/record/671444?ln=en> (accessed 10 June 2020).

14 CRC Committee (n 13) paras 70-74.

15 D Archard & M Skivenes 'Balancing a child's best interests and a child's views' (2009) 17 *International Journal of Children's Rights* 1.

16 NG Rodriguez 'Translating "best interest": Child welfare decisions at the US-Mexico border' (2016) 39 *Political and Legal Anthropology Review* 154. See also A Skelton 'Too much of a good thing: Best interests of the child in South African jurisprudence' (2019) 52 *De Jure* 559-561.

17 CRC Committee General Comment 14 CRC/C/GC/14 (2013), <https://www.refworld.org/docid/51a84b5e4.html> para 44 (accessed 26 June 2020).

18 S Varadan 'The principle of evolving capacities under the UN Convention on the Rights of the Child' (2019) 27 306.

19 *Gillick v West Norfolk and Wisbech Area Health Authority & Another (Gillick)* [1986] 1 AC 112, [1985] 3 All ER 402, [1985] 3 WLR 830.

20 *Christian Lawyers Association v Minister of Health* 2005 (1) SA 509 (T) (*Christian Lawyers*).

21 *Christian Lawyers* (n 20) 516D.

best interests of a child principle recognises a child as a reciprocal partner in the partnership and validates the child's autonomy.²²

3 Power imbalances in the three-way partnership

According to Kennedy, the imbalance of power in medical decision-making processes is primarily due to the fact that physicians often hold information and a skill-set which the child-patient and parents do not possess.²³ Regarding parents, parental control and authority mixed with an emotional and psychological connection to the child sometimes exaggerates a protectionist approach to a child's involvement in the partnership.²⁴ Nonetheless, parents have an unequivocal right to be involved in this partnership, first and foremost as it falls under their responsibility as primary caregivers.²⁵ For instance, under article 18 of CRC and article 20(1) of the African Children's Charter, parents have the primary responsibility for the upbringing and development of the child. Correspondingly, as primary caregivers, parents often hold critical health-related information about the child that may not be known to the physician. Thus, parents cannot, and should not, be excluded from this partnership as their role is crucial to the well-being of the child. Based on the legal recognition of parents as the primary caregivers and the strategic skill-set of physicians, it seems that the challenge of balancing powers within this partnership has less to do with the child-patient and more to do with parents and physicians.²⁶ In most African countries national legislations have defined the parental role and related responsibilities in the three-way partnership. For instance, in Uganda sections 5 and 6 of the Children's Act²⁷ confer on every parent or guardian the responsibility to care for their child and to ensure the child's well-being. In Ethiopia, article 20(3) of the Civil Code confers²⁸ on the guardian the power to submit a child

22 A Ford 'Do children have the right to contribute to medical decisions about their own care? An analysis of policy and practice in the United Kingdom and the United States' (2017) *Health and Human Rights Journal*, <https://www.hhrjournal.org/2017/08/do-children-have-the-right-to-contribute-to-medical-decisions-about-their-own-care-an-analysis-of-policy-and-practice-in-the-united-kingdom-and-united-states/> (accessed 13 June 2020).

23 I Kennedy *Treat me right: Essays in medical law and ethics* (1988) 387.

24 See, eg, on parents' motivations for the participation of their children in medical research, A Dar 'Decision-making about child participation in medical research: A relational approach' (2015) 27 *Child and Family Law Quarterly* 109.

25 D Archard *Children: Rights and childhood* (1993) 130.

26 C Himonga & A Cooke 'A child's autonomy with special reference to reproductive medical decision-making in South African law: Mere illusion or real autonomy' (2007) 15 *International Journal of Children's Rights* 323. See also RJ McDougall et al 'Overriding parents' medical decisions for their children: A systematic review of normative literature' (2013) 40 *Journal of Medical Ethics* 448.

27 Children Act, Cap 59 (amended) of 2016.

28 Civil Code Proclamation 165/1960.

to a medical examination or treatment, beneficial to their health. Similarly, articles 257(1) and (2) of the Revised Family Code of Ethiopia²⁹ provides that the guardian shall watch over the health of the minor and shall take the necessary measures for the recovery of the minor in case of sickness.

In other African countries, such as Tanzania, parents have a shared responsibility to take care and ensure the protection of a child through the provision of medical care.³⁰ In Egypt, parental involvement is recognised especially in cases of organ transplants. Section 116 of its Child Law³¹ warns that anyone who fails to recognise parental consent, especially with regard to organ transplants, shall be punished by imprisonment.³² In Nigeria, section 39(c)(i) of the Code of Medical Ethics provides an interesting twist both to parental involvement and the role of a child in the three-way partnership. It provides, *inter alia*, that children aged between 16 and 18

have a statutory right of their own to consent to procedures and this takes precedence over parental objections, but does not invalidate the right of others to consent on their behalf. However, where the child of this age group objects and parental consent is obtained in an emergency situation, appropriate treatment or procedure can be given.³³

The Nigerian Code of Medical Ethics makes crucial a point: Where a child is able to substantively and logically participate and consent to a medical process, parental opinion can be overridden.³⁴ As is further analysed in part 4, the issue of age is vital to demarcate the role of the child in the three-way partnership. For example, in *Gillick*, Mrs Gillick's objection to the provision of contraceptives to her daughters, without her prior knowledge and consent, was overruled by the Court. Lord Fraser concluded that it would be 'verging on the absurd to suggest that a girl or boy aged fifteen could not effectively consent, for example to have a medical examination of some trivial injury to his [or her] body or even to have a broken arm set'.³⁵ He went on to conclude:³⁶

29 The Revised Family Code Proclamation 213/2000 (Revised Family Code).

30 See, generally, secs 8 & 16 of the Law of the Child Act 21 of 2009 consolidating all the laws relating to children.

31 Child Law 12 of 1996 (amended by Law 126) of 2008.

32 According to sec 116 of the Child Law (n 31) anyone who fails to recognise parental consent, especially in the case of an organ transplant, shall be punished by imprisonment.

33 The Code of Medical Ethics of 2004 of Nigeria.

34 See also L Krappmann 'The weight of the child's view (article 12 of the Convention on the Rights of the Child)' (2010) 18 *International Journal of Children's Rights* 502.

35 *Gillick* (n 19) 169.

36 *Gillick* 405.

The consent of the parents should normally be asked, but they may not be immediately available. Provided the patient, whether a boy or girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorise the medical man to make the examination or give the treatment which he wishes.

Therefore, parental opinion is prioritised and only set aside if it is not in the child's best interests. Consequently, as discussed further below, the rights of a child and their parents continue to require constant safeguarding and balancing. As stated above, the contestations that take place within the three-way partnership seldom is between the child and the physician, but rather between the parents and the physician, where parents may challenge the medical approach or dominate the child-patient for personal, cultural or religious reasons.³⁷

As mentioned in the introduction, unlike the roles of parents and physicians, a child's role in the partnership is further weakened by the fact that international children's law does not provide contents to the role of the child-patient in medical decision-making processes. For example, article 5 of CRC simply guarantees the exercise of the child's right, including the right to self-determination, according to their evolving capacity. In this regard it directs adults (in the three-way partnership: parents and physicians) to provide appropriate direction and guidance in the exercise of their rights in accordance with a child's evolving capacity. Therefore, besides the fact that it is the child's health and a child has an unequivocal right to participate in all matters concerning their health, international children's law is implicitly and explicitly silent on the actual role of child-patients in the three-way partnership.

The undermined position of the child-patient in this partnership is further exacerbated by the child's age and maturity. The scope of a child's right to participate under CRC and the African Children's Charter reflect these limitations. Consequently, it grants powers to states and parents to give due weight to a child's views, based on the child's age and maturity. Thus, where a child expresses an opinion, the substance of such an opinion should be vetted against the impact it may or may not have on the health or well-being of the child-patient. For example, in the CRC Committee's Concluding Observations on

37 JMT Labuschagne et al 'Parental rights to participate in a child's personality development and its religious and moral upbringing and the child's right to freedom of choice: Observations on the field of tension caused by the irrational in a human rights dispensation' (2004) 25 *Obiter* 41 48-51.

Liberia, the Committee expresses that it is 'concerned that as a result of prevailing traditional attitudes, children are often not consulted about decisions affecting them ... in the family'.³⁸ In this regard the CRC Committee recommends that Liberia strengthen its efforts to ensure that children have the right to express their views, 'in the family ... and [in] other institutions and bodies as well as in society at large'.³⁹

Technically, from the outset, adults' judgment of a child's competence is pre-conceived even before consultations begin.⁴⁰ Kruger affirms that children's presumed lack of developmental maturity makes them uniquely vulnerable in a medical decision-making process.⁴¹ However, a child's right to participate in a medical decision-making process tempers the powers given to parents and physicians under international children's law, as the latter do not, separately and/or jointly, have the legal authority over a child's health without acting with due diligence. According to Freeman, this due diligence should extend to respecting the scope of the best interests of the child and child participation, the roles of the parties in the three-way partnership and specifically the responsibilities of parents in a medical decision-making process.⁴² As discussed in part 2, parents have an unequivocal obligation to act in the best interests of a child at all times. However, the absence of demonstrated and consistent protection of the best interests of the child will bring parental involvement and their decision-making capacity into question.⁴³

Nevertheless, within international children's law, the demand of paramountcy of the best interests of a child remains unclear. In *De Reuck v Director of Public Prosecutions*, for instance, the South African Constitutional Court held that 'paramount consideration' in

38 CRC Committee Concluding Observations: Liberia, 1 July 2004, CRC/C/15/Add.236, <https://www.refworld.org/docid/42d28f214.html> para 28 (accessed 14 June 2020).

39 CRC Committee (n 38) para 29.

40 See, eg, research conducted in Ireland, I Coyne et al 'Giving children a voice: Investigation of children's experiences of participation in consultation and decision-making in Irish hospitals' (2006), http://www.dcy.gov.ie/documents/research/Giving_Children_a_Voice.pdf (accessed 2 May 2019).

41 H Kruger 'The protection of children's right to self-determination in South African law with specific reference to medical treatment and operations' 2018 (21) *Potchefstroom Electronic Law Journal* 2.

42 M Freeman 'Rethinking Gillick' (2005) 13 *International Journal of Children's Rights* 201.

43 See, eg, the decision in *P v M* (590/2014) [2017] ZACPEHC 14 (14 February 2017) decided in the High Court of South Africa (Eastern Cape Local Division, Port Elizabeth) where Chetty J granted sole custody of a child from a divorced marriage to the applicant because the respondent has a poor record of acting in the best interests of the child concerned.

section 28(2) of the South African Constitution of 1996⁴⁴ does not automatically mean that a child's best interests can never be limited by other rights.⁴⁵ Accordingly, the weight of the understanding and application of a child's best interests should be governed by a thorough, candid and contextual analysis. Eekelaar suggests that a thorough judgment of what is best for a child depends on a case-by-case analysis.⁴⁶ He warns that 'if the best solution to the issue in question is considered to have a detrimental effect on a child's interest, it may need to be modified or abandoned ... the focus remains finding what is best for the child'.⁴⁷

Therefore, even though international children's law insists on the importance of meaningfully involving children in medical decision-making processes, parents and physicians have the ultimate decision-making power to ascertain whether it is in the best interests of a child to be included or excluded from the process.⁴⁸ However, no parental or physician's right or responsibility will have any substance or meaning if the medical decision arrived at is not in the best interests of the child.⁴⁹ A child's welfare must be the ambit within which any decision relating to a child is made. A medical decision is a crucial process in a child's life, which could either ensure continuity of a child's development or possibly end it. Hence, even though the child-patient might not make any substantive contribution to the process, it is crucial that as a minimum, there is some form of conversation within the partnership to permeate some level of access to information that would lead to an informed consent by the child to a preferred medical procedure. However, the question remains as to whether an equal partnership in medical decision-making processes involving children is at all times feasible.

As briefly mentioned above, from the outset there is an existing imbalance in the power structure between the physician, parent(s) and the child-patient. From a practical perspective this imbalance is manifested through a child's physical and psychological vulnerability which also affects their ability to make choices that are more progressive than those of adults. In a medical context, as mentioned,

44 Constitution of the Republic of South Africa, 1996 (Constitution).

45 *De Reuck v Director of Public Prosecutions* 2003 (3) SA 389 (W).

46 J Eekelaar 'The role of the best interests principle in decisions affecting children and decisions about children' (2015) 23 *International Journal of Children's Rights* 3.

47 Eekelaar (n 46) 5.

48 AJ Kleinfeld 'The balance of power among infants, their parents and the state' (1970) 4 *Family Law Quarterly* 63; see also SJ Baskin 'State intrusion into family affairs: Justifications and limitations' (1974) 26 *Stanford Law Review* 1383.

49 See, eg, *Kaiser v Chambers* 1969 (4) SA 224 (C) 228G, where the Court referred to the best interests of the child as a 'golden thread which runs through the whole fabric of our [South African] law relating to children'.

physicians hold technical information and skills and as such are vested with specific powers. Equally, from a natural and legal perspective, parents have an unmatched responsibility to provide primary care. Conversely, the child has no specific role apart from being the patient while having a right to participate in all decisions relating to its health.

In *Castell v De Greeff*⁵⁰ the Western Cape High Court provided content to the concept of a child's participation in the three-way partnership through the lens of a patient-focused approach. This method recognised the child's fundamental rights of autonomy and self-determination.⁵¹ In this case, the Court held that physicians have a legal obligation to obtain a patient's informed consent before any medical intervention.⁵² Even though this is the standard procedure, the case of children is different as it introduces limitations to this legal requirement to consent during a medical decision-making process due to the perceived immaturity of a child and the imposing presence of parents and physicians.

Notwithstanding the necessary parental presence and opinion, the Nigerian Court of Appeal in *Esanubor v Faweya*⁵³ held that where parental opinion regarding a child's health is not in the best interests of the child, it should be set aside by the medical doctor or a higher authority.⁵⁴ This case is crucial to understanding the complexity of the power imbalance that exists in the three-way partnership. Succinctly, the Court in *Esanubor* establishes that even though parents enjoy vast powers in the upbringing of their child, the best interests of the child trumps such authority. Furthermore, in a medical decision-making process a physician has the power to override parental opinion where it interferes with a child's best interests. Related to this, the following part presents an analysis of the two main delineating factors that constrain a child's role in the three-way partnership: a child's age and their maturity.

4 A child's age and maturity

The aspect of 'age' is central in children's rights jurisprudence. Under international children's law a 'child' is defined as anyone below the age of 18 years. As a result, every child is entitled to all the rights in CRC and the African Children's Charter. Under certain rights, for

50 *Castell v De Greeff* 1994 (4) SA 408 (C).

51 *Castell v De Greeff* (n 50) 425-426.

52 As above.

53 *Esanubor v Faweya* [2009] All FWLR (Pt 478) (CA) (*Esanubor*).

54 *Esanubor* (n 53) para 380.

instance, a child's right to be protected from economic exploitation, both instruments oblige state parties to provide for a minimum age for admission to employment.⁵⁵

Under a child's right to participate none of the instruments explicitly mandates state parties to provide for a minimum age for admission into a decision-making process on matters concerning the child. Instead, the instruments provide 'age' and 'maturity' as 'tools' to enable the state to give appropriate due weight to a child's views.⁵⁶ As discussed further in part 4.1, the aspects of age and maturity are different but interlinked concepts that are analysed as a combined caveat to a child's right to participate. As requirements, guiding state party and/or parental or adult interactions with children, 'age' and 'maturity' to date have been recognised as distinguished features that determine the weight given to a child's opinion on their health.⁵⁷ Broadly, this makes sense because not every child might be able to express an immediate opinion in a medical decision-making process. However, at a later stage the child may have an opinion and may wish to express it. As is argued below in part 4.1, the absence of an age indicator, as a starting point when ascertaining children's maturity and ability to participate in the partnership, has contributed to limiting children's enjoyment of their right to be involved in medical decision-making processes.

4.1 The importance of an age indicator

Except for CRC and the African Children's Charter, there is no other binding international human rights instruments with a proliferation of joint parental and state obligations. Both instruments assign parents and state parties with separate and joint duties to safeguard the effective protection of certain children's rights depending on the age of the child.⁵⁸ Also, as indicated above, both instruments stipulate that a child is any person below the age of 18 years. However, CRC indicates an exception: If the age of majority under the law applicable

55 See art 15 of the African Children's Charter and art 32 of CRC.

56 Other caveats contained in a child's right to participate include a child's ability to form an opinion, a child's ability to communicate their opinion freely and the due weight criterion. For further details on these caveats, see A Parkes *Children and international human rights law: The right of the child to be heard* (2013) 1.

57 See, generally, CRC Committee General Comment 12 *The right of the child to be heard* (2009) UN Doc CRC/C/GC/12 para 12.

58 See, eg, art 3 of CRC and art 4(1) of the African Children's Charter according to which the state and parents are obliged to ensure that the best interests of the child is the primary consideration in all actions concerning the child.

to the child is attained earlier that age will indicate the threshold.⁵⁹ The African Children's Charter contains no such exception.⁶⁰

Notwithstanding the indication of the age of 18 as the threshold to adulthood in international children's law, the definition of a child differs across different legal disciplines. For instance, in criminal matters the category of punishment a child offender receives depends on the age of the child. In *Centre for Child Law v Minister for Justice & Constitutional Development*⁶¹ the applicant brought an application to challenge the constitutionality of the Criminal Law Amendment Act⁶² providing the minimum sentence provision for children 16 and 17 years old at the time of the offence. Section 28 of the South African Constitution defines a child as anyone below the age of 18. South Africa furthermore is a state party to CRC and the African Children's Charter. Nevertheless, the Constitutional Court held that 'the minimum sentencing legislation, in so far, as it is applicable to children who are 16 and 17 years old is not inconsistent with the Constitution'.⁶³ Generally, across Africa there are varied ages of responsibility that are lower than the identified age of 18 stipulated in CRC and the African Children's Charter.⁶⁴ These inconsistencies reflect a seemingly irreconcilable clash between international children's law and domestic law.

As discussed in part 4, a child's right to participate does not identify a compulsory age limit that will mandate a child's involvement in a decision-making process. However, the state and parents are required to measure a child's opinion based on the child's age and maturity. As discussed further in part 4.2, this article argues that a child's age and not a child's maturity should be the deciding factor whether or not to involve a child in a medical decision-making process concerning the child. This is because striking a balance between a child's mental capacity and right to be involved in the three-way partnership, in respect of ascertaining the developmental level at which a child gains sufficient competence to participate in a

59 Art 1 CRC.

60 For more details on the differences between these instruments, see D Chirwa 'The merits and demerits of the African Charter on the Rights and Welfare of the Child' (2002) 10 *International Journal of Children's Rights* 157; D Olowu 'Protecting children's rights in Africa: A critique of the African Charter on the Rights and Welfare of the Child' (2002) 10 *International Journal of Children's Rights* 127.

61 *Centre for Child Law v Minister of Justice & Constitutional Development* 2009 (6) SA 632 (CC).

62 Criminal Law (Sentencing) Amendment Act 38 of 2007.

63 *Centre for Child Law* (n 61) 126.

64 See, eg, Child Rights International Network (CRIN) 'Minimum ages of criminal responsibility in Africa', <https://archive.crin.org/en/home/ages/Africa.html> (accessed 14 June 2020).

medical decision-making process, is a complex exercise. As is further argued below, an age indicator could provide a realistic and time-friendly measure for a child to participate meaningfully in a medical decision-making process.⁶⁵ The validity of an age indicator ostensibly is limited in context as, for practical reasons, a child's cognitive ability to withstand pressure in most cases matures with age.

Therefore, the institution of an age indicator to presume maturity and consequently decisional competence strengthens a child's right to participate. As pointed out in the introduction, the absence of an indication of when a child could meaningfully participate in a medical decision-making process is a significant gap in international children's law. The CRC Committee through its General Comment 12 has welcomed the introduction of 'age' as a basic indicator to ascertain children's maturity and level of competence to, for example, participate in a medical decision-making process.⁶⁶ As discussed further under 4.2, the Committee's position,⁶⁷ understood in conjunction with article 5 of CRC,⁶⁸ arguably endorses a flexible approach that recognises a child's evolving capacities and rejects arbitrary age restrictions.⁶⁹ Consequently, where a younger child, that is, a child who falls below the age indicator, demonstrates the mental capacity to express an informed view on their health-related treatment, due weight should be given to such views regardless of the child's age.⁷⁰

4.2 African examples of the implications of an age indicator

As highlighted throughout this article, the question of whether a child is competent to participate in a medical decision-making process is contentious. One of the contestations specifically refers to

65 CRIN (n 64) para 102.

66 As above.

67 See General Comment 12 para 102, where the Committee 'welcomes the introduction in some countries of a fixed age at which the right to consent transfers to the child, and encourages states parties to give consideration to the introduction of such legislation. Thus, children above that age have an entitlement to give consent without the requirement for any individual professional assessment of capacity after consultation with an independent and competent expert. However, the Committee strongly recommends that states parties ensure that, where a younger child can demonstrate capacity to express an informed view on her or his treatment, this view is given due weight.'

68 This article deals with parental guidance and the child's evolving capacities. It introduces the notion that a child should be allowed to participate in all matters concerning the child when the child acquires that ability to do so. It further mandates state parties to consider a child's level of development when instituting a minimum age of participation on particular issues.

69 CRIN 'Age is arbitrary: Setting minimum ages' 21, <https://www.crin.org/en/library/publications/age-arbitrary-discussion-paper-setting-minimum-ages> (accessed 8 April 2019).

70 As above.

the question of whether the decision to involve a child in the three-way partnership should be determined by the child's age, maturity or both. This article argues that it makes sense to consider both but 'age' should trump 'maturity' at the point of deciding whether or not to include a child in the partnership. The reason why it is important to consider age and not maturity at the point of involving a child in the partnership is because a child's ability to meaningfully engage in a decision-making process often is a function of intellectual reach that matures with age. Also, because the ability to ascertain a child's intellectual reach often requires special skills and considerable time, the aspect of age is critical.⁷¹ An age indicator, unlike a child's maturity, could provide a basic and an immediate response to the legal obligation to include or the practical challenge to exclude a child-patient from a medical decision-making process.⁷²

As argued above, the concept of child participation as it is prescribed under international children's law obliges physicians and parents to consider a child-patient competent to participate meaningfully in the three-way partnership. However, practically this is not achievable for several reasons.⁷³ Therefore, there is an urgent need to further delineate the concept of child participation under international children's law by adding a minimum age to allow physicians and parents to anticipate a child's competence. This is crucial as it will provide a fair and judicious starting point to ascertain a child's maturity.

Before considering the reasons for introducing such an age indicator, as is further discussed in part 4.3 below, and as a point of departure for such an initiative it is worth considering how different African jurisdictions have regulated the age of child participation in medical decision-making processes. Thus, to create a framework within which to understand the 'minimum age' requirement, some contrasting, not always uniform, examples of African domestic regulations are set out below.

71 E Ochaíta & MA Espinosa 'Children's participation in family and school life: A psychological and developmental approach' (1997) 5 *International Journal of Children's Rights* 279-284-88.

72 For an in-depth analysis of the presumptive competence of child, see H Rodham 'Children under the law' (1974) 9 *Harvard Educational Review* 22.

73 Some of these reasons could include a child's lack of sufficient competence, negative parental influence and severe medical conditions. For further details on these reasons and more, see P Grootens-Wiegers et al 'Medical decision-making in children and adolescents: Developmental and neuroscientific aspects' (2017) 17 *BMC Pediatrics* 2.

In South Africa section 129(2)(3) of chapter 7, part 3 of the Children's Act⁷⁴ confers on children over the age of 12 years the right to participate in medical decision-making processes relating to the child.⁷⁵ However, a child younger than 12 is allowed to participate if the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment required.⁷⁶ Therefore, section 129(2)(3) does not permanently eliminate a child under the age of 12 as a competent participant. Rather, it confirms the participation of all children of a certain age in the three-way partnership. However, the role of the child could be affected if the child fails to display the level of mental capacity during a participatory process. If the child is not mature enough to make a justiciable contribution, the Children's Act introduces parents and physicians as competent to make the relevant decisions⁷⁷ guided by the best interests of the child.⁷⁸

It is worth noting that according to the Children's Act, the responsibilities of parents and physicians are only activated when the child's contribution is not in their best interests. Therefore, even though there is an age indicator, a child's evolving capacity trumps the age indicator when a child displays sufficient aptitude even when the child is below the age of 12 years.⁷⁹ According to Appelbaum, this is a correct clinical position because a certain level of mental competence is needed to balance a child's autonomy with the legal requirement to protect a child's right to participate in a medical decision-making process.⁸⁰

In Mauritania the age limit of 12 is also recognised in accordance with the principles of Maliki Muslim law.⁸¹ However, unlike in South Africa, the age limit of 12 is not as an absolute primary determinant of a child's mental competence. In Mauritania the age limitation

74 Children's Act 38 of 2005 (Children's Act).

75 Children's Act (n 74) ch 7 part 3 sec 129(2)(a). See also DJ McQuoid-Mason 'Can children aged 12 years or more refuse lifesaving treatment without consent or assistance from anyone else?' (2014) 104 *South African Medical Journal* 466-467.

76 Children's Act (n 74) ch 7 part 3 sec 129(2)(a).

77 Children's Act (n 74) sec 129(4)(a)(b).

78 See ch 2 of the Act.

79 See, eg, sec 129(1) of the Children's Act, referring to sec 5(1) of the Choice on Termination of Pregnancy Act, which confers the right of consent to an abortion on every girl child (irrespective of age) when she has the mental capacity to do so.

80 PS Appelbaum 'Clinical practice. Assessment of patients' competence to consent to treatment' (2007) 357 *The New England Journal of Medicine* 1834.

81 See, eg, art 15 of the Code of Obligations and Contracts which stipulates that '[a]ny person in possession of his mental faculties and not having been forbidden so to do is fully capable of exercising his civil rights'. See also CRC Committee on the CRC Consideration of reports submitted by States Parties under article 44 of the Convention: Mauritania UN Doc CRC/C/8/Add.42 paras 18-29 & 47-48.

considers children under the age of 12 as absolutely incapable, and children from 12 and above as persons with limited mental capacity.⁸²

However, not all African states identify the age of 12 as a threshold for maturity. For example, in Tunisia article 42 of the Code for the Protection of the Child⁸³ sets the age indicator at the age of 13.⁸⁴ In Ethiopia⁸⁵ and Eswatini⁸⁶ children are not considered to have sufficient mental competence at any stage of their development. In article 7 of the Revised Family Code of Ethiopia⁸⁷ a minor is defined as anyone below 18. Moreover, article 257(2) of the Revised Family Code states that '[i]n case of sickness of the minor, the guardian shall take the necessary measures for his recovery'.⁸⁸ Similarly, in Eswatini the provisions of the Mental Health Order⁸⁹ recognises a child as anyone below 18 years. However, the Mental Health Order provides that persons under the age of 21 require parental consent to access medical services.⁹⁰

In Namibia a different approach to child participation has been developed. The Child Care and Protection Act⁹¹ holds that 'every child that is of an age, maturity and stage of development as to be able to participate in any matter concerning that child' should be allowed to participate. The provision proceeds to add that the child must be able to participate in 'an appropriate way'. Based on the detailed analysis of the context of child participation by the CRC Committee,

82 CRC Committee (n 81) para 19. This provision is supplemented by art 164 of the Personal Status Code which provides that '[a] person who reaches the age of discernment before reaching the age of majority does not enjoy full legal capacity'.

83 Code de La Protection de L'enfant Loi n° 95-92 du 9 Novembre 1995 (Code for the Protection of the Child).

84 See, generally, art 42 which states: 'Le délégué à la protection de l'enfance doit obligatoirement informer les parents et l'enfant âgé de 13 ans de leur droit de refuser la mesure proposée. Dans le cas où aucun accord n'est établi dans un délai de vingt jours à partir du moment où le délégué à la protection de l'enfance s'est saisi du cas, le dossier est soumis au juge de la famille. Il en est ainsi dans le cas où l'accord est résilié par l'enfant ou par ses parents ou par celui qui en a la charge.' For details, see Code de La Protection de L'enfant (n 83), relative à la publication du code de la protection de l'enfant.

85 See, eg, art 215 of the Revised Family Code of 2002 which states that '[a] minor is a person of either sex who has not attained the full age of eighteen years'.

86 The Age of Majority Act (1853) stipulates the age of majority to be 21 years. See also CRC Committee Initial Report of States Parties Due in 1997, Swaziland (2006) CRC/C/SWZ/1, <https://www.refworld.org/docid/45377ec90.html> para 66 (accessed 26 June 2020).

87 Revised Family Code (n 29).

88 See, generally, The Revised Family Code of 2000, <http://www.refworld.org/pdfid/4c0ccc052.pdf> (accessed 20 April 2020). See also CRC Committee Consideration of reports submitted by States Parties under Article 44 of the Convention: Ethiopia UN Doc CRC/C/129/Add.8 para 60.

89 Public Health Order: The King's Order-in-Council of 20/1978 (Mental Health Order).

90 CRC Committee Consideration of reports submitted by States Parties under Article 44 of the Convention: Swaziland (n 86) para 77.

91 Child Care and Protection Act 3 of 2015 (Child Care and Protection Act).

the addition of the latter condition arguably is counterproductive to the participation of the child and the best interests of the child as it further compounds a child's position in the three-way partnership in two distinct ways. First, it could be interpreted to require that a child must be able to articulate its opinion at the same level as adults. Second, it could also be interpreted to require that a child must be able to fully understand the subject matter of the decision-making process.⁹² Construed in this way, this arguably creates a high threshold for child participation.

4.3 Reasons for introducing an age indicator to determine maturity in medical decision-making processes

The importance of introducing an age indicator in domestic law, as a primary determinant of a child's maturity and mental competence to participate in a medical decision-making process, cannot be overstated. According to the CRC Committee, it indeed is a welcome idea.⁹³ Moreover, as argued throughout this article, the aspect of 'age' is more important in the implementation of children's right to participate in medical decision-making processes than it is in any other decision-making processes. This is so because health-related decisions are personal and an erroneous decision could lead to bodily harm or death. The CRC Committee has reaffirmed the importance of a comprehensive understanding of the context of children's right to participate in a medical decision-making process by stating that before parents give their consent, children of sufficient maturity should be given a chance to express their views freely and their views should be given due weight.⁹⁴ In this regard, Kassan and Mahery suggest that a child-patient should be allowed to participate in a medical decision-making process if they comply with two requirements, namely, age and maturity.⁹⁵

The suggestion made in this article, that African jurisdictions that do not include an age reference in terms of medical decision-making processes such as in South Africa and Mauritania, should be amended to include a reference to a fixed age that will allow a child to be involved in the three-way partnership formed around a

92 CRC Committee General Comment 12 (n 57). See also K Herbots & J Put 'The participation disc: A concept analyses of [a] child ['s right to] participation' (2015) 23 *International Journal of Children's Rights* 154.

93 CRC Committee (n 67).

94 CRC Committee General Comment 4 Adolescent health and development in the context of the Convention on the Rights of the Child UN Doc CRC/GC/2003/4 para 32.

95 D Kassan & P Mahery 'Special child protective measures in the Children's Act' in T Boezaart (ed) *Child Law in South Africa* 208-209.

medical decision-making process, may be justified based on three main considerations.

The first is the widespread domestication of international children's rights and the increasing development of domestic children's rights protection programmes on the continent. This arguably is related to the widespread acceptance and recognition of children as right bearers on the continent. Except for the Saharawi Arab Democratic Republic, all AU states are parties to CRC, and 49 out of these 54 states have also ratified the African Children's Charter.

Second, the need for an age indicator to safeguard a child's right to participate in a medical decision-making process specifically relates to the fact that it is different from other participatory processes.⁹⁶ Also, according to Grootens-Wiegers, a medical decision-making process requires adequate mental competence and the maturity to take responsibility for the decision made.⁹⁷ However, the content of child participation as stipulated in article 12 of CRC and articles 4(2) and 7 of the African Children's Charter only requires a child to express a view and not for the child to take responsibility for the decision made. It is the responsibility of parents and the physician in the three-way partnership to give due weight to the views of the child and to take responsibility for the final decision. As discussed in parts 4 1 and 4 2, an age indicator is necessary in the partnership to make it compulsory for a child of a certain age to express a view in a medical decision-making process.

Third, and related to the aforementioned considerations, is the impact of the increasing global recognition of a child, as an autonomous person and the growing re-ordering of parent-child relationship.⁹⁸ In *S v M*⁹⁹ Sachs J held that the ultimate responsibility of parents

is to ensure that [they] serve as the most immediate moral exemplars for their offspring. Their responsibility is not just to be with their children and look after their daily needs. It is certainly not simply to secure money to buy the accoutrements of the consumer society, such as cell phones and expensive shoes. It is to show their children how to

96 Eg, decision-making processes around a child's education, clothing and food evoke minimal levels of responsibility as compared to a medical decision-making process that could result in a permanent disability or death if not well thought out.

97 Grootens-Wiegers (n 73) 2.

98 For more on the parent-child relationship, see A Twum-Danso 'Reciprocity, respect and responsibility: The 3Rs underlying parent-child relationships in Ghana and the implications for children's rights' (2009) 17 *International Journal of Children's Rights* 415.

99 *S v M (Centre for Child Law as Amicus Curiae)* 2008 (3) SA 232 (CC).

look problems in the eye. It is to provide them with guidance on how to deal with setbacks and make difficult decisions. Children have a need and a right to learn from their primary caregivers that individuals make moral choices for which they can be held accountable.¹⁰⁰

What is more, a child's right to participate recognises that there are certain aspects of a child's private life and person that need protection. Some of these aspects include a child's bodily integrity, respect, freedom and autonomy. It is the combination of these unique features of a child's right to participation that influenced Freeman to regard this right as the kingpin of children's rights protection.¹⁰¹ In other words, the right to participation breathes life into and holds the other rights in CRC and the African Children's Charter together as it ensures a child's autonomy and ability to contribute to the enjoyment of all rights.

5 Conclusion

As technology and other sophisticated means of treatment are increasingly introduced into the medical field, medical decision-making becomes more complicated to explain and understand. As a result, physicians and parents are progressively faced with the difficult task of ascertaining whether or not to involve a child-patient in a medical decision-making process. As in most legal child protection schemes in Africa, when it is established that it is impossible for a child-patient to participate, parents and physicians are allowed to trump a child's right to participate and make decisions guided by the best interests of the child. Therefore, as argued in this article, the reference exclusively to the 'best interests' or to 'age' and/or 'maturity', without further clarifications or parameters, is largely insufficient in establishing and protecting a child in a medical decision-making process.

Children's right to participate has been lauded as an empowerment right. However, the inclusion of caveats in international children's law, such as age and maturity, has both complicated its implementation and opened up the door for further clarifications and protection under domestic law. Moreover, the inclusion of claw-backs in international children's law, such as the reference to the views of the child being given 'due weight', weakens the central intention of the protection of this right as it applies to children.

¹⁰⁰ *S v M* (n 99) para 134.

¹⁰¹ M Freeman 'The importance of a children's rights perspective in litigation' (1996) 2 *Butterworths Family Law Journal* 84.

As has been argued in this article, one of the obvious ways to ascertain a child's involvement in a medical decision is through an evaluation of the child's level of development and evolving capacity. However, since this approach generally is laborious and time consuming, the article has argued that the institution of an age indicator in domestic African law as the minimum threshold to involve a child in a medical decision-making process should be encouraged.