Ministry of Gender Equality and Child Welfare

Legal Assistance Centre

Embassy of Finland Windhoek

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MEDICAL INTERVENTIONS AND HIV TESTING

NOTE In this publication, "Ministry" and "Minister" refer to the Ministry and Minister responsible for child protection, and "*Guide*" means this *Guide to the Child Care and Protection Act* (which is published in separate chapters).

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The Child Care and Protection Act applies the principle of child participation to medical interventions, surgical operations and HIV testing, and sets criteria for determining when children are sufficiently mature to make independent or assisted decisions on these issues. It also provides special rules for consent for the medical examination of children who may have been abused or neglected.

1. Overview

The Child Care and Protection Act expands the rights of children to make independent decisions on their health care, or to participate in those decisions. Under certain circumstances, children have the right to decide on medical treatment on their own, without the consent of their parents or guardians. This is consistent with the approach taken by the Convention on the Rights of the Child to the evolving capacities of children.

Under the repealed Children's Act 33 of 1960 – when the age of majority was set at 21 – children could give independent consent to medical treatment from age 18. The Child Care and Protection Act has a more complex set of standards for decision-making by children, with the key age being 14. Because the rules for different health decisions differ somewhat, it is important to read the requirements carefully. The chart below is intended to serve as a quick guide.

Health decision	Consent requirements
Medical intervention age 14 PLUS sufficient maturity	**Child age 14 or older** assessed by medical practitioner as having **sufficient maturity and mental capacity** to understand the benefits, risks and implications of the medical intervention
Surgical operations age 14 PLUS sufficient maturity PLUS assisted by parent	**Child age 14 or older** assessed by medical practitioner as having **sufficient maturity and mental capacity** to understand the benefits, risks and implications of the surgical operation **AND assisted by parent or guardian**
Confidential medical counselling sufficient maturity	**Child of any age** with **sufficient maturity and mental capacity** to understand the benefits, risks and implications of the medical intervention (no parental consent required)
HIV-testing age 14 OR sufficient maturity	**Child age 14 or older** **Younger child** assessed by pre-test counsellor as having **sufficient maturity** to understand the benefits, risks and social implications of an HIV test
Disclosure of HIV-positive status age 14 OR sufficient maturity	**Child age 14 or older** **Younger child** assessed by pre-test or post-test counsellor as having **sufficient maturity** to understand the benefits, risks and social implications of disclosure.

Other key rules include the following:

- **Child-parents** who are competent to give medical consents for themselves can also make health decisions in respect of their own children.
- For children who lack capacity to give independent consent, the authority to make health decisions rests with the **child's parent or guardian** – but the parent or guardian is expected to consider the views of any child who is able to express an informed view.
- **If a child has no parent or guardian**, the child's **care-giver** can give consent in their place – with due consideration for the views of the child.
- In the event of **unreasonable refusal of consent, or inability to obtain consent**, the **Minister** can make the decision in the place of the child, parent, guardian or care-giver. **If the Minister refuses consent** in such circumstances, the **children's court** can give consent.
- A parent or guardian may not refuse consent to a medical intervention on a child on the grounds of **religious or other beliefs** unless there is a **medically-acceptable alternative.** This rule is intended to ensure that parents are not allowed to impose beliefs on a child which could result in harm to the child.
- In an **emergency**, consent for medical action in respect of a child can be given by the **senior official of the relevant health facility**.

Substituted consent requirements (in case of unreasonable refusal or lack of consent)	• Can be given by **Minister** on application by any person with an interest in the well-being of a child • If Minister refuses, can be given by **children's court** on application by any person with an interest in the well-being of a child
Consent in emergencies	• Can be given by **senior official of relevant health facility**

2. Key concepts

Consent: **Consent** means giving permission for a medical intervention. Consent must be voluntary and informed. **Informed consent** requires an understanding and appreciation of the risks of the medical intervention, the consequences of having or not having the intervention, and information about available alternatives. A medical practitioner has an ethical duty to make sure that no patient receives any treatment without informed consent. The Namibian Supreme Court noted in a 2014 case that informed consent has three components:

1. **Knowledge:** The patient must be informed about the nature and extent of the harm or risk.
2. **Appreciation:** The patient must comprehend and understand this information.
3. **Lawful consent:** The patient must give full and voluntary consent to the entire medical procedure, including its consequences. Valid consent also requires that the patient has the intellectual and emotional capacity to make the decision. For example, a patient cannot give meaningful consent if he or she is in severe pain and unable to think clearly.

◈ *Government of the Republic of Namibia v LM and Others* 2015 (1) NR 175 (SC), paragraphs 96-109

INFORMED CONSENT

Ethical Guidelines For Health Professions

Health Professions Council of Namibia, 2010

"A health professional should:

1. Give his or her patients the information they ask for or need about their condition, the treatment and prognosis.
2. Give information to patients in the way they can best understand it.
3. Refrain from withholding from his or her patients any information, investigation, treatment or procedure that is in the patient's best interest.
4. Apply the principle of informed consent as an on-going process.
5. Allow patients access to their medical records."

◈ General Ethical Guidelines, "Section Two — General Ethical Duties", point 2.3

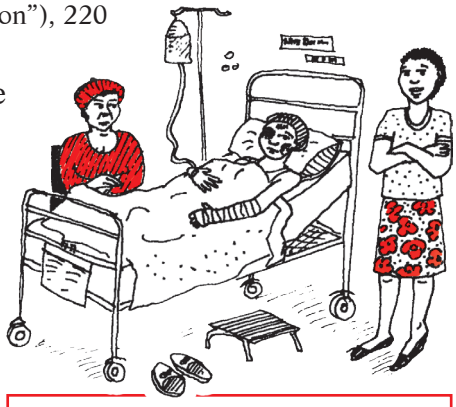
Medical intervention: This term is not defined, but the Act states that it "includes dental, physiological, psychological and psychiatric interventions". The lack of a specific definition was intentional, as the term is too broad and general to be easily explained.

This term is broader than the term "medical treatment" which was used in the previous Children's Act 33 of 1960. For example, it could include diagnostic tests, preventative measures (such as immunization or post-exposure prophylactics (PEP)), pregnancy-related procedures or blood transfusions, in addition to "treatment". It may encompass at least some forms of contraception, such as contraceptive pills or injections, intrauterine devices, and "morning-after" pills. The term "medical" may be interpreted to exclude procedures which are purely cosmetic in nature. The precise content of the term will be developed over time in case law.

◈ Child Care and Protection Act, sections 1 ("medical intervention"), 220

Surgical operation: This term is not defined in the Act. The term "surgical" can be understood to indicate that some incision or cutting of the body must be involved.

If the term is understood to cover any medical intervention which involves incision or cutting, it would *exclude* some relatively major procedures such as setting a broken bone or extracting a tooth under anaesthesia. On the other hand, by this measure, the term would *include* some relatively minor procedures such as a biopsy of a growth on the skin, the removal of a mole or a procedure performed on an ingrown toenail. Medical practitioners may be best placed to interpret what procedures fall within the term "surgical operation".



Proof of age for purposes of medical decisions: The child's age can be proved by an identity document or a birth certificate.

◈ Child Care and Protection Act, section 220

3. International framework

The **Namibian Constitution** does not explicitly address children's rights in respect of health and medical decision-making. Article 95 of the Constitution commits the State to policies aimed at "consistent planning to raise and maintain an acceptable level of nutrition and standard of living of the Namibian people and to improve public health". This goal can be accomplished more effectively with respect to children if there is appropriate child participation.

More directly, the **Convention on the Rights of the Child** recognises the rights of children to participate in decisions about their health and health care, as well as in decisions about the planning and provision of health services which are relevant to them. One aspect of this is children's evolving capacity to make decisions about their own health care. The Committee which monitors the Convention encourages States Parties to enact legislation on medical treatment without parental consent, in accordance with children's increasing age and maturity.

The Committee which monitors this Convention has also emphasised the importance of access to voluntary, confidential HIV counselling and testing services, with due attention to the evolving capacities of the child. It has also encouraged States Parties to ensure that adolescents (children over the age of 10) have access to free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, including family planning services.

- *Implementation Handbook for the Convention on the Rights of the Child*, UNICEF, 2007, pages 168-69
- Committee on the Rights of the Child, *General Comment No. 4* (2003), paragraph 9
- Committee on the Rights of the Child, *General Comment No. 15* (2013), paragraph 219
- Committee on the Rights of the Child, *General Comment No. 20* (2016), paragraphs 59-60, 62-63

Convention on the Rights of the Child (CRC)

Article 24(1)

"States Parties recognize 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. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

Right of the child to the enjoyment of the highest attainable standard of health

CRC General Comment No. 15 (2013)

"Article 12 [on child participation] highlights the importance of children's participation, providing for children to express their views and to have such views seriously taken into account, according to age and maturity. This includes their views on all aspects of health provisions, including, for example, what services are needed, how and where they are best provided, barriers to accessing or using services, the quality of the services and the attitudes of health professionals, how to strengthen children's capacities to take increasing levels of responsibility for their own health and development, and how to involve them more effectively in the provision of services, as peer educators. States are encouraged to conduct regular participatory consultations, which are adapted to the age and maturity of the child, and research with children, and to do this separately with their parents, in order to learn about their health challenges, developmental needs and expectations as a contribution to the design of effective interventions and health programmes."

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"The Committee recognizes that children's evolving capacities have a bearing on their independent decision-making on their health issues. It also notes that there are often serious discrepancies regarding such autonomous decision-making, with children who are particularly vulnerable to discrimination often less able to exercise this autonomy. It is therefore essential that supportive policies are in place and that children, parents and health workers have adequate rights-based guidance on consent, assent and confidentiality."

◈ Committee on the Rights of the Child, *General Comment No. 15* (2013), paragraphs 19 and 21 (footnotes omitted)

Adolescent health and development in the context of the Convention on the Rights of the Child

CRC General Comment No. 4 (2003)

"In order to promote the health and development of adolescents, States Parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters (art. 16). Health care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality. Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment."

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"With regard to privacy and confidentiality, and the related issue of informed consent to treatment, States Parties should (a) enact laws or regulations to ensure that confidential advice concerning treatment is provided to adolescents so that they can give their informed consent. Such laws or regulations should stipulate an age for this process, or refer to the evolving capacity of the child; and (b) provide training for health personnel on the rights of adolescents to privacy and confidentiality, to be informed about planned treatment and to give their informed consent to treatment."

◈ Committee on the Rights of the Child, *General Comment No. 4* (2003), paragraphs 11, 33

HIV/Aids and the Rights of the Child

CRC General Comment No. 3 (2003)

"The accessibility of voluntary, confidential HIV counselling and testing services, with due attention to the evolving capacities of the child, is fundamental to the rights and health of children. Such services are critical to children's ability to reduce the risk of contracting or transmitting HIV, to access HIV-specific care, treatment and support, and to better plan for their futures. Consistent with their obligation under article 24 of the Convention to ensure that no child is deprived of his or her right of access to necessary health services, States parties should ensure access to voluntary, confidential HIV counselling and testing for all children.

The Committee wishes to stress that, as the duty of States parties is first and foremost to ensure that the rights of the child are protected, States parties must refrain from imposing mandatory HIV/AIDS testing of children in all circumstances and ensure protection against it. While the evolving capacities of the child will determine whether consent is required from him or her directly or from his or her parent or guardian, in all cases, consistent with the child's right to receive information under articles 13 and 17 of the Convention, States parties must ensure that, prior to any HIV testing, whether by health-care providers in relation to children who are accessing health services for another medical condition or otherwise, the risks and benefits of such testing are sufficiently conveyed so that an informed decision can be made."

States parties must protect the confidentiality of HIV test results, consistent with the obligation to protect the right to privacy of children (art. 16), including within health and social welfare

settings, and information on the HIV status of children may not be disclosed to third parties, including parents, without the child's consent."

◈ Committee on the Rights of the Child, *General Comment No. 3* (2003), paragraphs 22-24

Implementation of the rights of the child during adolescence: HIV/AIDS
CRC General Comment No. 20 (2016)

"Adolescents are the only age group in which death due to AIDS is increasing. Adolescents may face challenges in gaining access to antiretroviral treatment and remaining in treatment; the need to gain the consent of guardians in order to access HIV-related services, disclosure and stigma are some barriers. Adolescent girls are disproportionately affected, representing two thirds of new infections. Lesbian, gay, bisexual and transgender adolescents, adolescents who exchange sex for money, goods or favours and adolescents who inject drugs are also at a higher risk of HIV infection.

The Committee encourages States to recognize adolescents' diverse realities and ensure that they have access to confidential HIV testing and counselling services and to evidence-based HIV prevention and treatment programmes provided by trained personnel who fully respect the rights of adolescents to privacy and non-discrimination. Health services should include HIV-related information, testing and diagnostics; information on contraception and the use of condoms; care and treatment, including antiretroviral and other medicines and related technologies for the care and treatment of HIV/AIDS; advice on suitable nutrition; spiritual and psychosocial support; and family, community and home-based care. Consideration should be given to reviewing HIV-specific legislation that criminalizes the unintentional transmission of HIV and the non-disclosure of one's HIV status."

◈ Committee on the Rights of the Child, *General Comment No. 20* (2016), paragraphs 62-63 (footnotes omitted)

Implementation of the rights of the child during adolescence
CRC General Comment No. 20 (2016): Health care

"The Committee urges States to adopt comprehensive gender and sexuality-sensitive sexual and reproductive health policies for adolescents, emphasizing that unequal access by adolescents to such information, commodities and services amounts to discrimination. Lack of access to such services contributes to adolescent girls being the group most at risk of dying or suffering serious or lifelong injuries in pregnancy and childbirth. All adolescents should have access to free, confidential, adolescent-responsive and non-discriminatory sexual and reproductive health services, information and education, available both online and in person, including on family planning, contraception, including emergency contraception, prevention, care and treatment of sexually transmitted infections, counselling, pre-conception care, maternal health services and menstrual hygiene.

There should be no barriers to commodities, information and counselling on sexual and reproductive health and rights, such as requirements for third-party consent or authorization. In addition, particular efforts need to be made to overcome barriers of stigma and fear experienced by, for example, adolescent girls, girls with disabilities and lesbian, gay, bisexual, transgender and intersex adolescents, in gaining access to such services. The Committee urges States to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions."

◈ Committee on the Rights of the Child, *General Comment No. 20* (2016), paragraphs 59-60 (footnotes omitted)

"ADOLESCENCE": The Committee has noted that individual children reach maturity at different ages. Therefore, it does not attempt to define adolescence. However, its most recent General Comment on adolescence focuses on the period from age 10 until the child's 18th birthday.

◈ Committee on the Rights of the Child, *General Comment No. 20* (2016), paragraph 5

4. Consent to medical interventions and surgical operations

4.1 Consent to medical intervention

The rules on medical interventions apply to interventions which do NOT involve surgical operations. A child age 14 or older with sufficient maturity can give independent consent.

When can the child give consent?: A child may give consent to a medical intervention in respect of himself or herself if –

(1) the child is **14 years of age** or older
AND
(2) the medical practitioner concerned is satisfied that the child has **sufficient maturity and the mental capacity to understand the benefits, risks and implications of the medical intervention**.

Note that this is a two-part test. The child must be BOTH age 14 or above AND of sufficient maturity and understanding to give consent. The age limit is designed to be an approximate cut-off point which will indicate when most children have reached the required state of development. But individual children have different characters and backgrounds, so the age limit alone will not provide an appropriate marker of maturity for all children.

◈ Child Care and Protection Act, section 220(1)(a)

Consent by parent, guardian or care-giver: If the child is not competent to give independent consent, then consent to medical intervention may be given by the child's parent or guardian. If a child is not competent to give independent consent to medical intervention but has the capacity to express an informed view on the matter, **the child's view must be given due consideration by the parent or guardian**.

If the child is competent to give independent consent, then the parent or guardian no longer has the power to make the decision on behalf of the child.

The Act defines "parent", in relation to a child, as a woman or a man in respect of whom parentage has been acknowledged or otherwise established. It *includes* the adoptive parent of a child. It *excludes*:

(1) the biological father of a child conceived through rape or incest;
(2) any person who is biologically related to a child by reason only of being the donor of egg or sperm for purposes of artificial fertilisation; or
(3) a parent whose parental responsibilities and rights in respect of a child have been terminated by a court order.

◈ Child Care and Protection Act, section 220(3)and (9)

What if parents disagree about medical intervention for a child?

The Act addresses the relationship between parent and child, but it does not contain rules about disagreement between parents on a child's health care issues. **Decisions about medical interventions will normally be the responsibility of the parent who is the child's custodian and guardian.** Married parents are joint custodians and equal guardians, while one parent will usually have sole custody and guardianship of a children born outside marriage. However, the situation could be complicated by the terms of parenting plan or a divorce order. Parents should be guided by the **child's best interests** in every situation.

◈ Married Persons Equality Act 1 of 1996, section 14
◈ Child Care and Protection Act, sections 99, 101(1)
◈ common law on custody and guardianship

Consent by care-giver: *If the child has no parent or guardian,* consent may be given by the child's care-giver in the place of the parent.

If a child is not competent to give independent consent but has the capacity to express an informed view on the matter, the child's view must be given due consideration by the care-giver.

Note that the Act does NOT allow a care-giver to give consent to a medical intervention in a situation where the parent or guardian is unavailable. There are separate provisions which apply in the case of an **emergency**. This is discussed below in section 4.6 of this chapter.

However, certain **parental powers are *transferred* to care-givers** when a child is placed in **alternative care** by means of a **court order**. These include certain powers regarding medical intervention. This issue is discussed below in section 7 of this chapter.

◈ Child Care and Protection Act, section 220(3) and (9)

Who is a care-giver?

"Care-giver" means any person other than a parent or guardian, who takes primary responsibility for the day-to-day care of a child and includes –

(a) a **foster parent**
(b) a **kinship care-giver** (a member of the child's family or extended family who is caring for a child with the express or implied consent of the child's parent or guardian, or because of a court order)
(c) a **primary caretaker** (a person other than the parent or other legal care-giver of a child, whether or not related to the child, who takes primary responsibility for the daily care of the child with the express or implied permission of the parent who has custody of the child)
(d) a person who cares for a child while the child is in a **place of safety**
(e) the person who is the **head of a facility where a child has been placed** (such as a children's home or a child detention centre)
(f) the **child who is the head of a child-headed household.**

◈ Child Care and Protection Act, section 1

Access to contraceptives

The Act does not explicitly address the issue of access to contraceptives by children or adolescents. Since "medical intervention" is not defined, it is not clear whether or not this term includes access to various forms of contraceptives.

Namibia's **National Policy on Sexual, Reproductive and Child Health (2013)** says that ***all sexually-active persons, regardless of age or marital status, have the right to access the contraceptive of their choice***, and that ***adolescents can access sexual and reproductive health services without parental consent after thorough counselling*** — including services related to family planning and sexually-transmitted infections (STIs).

> "20. All persons who are sexually active, regardless of age or marital status, shall have the right to be fully informed about available family planning options and methods, and shall have the right to receive the family-planning method of their choice.
>
> 21. Adolescents [ages 10-19] can access sexual and reproductive health services including family planning and STI services without parental consent after thorough counselling."

◈ *National Policy on Sexual, Reproductive and Child Health,* Windhoek: Ministry of Health and Social Services, 2013, section 3.5.1: paragraphs 20-21, section 3.5.2: page 18

A child who is mature enough to make independent decisions on medical intervention can still benefit from parental care and support.

4.2 Consent to a surgical operation

Consent to a surgical operation requires joint consent by a child over age 14 with sufficient maturity AND that child's parent.

When can the child give consent?: A child may give consent to a surgical operation in respect of himself or herself if –

(1) the child is **14 years of age** or older
AND
(2) the medical practitioner concerned is satisfied that the child has **sufficient maturity and the mental capacity to understand the benefits, risks and implications of the surgical operation**
AND
(3) the child is **duly assisted by his or her parent or guardian** OR (if the child does not have a parent or a guardian) the child's **care-giver**.

Note that this standard starts with a two-part test. As in the case of medical intervention, the child must be BOTH age 14 or above AND of sufficient maturity and understanding to give consent.

But here there is also a third element of the decision-making process. Even if the child satisfies the two-part test, **the child must also be "assisted" by a parent or guardian.** This works in the same way as the rules on a minor's lack of legal capacity; for instance, a minor child cannot bring a court case on his or her own without the "assistance" of a parent or guardian.

In short, where the child has sufficient maturity to consent to a surgical operation, the law essentially requires **joint consent of the child and a parent, guardian or caregiver**. (A child's care-giver can assist a child who has no parent or guardian. See the box on page 9 for the definition of "caregiver".)

◈ Child Care and Protection Act, section 220(1)(b)

Consent by a parent, guardian or care-giver: Where the child lacks the capacity to consent to a surgical operation, the decision on this issue is made by the child's **parent or guardian** acting alone. If the child has no parent or guardian, then the decision is made by the child's **care-giver** acting alone.

The process works in the same way as decisions on medical interventions. Where a child is not competent to give consent to a surgical operation but has the capacity to express an informed view on the matter, the child's view must be given due consideration by the parent or guardian who has the authority to give consent to the surgical operation (or by the care-giver if the child has no parent or guardian).

◈ Child Care and Protection Act, section 220(3) and (9)

Consent to sterilization

Consent to sterilization of a child is a special case which involves a procedure in terms of the **Abortion and Sterilization Act 2 of 1975**. Sterilization refers to a surgical operation performed for the purpose of making a person incapable of procreation, but the Act specifies that sterilization does not include the removal of the testicles or ovaries (which would have more far-reaching consequences).

Section 4(1) of that Act provides as follows:

> "A sterilization shall not be performed on any person who for any reason is incapable of consenting or incompetent to consent thereto, unless -
>
> (a) two medical practitioners, of whom one shall be a psychiatrist, have certified in writing that the person concerned is capable of procreating children and-
> (i) is suffering from a hereditary condition of such a nature that if he or she were to procreate a child, such child would suffer from a physical or mental defect of such a nature that it would be seriously handicapped; or
> (ii) due to a permanent mental handicap or defect is unable to comprehend the consequential implications of or bear the parental responsibility for the fruit of coitus;
>
> (b) the person who may in law consent to an operation beneficial to that person has granted written consent to the sterilization; and
>
> (c) the Minister has granted written authority for the sterilization."

To summarise, a child can be sterilized only under two circumstances: (1) The child has a hereditary condition which would produce a serious physical or mental handicap in any offspring. (2) The child has a permanent mental handicap or defect which makes him or her unable to understand the implications of procreation, or to bear the parental responsibility for a child.

Furthermore, a child could be sterilized only if (1) two medical practitioners (including at least one psychiatrist), find that the required justifications are present; (2) the child's parent or guardian (or if there is no parent or guardian, the child's caregiver) has given consent; and (3) the Minister of Health and Social Services has given consent.

◈ Abortion and Sterilization Act 2 of 1975, sections 1, 4(1)

4.3 Access to confidential medical counselling and advice

Any child who has **sufficient maturity** to understand the benefits, risks and implications of a medical intervention may access confidential medical counselling and advice without parental consent. This applies **regardless of the child's age**, where this is in the **best interests** of the child.

> The wording of this right indicates that even a child who is *under age 14* has a right to access confidential medical counselling and advice. The only requirements seem to be (a) **sufficient maturity** to understand the benefits, risks and implications of a medical intervention and (b) that the confidential medical counselling and advice would be in the **child's best interests**.

◈ Child Care and Protection Act, section 220(10)

Elizabeth is 13 years old. She is being sexually abused by her uncle but she has not told anyone. She knows that she is at risk of HIV infection, so she goes to her local clinic to ask for more information about how HIV is transmitted and what preventative measures are available to protect against HIV infection. The nurse at the clinic cannot give her pre-exposure prophylaxis (PreP) because this is a medical intervention and Elizabeth is not yet 14 years old, which is the first criteria to qualify to give independent consent. But the nurse can see that Elizabeth has sufficient maturity to understand the benefits, risks and implications of a medical intervention and so the nurse is able to give Elizabeth confidential medical counselling and advice without parental consent.

It is possible that during this discussion, Elizabeth may disclose that she is being sexually abused. If she does this, the nurse will have a mandatory duty to report the case to a social worker or police (see page 28). This means that, as a result of being able to access medical counselling, Elizabeth may be able to access the protective services that she vitally needs.

It is also possible that Elizabeth may NOT tell the nurse that she is being sexually abused. She might pretend that she is only seeking information for some future time when she becomes sexually active with a boyfriend of her own age. However, even in this scenario, Elizabeth has still started a process of reaching out to professionals who can help her. With time, she may feel that she is able to disclose the truth about the abuse and get help. Thus, whatever the outcome, being able to access medical counselling is an important means of connecting children with protective services.

DUTY OF CONFIDENTIALITY IN RESPECT OF CHILDREN AND OTHER PATIENTS WHO MAY LACK COMPETENCE TO GIVE CONSENT

Ethical Guidelines For Health Professions

Health Professions Council of Namibia, 2010

"6.4.1 Problems may arise if a health professional considers that a patient is incapable of giving consent to treatment or disclosure because of immaturity, illness or mental incapacity. If such patients ask the health professional not to disclose information to a third party, the health professional should try to persuade them to allow an appropriate person to be involved in the consultation. If they refuse and he or she is convinced that it is essential, in their medical interests, he or she may disclose relevant information to an appropriate person or authority. In such cases the health professional must tell the patient before disclosing any information, and, where appropriate, seek and carefully consider legal advice or the view of the legal guardian. The health professional should document in the patient's record the steps he or she has taken to obtain consent and the reasons for deciding to disclose information.

6.4.2 If the health professional believe that his or her patient is or was a victim of neglect or physical, sexual or emotional abuse and that the patient cannot give or withhold consent to disclosure, he or she should give information promptly to an appropriate responsible person or statutory agency, where he or she believes that the disclosure is in the patient's best interests. The health professional should usually inform the patient that he or she intends to disclose the information before doing so."

◈ "Guidelines for Protecting the Rights and Confidentiality of Patients", section 6.3

4.4 Assessing a child's decision-making capacity

Who decides?: The decision on the child's maturity and understanding is made by "**the medical practitioner concerned**".

The medical practitioner who is treating the child should be well-placed to assess whether the child understands the relevant health risks, benefits and implications. This medical practitioner is also likely to be objective about the child's decision-making capacity. Another reason for giving the medical practitioner this role is to avoid complicated procedures which might operate as barriers to a child's health care.

The standard: For both medical interventions and surgical operations, the test for the ability of a child over age 14 to give consent is that the child has "**sufficient maturity**" and the "**mental capacity**" to understand the "**benefits, risks and implications**" of the medical intervention or surgical operation.

The test for confidential medical counselling and advice is "**sufficient maturity**" to understand the benefits, risks and implications of a medical intervention, regardless of the child's age.

The Act gives no guidance on the criteria for assessing children's maturity and mental capacity. In practice, the Ministry of Health and Social Services will provide guidance on how to determine sufficient maturity and mental capacity.

At the time of writing, there is no case law on this question. Future court cases may give more content to the test. Some suggestions are provided in the boxes below.

◈ Child Care and Protection Act, section 220(1)(a)(ii) and (b)(ii)

Competence for decision-making relating to health

"The central elements of competence for decision-making relating to health are deemed to include:

- **Ability to understand and communicate relevant information**. The child needs to be able to understand the available alternatives, express a preference, articulate concerns and ask relevant questions.
- **Ability to think and choose with some degree of independence.** The child needs to be able to exercise a choice without coercion or manipulation and be capable of thinking through the issues for themselves.
- **Ability to assess the potential for benefit, risk and harm.** The child must be able to understand the consequences of different courses of action, how they will affect him or her, the risks involved and the short and long-term implications.
- **Achievement of a fairly stable set of values.** The child needs to have some value base from which to make a decision."

◈ G Lansdown, *The Evolving Capacities of the Child*, Innocenti Insight, Save the Children/UNICEF, 2005, page xi.

Issues to consider in addressing children's competence to make health decisions

"Alderson and Montgomery, in their analysis of the need for reform in the way children participate in their own health care decisions, conclude that many false adult assumptions limit children's participation. They observe that:

- The standards of informed consent actually achieved by many adult patients is low.
- Idealised standards of consent are unrealistic and discriminate against children.
- Adults, including doctors and parents, can make misguided decisions.
- Competence cannot be precisely defined or assessed.
- Excluding children from informed discussion can increase fear and undermine cooperation.
- Forcing treatment onto uncomprehending and resisting children sets an example of 'adult might is right'.
- Force ignores the growing evidence of very young children's ability to reason, understand, imagine, and feel terror and despair.
- Denying an adult's right to physical and mental integrity constitutes an assault; a very strong case is needed before this right is denied to children.
- Responding to children's reservations can help adults learn from children and to assess the risks and benefits of treatment more realistically.
- The burden of decision-making need not be carried out by children alone; respect can be combined with support.
- Young children can be wise and courageous.
- Children with experience of illness or disability can contribute unique and essential knowledge during decision-making.
- Children and adults can work together towards the best or least harmful decisions."

◈ G Lansdown, *The Evolving Capacities of the Child*, Innocenti Insight, Save the Children/UNICEF, 2005, page 55, citing P Alderson and J. Montgomery, *Health care choices*, Institute of Public Policy Research, London, 2001

Factors in assessing children's competence to make health decisions

In deciding whether a child is sufficiently mature, the following factors are useful:

- **Age**. Sufficient maturity is more likely the older the child.
- **Knowledge**. Children with knowledge about the relevant health issues are more likely to have sufficient maturity in respect of decision-making on those issues.
- **Experience**. Children with experience of the relevant health issues are more likely to meet the maturity requirements.
- **Judgement**. Children who show the ability to judge the advantages and disadvantages of the decision on the relevant health issue are likely to have the capacity to give informed consent.
- **Views**. Children who are able to articulate their views on the relevant health issue and whether it is in their best interests are likely to have sufficient maturity to give informed consent.
- **Circumstances**. A child's personal circumstances may be an important indicator of the child's ability, or lack thereof, to give independent informed consent. For instance, a child living independently from his or her family may be more likely to have sufficient maturity to make an independent and informed decision.

◈ adapted from Kitty Grant, Ray Lazarus, Ann Strode, Heidi van Rooyen and Marnie Vujovic, *Legal, ethical and counselling issues related to HIV testing of children, HIV testing of children: Legal guidelines for implementers,* South Africa: Human Sciences Research Council, 2012, page 17 (which considers competence to consent to HIV testing)

4.5 Substituted consent in non-emergency situations

There are special rules for emergency situations, discussed in the next section of this chapter. The procedure described here applies in *non-emergency* situations.

Lack of consent by PARENT, GUARDIAN OR CARE-GIVER: Any person with an interest in the well-being of a child can request the **Minister** to give consent to a medical intervention or a surgical operation in any one of four situations:

(1) The Minister can give consent if the parent, guardian or care-giver of the child **unreasonably refuses** to give consent, or to assist the child in giving consent.

(2) The Minister can give consent if the parent, guardian or care-giver of the child is **incapable** of giving consent or assisting the child in giving consent. For example, the only surviving parent might have a severe mental disability, or be unconscious because the entire family was in a road accident. The Minister may require medical evidence of the incapacity.

(3) The Minister can give consent if the parent, guardian or care-giver of the child cannot readily be traced. For example, this situation might arise where an abandoned child has been found in the veld. In other situations, the Minister may require evidence on why tracing is not possible or feasible.

(4) The Minister can give consent if the parent, guardian or care-giver of the child is **deceased**. The Minister may request a death certificate.

If the Minister refuses consent in any of these instances, any person with an interest in the well-being of the child may apply to a **children's court** for consent.

This is not an administrative review proceeding. It is a separate avenue to seek consent, which is intended to provide an extra safeguard for the child's best interests. However, it is not possible to approach the children's court for consent before first asking the Minister to give consent.

◈ Child Care and Protection Act, section 220(5) and (7)

Lack of consent by CHILD: Any person with an interest in the well-being of a child can request the **Minister** to give consent to a medical intervention or a surgical operation where the child is competent to give consent but **unreasonably refuses** to do so, or is **unable** to do so.

As in the case of parental consent, if the Minister refuses to overrule the child's lack of consent, any person with an interest in the well-being of the child may apply to a **children's court** for consent. This provides an extra safeguard for the child's well-being.

◈ Child Care and Protection Act, section 220(6)-(7)

The test for any decision regarding a child is what would be in the child's best interests.

Refusing consent on the grounds of religious or other beliefs

A person with responsibility for making health care decisions on behalf of a child may sometimes refuse consent on the grounds of their personal beliefs. For example, a parent who is a Jehovah's Witness might refuse to allow a child to receive a blood transfusion. A parent who believes in the power of traditional medicine might refuse to allow a child to receive other forms of medical treatment. While parents generally have the right to raise their children in the way that they see fit on matters of personal belief, this right has limits. A parent cannot impose his or her beliefs on a child in a way that is contrary to the child's best interests, or in a way that might violate the child's constitutional right to life.

If there is a medical intervention or a surgical procedure at stake which would be in the child's best interests, the Act says that **a parent, guardian or care-giver of a child may not refuse consent on the grounds of religious or other beliefs UNLESS that parent, guardian or care-giver can show that there is a medically accepted alternative**.

◈ Child Care and Protection Act, section 220(8)
◈ see *Hay v B & Others* 2003 (3) SA 492 (W) for a discussion of this issue in a different context
◈ see also *ES v AC* 2015 (4) NR 921 (SC), which considered the rights of the child in respect of the mother's refusal of treatment for herself on religious grounds in a potentially life-threatening situation

> "The right to life is a value that is constitutionally protected: 'There can be no more basic value constitutionally protected than the right to life.' *S v Makwanyane and Another* 1995 (3) SA 391 (CC) ... at para [144]. If the transfusion is not administered, the death of baby R is imminent. His right to life is an inviolable one. This is a right that is capable of protection. It is in the best interests of baby R that this right be protected. He will live as a human being, be part of a broader community and share in the experience of humanity. I am alive to the fundamental beliefs espoused by the [child's parents]. I respect their private religious beliefs. However, in the present matter, the evidence establishes that their beliefs negate the essential content of the right in question. The [infant's attending paediatrician] is adamant that baby R's best chance of survival would be by the immediate administration of a blood transfusion. The [parents'] concerns are understandable. However, they are neither reasonable nor justifiable. Their private beliefs cannot override baby R's right to life."
>
> ◈ *Hay v B & Others* 2003 (3) SA 492 (W), page 495

4.6 Emergencies

The Act provides a special consent procedure for emergencies since an emergency will often require quick decision-making.

What is an emergency?: The Act does not actually use the term "emergency", this is shorthand for what the Act describes as a situation where

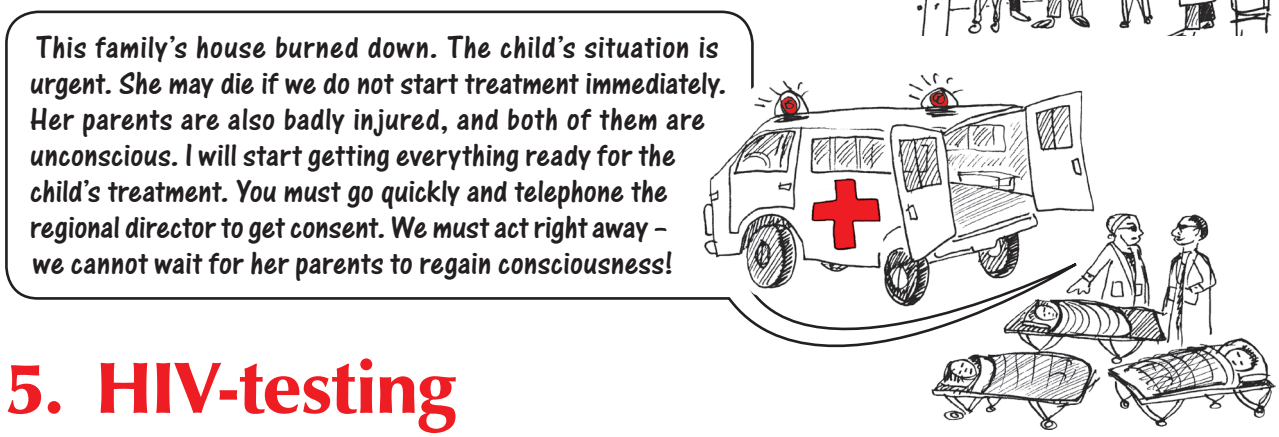
(1) a medical intervention or surgical operation is **necessary** to **preserve the life of a child** or to **save a child from serious or lasting physical harm or disability**
AND
(2) the situation is so **urgent** that the medical intervention or surgical operation should not be delayed in order to obtain the usual consent.

Who can give consent in an emergency?: In an emergency, consent for medical action in respect of a child can be given by the senior official of the health facility. This is:

- the **superintendent** of a State hospital
- the **regional director** of a State clinic
- an **acting superintendent** or **acting regional director**
- an **equivalent official in a private hospital or clinic**.

◈ Child Care and Protection Act, section 220(4)

TECHNICAL NOTE: The wording in the Act may be outdated. It appears that the reference in section 220(4) to the "regional director of a clinic" was probably intended to refer to the official at a clinic who is analogous to the "superintendent of a hospital". If the provision was intended to refer to the "regional director" in respect of a clinic, this administrative official is unlikely to be on the clinic premises when an emergency arises and may in practice need to be contacted by telephone to give consent in an emergency.



5. HIV-testing

Most diagnostic tests would fall under the heading of medical interventions. However there are special rules regarding HIV testing because of the stigma sometimes associated with HIV infection and because of the implications of HIV infection for other persons (such as the unborn child of a pregnant woman, a health care provider who is exposed to a patient's blood or a sexual partner).

❝ There may be complex considerations to be taken into account by parents, caregivers or children themselves when deciding to have an HIV test. HIV testing may have implications for the child's mother and her own HIV status, there may be fears of being stigmatised and discriminated against if the child is HIV-positive and, with older adolescents, there may be concern about testing HIV-positive and then facing community disapproval for having engaged in underage sexual activity. Before anti-retroviral (ARV) treatment was widely available, HIV testing was not always in the best interests of children. Knowledge of their HIV status could result in discrimination (for example, HIV-positive toddlers were excluded from pre-schools based on misguided fears that they posed a risk to other children).

Within the new context of widespread access to ARVs and the health advantages of early diagnosis of HIV, there are enormous benefits attached to HIV testing. Nevertheless, social factors often still act as barriers to HIV testing and can result in delays in children (and their caregivers) establishing their HIV status. Delaying HIV testing can have serious implications for the health of children who may be at risk or who are already infected with HIV. Therefore, it is important to promote HIV testing and to facilitate a greater uptake of HIV testing amongst children, whilst understanding the complexities that accompany such action. ❞

◈ Kitty Grant, Ray Lazarus, Ann Strode, Heidi van Rooyen and Marnie Vujovic, *Legal, ethical and counselling issues related to HIV testing of children, HIV testing of children: Legal guidelines for implementers,* South Africa: Human Sciences Research Council, 2012, pages 7-8

5.1 Consent to HIV testing

When can the child give consent?: A child may give independent consent to HIV testing in respect of himself or herself if –

(1) the child is **14 years of age** or older
OR

(2) the child is under the age of 14 years BUT the person who conducts the pre-test counselling is satisfied that the child is of **sufficient maturity to understand the benefits, risks and social implications of an HIV test**.

> **Note that this standard is DIFFERENT from the standard for independent consent to a medical intervention.** The standard for HIV testing is NOT a two-part test. Instead, it has *two alternative standards* for establishing the child's right to give independent consent to HIV testing. (1) The child must be age 14 or above. If the child has reached age 14, no other assessment is required. (2) If the child is under age 14, the child can nevertheless give independent consent to an HIV test if the child is determined by the pre-test counsellor to have sufficient maturity. The child can give independent consent to an HIV test if EITHER of these rules applies.

◈ Child Care and Protection Act, section 220(2)

Consent to an HIV test on a child by a parent or guardian: Where the child lacks the capacity to consent to an HIV test, the decision on this issue is made by the child's parent or guardian. If the child has no parent or guardian, then the decision is made by the child's care-giver. The parent or guardian (or if there is no parent or guardian, the care-giver) can consent to an HIV test on a child only if the test is in the child's best interest.

> An HIV test can enable a child to be provided with life-saving medical intervention.
>
> For example, suppose that a young child has been raped, or has otherwise encountered bodily fluids which could expose the child to HIV. The child should automatically receive immediate post-exposure prophylaxis (PEP) in such circumstances, but it will be important to know if the child was actually exposed to HIV to inform a decision on whether or not to continue preventative medication. An HIV test in these circumstances would clearly be in the child's best interests.
>
> Another example is where two 13-year-old children have had a consensual sexual relationship. Neither child has committed a criminal offence because they are of the same age. However, sexual activity at such a young age would suggest that a range of steps to protect the children should be explored. Taking an HIV test is one such step, particularly if one of the children has been in a sexual relationship with someone else before. An HIV test in these circumstances would almost certainly be in both children's best interests.

◈ Child Care and Protection Act, section 221(1)(a)

Lack of consent: The procedures for addressing lack of consent work in the same way for an HIV test as for a medical intervention.

Any person with an interest in the well-being of a child can request the **Minister** to give consent to a medical intervention or a surgical operation if the **PARENT, GUARDIAN OR CARE-GIVER OF THE CHILD unreasonably refuses** to give consent, is **incapable** of giving consent, **cannot readily be traced** or is **deceased**. If the Minister refuses consent in any of these instances, any person with an interest in the well-being of the child may apply to a **children's court** for consent.

Any person with an interest in the well-being of a child can request the **Minister** to give consent to an HIV test where the **CHILD** is competent to give consent but **unreasonably refuses** to do so, or is **unable** to do so. If the Minister refuses consent in either of these instances, any person with an interest in the well-being of the child may apply to a **children's court** for consent.

◈ Child Care and Protection Act, section 221(1)(3)

Documentation of consent

"Consent for testing children should be carefully documented."

◈ *National Guidelines on HIV Testing Services*, Windhoek: Ministry of Health and Social Services, 2018, page 8

"Mortality is very high in the first year of life among **infants** infected with HIV who do not receive treatment Therefore, early HIV testing, prompt return of results and rapid initiation of treatment is important."

"Perinatally infected **adolescents** need urgent diagnosis so as to access HIV care and treatment. Adolescence is a period of high risk of HIV infection, especially for adolescent KP and girls who are generally more vulnerable to HIV infection than boys." [KP stands for key populations, which are groups who are at increased risk for HIV due to specific higher-risk behaviour.]

◈ *National Guidelines on HIV Testing Services*, Windhoek: Ministry of Health and Social Services, 2018, pages 18, 21 (emphasis added)

5.2 HIV testing of a child regardless of consent

There are three situations where an HIV test can be performed on a child without the consent of either the child or the child's parent, guardian or care-giver:

(1) The test is necessary to establish whether a person who is working with the child in a health care setting may have been exposed to HIV due to contact with any relevant substance from the child's body. For example, this would apply in a situation where there is a needle stick injury that might expose a health care provider to HIV.

(2) The test is necessary to establish whether a person in some other context may have been exposed to HIV due to contact with any relevant substance from the child's body IF the test in these circumstances is authorised by a court. For example, suppose that a 10-year-old child was in an accident at school, with the result that several other children

were exposed to the child's blood. The parents of the other children want the child in question to have an immediate HIV test to inform their decision on preventative treatment for their children. The 10-year-old child's parents might refuse to consent to this test. In such a case, it would be possible for an involuntary HIV test to be administered, but ONLY if a court ordered it.

The Act does not specify what "**court**" means for the purposes of this provision. It could be a children's court, a High Court or the Supreme Court considering a case on appeal.

(3) The child is pregnant. A test in these circumstances could reveal whether or not the pregnant child needs medication to prevent mother-to-child transmission of HIV.

Note that in the first two circumstances, the HIV test must be "**necessary**". This means that the HIV test of the child must be the only way in which the health care worker or other person can know about the HIV status of the child and that there are no less invasive means to get this information. For example, if the child has already been tested and found HIV-positive, this information could be provided by the parents rather than subjecting the child to another test.

In all three of these circumstances, the interests of the **third parties** are of clear concern. This is why these circumstances are exceptions to the normal approach to consent. Furthermore, the interests of the child in question will not usually be negatively affected by testing in these circumstances. An HIV test is not unduly intrusive for the child, and the child will normally benefit from knowing his or her own HIV status, since this information can open the door to life-saving treatment.

◈ Child Care and Protection Act, section 220(1)(b)

5.3 Pre and post-test counselling

Pre-test counselling: Regardless of the circumstances of the HIV test, a child may be tested for HIV only after proper counselling is provided by an appropriately trained person:

(1) The **child** must receive counselling, unless the person doing the counselling is satisfied that the child's young age or lack of maturity would prevent the child from benefitting from counselling. For example, it would obviously not be helpful to counsel an infant.

(2) The child's **parent, guardian or care-giver** must receive counselling *where he or she has knowledge of the test*. If the parent, guardian or care-giver is the decision-maker, he or she will obviously have this knowledge. Where the child has the required age or capacity to be the decision-maker on testing and disclosure, the decision on whether to inform the parent or guardian of the test or its outcomes will rest with the child.

Post-test counselling: Regardless of the circumstances of the HIV test, the same rules apply to post-test counselling for the child and/or the child's parent, guardian or care-giver. In other words, anyone who received pre-test counselling must also receive post-test counselling by an appropriately trained person.

◈ Child Care and Protection Act, section 222

HIV test counselling

"Clients should receive pre-test information either as individuals or in a group setting. If clients request the opportunity to ask questions after a group session, this service should be provided in a private setting. When the test results are ready, clients should receive post-test counselling based on the specific HIV test result in a private setting."

◈ *National Guidelines on HIV Testing Services*, Windhoek: Ministry of Health and Social Services, 2018, page 9

When consent to HIV testing does not match consent to HIV treatment

The test for a child's competence to give independent consent to HIV testing is *different* from the test for a child's competence to give independent consent to medical intervention (which would include HIV treatment). It is possible for a child under age 14 to be competent to consent to HIV testing, but it is *not* possible for a child under age 14 to be found competent to consent to medical intervention. One practical problem which may result is that a child could be competent to consent to HIV testing without being competent to consent to HIV treatment if the test results are positive. In such a situation, the child could be counselled during pre-testing (1) to agree that the parent or guardian can be contacted to authorise treatment or (2) to postpone the testing. It may be better to delay testing rather than to test a child who cannot access treatment if the test is positive because of the child's reluctance to involve the parent or guardian.

◈ Child Care and Protection Act, section 220(1) compared to section 221(2)

5.4 Confidentiality of HIV-positive status of children

There are strict rules on the confidentiality of information about a child's HIV-positive status. Violation of confidentiality in respect of this issue is a crime.

There are separate rules for HIV testing and disclosure of HIV-positive status because these issues do not always arise together.

For example, a child who was tested some time ago with parental consent might now want to disclose the test results to access treatment independently, regardless of the parent's views on this.

Disclosure with consent: A child may give independent consent to his or her own HIV-positive status if –

(1) the child is **14 years of age** or older
OR
(2) the child is under the age of 14 years BUT the person who conducts the pre-test or post-test counselling is satisfied that the child is of **sufficient maturity to understand the benefits, risks and social implications of disclosure**.

Where a child is competent to give consent to an HIV test, the child is almost certainly competent to consent to disclosure of an HIV-positive status. It is likely that a child who understands the implications of HIV *testing* will also understand the implications of *disclosure of the test results*.

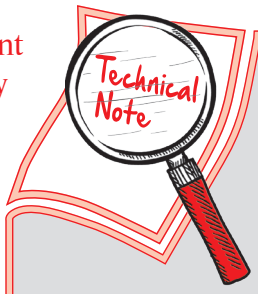
Where the child lacks the capacity to consent to disclosure of his or her HIV status, the decision on this issue is made by the child's parent or guardian. If the child has no parent or guardian, then the decision is made by the child's care-giver.

The procedures for addressing lack of consent to disclosure of HIV status by the child, or by the child's parent, guardian or care-giver, work in the same way as for an HIV test.

Disclosure without consent: Disclosure by a person of a child's HIV-positive status WITHOUT the appropriate consent is permissible ONLY in very limited circumstances:

(1) Disclosure is within the scope of the person's powers and duties in terms of the Child Care and Protection Act or any other law.
(2) Disclosure is necessary for the purpose of carrying out the provisions of the Child Care and Protection Act.
(3) Disclosure is for the purpose of legal proceedings.
(4) Disclosure is made in terms of a court order.

For example, an application for adoption requires an adoption report prepared by a social worker with comprehensive details regarding the adoptable child, including a medical report on the health status of the child and any special needs of the child. (See Child Care and Protection Act, section 175(1)(b) and Child Care and Protection Regulations, regulation 68.) It would be important to



Section 223(1) of the Act states that "A person may not disclose the fact that a child is HIV-positive without consent given in terms of subsection (2)", except for certain limited exceptions. Subsection (2) refers only to the ability of a *child* to give independent consent.

However, consent by a *parent or guardian* is imported into this section by subsection 223(3), which states: "For the purpose of consent, section 220(2) to (7) applies with necessary changes to this section."

Therefore, section 223(3) imports the rules on consent in section 220(2)-(7) into the concept of consent in section 223.

This would indicate that section 223(1) applies when the child refuses consent OR where the child is not competent to give consent and the parent, guardian or care-taker refuses consent.

◈ Child Care and Protection Act, section 223(1) and (3)

Confidentiality

"Confidentiality is the right of the individual to privacy and dignity and must be maintained at all times. It pertains to the individual's disclosure of personal information in a relationship of trust, with the expectation that it will not be divulged to others in ways that are contrary to the rights of the client. Discussions between the [HIV Testing Services] provider and the client should be confidential. This means that the information discussed should not be disclosed to anyone else without the consent of the person being tested. Shared confidentiality is when the [HIV Testing Services] provider shares the individual's information with other service providers who are involved in the care of the individual or with other people with permission from the client. Confidentiality should not be used to reinforce secrecy, stigma or shame."

◈ *National Guidelines on HIV Testing Services*, Windhoek: Ministry of Health and Social Services, 2018, page 9

include information that a child was HIV-positive in this report, to make sure that the parents were prepared to ensure that the child received appropriate treatment and medication.

Penalty for unlawful disclosure: Unlawful disclosure of a child's HIV-positive status is a crime which is punishable by a fine not of up to N$20 000 or imprisonment for up to five years, or both.

◈ Child Care and Protection Act, section 223

6. Consent by child-parents

When can a child who has become a parent give consent to health services in respect of his or her own child?

The Act does not use the term "child-parent", for this situation, but this term provides a useful shorthand.

A child-parent who is competent to consent to a medical intervention, a surgical operation, HIV testing or disclosure of HIV status in respect of himself or herself is also competent to consent to these things in respect of his or her child.

This means that a child-parent can consent to medical intervention or a surgical operation on his or her child if the child-parent is at least 14 years old AND the medical practitioner concerned is satisfied that the child-parent has sufficient maturity and the mental capacity to understand the benefits, risks and implications of the medical intervention or surgical operation.

This means that a child-parent can consent to HIV testing or disclosure of HIV status in respect of his or her child if the child-parent is at least 14 years old OR the child-parent's HIV test counsellor is satisfied that the child-parent has sufficient maturity to understand the benefits, risks and social implications of the test or the disclosure.

If the child-parent does NOT have the required capacity for independent decision-making on these issues, then the child-parent's own parent or guardian would hold the decision-making power for the child of the child-parent.

The rules on emergency situations and the rules on lack of consent would apply in the usual way to decision-making in this situation.

◈ Child Care and Protection Act, sections 220(2), 221(3), 223(3)

7. Health care decision-making powers of alternative care-givers

Certain parental powers are *transferred* to care-givers when a child is placed in alternative care *by means of a court order*. These include certain powers regarding health care decisions.

When a child is placed *by court order* with a **foster parent** or a **kinship care-giver**, or in a **residential child care facility**, that care-giver has certain health-related duties:

(1) That care-giver must obtain **basic medical intervention** for the child if reasonable grounds exist to believe that the child requires such intervention.

(2) That care-giver must ensure that the child obtains a **surgical operation** IF
   (a) there are **reasonable grounds** to believe that the **child urgently requires the operation** AND
   (b) that **deferring it to permit consultation** with the child's parent (or other person from whom custody was transferred) **would prejudice the child's health or welfare**.

The management of a residential child care facility may delegate these responsibilities to the facility's manager.

◈ Child Care and Protection Act, section 149(4)-(5)

8. Examination and treatment of abused or neglected child

There is an exception to the general rules on consent when certain health practitioners encounter a child whom they suspect of having been abused or deliberately neglected.

This exception is necessary because the child's parent or care-giver may be responsible for the abuse or neglect, or may want to protect some other person who was responsible. In such a situation, the parent may refuse consent for examination or treatment which the child needs.

The rules which apply to emergencies may be relevant in this situation as well. (See section 4.5 above.)

Who can utilise the exception?: The exceptions can be utilised by a medical, dental, social work, psychology, nursing or allied health practitioner, who is acting within the scope of his or her duty.

◈ Child Care and Protection Act, section 224(1)

When does the exception apply?: The exceptions apply when the health practitioner suspects that a child has been abused or deliberately neglected.

◈ Child Care and Protection Act, section 224(1)

What does the exception allow?: In this situation, the health practitioner may do certain things WITHOUT THE CONSENT of the child's parent, guardian or care-giver – regardless of the age of the child.

(1) The health practitioner may **conduct an assessment or examination** of the child for medical or forensic purposes or both. "Forensic" refers to examining the child with a view to collecting evidence that may be use in court. For example, this would apply to the administration of a rape kit in respect of a child who is suspected to have been sexually abused.

(2) The health practitioner may **provide any reasonable medical interventions required to respond to the suspected abuse or neglect**. For example, a doctor who suspects a form of sexual abuse which could have transmitted HIV may provide post-exposure prophylaxis (PEP).

There is one caveat: **The health practitioner may NOT administer general anaesthetic to the child without following the normal consent procedures.**

For example, it may sometimes be desirable to administer a general anaesthetic to conduct a thorough examination of a very young child in the case of sexual abuse. But, because general anaesthetic always has some risks, its use is not exempted from the usual consent requirements. This means that the use of a general anaesthetic would require consent from the child or from the child's parent, guardian or care-giver depending on the child's age and maturity, or substituted consent from the Minister or ultimately from a children's court.

◈ Child Care and Protection Act, section 224(1)

Child participation: A health practitioner who is utilising the exception to the normal procedures must obtain the oral or written consent of the child being assessed or examined IF the child is of sufficient maturity and has the mental capacity to understand the reasons for the assessment or examination.

But the health practitioner may proceed without the child's consent if he or she considers this to be in the child's best interests. If no consent was obtained from a child even though the child did appear to have the required level of maturity and understanding, the health practitioner must –

- record in writing the reasons for proceeding without the child's consent, and
- explain the situation to the child if the child appears to the health practitioner to be capable of understanding the explanation.

◈ Child Care and Protection Act, section 224(2)

Guidelines for the examination of an abused or neglected child

The Act contains some guidelines for a person who is conducting an assessment or examination of a child who is suspected of having been abused or deliberately neglected. These guidelines are intended to ensure that such children are not subjected to any further trauma. The guidelines must be followed insofar as possible and practical; the Act acknowledges that there is a need for some flexibility.

(1) The health practitioner should address the child in a **language which the child understands**.
(2) The health practitioner should allow the child to be accompanied by a s**upport person** of the child's choice, unless the child expresses a wish not to be accompanied by any support person (in a case where the child has sufficient maturity and mental capacity to understand the reasons for the assessment or examination).
(3) The health practitioner should **treat the child with empathy, care and understanding**, and show due respect for the child's right to privacy and confidentiality.
(4) The health practitioner should examine or assess the child in a **child-friendly environment.**
(5) The health practitioner should conduct the assessment or examination in **private**, outside the presence of any one who is not required to be present.
(6) The health practitioner should **respect the child's dignity**.

◈ Child Care and Protection Act, section 224(3)

Practical suggestions for child-sensitive medical examinations

The Child Care and Protection Act does not include any detailed guidance on what constitutes a child-friendly environment for examination or assessment, or what steps can be taken to promote empathy, care and understanding for the child. The following practical suggestions come from the United States:

"
- Assess the child/adolescent's level of fearfulness before the exam. This information will be helpful in determining appropriate preparation strategies.
- Be aware of fears specific to age or developmental level and be familiar with some management techniques.
- Allow the child/adolescent as much control as possible during all phases of the exam.
- Ascertain the child/adolescent's understanding about the reasons for the exam as well as what he/she thinks will happen during the exam. Explain the exam in child-friendly language that uses developmentally appropriate words. Remember that children often interpret statements very literally.
- Use dolls or other visual methods with younger children to demonstrate the exam procedures. Allow the child to play the role of the medical provider. This may provide the child with a sense of control and mastery over the situation while allowing emotional distance.
- Allow children and adolescents to choose whether they would like a parent or caregiver present during the examination. In order to prevent placing unnecessary pressure on the child/adolescent, avoid asking him/her to decide in front of that adult.
- Be careful about physical boundaries. Avoid touching the child/adolescent except for examination purposes.
- Consider using relaxation techniques with older children and adolescents. (e.g., progressive muscle relaxation, controlled breathing exercises, guided imagery).
- If the parent/caregiver is present during the exam, assign that person a specific role or task to perform. This will diminish anxiety and will likely decrease the child/adolescent's fear as well.
- Avoid the use of medical restraints or force of any kind during the examination. If the child/adolescent refuses an examination, the medical provider and parent/caregiver should consider the ramifications of this refusal. If there is suspicion of injury or infection and the child/adolescent is too frightened or unwilling to cooperate, consider anaesthesia.
- In every case, the medical and emotional needs of the child/adolescent should come before the legal needs."

◈ Anne A Botash, MD, "physical examination",
Child abuse evaluation & treatment for medical providers,
Syracuse, New York: SUNY Upstate Medical University, 2005-2019,
online book available at www.childabusemd.com.

Mandatory reporting duty: People who perform professional or official duties involving children are required to make a report if, during the course of their duties, they come across "information that gives rise to a suspicion that a child is or may be in need of protective services". In such a case, they must alert police or any State-employed social worker. The mandatory reporting duty applies even if the information on which the belief is based is protected by a professional privilege, such as doctor-patient privilege.

This applies to health professionals, including doctors, dentists, nurses, pharmacists, psychologists and psychological counsellors, physiotherapists, speech and occupational therapists and traditional health practitioners.

Professionals covered by the provision on mandatory reporting are expected to make their reports on **Form 13A**, which is appended to the Child Care and Protection Regulations (or in a similar format). Health professionals should ideally keep a stock of these forms on hand. The professional who is making the report may not have all the information which the form requests, but he or she should provide as much information as possible.

A report from a professional cannot be made anonymously, but the identity of the person who made the report can be kept confidential unless the interests of justice require otherwise.

Failure to report is a crime punishable by a fine of up to N$20 000, or imprisonment for up to five years, or both.

◈ Child Care and Protection Act, sections 131-132
◈ Child Care and Protection Regulations, regulation 44(1), Form 13A

DUTY OF CONFIDENTIALITY AND CHILDREN AT RISK

Ethical Guidelines For Health Professions
Health Professions Council of Namibia, 2010

"10.4 A minor patient of mine has recently been admitted to hospital suffering serious injuries from abuse. His or her father is now being prosecuted. I've been asked to provide information about the child and her family for a Children's Court inquiry. I'm the General Practitioner to the child's father and he refuses to consent to the release of information, what should I do?

This inquiry is intended to identify why the child has been seriously harmed, to learn lessons from mistakes and to improve systems and services for children and their families. The overall purpose is to protect children from a risk of serious harm. The health professionals should therefore co-operate with requests for information, even where the child's family does not consent, or if it is not practicable to ask for their consent. Exceptionally, he or she may see a good reason not to disclose information; in such cases the health professionals should be prepared to explain his or her decision to the Council."

◈ Frequently Asked Questions", Point 10.4