Children's right to health: A contextual analysis of the influences of Jehovah's Witness-guardians' consent to life-saving medical procedures for children in Zambia

Submitted in partial fulfilment of the requirements of the Master of Laws Degree

(Human Rights and Democratisation in Africa)

by

Bwalya Chisanga

Prepared under the supervision of

Dr Akinola Akintayo

Faculty of Law, University of Lagos, Nigeria

and

Dr Elvis Fokala

Faculty of Law, University of Pretoria, South Africa

29 October 2021

Plagiarism declaration

I, Student number **21801470** declare as follows:

1. I understand what plagiarism entails and I am aware of the University's policy in this regard.
2. This dissertation is my own, original work. Where someone else's work has been used (whether from a printed source, the internet, or any other source), due acknowledgment has been given and reference made according to the requirements of the Faculty of Law.
3. I did not make use of another student's work and submit it as my own.
4. I did not allow anyone to copy my work with the aim of presenting it as his or her own work.

Signature: B.C

Date: 29 October 2021

Dedication

This dissertation is dedicated to my beautiful mother, and to all the children in the world.

Acknowledgments

I would not have completed this dissertation without the endless support and guidance I received from various people and organisations. My deepest gratitude goes to my lovely mother, who gained her wings when I was half-way through this LLM. I wish you were here; I miss you every day, and I will always love you.

My profound gratitude to the entire team at the Centre for Human Rights, for giving me an opportunity to further my studies and advance my career. Further, I extend my sincere gratitude to both the European Union through the Global Campus of Human Rights, and the Right Livelihood Foundation for funding my studies.

I also appreciate my supervisors: Dr Akinola Akintayo and Dr Elvis Fokala for their timely feedback, insightful guidance and for stretching my intellectual capabilities. Special thanks to Professor Kenneth Mwenda, Landilani Banda, Moses Ngulube, Aretha Miyoba and Vanessa Simamba, for their sacrifices and assistance during my studies. Finally, I thank my family- especially my little best friend Adrian Chama-Botha and my siblings, my friends, HRDA classmates, and colleagues who supported me in different ways throughout my studies. May your sun never set!

Abbreviations

ACRWC	African Charter on the Rights and Welfare of the Child
AET	Adverse Effect Theory
AU	African Union
BIC	Best Interests of the Child
BMAT	Better Medical Alternatives Theory
BoR	Bill of Rights
BT	Blood Transfusion
CARHT	Children as Right-Holders Theory
CCYP	Commissioner for Children and Young People
CDO	Child Development Officer
CHP	Children's Health-Care Partnerships
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CTR	Care Treatment and Rehabilitation
DCD	Department of Child Development
ECHR	European Convention on Human Rights
GAT	Guardian's Authority Theory
GBV	Gender Based Violence
HCU	Health Care User
HRA	Human Rights Act

ICRTH	Inclusive Interpretation of Children's Right to Health
JW	Jehovah's Witnesses
LGAT	Limited Guardian's Authority Theory
LSGD	Life, Survival, Growth and Development
MHA	Mental Health Act
MHCA	Mental Health Care Act
MLTI	Major Long-Term Issue
NHA	National Health Act
PDA	Persons with Disabilities Act
RIAA	Ratification of International Agreements Act
RTH	Right to Health
SADC	Southern Africa Development Community
SCD	Sickle Cell Disease
UN	United Nations

Table of contents

1. Introduction

1.1. Background

Children comprise approximately 27% of the total world population,[1] with almost half of the current population in Africa being under 18 years of age.[2] 'Age' is central in children's rights discourse, and it starts with the definition of a child. According to article 1 of the United Nations (UN) Convention on the Rights of the Child (CRC),[3] every person below the age of 18 is a child, unless majority is attained earlier under applicable laws. Similarly, article 2 of the African Charter on the Rights and Welfare of the Child (ACRWC),[4] provides without any exception like that under the CRC, that a child is anyone below the age of 18. Therefore, international children's rights law generally provides that everyone below the age of 18 is a child who is entitled to all the rights provided in the CRC and the ACRWC. According to article 24 of the CRC and article 14 of the ACRWC respectively, children have the right to enjoy the highest and best attainable standard of health. Both instruments not only espouse the state's primary duty to ensure the full implementation of this right, but also outline the specific measures that need to be taken in this regard.[5]

Zambia ratified both the CRC and the ACRWC on 6 December 1991[6] and 2 December 2008,[7] respectively. The ratification of these instruments has been tailed by adopting domestic laws for the protection of children's rights, like the Juveniles Act.[8] The Constitution of Zambia[9] also guarantees children's rights like the right to life[10] under its

[1] Gap minder 'The world has reached peak number of children!' (2021) https://www.gapminder.org/news/world-peak-number-of-children-is-now/ (accessed 21 August 2021).
[2] United Nations International Children's Emergency Fund 'Children in Africa: Key statistics on child survival and population' (2017) https://data.unicef.org/wp-content/uploads/2019/01/Children-in-Africa.pdf (accessed 27 August 2021).
[3] Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) E/CN.4/RES/1990/74.
[4] African Charter on the Rights and Welfare of the Child (adopted 1 July 1990, entered into force 29 November 1999) CAB/LEG/24.9/49.
[5] n3 and n4 article 2.
[6] UN Human Rights Treaty Bodies 'UN Treaty Body Database' (2021) https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=194&Lang=EN accessed 27 August 2021).
[7] African Union 'African Charter on the Rights and Welfare of the Child' (2021) https://au.int/sites/default/files/treaties/36804-sl-AFRICAN%20CHARTER%20ON%20THE%20RIGHTS%20AND%20WELFARE%20OF%20THE%20CHILD.pdf (accessed 26 August 2021).
[8] Juveniles Act chapter 53 of the laws of Zambia.
[9] Constitution of Zambia Act 2 of 2016.
[10] As above article 12.

Bill of Rights (BoR).[11] However, to a greater extent, there are gaps in the domestication of the CRC and ACRWC into Zambia's national law.[12] Comparatively, African countries like South Africa have the Children's Act,[13] which codifies children's rights issues like the right to health (RTH), unlike Zambia.

This study focusses on the Jehovah's Witnesses (JW), a Christian group accounting for a ratio of 1 to 89 of the total Zambian population,[14] as at 23 October 2021.[15] The rationale for focusing on this group is because of their fundamental beliefs, which explicitly proscribe them from 'accepting whole blood or its primary components in any form.'[16] The JW believe that there are valid medical reasons to avoid blood transfusions (BT)[17] and that God commands abstinence from blood, because it represents what is sacred to Him.[18] On this basis, their belief is that they, like the children for whom they are responsible, should not receive BT.[19] Requests for consent to blood or blood product administration is therefore likely to be refused in any circumstance.[20] This belief system has actual or potential harm on the RTH for children requiring BT.

The need for BT arises frequently in children's healthcare to treat injuries and illnesses affecting the blood.[21] These illnesses include sickle cell disease (SCD), thalassemia, aplastic anemia and other illnesses due to disease-modifying treatments, such as chemotherapy for cancer.[22] BT is also needed for the treatment of children have lost blood due to an injury or surgery.[23] JW in Zambia have in the past and currently refused to consent to BT for their children solely on the basis of their religious beliefs. As recent as November 2015, the High Court (HC) for Zambia in the landmark

[11] As above articles 11-26.
[12] Save the Children 'Protecting children in Zambia from violence, abuse, neglect and exploitation' (2011) https://resourcecentre.savethechildren.net/node/4444/pdf/4444.pdf (accessed 4 September 2021).
[13] Children's Act 38 of 2005.
[14] Watch Tower Bible and Tract Society of Pennsylvania 'JW in Zambia' (2021) https://www.jw.org/en/jehovahs-witnesses/worldwide/ZM/ (accessed 18 August 2021).
[15] As above.
[16] Watch Tower Bible and Tract Society of Pennsylvania 'What does the Bible say about BT?' (2021) https://www.jw.org/en/bible-teachings/questions/bible-about-blood-transfusion/ (accessed 27 August 2021).
[17] For the purposes of this dissertation, 'blood transfusion9 (BT)' includes the transfusion of blood and blood products.
[18] n 16.
[19] Good Hope Hospital 'Policy for treatment of JW adults & children' (2020) https://www.transfusionguidelines.org (accessed 18 August 2021).
[20] As above.
[21] Yale Medicine 'BT for children' (2021) https://www.yalemedicine.org/conditions/child-blood-transfusions (accessed 27 August 2021).
[22] As above.
[23] As above.

case of *Monze Muyeka* v *Miniva Nakamba*[24] overruled the decision of a JW guardian[25] who refused requisite consent to BT for her three-year-old child with SCD, because of her religious belief. JW therefore form a significant group of interest with respect to the enjoyment of the highest and best attainable standard of health by children in Zambia.

The UN Committee on the Rights of the Child (the Committee) interprets article 24 of the CRC as an inclusive right concerning timely and appropriate prevention, and health promotion,[26] among others. The Committee further guides that the RTH encompasses children's right to grow and develop to their full potential, under conditions enabling them to attain the best standard of health.[27] Thus, there are several principles and premises relevant for realising children's RTH. These include the best interests of the child (BIC),[28] the right to be heard,[29] the right to life[30] and evolving capacities of the child.[31]

This dissertation assesses whether Zambia's current legal framework adequately and effectively protects children's RTH in view of guardians' religious-based denial of consent to BT. The analysis focuses on the competing norms between the JW guardians' authority to chart their children's moral and religious developments, and the children's RTH. The study identifies South Africa and the United Kingdom as comparators and analyses their respective frameworks for protecting children's RTH. Subsequently, it discusses Zambia's framework for protecting children's RTH, identifying the shortcomings, and drawing learning points from the comparators' frameworks. Consequently, the dissertation provides recommendations for implementation to attain an effective and robust children's RTH regime in Zambia.

[24] *Monze Muyeka v Miniva Nakamba 2015/HP/0974*.
[25] For the purposes of this dissertation, 'guardians' includes parents, care-givers and any other persons exercising legal responsibility over children and their welfare.
[26] UN Committee on the Rights of the Child 'General comment no 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health article 24' (17 April 2013) CRC/C/GC/15 https://www.refworld.org/docid/51ef9e134.html (accessed 27 August 2021).
[27] As above paragraph 2.
[28] As above paragraph 12-15.
[29] As above paragraph 19.
[30] As above paragraph 16-18.
[31] As above paragraph 20-22.

1.2. Problem statement

Children require particular care with regards to their health.[32] Guardians have the primary responsibility of the upbringing and development of children, including the decision-making authority over their healthcare, which must be in the child's best interest.[33] Put simply, guardians cannot, and should not, be excluded from the partnership in children's health care because their role is crucial to the well-being of the child.[34] Consequently, children's RTH is in a precarious situation because of the various factors informing their guardians in making those health-care decisions. Children's RTH is likely to be violated, when the denial of requisite consent to BT is based solely on religious beliefs,[35] and not the BIC. The growing population of JW in Zambia and their religious beliefs which proscribe medical procedures like BT, raises serious concerns about children RTH.

Medical personnel are obliged to uphold refusal of consent to BT by adult JW, even when life threatening. However, the position regarding children in such situations is unclear. Therefore, medical personnel with their health facilities, have resorted to seek court orders to sanction the use of blood products without removing all guardians' authority.[36] This is unsustainable and ineffective given that BT is often required under emergency-circumstances, whereas the process of seeking and acquiring court orders is seldom ever instantaneous in Zambia. The complex legal procedures and costs for acquiring court orders are additional impediments. This situation prevents medical personnel from providing children in Zambia timely life-saving health care, which adversely affects their health, and is sometimes fatal. This not only violates children's RTH, but also the principles and premises for realizing this right, as discussed above.

---

[32] n 4 preamble.
[33] TM Smith 'Pediatric decision-making: Help parents protect, empower kids' (26 December 2019) https://www.ama-assn.org/delivering-care/ethics/pediatric-decision-making-help-parents-protect-empower-kids (accessed 5 September 2021).
[34] E Fokala and A Rudman 'Age or maturity? African children's right to participate in medical decision-making processes' (2020) 20 *African Human Rights Law Journal* 667-687.
[35] L Ramphele 'KZN parents taken to court for denying their child medical intervention' (19 October 2019) http://www.capetalk.co.za/articles/324777/kzn-parents-taken-to-court-for-denying-their-child-medical-intervention (accessed 1 May 2021).
[36] n 19 page 13.

1.3. Research questions

The main research question in this study is: How can JW guardians exercise their authority over children's healthcare in a manner that protects the RTH for children in Zambia? The following are the supporting questions:

a. What theories exemplify the interplay between JW guardians' authority over the moral and religious developments of their children, and children's RTH?
b. What lessons can Zambia draw from the United Kingdom and South Africa to maximise the protection of children's RTH in Zambia?
c. Having regard to the specific contexts of child healthcare provision and the influences of JW doctrines in Zambia, is the current legal framework adequate and effective to protect children's RTH?
d. What recommendations can be suggested to ensure the effective protection of children's RTH in Zambia?

1.4. Methodology

This research will be desk-based and will adopt a human rights-based research approach, in view of Zambia's ratification of the CRC and the ACRWC. Among the primary sources are human rights instruments and general comments of committees, acts, bills, and case law. The study also uses secondary sources including books, journal articles, commentaries, and dissertations. Additionally, comparative legal research will be conducted to discern lessons from foreign jurisdictions on approaching children's RTH to shape necessary reform in Zambia.

1.5. Literature review

The topic of children's RTH and other factors related thereto, has attracted a considerable amount of interest from scholars, policy, and law makers globally. Lloyd provides a theoretical analysis of children's rights in Africa.[37] She refers to the ACRWC's article 26, which specifically provides for children's protection from apartheid and discrimination, in arguing that the ACRWC has successfully achieved its purpose of addressing Africa-

[37] A Lloyd 'A theoretical analysis of the reality of children's rights in Africa: An introduction to the African Charter on the Rights and Welfare of the Child' (2002) *African Human Rights Law Journal 2 No 1,* 11.

specific challenges for children.[38] Considering the interplay between children's illnesses and injuries whose course of treatment requires BT, and the role of religion in influencing guardian's decisions in children's healthcare in Africa, this dissertation diverts from Lloyd's findings that Africa-specific challenges are adequately addressed in the ACRWC. For instance, the World Health Organisation reports that about 200 000 out of the 300 000 infants born yearly with major hemoglobin disorders include cases of SCD in Africa.[39] Yet, there is no specific framework protecting children's RTH when their guardians refuse consent to lifesaving medical treatments like BT, on the sole basis of their religious beliefs. This dissertation fills the gap identified in Lloyd's research.

The Committee establishes the importance of approaching children's health from a child-rights perspective.[40] In doing so, the Committee identifies several premises and principles necessary for realizing children's RTH. Four of them are relevant to this study. First, is the principle of the BIC,[41] which must be observed in all health-related decisions concerning individual children, after having heard their views according to article 12 of the CRC.[42] Second, is the right to be heard[43] which includes children's entitlement to have their views heard on all aspects of health provisions, including what services they need, and the attitudes of health professionals,[44] among others. Third, is the evolving capacities and the life course of the child,[45] which recognizes that children's evolving capacities affect their independent decision making on health issues. The Committee also notes that there are often inconsistencies about children's autonomous decision-making.[46] Last, is the right to life, survival, and development,[47] which has many underlying risks and protective factors that need to be systematically identified, to devise pragmatic interventions based on evidence, which carter to all the determinants during the life course.[48] While acknowledging the adequacy of the Committee's writings in expounding

[38] A Lloyd (n 37) page 13.
[39] World Health Organisation 'Sickle-cell anemia' 24 April 2006 https://apps.who.int/gb/ebwha/pdf_files/WHA59/A59_9-en.pdf (accessed 19 August 2021).
[40] n 26 paragraph 1.
[41] n 3 article 3(1).
[42] n 26 paragraph 12.
[43] n 3 article 12.
[44] n 26 paragraph 19.
[45] n 26 paragraph f.
[46] n 26 paragraph 21.
[47] n 3 article 6.
[48] n 26 paragraph 16.

on children's RTH, its limitation is in its universal approach to children's RTH. Therefore, this dissertation seeks to keep the magnifying lens on the healthcare challenges ravaging children in Africa, particularly in Zambia and the religious influences which have ultimately impeded children's RTH.

As far back as 1979, authors like Wald have cautioned about the vulnerability of children's rights to violations by their care givers.[49] He posits that sometimes, adults make decisions that have far-reaching consequences for children and are not in children's best interests. Similarly, Ekundayo reiterates that parental control and protection could sometimes be harmful and oppressive to children.[50] Additionally, Woolley explains that the law allows both children and the state to limit and intervene in guardians' decisions over their children's healthcare.[51] Wooley further finds that competent children can consent to treatment, like the state can interfere when guardians' healthcare decisions are not in the BIC. However, all the preceding literature is generic and not catered to the context, and challenges affecting children's RTH in Zambia. This study fills in that gap.

In analysing the legal aspects of refusal of BT by JW, Petrini outlines the specific Bible verses which influence the doctrine proscribing BT among JW.[52] He however opines that the said verses prohibited the ingestion of blood as food, which position only changed after an article in the JW's magazine argued that food and BT are the same. Petrini notes that the doctrine proscribing BT is a matter of debate even among JW,[53] with the possibility that in the future, the official position may change, or at least become less rigid.[54] However, Petrini's work is focused on Italy and does not focus on children, unlike this dissertation whose focus is on Zambia and children. Meanwhile, McQuoid-Mason investigates whether in circumstances of a guardian's refusal to BT, guardians must apply

[49] M Wald 'Children's rights: A framework for analysis' (1979) Vol 12 *University of California Davis Journal* 255-282.
[50] O Ekundayo 'Does the African Charter on the Rights and Welfare of the Child only underline and repeat the Convention on the Rights of the Child provisions: Examining the similarities and differences' (2015) Vol 5 no 7(1), *International Journal of Humanities and Social Science* 143.
[51] SL Woolley 'The limits of parental responsibility regarding medical treatment decisions' (10 January 2011) https://pubmed.ncbi.nlm.nih.gov/21220259/ (accessed 27 August 2021).
[52] C Petrini 'Ethical and legal aspects of refusal of BT by JW, with particular reference to Italy' (2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3934270/ (accessed 27 August 2021).
[53] R Gillon *Refusal of potentially life-saving BT by JW: should doctors explain that not all JWs think it's religiously required?* (2000) 299–301 quoted in C Petrini 'Ethical and legal aspects of refusal of BT by JW, with particular reference to Italy' (2014).
[54] L Elder *Why some JW accept blood and conscientiously reject official Watchtower Society blood policy* (2000) 375 quoted in C Petrini 'Ethical and legal aspects of refusal of BT by JW, with particular reference to Italy' (2014).

to reverse the decision by medical personnel to give children lifesaving BT; or: doctors must apply to court to overcome the guardian's refusal to consent to BT.[55] However, this literature addresses these questions based on South Africa's Constitution[56] and Children's Act.[57] This dissertation is customised to the Zambian context.

Fokala and Rudman extensively discuss the operation of children's right to participation in medical decision-making processes.[58] They note that children's healthcare-partnerships (CHP) include children themselves, medical personnel, and the guardians. However, these scholars posit that in most cases, medical personnel and guardians have clear mandates in CHP, especially during severe and life-threatening cases, while the child's role is ill-defined and sometimes non-existent. This literature is insightful to this study because it uses a human rights-based approach, rooted in both the CRC and ACRWC. However, it is not specific to the Zambian context unlike the present study. Similarly, and in agreement with the problem statement of this study, Mujajati and Chirwa in 'Exploring medical law and ethics in Zambia,' reiterate the inconclusiveness and uncertainty involved in medical healthcare involving BT of children under the care of JW guardians in Zambia.[59] Notwithstanding, this literature does not use the human-rights approach. Meanwhile, Muyoba finds that there are three main arguments in favor of JW's belief against BT.[60] First, the Bible prohibits blood intake, and thus Christians should never accept BT or donate their own blood for transfusion. Second, blood can transmit diseases like hepatitis, AIDS, Syphilis, measles, and other blood-transmitted infections. Last, there are quality alternatives, which makes BT unnecessary. Muyoba further explains that the situation in Zambia on BT is such that all medical procedures require the patient's consent and in the cases of a child, medical personnel have no right to do otherwise if the guardians refuse to give consent. Although this literature focusses on BT among Zambia's JW, it is an ethical assessment of the relationship between the church and the state. Meanwhile, this dissertation focusses on children's RTH and its

[55] DJ McQuoid-Mason 'Parents refusing BT for their children solely on religious grounds: Who must apply for the court order?' (February 2020) http://www.scielo.org.za/pdf/samj/v110n2/08.pdf (accessed 27 August 2021).
[56] Constitution of the Republic of South Africa Act 108 of 1996.
[57] n 13.
[58] n 34.
[59] A Mujajati and J Chirwa *Medical law and ethics in Zambia* (2020) at page 77.
[60] P Muyoba 'An ethical assessment of the relationship between the church and the state: a case of BT among the JW of Mpika and Lusaka districts' master's degree dissertation, University of Zambia, 2005 at page 18-19.

interplay with JW doctrine proscribing BT, using the human rights approach. This study also draws lessons from comparative foreign laws.

1.6. Scope and limitations of the study

This dissertation's limitations are in three aspects. First, the research will be based on desk research, due to the time limitations. This affects some perspectives which might not have been reported. Notwithstanding, it will include as much relevant and recent information as possible. Second, the study focuses on JW guardians' denial of consent solely based on their religious beliefs to blood-related, life-saving medical procedures for children in Zambia. Therefore, the study does not cover situations where the health facilities, goods or services are not available. Last, due to the unavailability of BT-related health statistics for children in Zambia, this study does not include statistics of the number of children requiring BT under the care of JW guardians. Consequently, there are no specific statistics on the number of JW guardians who have refused consent to medical procedures involving BT in Zambia.

1.7. Structure of Chapters

This dissertation is divided into five Chapters. The first Chapter provides the background and thereafter justifies the need for this research. It also includes the research questions, the methodology employed in undertaking this research, the literature review, and limitations of the study. Chapter Two is the theoretical framework of this dissertation. It provides the theories which underpin and explain the interplay between JW guardians' authority which form the basis of their children's healthcare decisions on one hand, and children's RTH on the other hand. Chapter Three examines the legal frameworks for the protection of children's RTH in the United Kingdom and South Africa, and further provides an analysis of the norms and operation of both legal frameworks. This is in order to highlight learning points for possible law reform for attaining an effective framework for the protection of children's RTH in Zambia. Subsequently, Chapter Four delves into Zambia's legal framework for the protection of children's RTH. In view of the comparative study in the preceding Chapter, this Chapter identifies the weaknesses and gaps in Zambia's children RTH framework, by drawing lessons from the foreign laws examined.

Subsequently, Chapter Five concludes the study. It summarises the findings and provides the appropriate recommendations for the implementation of an effective and adequate children's RTH framework in Zambia.

2. Theoretical framework

2.1. Introduction

The preceding Chapter set out the background of this study and outlined the research schema. This Chapter explores the theories which underpin the interplay between JW guardians' authority over the moral and religious developments of their children on the one hand, and children's RTH on the other hand. Hence, it is classified into two. The first part discusses the four theories explaining why JW guardians refuse to consent to medical procedures involving BT for their children. The second part is a discussion of the theoretical framework for the transcending of children's RTH over their guardian's authority to make medical decisions for their children.

2.2. Why Jehovah's Witnesses guardians refuse to consent to BT-medical procedures for their children

Refusal of JW to BT is bottomed upon several theories advanced by both JW and non-JW. These include renowned global medical personnel and institutions, who justify the avoidance of BT for both the adults and children. These are discussed hereunder.

2.2.1. The Biblical Theory

As the name suggests, this theory is based on JW's interpretation and understanding of Bible scriptures. According to that understanding, the Biblical Theory holds that although there are valid medical reasons for the avoidance of BT, the most important is God's command for abstinence because blood represents what is sacred to Him.[61] In this regard, reference is made to the following Bible scriptures:[62]

- *Leviticus 17:11* "For the life of a creature is in the blood, and I have given it to you to make atonement for yourselves on the altar; it is the blood that makes atonement for one's life."

[61] Watch Tower Bible and Tract Society of Pennsylvania 'What does the Bible say about BT?' (2021) https://www.jw.org/en/bible-teachings/questions/bible-about-blood-transfusion/ (accessed 5 September 2021).
[62] As above.

- *Colossians 1:20 "*…And through Him to reconcile to Himself all things, whether things on earth or things in heaven, by making peace through his blood, shed on the cross."

Further, this theory prohibits the acceptance of whole blood or its primary components in any form, whether offered as food or as a transfusion,[63] by reference to the following scriptures:[64]

- *Genesis 9:4* "…But you must not eat meat that has its lifeblood still in it."

This Chapter (Genesis 9) is 'God's covenant with Noah,' hence the above verse is part of God's command to Noah, his family, and the rest of mankind (by virtue of being Noah's descendants) to refrain from consuming lifeblood.

- *Leviticus 17:14* "…Because the life of every creature is its blood. That is why I have said to the Israelites, you must not eat the blood of any creature, because the life of every creature is its blood; anyone who eats it must be cut off."
- *Acts 15:20* "Instead we should write to them, telling them to abstain from food polluted by idols, from sexual immorality, from the meat of strangled animals and from blood."

The above shows why the Biblical Theory holds that God views blood as the custodian of the soul, or life, which are all His. Further, it shows why JW believe that God views the law against eating blood seriously. Based on this theory, issues concerning blood are 'religious' rather than medical, and both the old and new testaments of the Bible clearly command people to abstain from blood.[65] Further, avoiding the intake of blood is not only in obedience to God, but also out of respect for Him, as the giver of life.[66] The following Bible scriptures further reinforce this theory:[67]

- *Leviticus 17:10 "*I will set my face against any Israelite or any foreigner residing among them who eats blood, and I will cut them off from the people."
- *Deuteronomy 12:23 "*But be sure you do not eat the blood, because the blood is the life, and you must not eat the life with the meat."

---

[63] As above.
[64] As above.
[65] Watch Tower Bible and Tract Society of Pennsylvania 'Why don't JW accept BT?' (2021) https://www.jw.org/en/jehovahs-witnesses/faq/jehovahs-witnesses-why-no-blood-transfusions/ (accessed 4 September 2021).
[66] As above referring to Leviticus 17:14.
[67] As above.

- *Acts 15:28-29* "It seemed good to the Holy Spirit and to us not to burden you with anything beyond the following requirements: you are to abstain from food sacrificed to idols, from blood, from the meat of strangled animals and from sexual immorality. You will do well to avoid these things."

Notwithstanding the above, it was not until 1945 that the Watch Tower Bible and Tract Society (the legal organisation of leaders of the congregation of JW) concluded that BT is contrary to Divine law.[68] Opponents of the Biblical Theory believe that the above verses clearly proscribe the ingestion of blood as food, and that the only basis for believing that food and BT amount to the same thing is the article published in the movement's magazine 'The Watch Tower', on 1 July 1951.[69] Notwithstanding, this theory remains the most relied on for the refusal of BT among JW guardians.

2.2.2. The Better Medical Alternatives Theory

The second theory is the Better Medical Alternatives Theory (BMAT) which as the name suggests, holds that there are alternatives to BT offering more advantages than BT itself. Hence, leading medical personnel and institutions globally are increasingly seeing the advantages of 'bloodless' medicine and surgery.[70] Among them is the John Hopkins Center for Bloodless Medicine and Surgery, which reports that bloodless medicine and surgery is an alternative to BT which among other benefits, has been shown to reduce infections and help patients recover faster.[71] Medical personnel have also expressed deep concern about the unnecessary administration of BT, for example to burn patients. [72] A growing body of research reveals that health facilities globally are using donated blood in larger quantities than required in the healthcare of patients.[73] The BMAT also holds that

[68] n 52.
[69] As above.
[70] Watch Tower Bible and Tract Society of Pennsylvania 'Medical alternatives to BT' (2021) https://www.jw.org/en/library/magazines/g201209/medical-alternatives-to-blood-transfusions/ (accessed 3 September 2021); Bloodless medicine is a set of evidence-based strategies that enable healthcare providers to treat patients safely and effectively without the transfusion of allogeneic whole blood or its primary components according to the International Training Center for Bloodless Medicine and Surgery 'History of Bloodless Medicine and Surgery' (2021) https://www.medstarbloodless.org/history-of-bloodless-medicine-and-surgery (accessed 4 September 2021).
[71] John Hopkins University 'The Center for Bloodless Medicine and Surgery' (2021) https://www.hopkinsmedicine.org/bloodless_medicine_surgery/ (accessed 2 September 2021).
[72] SCP Williams and Stanford University 'What's behind the decline in BT?' (2013) https://sm.stanford.edu/archive/stanmed/2013spring/article5.html (accessed 4 September 2021).
[73] As above.

the ingrained idea in medicine that people will die if they do not have a certain level of blood is not correct for most patients, in most cases.[74] Instead, these patients can be adequately cared for by just applying some easy strategies other than BT.[75]

The BMAT is also supported by renowned studies. First is the study of surgery patients including JW who refused BT and non-JW who had BT, during the period of 1991 to 2012, at Brugmann University Hospital.[76] This study found that there is no difference in outcomes like postoperative mortality or morbidity between JW and non-JW populations.[77] The second study involved 322 JW and 87 453 non-JW, who underwent cardiac surgery from 1 January 1983 to 1 January 2011.[78] This study concluded that the JW, who did not receive BT, had fewer acute complications and shorter length of post-surgery hospitalisations than the latter matched patients who received transfusions.[79] However, caution is given that the better outcomes might not have been due to the absence of BT, but the differences in care received. This was because the JW patients were treated with more precaution, by being treated for low blood levels before surgery and using health-enhancing devices like intraoperative cell salvage device.[80] The BMAT also holds that BT only became entrenched in medical practice after World War II when it was heavily relied on,[81] thus it can be argued that it is a 'new addition' to medical practice. BMAT therefore holds that BT as a medical treatment is not 'do or die' and can certainly be dispensed with.

2.2.3. The Adverse Effect Theory

The third theory is the Adverse Effect Theory (AET), which is closely linked to the BMAT. It argues that BT can result in significant adverse results on the health of patients, hence the need to avoid it. In addition to reducing costs related to buying, storing, processing,

---

[74] As above.
[75] As above.
[76] National Center for Biotechnology Information 'Outcomes from cardiac surgery in JW patients: experience over twenty-one years' (14 April 2016) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4831181/ (accessed 6 September 2021).
[77] As above.
[78] G Pattakos and CG Koch 'Outcome of patients who refuse transfusion after cardiac surgery: a natural experiment with severe blood conservation' (13 August 2012) https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1211993 (accessed 4 September 2021).
[79] As above.
[80] n 72.
[81] International Training Center for Bloodless Medicine and Surgery 'History of Bloodless Medicine and Surgery' (2021) https://www.medstarbloodless.org/history-of-bloodless-medicine-and-surgery (accessed 4 September 2021).

testing and transfusing blood, bloodless techniques reduce the risk of transfusion-related infections and complications that keep patients in the hospital longer.[82] These include immunologic reactions, infections, inefficacy, and others which can sometimes result in death and severe disability.[83] Transfusion of blood products is associated with several complications and most of these are due to immunological reactions (IR), which are more frequent than infections.[84] These IR include acute hemolytic anemia, most often due to human error in cross-matching of mismatch blood types, and transfusion-associated graft versus host disease, which occurs in immuno-deficient patients whose body failed to eliminate the donor's T cells.[85]

The AET further holds that blood products transfusion can cause infectious complications through three mechanisms.[86] First, is the transfusion of microbes present in asymptomatic donor blood (mainly viruses) and second, through contamination of stored blood products (primarily bacteria in platelets).[87] Last, is the transfusion-related immunosuppression predisposing to post-operative infections, whereby the risk of infection increases with the amount of red blood cell units or blood products transfused, and patients requiring chronic BT are the most vulnerable.[88]

Additionally, this theory maintains that despite the remarkable progress achieved in blood or blood products safety in the last 30 years since the identification of the Human Immunodeficiency Virus and Hepatitis C Virus, concerns still proliferate with the risk of transmission from emerging infectious agents.[89] For microbes to be transmitted by transfusion, there must be: presence of the agent in blood during the donor's asymptomatic phase; the agent's survival in blood during processing: and the agent must be recognized as responsible for a clinical illness in a proportion of the infected recipients.[90] These have been reported in some cases. Although the risk of these transfusion-transmitted infections is very low in industrialised countries (generally less

[82] n 72.
[83] IW Fong 'BT-associated infections in the twenty-first century: new challenges.' (7 March 2020) 191–215 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7120358/ (accessed 5 September 2021).
[84] As above.
[85] As above.
[86] As above.
[87] As above.
[88] As above.
[89] As above.
[90] As above.

than 1 in a million units), blood safety in developing countries, especially in Africa, is still not assured.[91] Compounding the problem of blood and blood product safety with respect to infectious agents, are new emerging infectious microbes that are not being routinely tested for in donated blood.[92]

2.2.4. The Guardians' Authority Theory

The Guardians' Authority Theory (GAT) is based on the guardians' power to make important decisions in relation to a child, which includes making healthcare decisions, in the BIC.[93] Based on this theory, the guardians' knowledge of their child's interests supports the rebuttable presumption that they act in the child's interests, and that they know better than others what those interests are.[94] Arguably, this theory is reflected in international children's rights law because articles 20(1) and 18(1) respectively of the ACRWC and CRC provide for guardians' primary responsibility over the child's welfare.

Mostly, decisions over children's welfare can be taken by one guardian, thus, it is not always necessary to seek the consent of another guardian, unless the decision to be made is a major long-term issue (MLTI) affecting the child.[95] MLTI are issues about the care, welfare, and development of a child of a long-term nature, which include decisions about health, religious and cultural upbringing.[96] In most jurisdictions, including Zambia, guardians who are unable to agree on decisions concerning the upbringing of their child often resort to family mediation, before they apply to court for a Specific Issue Order or a Prohibited Steps Order.[97] This order empowers the state, through the court to make decisions on the guardians' behalf, guided by the BIC.[98] This study finds that this theory underlies the other three theories above. This is because it explains the general rule that

[91] As above.
[92] As above.
[93] Child law advice 'Parental responsibilities' (2021) https://childlawadvice.org.uk/information-pages/parental-responsibility/ (accessed 4 September 2021).
[94] S Sheldon and S Wilkinson 'Should selecting savior siblings be banned?' *J Med Ethics* 2004; 30: 533–537 quoted in T Dare 'Parental rights and medical decisions' (2021) https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1460-9592.2009.03094.x (accessed 4 September 2021).
[95] n 93.
[96] Robinson Gill Lawyers 'The meaning of parental responsibility' (2021) https://www.robinsongill.com.au/resource/the-meaning-of-parental-responsibility/ (accessed 4 September 2021).
[97] As above.
[98] As above.

guardians, are primarily entitled to decide the course of their children's healthcare, based on whichever theory they rely on.

2.3. Why children's right to health transcends the guardian's authority

Children's RTH supersedes the guardians' authority. The following theories explain why.

2.3.1. Limited Guardians' Authority Theory

There are critical moments when children need to have their rights affirmed and protected from the authority of guardians, the government, or both.[99] Guardians' authority can be subject to limitations, for instance when the guardians are unable to agree on decisions about their child, as discussed above. All such derogations from the GAT are covered under the auspices of the Limited Guardian's Authority Theory (LGAT). As the name suggests, the theory posits that guardians' authority over children is not absolute because it is exercisable subject to certain limitations. The LGAT was established in the landmark case of *Gillick v West Norfolk*,[100] adjudicated by the House of Lords. In this case, which deals with the legal position of guardians, Lord Fraser states that guardians' authority is never for the benefit of the guardian, but the child, and is justified only if it enables guardians to perform their duties towards the child. Although this case speaks to the importance of guardians' consent to a child's healthcare, it warns that the guardians' authority must be in the BIC, therefore it is neither perpetual nor limitless. It is no wonder that the HC for Zambia in the *Muyeka* case (discussed in Chapter 1), held that:

> The child is a minor and has not made a valid and informed decision to be a JW and so the Respondent cannot impose her beliefs on him as regards medical treatment particularly in this case where the medical treatment is of life saving nature. The time will come when the child will be validly able to make that decision over its own treatment based on religious beliefs when it attains the age of majority. In the meantime, what is required is that the best treatment as advised by the medical doctors, which include BT when the child is in a crisis, should be done in the BIC.[101]

[99] B Lesley 'Judge Barrett, what is right for children?' (26 October 2020) https://firstfocus.org/blog/judge-barrett-what-is-right-for-children (accessed 18 September 2021).
[100] *Gillick v West Norfolk 1986] 1 AC 112 [1985] 3 All ER 402 [1985] 3 WLR 830, paragraph 2.*
[101] n 24.

Further, the LGAT curtails the dominant power imbalances in healthcare decisions between children and guardians because of the systematic exclusion of children from the decision-making conversation, or their disempowerment or intimidation.[102] This explains the medical personnel's ethical and legal duty to advocate for the BIC, when the guardians' decisions are potentially dangerous to the child's health.[103] As a general rule, medical personnel are mandated to challenge guardians' decisions when those decisions place the child at significant risk of serious harm.[104] Therefore, the LGAT is the starting point for justifying the transcending of children's RTH over the guardian's rights and responsibilities, because it answers 'yes' to the question of whether or not guardian's authority can be limited.

2.3.2. Children as Rights'-Holders Theory

The Children as Rights'-Holders Theory (CARHT) digresses from the historical view, where children were regarded simply as the chattel of their guardians, particularly their fathers.[105] In the past, the law relating to children focused not on their rights, but on the rights of adults with respect to their children.[106] As a result, churches and other charitable organizations provided the little protection that was available to children, out of moral obligation.[107] The first international instrument dealing specifically with children was the 1924 Declaration of the Rights of the Child, which neither provided for the rights of the child nor the state's obligations towards them.[108] This Declaration bespeaks how children were regarded as being an object, not a subject, of international law - a view consistent with the then dominant perception of the child as being first and foremost in need of protection.[109] Regardless of its limitations, the Declaration established the concept of

[102] L Boland and ID Graham 'Barriers and facilitators of pediatric shared decision-making: a systematic review' (2019) https://implementationscience.biomedcentral.com/track/pdf/10.1186/s13012-018-0851-5.pdf (accessed 6 September 2021).
[103] University of Washington 'Parental decision making' (2018) https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/detail/72 (accessed 5 September 2021).
[104] As above.
[105] H Rodham 'Children Under the Law' (1973) 43 *Harvard Education Review* 487-489; MR Ventrell 'Rights & Duties: An Overview of the Attorney-Child Client Relationship' (1995) 26 *Loyola University of Chicago Law Journal* at pages 259-261 quoted in SD Hawkins 'Protecting the rights and interests of competent minors in litigated medical treatment disputes' (1996) 64 *Fordham Law Review* at page 2076.
[106] MR Ventrell 'Rights and duties: An overview of the Attorney-Child Client Relationship' *Loyola University of Chicago Law Journal* (1995) 26 at page 261.
[107] Ventrell (n 106) at page 261-262.
[108] Declaration of the Rights of the Child, adopted 25 September 1924, League of Nations.
[109] R Stern 'The child's right to participation-reality or rhetoric?' (2006) Doctor of Laws Dissertation, Uppsala University at page 32.

children's rights on an international level. Subsequently, the necessity of paying special attention to children's rights was discussed in the drafting of the 1948 Universal Declaration of Human Rights.[110] This was before the adoption of the 1959 Declaration of the Rights of the Child,[111] which neither provided for the views of the child, nor gave any importance of these views.[112]

Departing from this position is the CARHT, which was invoked by the recognition of the equality of children's rights with those of adults evolved over the decades.[113] This was during the development of international children's rights law in the beginning of the twentieth century.[114] Particularly, the CARHT was introduced with the adoption of the CRC in 1989, which provides a framework for children's civil, political, economic, social, and cultural rights. In addition to the substantive articles, the CRC's preamble extensively provides for its background, aims, and purposes. Children are holders of all the rights enshrined in the CRC, thus they are entitled to special protection measures and, in accordance with their evolving capacities, the progressive exercise of their rights.[115]

The growth of the CARHT in international law is arguably divided into three stages: the first is the recognition by the international community that all individuals, including children, are objects of international law and require international protection; the second is the granting of specific substantive rights to children and; the third stage is the acknowledgement that children must possess adequate procedural capacity to ably exercise and claim such rights and freedoms.[116] This reiterates the position held in the CARHT, that children are entitled to full exercise of their rights although this is not always sufficiently acknowledged in the case law and practice of various states, international courts and tribunals.[117] Consequently, the Committee has expressed concern that in

[110] UN General Assembly 'Universal Declaration of Human Rights' (10 December 1948) 217 A (III) https://www.refworld.org/docid/3ae6b3712c.html (accessed 16 September 2021).
[111] UN General Assembly 'Declaration of the Rights of the Child' (20 November 1959) A/RES/1386(XIV) https://www.refworld.org/docid/3ae6b38e3.html (accessed 16 September 2021).
[112] R Stern (n 109) at page 33.
[113] SD Hawkins 'Protecting the rights and interests of competent minors in litigated medical treatment disputes' (1996) 64 *Fordham Law Review* at page 2076.
[114] R Stern (n 109) at page 30-31.
[115] UN Committee on the Rights of the Child 'General comment 7 (2005): Implementing child rights in early childhood' (20 September 2006) CRC/C/GC/7/Rev.1 https://www.refworld.org/docid/460bc5a62.html (accessed 18 September 2021).
[116] GV Bueren 'The international law on the rights of the child' (1995) 19 *Fordham International Law Journal* at pages 832-839
[117] R Stern (n 109) page 31.

implementing their obligations under the CRC, states have not given sufficient attention to children as rights holders and to the laws, policies and programs required to realize their rights during this distinct phase of their childhood. [118]

2.3.3. Inclusive Interpretation of Children's Right to Health Theory

Children's RTH contains a set of freedoms and entitlements,[119] hence the Committee reaffirms that the CRC is to be applied holistically in early childhood, taking account of the principles of universality, indivisibility, and interdependence of all human rights.[120] The Inclusive Interpretation of Children's Right to Health Theory (ICRTH) encapsulates the principle that the RTH is an inclusive right, hence several other factors and rights are dependent or interlinked to it. Particularly, children's RTH has long been understood to extend beyond protection from immediately identifiable infringements like limitations on access to health care or services. It includes all the rights and freedoms determining children's health, like the rights to non-discrimination, access to health-related education and information, and freedom from harmful traditional practices.[121] Children's RTH is not only important in and of itself, but its realisation is indispensable for the enjoyment of all the other CRC-right, and its achievement depends on the realization of many other rights outlined in the CRC.[122] The rights and principles relevant to this study are discussed below.

Best interests of the child

The comprehensive interpretation of children's RTH entails that the BIC[123] must be observed in children's health-related decisions. Particularly, children's best interests should be based *inter alia* on their physical needs, age, and relationship with guardians, after having heard their views.[124] The duty of states to consider the child's best interests is an all-encompassing comprehensive obligation binding public and private social

[118] n 115.
[119] n 26 paragraph 24.
[120] n 115.
[121] Office of the UN High Commissioner for Human Rights and World Health Organization 'The right to health, fact sheet 31' (June 2008) www.ohchr.org/Documents/Publications/Factsheet31.pdf.(accessed 16 September 2021).
[122] n 26 paragraph 7.
[123] n 3 article 3(1).
[124] n 26 paragraph 12.

welfare institutions, courts of law and other bodies dealing with children.[125] Although guardians are not explicitly mentioned in article 3(1), the BIC 'will be their basic concern',[126] as it applies to all institutions whose work and decisions affect children.[127]

Right to life, survival, and development

The integrative approach to children's RTH encompasses the obligation of states to ensure the life, survival, growth and development (LSGD) of the child.[128] This is inclusive of the physical, mental, moral, spiritual and social dimensions of their development.[129] This also means that all the risks and protective factors underlying the child's LSGD need to be systematically identified, to design and implement pragmatic solutions confronting the determinants during children's life course.[130] This further entails that any act(s) or omission(s) which violate children's RTH, can potentially or actually violate the LSGD of children must be identified. To this effect, guardians' failure to obtain medical services for children when they have the means, knowledge, and access to services to do so, including withholding essential medical care, is a form of violence against children classified as 'negligent treatment'.[131]

Evolving capacity and life course of the child

The ICRTH further includes the evolving capacity and life course of the child.[132] This means the stages of the child's development which are cumulative, whereby each stage has an impact on subsequent phases influencing children's health.[133] *C*hildren's evolving capacities have a bearing on their independent decision-making about their health issues.[134] The Committee has derived a role and function for 'evolving capacities' of children which is classified into three broad categories:

[125] UN Committee on the Rights of the Child 'General comment 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)' (29 May 2013) CRC /C/GC/14 https://www.refworld.org/docid/51a84b5e4.html (accessed 16 September 2021).
[126] n 3 article 18(1).
[127] n 125 page 8.
[128] n 3 article 6.
[129] n 26 paragraph 16.
[130] As above.
[131] UN Committee on the Rights of the Child 'General comment 13 (2011): The right of the child to freedom from all forms of violence' (18 April 2011) CRC/C/GC/13 page 8-9 https://www.refworld.org/docid/4e6da4922.html (accessed 16 September 2021).
[132] n 3 article 5 and 14(2).
[133] n 26 paragraph 20-21.
[134] As above.

> First, is evolving capacities as an enabling principle, in which the term is used to empower children's agency in the exercise of their rights under the CRC; second, is evolving capacities as an interpretative principle, in which the term is used to interpret specific provisions of the Convention in a manner that recognises children's capacities in the exercise of their rights and; third, is evolving capacities as a policy principle, in which the term is used to guide States in policy-making and programming on children's rights.[135]

It is further suggested that the Committee's use of 'evolving capacities' has introduced a role and function for the term that goes well beyond the scope of article 5 of the CRC. In so doing, the Committee has recognised a broader principle of evolving capacities under the CRC that not only informs the framework of guardians' direction and guidance, but the interpretation and implementation of the whole of the CRC.[136]

The right to be heard

To add, the inclusive approach to children's RTH envisages the respect for a child's right to express their views and to participate in promoting their own healthy development and well-being for the realization of other rights.[137] This includes children's own views on all aspects of health provisions, including, what services are needed, how and where they are best provided,[138] among others. To ensure that children are effectively heard on health-issues affecting them, states are encouraged to conduct regular participatory consultations adapted to the child's age and maturity.[139] These consultations must also be done separately with the guardians, to learn about the child's health challenges, developmental needs and expectations, as a contribution to the design of effective interventions and health programmes.[140] Further, children are entitled to information about proposed medical treatments and their effects and outcomes, in formats appropriate and accessible to children with disabilities.[141] Notably, states are mandated to introduce legislation or practices ensuring children's access to confidential medical

[135] S Varadan 'The Principle of Evolving Capacities under the UN Convention on the Rights of the Child' (2019) 27(2) *The International Journal of Children's Rights* page 306-338.
[136] As above.
[137] UN Committee on the Rights of the Child 'General comment 12 (2009): The right of the child to be heard' (20 July 2009) CRC/C/GC/12 paragraph 98 https://www.refworld.org/docid/4ae562c52.html (accessed 16 September 2021).
[138] n 26 paragraph 19.
[139] As above.
[140] As above.
[141] n 137 paragraph 100.

counselling and advice, without guardians' consent, whenever required for the child's safety or well-being.[142]

2.4. Conclusion

This Chapter discussed the theories explaining JW guardians' refusal of consent to medical procedures involving BT for their children. It also discussed the theoretical framework justifying the transcending of children's RTH over their guardian's authority to make medical decisions on their behalf. The former theories effectively cast light on why JW guardians elect to refuse to consent to medical procedures involving BT for their children. The Biblical Theory appears to have the greatest influence on the course of medical treatment of children under the care of JW guardians. This study observes that the BMAT and the AET are both supported by scientific findings, while the GAT is to a large extent derived from the international children's rights discourse. However, the Biblical Theory is based purely on the 'understanding' of Bible scriptures. This explains the great level of controversy and uncertainty it attracts especially with respect to children's RTH, considering that its application may have potential or actual adverse effects on children.

This Chapter explained that the Biblical Theory is trumped by the theories justifying the trump of children's RTH over guardians' authority. To start with, guardian's authority is not limitless, because it is exercisable only as far as the guardians use it for the child's best interests. Thus, it is possible for the state, its agents, or other persons to be conduits for the limitation of guardian's authority in the healthcare of children, when circumstances so demand. To add, the historical view of children as chattels without rights distinct from their guardians has become obsolete with the development of international children's rights law. This is because children are rights-holders themselves. Therefore, guardians cannot, in the exercise of their own rights like the freedom of religion and conscience, by acts or omissions, infringe on children's RTH. Hence, JW guardians cannot impose their religious practices on their children to the latter's detriment. Lastly, the ICRTH entails that, several freedoms and entitlements of children are incidental and dependent on the RTH as discussed above. Put simply, children's RTH should be protected, to ensure that

[142] As above paragraph 101.

they, like their guardians, can grow into healthy adults and make decisions for themselves about what religion they belong to and how to practice that religion, if at all.

3. Protecting children's right to health in Zambia: Lessons from comparative foreign laws

3.1. Introduction

Chapter Two discussed the different theoretical foundations underlying the interplay between JW guardians' authority over the moral and religious developments of their children, and children's RTH in Zambia. Thus, it formed the theoretical basis of the dissertation. Suffice to state that, while all the theories ably influence the discourse of children's RTH as it may play out under the auspices of JW guardians, the Biblical Theory is dominant in the religious practice of JW. The crux of Chapter Two is that children's RTH supersedes guardian's authority, including those exercised based solely on religious beliefs.

This Chapter draws pragmatic lessons by examining norms and practices dealing with children's RTH issues in the United Kingdom and South Africa. Thus, it lays a proper foundation for the discussion on improving Zambia's legal framework by drawing lessons for optimising the protection of children's RTH from the comparative foreign laws. The legal regimes of the United Kingdom and South Africa have been strategically chosen for the comparative study. Hence, the first part of the Chapter justifies the selection of these two regimes, before examining their legal frameworks for protecting children's RTH. Subsequently, this Chapter analyses the norms and practices of both legal regimes, including their respective efficacies and shortcomings. This analysis informs the examination and assessment of Zambia's children's RTH protection-framework in Chapter Four. Further, it paves the way for suggested reforms and recommendations of the latter framework in Chapter Five of the dissertation.

3.2. Justification for South Africa and the United Kingdom as comparators

3.2.1. Why South Africa?

Children's rights are one of the focus areas identified by the South African Human Rights Commission as requiring a dedicated focus, to effectively fulfil its mandate of promoting

and protecting the realisation of rights in South Africa.[143] To this end, South Africa's children's rights laws provide useful insights to Zambia for various reasons. First, South Africa has one of the most extensive children's rights legislation in Africa, which gives effect to the country's Constitutional provisions on children's rights.[144] The principal child protection law in South Africa is the Children's Act.[145] Second, the said Children's Act gives effect to South Africa's obligations on the wellbeing of children in terms of the international instruments by which it is bound.[146] These include the CRC and ACRWC, thus the Children's Act is useful in the development of a children's rights framework in Zambia that conforms to international human rights standards. Third, both Zambia and South Africa are members of the African Union (AU) and Southern African Development Community (SADC), which have instruments on children's rights that may influence their respective national laws. Both countries have ratified the CRC and ACRWC,[147] and are bound by these instruments.

3.2.2. Why the United Kingdom?

There are several justifications for the study's reliance on the laws of the United Kingdom. First, as a former colony, Zambia's legal system is based on the English legal system.[148] Article 7 of Zambia's Constitution provides for the laws of Zambia, which include 'the laws and statutes which apply or extend to Zambia, as prescribed'. This position is congruent with the English Law (Extent of Application) Act,[149] which provides that:

> Subject to the provisions of the Constitution of Zambia and to any other written law- (a) the common law; and (b) the doctrines of equity; and (c) the statutes which were in force in England on the 17th August, 1911 (being the commencement of the Northern Rhodesia Order in Council, 1911); and (d) any statutes of later date than that mentioned in paragraph

[143] South African Human Rights Commission 'Children's Rights and Basic Education' (2021) https://www.sahrc.org.za/index.php/focus-areas/children-s-rights-and-basic-education (accessed 29 September 2021).
[144] n 56 (Constitution of South Africa) section 28.
[145] n 13 (Children's Act of South Africa).
[146] As above section 2(c).
[147] Ratified by South Africa on 7 January 2000 and 16 June 1996 respectively.
[148] Global Legal Group 'Zambia: Litigation and dispute resolution laws and regulation' (15 February 2021) https://iclg.com/practice-areas/litigation-and-dispute-resolution-laws-and-regulations/zambia (accessed 5 October 2021).
[149] The English Law (Extent of Application) Act chapter 11 of the Laws of Zambia.

(c) in force in England, now applied to the Republic, or which hereafter shall be applied thereto by any Act or otherwise; shall be in force in the Republic.[150]

Consequently, as it stands, Zambia's legal system is more compatible for importation of English Law on children's rights. Second, the United Kingdom ratified the CRC on 6 December 1991.[151] The four nations of the United Kingdom: England, Northern Ireland, Scotland, and Wales, each have their own child protection system and laws.[152] These laws, which will be discussed later in this Chapter, *inter alia* provide for the concept of parental responsibility and the paramountcy of children's welfare when a matter under the Act is before a court.[153] Hence, the United Kingdom framework's importation of the principles underlying the CRC into its domestic laws will be useful in the improvement of Zambia's children's rights protection framework. Third, some of the United Kingdom's legislation like the Children's Act is supplemented by the Human Rights Act,[154] which incorporates the rights set out in the European Convention on Human Rights (ECHR)[155] into domestic British law.[156] As such, the United Kingdom's domestication of the ECHR can inform Zambia's enhancement of the children's rights regime, by guiding and informing its domestication of the regional child protection instrument, the ACRWC.

3.3. Legal framework for the protection of children's right to health

3.3.1. South Africa

Approximately one-third (33.7%) of South Africa's population were children in the year 2019.[157] South Africa initially showed commitment to children's RTH when it ratified the

[150] As above section 2.
[151] Office of the High Commissioner on Human Rights 'Human rights bodies' https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=185 (accessed 29 September 2021).
[152] National Society for the Prevention of Cruelty to Children 'Child protection system in the United Kingdom' (2021) https://learning.nspcc.org.uk/child-protection-system (accessed 5 October 2021).
[153] D Foster 'An overview of child protection legislation in England' (19 February 2020) https://researchbriefings.files.parliament.uk/documents/SN06787/SN06787.pdf (accessed 5 October 2021).
[154] Human Rights Act of 1998 chapter 42.
[155] European Convention on Human Rights (adopted 4 November 1950, entered into force on 3 September 1953) ETS 5.
[156] Equality and Human Rights Commission 'Human Rights Act' (2021) https://www.equalityhumanrights.com/en/human-rights/human-rights-act (accessed 5 October 2021).
[157] Department Statistics South Africa 'Education series volume VII: Children's education and well-being in South Africa 2018' (26 February 2021) http://www.statssa.gov.za/?p=14044 (accessed 4 October 2021).

CRC in 1995, and subsequently adopted the Constitution in 1996.[158] Pursuant to section 7(2) of the Constitution, the state has an obligation to respect, protect, promote, and fulfil all the rights in the BoR which includes health care rights. Children's RTH is provided for in two sections of the Constitution. First, section 27(1) accords the right to access health care services for all people in South Africa, and second, section 28(1)(c) entitles every child to the right to basic health care services. In addition to the Constitution, South Africa currently has three primary pieces of legislation regulating children's health care rights, which are the Children's Act briefly discussed above, National Health Act,[159] and Mental Health Care Act.[160] South Africa also has several health-related legislations including the Termination of Pregnancy Act[161] and Sexual Offences (Amendment) Act.[162] However, this study focusses on the primary legislation.

The Children's Act

The Children's Act was adopted in 2005 to give effect to children's rights as guaranteed in the Constitution. It sets out principles relating to the care and protection of children.[163] The Act defines children as all persons below the age of 18,[164] in conformity with international children's rights standards. According to section 4, the 'Implementation of the Act,' all organs of government at the national, provincial, and local levels have an obligation to take reasonable measures, to the maximum extent of available resources, to achieve the realisation of the objects of the Act. Section 5 provides that in the implementation of the Act, all organs of the state must cooperate to develop a standardized approach to coordinate and integrate the services delivered to children. Section 6(2) of the Act provides that:

> All proceedings, actions or decisions in a matter concerning a child must respect, protect, promote, and fulfil the child's rights set out in the BoR, the best interests of the child standard set out in section 7 and the rights and principles set out in this Act, subject to any lawful limitation

[158] MB Eveleigh 'Children's rights of access to health care services and to basic health care services: A critical analysis of case law, legislation and policy' 42 (2016) *De Jure Law Journal* at pages 307-325.
[159] National Health Act 61 of 2003.
[160] Mental Health Care Act 17 of 2002.
[161] Termination of Pregnancy Act 92 of 1996.
[162] Sexual Offences (Amendment) Act 32 of 2007.
[163] n 13 preamble.
[164] As above section 1.

Section 7 of the Act comprehensively enlists the standards of the best interests of the child. To this effect, it provides that where any provision of the Act requires the BIC, several factors must be considered. These include: the nature and personal relation between the child and the guardian (or any person relevant in the circumstance); the attitude of the guardian towards the child or in the exercise of the guardians' authority; the likely effect on the child of any change in the circumstance of the child; any relevant characteristics of the child; and any of the child's chronic illness. Section 9 provides that the BIC is of paramount importance in all matters concerning the child's wellbeing, protection, and care. In addition, section 10 of the Act provides for the child's right to participation: to be involved in the decision-making process on issues related to them, including healthcare issues.

Particularly relevant to this study, both sections 11(3) and 12(1) of the Children's Act prohibit religious practices that are detrimental to the child's wellbeing, albeit the former provision makes specific reference to children with disabilities or chronic illnesses. Further, according to section 13 of the Act, children have the right to information on healthcare, which is relevant and accessible to them. This includes access to information on the health status causes and treatment. Children affected by a matter to be adjudicated or any other persons acting on their behalf, are entitled to approach the court for an appropriate relief, when any right in the BoR or the Act is either infringed or threatened to be infringed.[165] Evidently, this Act adopts most of principles under the CARHT because it gives children entitlements as rights' holders who are distinct from their guardians.

National Health Act

The National Health Act (NHA) of 2005 provides the framework for the realisation of South Africa's structured uniform health system, considering the obligations imposed by the Constitution and other laws applicable to health services.[166] It establishes a national health system made up of both the public and private health sector.[167] It also highlights the rights and duties of health care providers, workers, establishments, and users.[168] The

[165] As above section 15.
[166] n 159 preamble.
[167] As above section 2(a)(i).
[168] As above section 2(b).

NHA further provides for the protection, promotion and fulfilment of children's rights to basic health care services contemplated in section 28(1)(c) of the Constitution.[169] It makes provision for the categories of people eligible for free health services in state-funded facilities, which includes children under the age of six who are not members or beneficiaries of medical aid schemes.[170] This gives legal force to the government policy on providing free health care services to children under the age of six.[171] The reference to 'health services' in section 4(3)(c) rather than 'primary health care services', implies that all services, not just primary health care services, must be provided free of charge to children under the age of six.[172]

However, the Act empowers the Minister of Health, in consultation with the Minister of Finance, to prescribe conditions and categories of people eligible for free health services in public health establishments.[173] In prescribing such conditions, the Minister is obliged to consider the range of free health services available, and the needs of vulnerable groups such as children, among others.[174] The NHA has no specific provision on the rights of children as 'health care users (HCU)', but defines it by reference to the Child Care Act (CCA). The CCA has been repealed by the Children's Act[175] discussed above.

Pursuant to section 12(1) of South Africa's Interpretation Act,[176] the relevant provision for the rights of children as HCU is now section 129 of the Children's Act, which is relevant to this study. The said section provides for consent to medical treatment and surgical operations and allows children to independently consent to medical treatment on two conditions. First, the child must be aged over 12 and second, have sufficient maturity and mental capacity to understand the risks, benefits, and other implications of the treatment.[177] These two conditions are also prerequisite in allowing children to independently consent to their own surgical operations, in addition to the requirement that they are duly assisted by their guardians. Section 7 of the NHA provides for consent

[169] As above section 2(c)(i)-(iii).
[170] As above section 4(3)(a).
[171] n 158.
[172] As above
[173] n 159 section 4(1).
[174] As above section 4(2)(a)-(d).
[175] As above section 1.
[176] The Interpretation Act 33 of 1957.
[177] n 13 section 129(2)(a)-(b).

of users, and states that 'subject to section 8, a health service may not be provided to a user without the user's informed consent.' This section, read together with section 129 of the Children's Act, is to the effect that HCU have the right to consent to a health service provided that the user is aged 12, mature enough and capable of understanding the benefits, risks, and other social implications. Health care providers must take all reasonable steps to obtain the user's informed consent.[178] Section 6 of the Act states that HCU must have full knowledge of their health, and provides that:

> Every health care provider must inform a user of-(a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user; (b) the range of diagnostic procedures and treatment options generally available to the user; (c) the benefits, risks and consequences generally associated with each option; and (d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal. (2) The health care provider concerned must, where possible, inform the user as contemplated in subsection (1) in a language that the user understands and in a manner which considers the user's level of literacy.

Further, section 8(1) of the NHA provides that HCU have the right to participate in any decisions affecting their personal health and treatment. According to section 8(2)(a) of the Act, where consent is given by a person other than the HCU, such a person must, if possible, consult the user before giving the required consent. Where a HCU lacks the legal capacity to give the informed consent required under section 7, such HCU must be informed as contemplated in section 6, if they are capable of understanding.[179] All health care providers, workers or establishments may not refuse a person emergency medical treatment,[180] which is treatment necessary for the prevention of serious or fatal effects on a person's health.

Mental Health Care Act

The Mental Health Care Act (MHCA)[181] as its name suggests, provides a legal framework for mental health. It provides for the care, treatment, and rehabilitation (CTR) of persons

[178] n 159 section 7(2).
[179] As above section 8(2)(a).
[180] As above section 5.
[181] n 160.

who are mentally ill, among others,[182] and highlights the rights and duties of mental HCU.[183] The Act refers to a child younger than 18 years in its definition of 'mental health care user'.[184] Notwithstanding, the MHCA makes negligible reference to the mental health needs of children, who have special needs from other mental HCU. Under section 9 of the Act, health care providers and establishments can only give CTR services or admit a mental HCU if certain conditions are satisfied. First, the mental HCU must consent to the CTR services, or to admission. Second, the health care provider must be authorised by a court order or a review board. Third, due to mental illness, any delay in providing CTR services, or admission may result in: the death or irreversible harm to the health of the user; user inflicting serious harm to themselves or others; or the user causing serious damage to or loss of property belonging to themselves or others.

All people, including children, capable of making an informed decision, can submit themselves voluntarily to treatment and admission.[185] Children are subsequently entitled to appropriate CTR services, or to be referred to an appropriate health establishment.[186] Further, section 9(1)(a)-(b) of the MHCA provides that CTR services, or admission to a mental health care facility, can only be done with consent, by a court order, or a review board. However, section 9(1)(c), is to the effect that children incapable of making an informed decision on the necessity of CTR services due to mental illness, which may cause adverse effects to them or other persons, can receive assisted CTR services.[187] Subject to section 9(1)(c), a mental HCU may not be provided with assisted CTR services without consent, unless a written application for CTR services is made to the head of the health establishment concerned, and approved.[188] Section 27 of the MHCA outlines the criterion for the application for assisted CTR services of a child. It provides that the said application must be made by specific persons like the guardian or the child-HCU.[189]

[182] As above preamble.
[183] As above chapter II.
[184] As above chapter I.
[185] As above section 25.
[186] As above.
[187] As above section 9 (1)(c).
[188] As above section 26
[189] As above section 27(1)(a)(i).

3.3.2. United Kingdom

The Human Rights Act (HRA) gives further effect to rights and freedoms guaranteed under the ECHR.[190] It applies to all public bodies in the United Kingdom, such as the central government, the police, and other local authorities and bodies exercising public functions.[191] Section 3 of the HRA provides that primary legislation and subordinate legislation must be read and given effect in a way which is compatible with the ECHR rights. The courts are entitled to determine whether a provision of primary legislation is compatible with rights in the ECHR.[192] If the court is satisfied that the provision is incompatible with any right in the ECHR, it may make a 'declaration of incompatibility'.[193] Apart from the HRA which is binding on all persons and bodies, the United Kingdom's four nations: England, Northern Ireland, Scotland, and Wales, each have their own child protection system and laws.[194] Each nation has a framework of legislation, guidance, and practice which help to identify children who are at risk of harm, take action to protect those children, and prevent further abuse occurring.[195] Further, each nation is responsible for its own policies and laws around health, including child safeguarding and protection.[196]

England

The Department for Education is responsible for child protection in England.[197] It sets out how policy, legislation, and statutory guidance for the child protection system should work.[198] England's Children Act[199] provides the legislative framework for child protection in the country. The Act establishes key principles, including the paramountcy of children's welfare in any court proceedings involving the upbringing of a child.[200] It further provides for guardians' responsibility by stating that, where a child's father and mother were married to, or civil partners at the time of the child's birth, they shall each have parental

[190] n 154 preamble.
[191] Liberty 'The Human Rights Act' (2021) https://www.libertyhumanrights.org.uk/your-rights/the-human-rights-act/ (accessed 6 October 2021).
[192] n 154 section 4(1).
[193] As above section 4(2).
[194] n 152.
[195] As above.
[196] As above.
[197] As above.
[198] As above.
[199] Children Act 1989 chapter 41.
[200] As above section 1(1).

responsibility for the child.[201] 'Parental responsibility' is defined as all the rights, duties, powers, responsibilities and authority which by law, a parent has in relation to the child.[202] This Act is bolstered by the Children Act of 2004,[203] whose section 10 provides for co-operation of local authorities to improve well-being of children. It provides that:

> (1) Each local authority in England must make arrangements to promote co-operation between-(a)the authority; (b)each of the authority's relevant partners; and (c)such other persons or bodies as the authority consider appropriate, being persons or bodies of any nature who exercise functions or are engaged in activities in relation to children in the authority's area. (2) The arrangements are to be made with a view to improving the well-being of children in the authority's area so far as relating to-(a)physical and mental health and emotional well-being; (b)protection from harm and neglect…

Both Acts discussed above are amended by the Children and Social Work Act,[204] which received Royal Assent on 27 April 2017.[205] Section 1(1) of this Act provides for 'Corporate Parenting Principles' and states that:

> (1)A local authority in England must, in carrying out functions in relation to the children…mentioned in subsection (2), have regard to the need - (a)to act in the best interests, and promote the physical and mental health and well-being, of those children; (b)to encourage those children to express their views, wishes and feelings; (c)to consider the views, wishes and feelings of those children…

The Act also establishes the Child Safeguarding Practice Review Panel, to review and report on serious child protection cases that are complex, or of national importance.[206]

Wales

The Social Services and Well-being (Wales) Act[207] 2014 came into force in April 2016, and provides the legal framework for social service provision in Wales.[208] At a local level, regional safeguarding children boards co-ordinate and ensure the effectiveness of work

[201] As above section 2(1).
[202] As above section 3(1).
[203] Children Act 2004 chapter 31.
[204] Children and Social Work Act 2017 chapter 16.
[205] n 152.
[206] n 204 sections 12-15.
[207] Social Services and Well-being (Wales) Act 2014.
[208] As above preamble.

to protect and promote the welfare of children.[209] They are responsible for local child protection policy, procedure, and guidance.[210] This Act defines 'well-being of children', as well-being in relation to the mental and physical health and development, emotional well-being, and protection from abuse and neglect.[211] A 'child' is defined as a person who is under the age of 18,[212] in conformity with international law standards.

Northern Ireland

The Northern Ireland Executive, through the Department of Health, is responsible for child protection in Northern Ireland, and sets out the child protection system-legislation.[213] The Safeguarding Board for Northern Ireland co-ordinates and ensures the effectiveness of work to protect and promote the welfare of children.[214] The Children (Northern Ireland) Order,[215] provides the legislative framework that governs the response to, and services provided for children in need of support, at risk of harm and for those who have suffered abuse and harm.[216] For children in need of support, the legislation imposes a general duty on Health and Social Care Trusts in Northern Ireland to provide a range of services for children defined as 'in need' in their locality.[217] Section 17 provides that:

> For the purposes of this part, a child shall be taken to be in need if-(a)he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by an authority under this part; (b)his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or (c)he is disabled, and 'family', in relation to such a child, includes any person who has parental responsibility for the child and any other person with whom he has been living

[209] n 152.
[210] As above.
[211] n 207 section 2(2)-(3).
[212] As above section 3(3).
[213] n 152.
[214] As above.
[215] Children (Northern Ireland) Order 1995 No 755 (N.I.2).
[216] Queen's University Belfast 'United Kingdom Northern Ireland Report' (2021) https://www.qub.ac.uk/sites/participation-for-protection/FileStore/Filetoupload,886288,en.pdf (accessed 9 October 2021).
[217] n 215 part IV as read with specific reference to section 18(1)-(2).

Scotland

The Scottish Government is responsible for child protection in Scotland; hence it sets out policy, legislation, and statutory guidance of the child protection system.[218] Meanwhile, the Child Protection Committees are responsible for multi-agency child protection policy, procedure, guidance, and practice.[219] The Children and Young People (Scotland) Act[220] provides for children's rights, and the services and support for, or in relation to children.[221] Part I of the Act provides for the rights of children. It further outlines the duty of the Scottish Ministers to consider actions to be taken to advance CRC requirements.[222] The said Ministers also have an obligation to promote public awareness and understanding of children's rights, including appropriate awareness and understanding among children.[223] The Act further outlines the Ministers' duty to present a report to parliament every three years on the steps taken to effect the CRC requirements in Scotland.[224] Further, the Act refers to the Commissioner for Children and Young People (CCYP) Act of 2003.[225] It establishes the CCYP's mandate to *inter alia*, investigate the extent to which service providers, including health care providers, regard the rights, interests and views of children in making decisions or actions affecting those children.[226]

3.4. Features and evaluation of the comparative foreign laws

3.4.1. South Africa

From the foregoing discussion, it is evident that South Africa has a comprehensive legislative framework for the protection of children's RTH. The features and evaluation of this framework are hereon analysed. The MHCA deals specifically with mental health issues hence for the purposes of this study, it is not included in the analysis. South Africa has made strides to conform to its international children's rights obligations as outlined in the CRC and the ACRWC, both of which it has ratified. Notably, the entrenchment of children's RTH in sections 27(1) and 28(1)(c) of the Constitution gives it the force of

[218] n 152.
[219] As above.
[220] Children and Young People (Scotland) Act 2014 asp 8.
[221] As above preamble.
[222] As above section 1(1).
[223] As above section 1(3).
[224] As above section 1(4).
[225] As above section 5(1).
[226] As above section 5.

enforceability. Moreover, section 28(1)(c) is absolute because it is not qualified by, or subject to progressive realisation and available resources like the general RTH applying to everyone else in section 27 of the Constitution. According to section 167(5) and 167(7) of South Africa's Constitution, the Constitutional Court, which is the highest court in constitutional matters,[227] has the jurisdiction over the interpretation, protection, and enforcement of the Constitution. Hence, its findings are binding on all bodies and persons in South Africa.

Despite the obvious importance and significance of children's access to RTH services, which is evident in the Constitution, the Constitutional Court (Concourt) has largely avoided basing its decisions on section 28(1)(c) of the Constitution.[228] Further, there have been a limited number of cases in which the right of access to health care services has been invoked.[229] As a result, there is relative scarcity of judicial authority in South Africa on the interpretation of children's right to health care.[230] Notwithstanding, in the case of *Minister of Health and Others v Treatment Action Campaign and Others,*[231] concerning health care rights, the Concourt based much of its reasoning on its earlier decision involving the constitutional right to housing. This is in the case of *Government of the Republic of South Africa and Others v Grootboom and Others,*[232] where the Concourt held that the unqualified application of section 28(1)(c) produces an anomalous result.[233] The court also held that the unqualified interpretation of this section meant that guardians with children were to be accommodated with their children, while those who did not have children, no matter how old, disabled or otherwise deserving they may be, would remain without any form of relief.[234] The court further warned about the danger of children being used as stepping stones to housing by their parents, instead of being valued for who they are.[235]

---

[227] n 56 section 167(3)(a).
[228] n 158.
[229] Eveleigh (n 158 as above) referring to the cases of *Soobramoney v Minister of Health, KwaZulu Natal* 1998 1 SA 765 (CC), *B v Minister of Correctional Services* 1997 (6) BCLR 789, *Treatment Action Campaign v Minister of Health* 2000 BCLR (4) 356 (T).
[230] As above.
[231] *Treatment Action Campaign v Minister of Health 2000 BCLR (4) 356 (T).*
[232] *Government of the Republic of South Africa and Others v Grootboom and Others 2001 (1) SA 46 (CC)*
[233] As above paragraph 71.
[234] As above.
[235] As above.

Notwithstanding and particularly relevant to this study, the position regarding BT of children is that, medical personnel who wish to overrule guardians' refusal to consent to BT for their child can approach the HC, as the upper guardian of all minor children.[236] The HC in the case of *Hay v B and Others*[237] held that a refusal by guardians to consent to a life-saving BT for a minor child solely on religious grounds is unconstitutional,[238] and therefore unlawful. The court, relying on section 28(2) of the Constitution, held that the BIC are of paramountcy in every matter concerning the child. Further, the court held that the BIC are the single most important factor to be considered when balancing or weighing children's competing rights and interests. The brief facts in the *Hay* case are that a pediatrician applied to the HC for an urgent order allowing her to give a life-saving BT to a child against the wishes of the guardians. The guardians had opposed the doctor's application on the grounds that BT were contrary to their religious beliefs as JW.

Furthermore, the Children's Act serves as a significant and effective law in protecting children's RTH from actual or potential violations caused by the guardian's refusal to BT based on religious beliefs. Specifically, its sections 11(2) and 12(1) expressly prohibit religious practices that are detrimental to the child's wellbeing, in conformity with South Africa's international children's rights obligations. Article 1(3) of the ACRWC provides that any religious practice inconsistent with the rights in the Charter shall, to the extent of such inconsistency, be discouraged. Similarly, article 24(3) of the CRC provides that states have an obligation take all effective and appropriate measures with a view to abolish traditional practices prejudicial to children's health. As provided above, the ACRWC 'discourages' detrimental religious practices, while the CRC obligates states to take measures 'with a view to abolish traditional practices detrimental to children's health'. Hence, it can be said that the Children's Act more effectively protects children's RTH from religious-based violations, because it is succinct and clear in its prohibition, in comparison with the ACRWC and CRC, which leave room for such violations.

[236] D McQuoid-Mason 'Parental refusal of BT for minor children solely on religious grounds — the doctor's dilemma resolved' (January 2005) https://journals.co.za/doi/pdf/10.10520/EJC68333 (accessed 5 October 2021).
[237] *Hay v B and Others 2003 (3) SA 492 (W) 494-495.*
[238] As above.

Meanwhile, this study finds that there are three notable reasons which support the efficacy of the NHA in protecting children's RTH. First, is in its recognition that children are a vulnerable group,[239] who have specific health care needs. Second, is that it empowers the Minister of Health to prescribe conditions and categories of persons eligible for free health services in public health establishments, including vulnerable groups like children. This can be progressive by allowing children from low-income households who are unable to afford for health services, to access RTH services. Third, is that its section 7 as read together with section 129 of the Children's Act provide for children's right to consent to a health service, if they are 12 years of age, mature enough and capable of understanding the benefits, risks, and other social implications.

However, it is noted that difficulties persist for health care providers to ensure that children's constitutionally protected health care rights are fulfilled. This is because the NHA's definition section omits to define the concept of 'basic health care services'.[240] As this term is not generally used in international instruments or national constitutions, its content and definition is unclear.[241] Consequently, this lack of clarity exposes children's RTH to violations. Additionally, although the Act gives the Minister of Health discretion to prescribe conditions for free health care for categories of people,[242] it is arguable that the inclusion of this section means that children's right to free health care is not adequately safeguarded.[243] Moreover, notwithstanding that the Act enables the Minister to determine the types of free health services that should be provided, this power has yet to be exercised.[244] Consequently, the NHA does not function as it should in protecting children's RTH in South Africa.

3.4.2. United Kingdom

From the preceding discussions, the United Kingdom's children's RTH legislative regime offers insightful features to inform Zambia's RTH legal framework. The HRA, which

[239] As above section 2(c)(iv).
[240] As above section 1.
[241] K Pillay 'The National Health Bill: A step in the right direction?' 2002 *ESR Review: Economic and Social Rights in South Africa* 11 cited in Eveleigh (n 158).
[242] As above section 4(2)(a)-(d).
[243] MB Eveleigh and A Nienaber 'Healthcare for children: Does South Africa's legislation comply with the country's responsibilities in terms of the Convention of the Child and the Constitution?' 2012 *Potchefstroom Electronic Law Journal*, 103-138.
[244] n 158.

applies to the entire United Kingdom, gives effect to the rights and freedoms guaranteed under the ECHR.[245] It further obligates all persons, bodies, and institutions, including the courts, to read and give effect to all legislation in a manner compatible with the rights in the ECHR. Furthermore, an underlying feature among the United Kingdom's four nations is that they have institutions designated to children's RTH issues. Notwithstanding, each nation has a framework of legislation for protecting children's RTH. To start with, England's Department for Education is responsible for child protection, hence it sets out how the three main legislation for the child protection system should work.[246] First, is the Children Act, which establishes the paramountcy of the child's welfare in any court proceedings involving the upbringing of a child, in line with the CRC. Second is the Children Act of 2004, which obliges all local authorities to employ measures to improve children's physical health and protect them from harm. Third, is the Children and Social Work Act, which implores local authorities to act in children's best interests, and to encourage and consider their views. From above, it is evident that England's legislation aligns with the core principles set out in the international children's rights framework, particularly the CRC.

Likewise, Wales's Social Services and Well-being Act provides for the regional safeguarding children boards whose duty is to ensure that children's welfare is protected and promoted. This includes the mental and physical health, and protection from any form of abuse as set out in the CRC. Additionally, Northern Ireland's Executive, through the Department of Health, is responsible for child protection in that country. The Children (Northern Ireland) Order imposes a general duty on Health and Social Care Trusts in Northern Ireland to provide a range of services for children with ill-health and likely health impairments in the absence of intervention, among others. This is progressive in protecting children's RTH because of the intervention this legislation offers to children whose RTH is at risk of violations by their guardians, or other people. Lastly, Scotland's Children and Young People Act provides for children's rights, and further outlines the Ministers' duty to take actions to advance CRC requirements. The Act also provides for the Ministers' obligation to report to Parliament on the steps taken to implement the CRC

[245] n 154 preamble.
[246] As above.

requirement. It establishes the CCYP's mandate to investigate the extent to which service providers, including health care providers, regard the rights, interests, and views of children in making decisions or actions affecting those children.

3.5. Conclusion

This Chapter has analysed the legal frameworks for the protection of children's RTH in South Africa and the United Kingdom. In doing so, it first outlined the justification for choosing the two countries as comparators in this study. The Chapter subsequently analysed South Africa's children's RTH framework. It discussed the relevant provisions in the Constitution, and the Children's and National Health Acts respectively. This was followed by a discussion of the United Kingdom's children's RTH framework generally. Subsequently, the Chapter outlined the frameworks of the four nations specifically. The immediately preceding discussion analysed the pertinent features of both comparators' frameworks, including their norms and practices and shortcomings. While both regimes have comprehensive children's RTH frameworks which, to a greater extent, are reflective of international children's rights laws, they both offer different lessons in protecting children's RTH.

Evidently, children's RTH protection framework in South Africa is strengthened by the Constitution, Children's Act and the NHA, among others. Although the Constitution does not qualify children's RTH by imposing prerequisites for its exercise, South Africa's Concourt has taken a qualified interpretation of children's RTH. However, and relevant to this study, is the HC's position that refusal by guardians to consent to a life-saving BT for children solely on religious grounds is both unconstitutional and unlawful. Additionally, the Children's Act not only reflects South Africa's international children's rights obligations, but also more effectively protects RTH-violations on religious grounds, in comparison to the ACRWC and the CRC. Similarly, the NHA recognises the vulnerability of children and gives the health minister the discretion to allow free health services to children, although this discretion has not yet been exercised. Similarly, the United Kingdom's HRA domesticates the provisions in the ECHR. Each of the four nations of the United Kingdom not only has specific legislation but has dedicated institutions to enforce and protect children's RTH. The underlying feature between the

children's RTH protection framework of the two countries is that they both have strong legislative frameworks, which are complemented by child protection institutions. Therefore, Zambia can derive lessons to inform and guide its creation of a progressive and comprehensive children's RTH framework.

The next Chapter analyses Zambia's framework for protecting children's RTH. Subsequently, it makes recommendations for reforms in Zambia's framework to attain an effective children's RTH framework which will be reflective of international human rights norms. These recommendations are guided by the insights in the present Chapter drawn from the legal frameworks of South Africa and the United Kingdom.

4. Zambia's legal framework for the protection of children's right to health

4.1. Introduction

Chapter Three laid the foundation for the assessment and discussion on improving Zambia's legal framework. To achieve this, it drew lessons for optimising the protection of children's RTH from the United Kingdom and South Africa, after providing a justification for choosing these two jurisdictions as comparators. The Chapter also discussed the operation of both frameworks, in addition to the analysis of their efficacies and shortcomings. This Chapter assesses the adequacy and effectiveness of Zambia's legal framework in protecting children's RTH. The relevant legal frameworks are first, the applicable international and regional children's rights instruments. This includes the CRC and ACRWC, both of which Zambia has ratified and is bound by, although neither of these instruments have been domesticated. Second, is the Constitution. Third, is Common Law, and fourth, are the various statutes applicable to children's RTH. This Chapter identifies the shortcomings in Zambia's frameworks and draws lessons from the comparative foreign laws in the preceding Chapter.

International law must be domesticated through an Act of Parliament before it can be applied. This is because Zambia is a dualist state, which views international law and domestic law as two separate legal systems.[247] This position is reflected in article 7 of the Constitution, which enlists the laws of Zambia, but does not provide for the status of international law in the legal framework.[248] Hence, the Ratification of International Agreements Act (RIAA)[249] provides for the ratification of international agreements and the domestication process,[250] which are prerequisite for the application of international law in Zambia. Owing to the non-domestication of the above children's rights instruments and their non-applicability domestically because of their non-domestication, coupled

[247] Policy Research and Monitoring Centre 'Status of ratification of international and regional treaties'(December 2020)https://pmrczambia.com/wp-content/uploads/2020/12/Status-of-Ratification-of-International-and-Regional-Treaties-1.pdf (accessed 9 September 2021).
[248] n 9 article 7(a) to (e).
[249] Ratification of International Agreements Act 34 of 2016.
[250] As above preamble.

with the limited space available to conduct the enquiry, this research is confined to the assessment of Zambia's domestic framework.

From the onset, it must be clear that Zambia currently does not have legislation which codifies all children's issues. Although the Government as at 22 January 2016, was reviewing the Children's Code Bill, which consolidated the laws providing for the rights and welfare of children,[251] among others, it has not been enacted. It is for this reason that non-governmental organisations like the Centre for Human Rights, have recommended that Zambia should urgently enact the Children's Act to ensure all children in enjoy their fundamental rights and freedoms guaranteed under the ACRWC.[252]

4.2. The Constitution

The Constitution is the supreme law of the Republic of Zambia and any other written law, customary laws, and customary practices inconsistent with its provisions, is void to the extent of the inconsistency.[253] Article 266 of the Constitution, in conformity with international children's rights law, defines a 'child' as a person who has attained, or is below, the age of 18. Civil and political rights are primarily provided for under the BoR, in addition to the preamble which obligates the people of Zambia to uphold the human rights and fundamental freedoms of every person.[254] These rights are legally enforceable,[255] unlike the economic, social and cultural rights which are not justiciable, because they are implied under part IX, 'The General Principles of Devolved Governance.[256] This means that they are to be realised progressively. Thus, Acts of Parliament, which are lower than the Constitution in hierarchy, function as avenues for the exercise of these economic and social rights. For instance, the RTH is partly provided

[251] UN Human Rights Office of the High Commissioner 'Committee on the Rights of the Child examines the report of Zambia' https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16987&LangID=E (accessed 18 September 2021).
[252] Center for Human Rights 'Brief to Zambia's initial report on the implementation of the African Charter on the Rights and Welfare of the Child (Reporting period: 2008 – 2017)' (19 April 2018) https://www.chr.up.ac.za/images/researchunits/cru/news/files/2018_brief_to_zambias_initial_report_to_the_acerw_2008_2017.pdf (accessed 18 September 2021).
[253] n 9 article 1(1).
[254] n 9 articles 11 – 26.
[255] n 9 article 28.
[256] n 9 article 147.

for in the Mental Health Act,[257] although this Act, as the name suggests, applies to mental health needs, and is not specific to children who have distinct needs.

Notwithstanding, the Constitution provides that the laws consist of the 'laws and statutes which apply or extend to Zambia, as prescribed.'[258] This includes international law which Zambia is party to. In view of the inclusive interpretation of children's RTH prescribed by international law, which is discussed in Chapter Two, several articles in the BoR relating to civil and political rights can be relied on in arguing for the Constitution's protection of children's RTH in Zambia. It is evident that the RTH has clear links to many other rights, both civil and political-like the right to life, and the right not to be subjected to torture or cruel, inhuman or degrading treatment.[259] Article 12 of the Constitution provides for the right to life and states that 'no person shall be deprived of his life intentionally except in execution of the sentence of a court in respect of a criminal offence under the law in force in Zambia of which he has been convicted.' This provision is to the effect that no acts or omissions by any person should result in the deprivation of children's right to life, including those which adversely impact on children's RTH, and therefore, might result in loss of life.

Additionally, withholding essential medical care is a form of violence against children classified as 'negligent treatment'.[260] Consequently, any person whose acts or omissions are prejudicial to children's RTH contravenes article 15 of the Constitution, which provides that no person shall be subjected to torture, or to inhuman or degrading punishment or other like treatment. Furthermore, children's RTH envisages that children must not only be given an opportunity to be heard, but also those views must be considered in making healthcare decisions. In this regard, article 20(1) of the Constitution states that:

> Except with his own consent, no person shall be hindered in the enjoyment of his freedom of expression…freedom to hold opinions without interference, freedom to receive ideas and information without interference, freedom to impart and communicate ideas and

[257] Mental Health Act 6 of 2019.
[258] n 9 article 7(e).
[259] I Byrne 'Making the right to health a reality: legal strategies for effective implementation' (September 2005) https://www.escr-net.org › files › health paper (accessed 18 September 2021).
[260] n 131.

> information without interference, whether the communication be to the public generally or to any person or class of persons, and freedom from interference with his correspondence.[261]

Lastly, article 24(2) of the Constitution, like article 15 discussed above, provides for the protection of 'young persons' from exploitation and states that 'all young persons shall be protected against physical or mental ill-treatment, all forms of neglect, cruelty or exploitation'. This article offers protection from all forms of neglect, including neglect of children in healthcare, which maybe prejudicial to their RTH. However, in this article 'young person' means any person under the age of 15 years,[262] which is not in conformity with international children's rights law. As discussed above, the Constitution does not guarantee socio-economic rights like the RTH, unlike the civil and political rights which are entrenched in the BoR and are thus justiciable. However, using the inclusive interpretation of the RTH in the international law framework, the protection of children's RTH can be deduced from articles 12, 15, 20(1) and 24(2) of the Constitution. Notwithstanding, international law is only applicable in Zambia when it is domesticated as discussed above. In the absence of domestication, international law is enforceable only when Constitutional provisions are interpreted using international law, by the courts.[263] Owing to the dependency of the RTH on the court's interpretation of the Constitution, children's RTH in Zambia is in a precarious situation, because it is at the discretion of a judge who may not adopt a human-rights based approach.

4.3. Common law

Zambia is a former British colony and English 'Common Law shall be in force in the Republic', subject to the provisions of the Constitution and to any other written law.[264] At Common Law, all competent adults can consent to and refuse medical treatment. If consent is not established, there may be legal consequences for medical personnel, under the law of trespass, unless there is a lawful justification, such as an emergency or

[261] n 9 article 20(1).
[262] n 9 article 24(4).
[263] L Mushota 'International law, women's rights and the courts: A Zambian perspective' (11 August 2017) https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/11Mushota.pdf (accessed 23 September 2021).
[264] n 149 section 2(1).

necessity.[265] This applies to children under the care of guardians, because the latter can claim for damages if the medical personnel perform treatment on their child without consent, unless the refusal of consent is deemed to be detrimental to the child's health. Trespass to the person protects people against unsanctioned interference with their bodies, and is actionable *per se*. This means that the tort is actionable when the interference occurs, without the need for the claimant to establish any recognised form of damage such as personal injury, psychiatric illness, or economic loss.[266]

In contrast, the failure by people with authority over the child to protect that child's RTH, including medical personnel and guardians respectively, can lead to an action in negligence. Negligence is the most encountered tort for medical personnel, for which the damage is either death, physical, pathological or psychiatric injury, or a combination of any of these.[267] The damage is caused by act(s) or omission(s) by medical personnel that extends hospitalisation and (or) disables someone at discharge or death.[268] A likely sequence of events starts with a duty of care; leading to poor or absent standard of care, termed negligence; leading to an adverse event, culminating in damage.[269] Notably, medical personnel are held to the standard of care expected from reasonable and similarly trained professionals, therefore they are liable for neglecting to perform their duties to this standard, and this neglect causes harm to a patient. Medical personnel have the duty to provide all information necessary to enable patients make informed decisions about medical treatment.[270] Medical negligence attracts compensatory damages for economic or non-economic losses, and sometimes, special damages.[271] Further, it encompasses a guardian's denial of, or delay in seeking the healthcare, and particularly the failure to allow needed care as recommended by a competent healthcare professional for a physical

[265] Australian Law Reform Commission 'Informed consent to medical treatment' (20 May 2014) https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-dp-81/10-review-of-state-and-territory-legislation/informed-consent-to-medical-treatment/ (accessed 18 September 2021).
[266] As above.
[267] R Cheluvappaa and S Selvendran 'Medical negligence - Key cases and application of legislation' (17 July 2020) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7413923/#bib23 (accessed 18 September 2021).
[268] As above.
[269] As above.
[270] TJ Paterick 'Medical informed consent: general considerations for physicians' (1 March 2008) https://www.mayoclinicproceedings.org/article/S0025-6196(1160864-1/fulltext#relatedArticles (accessed 18 September 2021).
[271] n 267.

injury, illness, medical condition or impairment.[272] Notwithstanding that Common Law offers protection to children's RTH through the Law of Torts, with possible tortious claims discussed above, it has a limited scope because it offers post-facto protection, that is, protection after the right has been violated.

4.4. Statutory protection of children's RTH

It is noteworthy that all the statutes which speak to children's RTH, except the Juveniles Act,[273] are not customized to children, but are general and apply to every person. Hence, this research departs from the generalisation in the statutes, to children only. The relevant statutes from which the protection of children's RTH can be deduced in Zambia are discussed below.

4.4.1. Penal Code Act

The Penal Code Act,[274] in section 169, provides that guardians of 'a child of tender age' who are either unable, refuse or neglect to provide (being able to do so) necessaries for that child, resulting in the injury of the child's health, are guilty of a misdemeanor. The Act further provides for the duties relating to the preservation of life and health. Particularly, section 210 provides for the 'responsibility of the person who has charge of another', which includes guardians and medical personnel with authority over children's healthcare. It provides that:

> It is the duty of every person having charge of another who is unable by reason of age…to withdraw himself from such charge, and who is unable to provide himself with the necessaries of life, whether the charge is undertaken under a contract, or is imposed by law, or arises by reason of any act, whether lawful or unlawful, of the person who has such charge, to provide for that other person the necessaries of life; and he shall be deemed to have caused any consequences which adversely affect the life or health of the other person by reason of any omission to perform that duty.[275]

[272] United States Department of Health and Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau Office on Child Abuse and Neglect 'Child neglect: a guide for prevention, assessment and intervention' (2006) https://www.childwelfare.gov/pubPDFs/neglect.pdf (accessed 18 September 2021).
[273] n 8.
[274] Penal Code Act chapter 87 of the Laws of Zambia.
[275] As above section 210.

From the foregoing provisions, any person responsible for a child has the responsibility to provide all necessary support and care to sustain the child's life. This includes enabling a child access to, and benefit from, necessary healthcare services and treatment because such a person is deemed liable for any negative effects on the child's life or health caused by their act(s) or omission(s) in failing to perform their duty. Like Common Law above, this protection of children's RTH in this provision is limited in scope. This is because it punishes the detrimental acts or omission by persons responsible for children after the right has already been violated. Moreover, the Penal Code Act, as its name suggests, provides for the penalisation of offences, and applies to all persons under the Zambian jurisdiction, hence it is not specifically catered to children, who have distinct needs.

4.4.2. Persons with Disabilities Act

The Persons with Disabilities Act (PDA)[276] provides for the domestication of the Convention on the Rights of Persons with Disabilities (CRPD), its Optional Protocol and other international instruments on persons with disabilities to which Zambia is party. The PDA's definition of a child is in conformity with international children's law, as it defines children as all persons below the age of 18. According to section 2 of the Act, 'disability' is 'any physical…or mental impairment that alone, or in combination with social or environmental barriers, hinders the ability of a person to fully or effectively participate in society on an equal basis with others.'[277] Section 27 of the Act enjoins the state's duty to provide health services needed by persons with disabilities primarily because of their disabilities. The treatment, management, or prevention of disabilities in children falls under the ambits of children's RTH. Hence, the PDA as a domestication of the CRPD, protects the RTH of children in Zambia. However, it is specific to persons with disabilities hence it excludes children without disabilities. Moreover, the PDA is not customized to address the specific needs of children, because it applies to all persons with disabilities in Zambia.

[276] Persons with Disabilities Act 6 of 2012.
[277] As above section 2.

4.4.3. Anti-Gender Based Violence Act

The Anti-Gender Based Violence (GBV) Act[278] protects children's RTH because it provides for the protection of victims of GBV, and constitutes the Anti-GBV Committee, among others. It defines GBV as including:

> Physical abuse, which is any act, omission or behavior or threat of any such act, which results in death or is likely to result in the direct infliction of physical…or mental injury to any person and includes subjecting another person to torture or other cruel, inhumane or degrading treatment or punishment.[279]

However, this Act describes a 'child' as any person below the age of 16, in violation of international children's rights law. Additionally, it does not sufficiently address children's RTH.

4.4.4. Mental Health Act

The Mental Health Act (MHA)[280] *inter alia,* gives effect to 'certain provisions of the CRPD, and the improvement of mental care General Assembly Resolution 46/119 of 17 December 1991 and other international human rights instruments to which Zambia is a State Party.'[281] The Act provides that a 'child' is defined as provided in the Constitution, that is, any person who is either aged 18 or below. This in in conformity with international human rights norms. The MHA further provides that 'mental health' is a state of well-being in which a person realises their potential to cope with the normal stresses of life, can work productively and is able to contribute to their community.[282] Additionally, mental health care includes analysis and diagnosis of a person's mental condition, CTR and palliation services for a mental illness or suspected mental illness.[283] The Act provides that all persons shall respect, safeguard the dignity, and uphold the rights of children with mental illness.[284] It further prohibits the exploitation or subjection of such children to abuse, violence or degrading treatment including in the gender based aspects.[285] Notably,

[278] Anti-Gender Based Violence Act 1 of 2011.
[279] As above section 3.
[280] n 257.
[281] As above preamble.
[282] As above section 2.
[283] As above.
[284] As above section 5.
[285] As above section 6(2).

persons who commit an offence under this Act for which a specific penalty is not provided, are liable, on conviction, to pay a fine, or to imprisonment for a period not exceeding one year, or both.[286] However, the MHA is limited to the mental health-needs, hence it is does not adequately protect children's RTH.

4.4.5. Juveniles Act

The Juveniles Act[287] provides for *inter alia*, the custody and protection of juveniles in need of care.[288] It defines 'juvenile' and 'child' respectively as, a person who has not attained the age of 19 including a child and a young person, and a person who has not attained the age of 16.[289] Further, a juvenile who has no guardian(s) or whose guardian(s) is (are) unfit to exercise care and guardianship or is not exercising proper care and guardianship or is exposed to physical danger or is beyond control, requires care, control or protection from the state.[290] However, this Act, as deduced from its definition, deals with children in conflict with the law. Hence, it excludes the majority children, who are not in conflict with the law. More importantly, the Juveniles Act neither addresses children's RTH explicitly nor adequately.

4.4.6. Employment Code Act

The Employment Code Act[291] *inter alia* regulates the employment of young persons, and children.[292] Section 81(1) of the Act prohibits all persons from employing children in any public or private industrial undertaking, or in any branch of the industrial undertaking. However, this section is derogable as it is inapplicable to work done by children in technical schools or similar institutions, where approved and supervised by the Permanent Secretary or other appointees.[293] Notwithstanding**,** it is apparent that the Act bestows upon Permanent Secretary or other appointees, the power enable the employment of children, subject to certain conditions. This further weakens the protection offered to children in Zambia. Moreover, the specifically deals with the

[286] As above section 40.
[287] n 8.
[288] As above preamble.
[289] As above section 2.
[290] As above section 9(a).
[291] Employment Code Act 3 of 2019.
[292] As above preamble.
[293] As above section 81 (2).

employment of young persons and children, and does not adequately address children's RTH.

4.5. Shortcomings in Zambia's framework and lessons from comparators

First, it is evident that Zambia's Constitution does not expressly protect children's RTH, although it can be deduced from articles 12, 15, 20(1) and 24(2) of the Constitution as discussed above. Notwithstanding, the ICRTH can only be applicable upon the court's interpretation of Constitutional provisions using international human rights norms. This places the RTH of children in Zambia in a precarious situation because there is a possibility that some judges may not take the human rights-based approach, which is favourable to the protection of children's RTH. Lessons in this regard can be drawn from South Africa, where children's RTH is constitutionally entrenched. Although South Africa's Concourt has taken a qualified and limited interpretation of children's RTH, its constitutional entrenchment explicitly gives it superiority over all other conflicting laws and practices. Moreover, as discussed in Chapter Three, section 28 of South Africa's Constitution is reinforced by *inter alia* Children's Act, to the effect that the current law as held by the HC is that refusal by guardians to consent to a life-saving BT for children solely on religious grounds, is unconstitutional and unlawful. Further, the Common Law protection of children's RTH is limited because the protection is post-facto - after the right has already been violated.

Second, Zambia has much to learn from the United Kingdom, which serves as a good model because, it has given effect to its international children's RTH obligation by domesticating the ECHR's provisions through the HRA. Further, each of the four nations of the United Kingdom has legislation to enhance the protection of children's RTH. Consequently, Zambia's children's RTH framework must not only incorporate its international children's rights obligations as a ratifier of both the CRC and ACRWC, but must also respond to the specific challenges confronting children's RTH in the country.

Third, as discussed above, both comparators evidence that children's RTH can only be effectively and adequately protected when there are first, comprehensive legislative

frameworks, and second, strong and efficient children's rights protection institutions. Zambia has shown its commitment to the protection of children's RTH through two institutions. First, is the Children's Court of the HC,[294] which plays a pivotal role in interpreting the children's RTH framework, given the binding and enforceable nature of the HC judgments. Second, is the Department of Child Development (DCD) under the Ministry of Youth, Arts and Sports,[295] comprised of the Director and three Chief Child Development Officers (CDO) who are in charge of inspection and child protection, and information, education, and communication respectively.[296] The DCD is tasked with the coordination of child development programs, domestication of the CRC, and the promotion and protection of children's rights to survival development, protection and participation.[297] Although it serves as a good avenue for protecting children's RTH, it has yet to acquire a desirable level of visibility and efficacy in protecting children's RTH. This shortcoming, coupled with the lack of children's RTH specific legislation entails that Zambia's children's RTH framework is neither adequate nor efficient. Hence, there is dire need to address these shortcomings in Zambia's children's RTH frameworks.

4.6. Conclusion

This Chapter reviewed the scope and extent of the protection of children's RTH under Zambia's current legal framework, particularly, the Constitution, Common Law and relevant Acts of Parliament. The Chapter found that Zambia's current legal framework for protecting children's RTH is not only inadequate, but also inefficient because it leaves room for infringement. It also identified lessons that Zambia's children's RTH framework can adapt from the frameworks of both the United Kingdom and South Africa. The Chapter below provides the summary, findings, and conclusion of this study. It includes the recommendations deduced from the present Chapter for implementation to attain a robust and effective children's RTH framework in Zambia.

[294] n 9 article 133(2).
[295] Ministry of Youth, Arts and Sports 'Department of Child Development' (2021) https://www.myscd.gov.zm/?page_id=5229 (accessed 17 September 2021).
[296] As above.
[297] As above.

5. Conclusions and recommendations

5.1. Synopsis of conclusions

This study assessed the adequacy and efficacy of Zambia's legal framework for protecting children's RTH from violations occasioned by guardian's religious standpoints. Particularly, the study focused on JW guardians, whose religious doctrines proscribe BT, even under life-threatening circumstances. Chapter One comprised of this study's background, research problem, research questions, methodology and literature. Chapter Two provided the theoretical framework and discussed the theories underpinning the interplay between JW guardians' authority, and children's RTH. Chapter Three examined the children's RTH frameworks in the United Kingdom and South Africa, and analysed the operation, efficacies, and deficiencies of both legal frameworks. Chapter Four analysed Zambia's existing legal framework for protecting children's RTH and concluded that this framework is neither effective nor adequate. This Chapter also identified learning points from the frameworks of South Africa and the United Kingdom. The present Chapter Five is a conclusion and summary of the entire study, which includes recommendations to address the shortcomings in Zambia's children's RTH framework.

5.2. Recommendations

Based on the previous Chapter's analysis of the shortcomings in Zambia's children's RTH framework, the following are the recommendations for implementation to achieve a robust and effective framework for protecting children's RTH.

5.2.1. Recognition and constitutional entrenchment of children's right to health

The protection of children's RTH in Zambia is of peculiar importance for two reasons. First, guardians have the primary responsibility of the child's upbringing and wellbeing, meaning that the protection of children's RTH is generally dependent on them. Second, the violation of the RTH threatens and has ripple effects on other rights, including the right to life. Children's RTH is implicitly protected under articles 12, 15, 20(1) and 24(2) respectively of Zambia's Constitution, which provide for the right to life, freedom from torture, or inhuman or degrading punishment or other like treatment, freedom of

expression, and the protection of 'young persons' from exploitation. These rights, which are entrenched in the BoR,[298] are legally enforceable,[299] thus they offer protection to children's RTH by deduction, as discussed in this study.

However, this approach does not effectively or adequately protect children's RTH because the recognition, interpretation, and scope of the RTH of children by reliance on the above constitutional provisions is at the discretion of a judge, who may not adopt a human rights-based approach. Meanwhile, socio-economic rights like the RTH are to be realised progressively, as provided under the Constitution's part IX,[300] thus they are not justiciable. However, it is recommended that the RTH for children in Zambia must be explicitly included in the Constitution, separate from the above constitutional provisions, because of the precarious nature of children's RTH as discussed above. Ideally, this provision should be entrenched in the BoR, to give it the force of justiciability. However, pursuant to article 79(3) of the Constitution, the BoR can only be altered by the National Assembly after a national referendum, by not less than 50% of persons entitled to be registered as voters for the purposes of presidential and parliamentary elections. Given the failure to meet this threshold in Zambia's most recent referendum to change the BoR on 11 August 2016,[301] there is a possibility that another referendum for the inclusion of children's RTH in the BoR may not be successful. Therefore, in the meantime, children's RTH can be provided as a general provision in the Constitution, to give it the status of superiority over other laws and practices.

5.2.2. Promulgation of a comprehensive children's right to health legislation

Zambia has ratified both the CRC and the ACRWC, neither of which treaties have been domesticated. Considering the existing potential or actual threats to children's RTH in Zambia, a comprehensive law regulating guardian's authority and protecting the RTH of children is indispensable. The proposed Children's Act, as discussed in this study, was a

[298] n 9 articles 11-26.
[299] n 9 article 28.
[300] n 9 article 147.
[301] C Lumina 'Zambia's failed constitutional referendum: what next?' (12 September 2016) https://constitutionnet.org/news/zambias-failed-constitutional-referendum-what-next (accessed 18 September 2021).

step in the right direction in enhancing children's rights generally. However, it has not been enacted, and its provisions did not adequately protect children's RTH from religious-based violations by their guardians. Therefore, a children's RTH protection law should be formulated, with a human rights-centered approach. This law must be determined after wide stake-holder consultations, extensive comparative studies with other jurisdictions like those discussed in this study, and specific consideration of how best to protect children's RTH, in view of guardian's authority. The preamble and object clause of this legislation must expressly state that the Act is for the protection of the children's RTH and limitation of guardian's authority in children's healthcare.

The following should be paramount in the Act. First, children's RTH should be defined using the inclusive interpretation, in accordance with international children's rights law. Second, the definition of children must include them as distinct rights'-holders who must be allowed to make their own healthcare decisions if they have sufficient capacity and knowledge. Third, the Act should expressly give medical personnel authority to override the guardian's authority in circumstances where children's RTH is under threat including the denial of requisite consent to potentially lifesaving medical procedures like BT on purely religious grounds. This lesson is deduced from South Africa's Children's Act whose sections 11(2) and 12(1) expressly prohibit religious practices that are detrimental to the wellbeing of the child, in conformity with international children's rights obligations. Further, the Act should go beyond prohibition of detrimental religious practices. Hence, it must penalise guardians and medical personnel respectively, for acts or omissions-religious or otherwise, detrimental to children's RTH and failure to take measures for children's RTH-protection.

5.2.3. General recommendations

The DCD operations must be heightened and revamped by allocating sufficient resources to allow the employment of more CDOs, who can be stationed at healthcare facilities to provide support in cases of threats to children's RTH. The DCD must work in collaboration with the health and justice ministries which oversee all national health matters and legal affairs respectively. Additionally, there must be strategic sensitisation of stakeholders about children's RTH including members of the judiciary like judges,

JWs, guardians, medical personnel, and children themselves. Further, there must be concerted efforts to protect children's RTH. First, the Zambian Human Rights Commission and human rights activists, and organisations must take purposeful actions to enhance children's RTH, in collaboration with organisations like the UN International Children's Emergency Fund, which work to *inter alia*, protect children's RTH in Zambia.[302] Second, comprehensive database documenting the trends and changes in children's RTH issues and other related issues must be developed. This will encourage scholars and children's rights-focused institutions in Zambia, to produce pragmatic and comprehensive solutions to children's RTH challenges in Zambia. Third, government departments and ministries, and children's rights organisations must develop adequate and comprehensive protection policies for children's RTH. The above, if implemented, will drive Zambia to becoming one of the model countries on the continent for the protection and promotion of children's RTH.

[302] United Nations International Children's Emergency Fund 'UNICEF's work in Zambia' (2021) https://www.unicef.org/zambia/what-we-do (accessed 16 September 2021).

Bibliography

Books

Mujajati, A and Chirwa, J *Medical law and ethics in Zambia* (Thorn Bird Literary Agency 2019)

Articles

Bueren, GV 'The international law on the rights of the child' (1995) *Fordham International Law Journal* 832-839

Ekundayo, O 'Does the African Charter on the Rights and Welfare of the Child only underline and repeat the Convention on the Rights of the Child provisions: Examining the similarities and differences' (2015) *International Journal of Humanities and Social Science* 143

Elder, L 'Why some JW accept blood and conscientiously reject official Watchtower Society blood policy' (2000) *J Med Ethics* 375–380

Eveleigh, MB 'Children's rights of access to health care services and to basic health care services: A critical analysis of case law, legislation and policy' (2016) *De Jure Law Journal* 42

Eveleigh, MB and Nienaber, A 'Healthcare for children: Does South Africa's legislation comply with the country's responsibilities in terms of the Convention of the Child and the Constitution?' (2012) *Potchefstroom Electronic Law Journal* 103-138

Fokala, E and Rudman, A 'Age or maturity? African children's right to participate in medical decision-making processes' (2020) *African Human Rights Law Journal* 20

Gillon, R 'Refusal of potentially life-saving BT by JW: should doctors explain that not all JWs think it's religiously required?' (2000) *J Med Ethics* 299-301

Hawkins, SD 'Protecting the rights and interests of competent minors in litigated medical treatment disputes' (1996) *Fordham Law Review* 64

Lloyd, A 'A theoretical analysis of the reality of children's rights in Africa: An introduction to the African Charter on the Rights and Welfare of the Child' (2002) *African Human Rights Law Journal* 2

Pillay, K 'The National Health Bill: A step in the right direction?' (2002) *ESR Review: Economic and Social Rights in South Africa* 11

Rodham, HR 'Children under the law' (1973) *Harvard Education Review* 467

Sheldon, S and Wilkinson, S 'Should selecting saviour siblings be banned?' (2004) *J Med Ethics* 533–537

Varadan, S 'The principle of evolving capacities under the UN Convention on the Rights of the Child' (2019) *The International Journal of Children's Rights* 27(2)

Ventrell, MR 'Rights and duties: An overview of the attorney-child client relationship' (1995) *Loyola University of Chicago Law Journal* 26

Wald, M 'Children's rights: A framework for analysis' (1979) *University of California Davis Journal* 255-282

Official documents

African Union

African Charter on the Rights and Welfare of the Child (adopted 1 July 1990, entered into force 29 November 1999) CAB/LEG/24.9/49

European Union

European Convention on Human Rights (adopted 4 November 1950, entered into force on 3 September 1953) ETS 5

South Africa

Children's Act 38 of 2005
Constitution of the Republic of South Africa Act 108 of 1996
Mental Health Care Act 17 of 2002

National Health Act 61 of 2003

Sexual Offences (Amendment) Act 32 of 2007

Termination of Pregnancy Act 92 of 1996

The Interpretation Act 33 of 1957

United Kingdom

Children (Northern Ireland) Order 1995 no 755 (NI2)

Children Act 1989 Chapter 41

Children Act 2004 Chapter 31

Children and Social Work Act 2017 Chapter 16

Children and Young People (Scotland) Act 2014 asp 8

Human Rights Act of 1998 Chapter 42

Social Services and Well-being (Wales) Act 2014

United Nations

Convention on the Rights of the Child (adopted 20 November 1989, entered into force 2 September 1990) E/CN.4/RES/1990/74

Declaration of the Rights of the Child (adopted 20 November 1959) A/RES/1386(XIV)

Declaration of the Rights of the Child (adopted 25 September 1924) League of Nations

General comment 12 (2009): The right of the child to be heard' (20 July 2009) CRC/C/GC/12

General comment 13 (2011): The right of the child to freedom from all forms of violence' (18 April 2011) CRC/C/GC/13

General comment 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1)' (29 May 2013) CRC /C/GC/14

General comment 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health article 24 (17 April 2013) CRC/C/GC/15

General comment 7 (2005): Implementing child rights in early childhood (20 September 2006) CRC/C/GC/7/Rev 1

Universal Declaration of Human Rights (10 December 1948) 217 A (III)

Zambia

Anti-Gender Based Violence Act 1 of 2011

Constitution of Zambia Act 2 of 2016

Employment Code Act 3 of 2019

Juveniles Act chapter 53 of the laws of Zambia

Juveniles Act chapter 53 of the laws of Zambia

Mental Health Act 6 of 2019

Penal Code Act chapter 87 of the laws of Zambia

Persons with Disabilities Act 6 of 2012

Ratification of International Agreements Act 34 of 2016

The English Law (Extent of Application) Act chapter 11 of the Laws of Zambia

Case law

South Africa

B v Minister of Correctional Services 1997 (6) BCLR 789

Government of the Republic of South Africa and Others v Grootboom and Others 2001 (1) SA 46 (CC)

Hay v B and Others 2003 (3) SA 492 (W) 494-495

Soobramoney v Minister of Health, KwaZulu Natal 1998 1 SA 765 (CC)

Treatment Action Campaign v Minister of Health 2000 BCLR (4) 356 (T)

Zambia

Monze Muyeka v Miniva Nakamba 2015/HP/0974

United Kingdom

Gillick v West Norfolk 1986] 1 AC 112 [1985] 3 All ER 402 [1985] 3 WLR 830

Internet sources

African Union 'African Charter on the Rights and Welfare of the Child' (2021) https://au.int/sites/default/files/treaties/36804-sl-AFRICAN%20CHARTER%20ON%20THE%20RIGHTS%20AND%20WELFARE%20OF%20THE%20CHILD.pdf (accessed 26 August 2021)

Australian Law Reform Commission 'Informed consent to medical treatment' (20 May 2014) https://www.alrc.gov.au/publication/equality-capacity-and-disability-in-commonwealth-laws-dp-81/10-review-of-state-and-territory-legislation/informed-consent-to-medical-treatment/ (accessed 18 September 2021)

Boland, L and Graham, ID 'Barriers and facilitators of pediatric shared decision-making: a systematic review' (2019) https://implementationscience.biomedcentral.com/track/pdf/10.1186/s13012-018-0851-5.pdf (accessed 6 September 2021)

Byrne, I 'Making the right to health a reality: legal strategies for effective implementation' (September 2005) https://www.escr-net.org › files › health paper (accessed 18 September 2021)

Center for Human Rights 'Brief to Zambia's initial report on the implementation of the African Charter on the Rights and Welfare of the Child (Reporting period: 2008 – 2017)' (19 April 2018) https://www.chr.up.ac.za/images/researchunits/cru/news/files/2018_brief_to_zambias_initial_report_to_the_acerw_2008_2017.pdf (accessed 18 September 2021)

Cheluvappaa, R and Selvendran, S 'Medical negligence - Key cases and application of legislation' (17 July 2020) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7413923/#bib23 (accessed 18 September 2021)

Child law advice 'Parental responsibilities' (2021) https://childlawadvice.org.uk/information-pages/parental-responsibility/ (accessed 4 September 2021)

Department Statistics South Africa 'Education series volume VII: Children's education and well-being in South Africa 2018' (26 February 2021) http://www.statssa.gov.za/?p=14044 (accessed 4 October 2021)

Equality and Human Rights Commission 'Human Rights Act' (2021) https://www.equalityhumanrights.com/en/human-rights/human-rights-act (accessed 5 October 2021)

Fong, IW 'BT-associated infections in the twenty-first century: new challenges.' (7 March 2020) 191–215 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7120358/ (accessed 5 September 2021)

Foster, D 'An overview of child protection legislation in England' (19 February 2020) https://researchbriefings.files.parliament.uk/documents/SN06787/SN06787.pdf (accessed 5 October 2021)

Gap minder 'The world has reached peak number of children!' (2021) https://www.gapminder.org/news/world-peak-number-of-children-is-now/ (accessed 21 August 2021)

Global Legal Group 'Zambia: Litigation and dispute resolution laws and regulation' (15 February 2021) https://iclg.com/practice-areas/litigation-and-dispute-resolution-laws-and-regulations/zambia (accessed 5 October 2021)

International Training Center for Bloodless Medicine and Surgery 'History of Bloodless Medicine and Surgery' (2021) https://www.medstarbloodless.org/history-of-bloodless-medicine-and-surgery (accessed 4 September 2021)

John Hopkins University 'The Center for Bloodless Medicine and Surgery' (2021) https://www.hopkinsmedicine.org/bloodless_medicine_surgery/ (accessed 2 September 2021)

Lesley, B 'Judge Barrett, what is right for children?' (26 October 2020) https://firstfocus.org/blog/judge-barrett-what-is-right-for-children (accessed 18 September 2021)

Liberty 'The Human Rights Act' (2021) https://www.libertyhumanrights.org.uk/your-rights/the-human-rights-act/ (accessed 6 October 2021)

Lumina, C 'Zambia's failed constitutional referendum: what next?' (12 September 2016) https://constitutionnet.org/news/zambias-failed-constitutional-referendum-what-next (accessed 18 September 2021)

McQuoid-Mason, D 'Parental refusal of BT for minor children solely on religious grounds — the doctor's dilemma resolved' (January 2005) https://journals.co.za/doi/pdf/10.10520/EJC68333 (accessed 5 October 2021)

McQuoid-Mason, DJ 'Parents refusing BT for their children solely on religious grounds: Who must apply for the court order?' (February 2020) http://www.scielo.org.za/pdf/samj/v110n2/08.pdf (accessed 27 August 2021)

Ministry of Youth, Arts and Sports 'Department of Child Development' (2021) https://www.myscd.gov.zm/?page_id=5229 (accessed 17 September 2021)

Mushota, L 'International law, women's rights and the courts: A Zambian perspective' (11 August 2017) https://www.southernafricalitigationcentre.org/wp-content/uploads/2017/08/11Mushota.pdf (accessed 23 September 2021)

National Center for Biotechnology Information 'Outcomes from cardiac surgery in JW patients: experience over twenty-one years' (14 April 2016) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4831181/ (accessed 6 September 2021)

National Society for the Prevention of Cruelty to Children 'Child protection system in the United Kingdom' (2021) https://learning.nspcc.org.uk/child-protection-system (accessed 5 October 2021)

Office of the High Commissioner on Human Rights 'Human rights bodies' https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=185 (accessed 29 September 2021)

Office of the UN High Commissioner for Human Rights and World Health Organization 'The right to health, fact sheet no. 31' (June 2008) www.ohchr.org/Documents/Publications/Factsheet31.pdf.(accessed 16 September 2021)

Paterick, TJ 'Medical informed consent: general considerations for physicians' (1 March 2008) https://www.mayoclinicproceedings.org/article/S0025-6196(1160864-1/fulltext#relatedArticles (accessed 18 September 2021)

Pattakos, G and Koch, CG 'Outcome of patients who refuse transfusion after cardiac surgery: a natural experiment with severe blood conservation' (13 August 2012) https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1211993 (accessed 4 September 2021)

Petrini, C 'Ethical and legal aspects of refusal of BT by JW, with particular reference to Italy' (2014) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3934270/ (accessed 27 August 2021)

Policy Research and Monitoring Centre 'Status of ratification of international and regional treaties '(December 2020)https://pmrczambia.com/wp-content/uploads/2020/12/Status-of-Ratification-of-International-and-Regional-Treaties-1.pdf (accessed 9 September 2021)

Queen's University Belfast 'United Kingdom Northern Ireland Report' (2021) https://www.qub.ac.uk/sites/participation-for protection/FileStore/Filetoupload,886288,en.pdf (accessed 9 October 2021)

Ramphele, L 'KZN parents taken to court for denying their child medical intervention' (19 October 2019) http://www.capetalk.co.za/articles/324777/kzn-parents-taken-to-court-for-denying-their-child-medical-intervention (accessed 1 May 2021)

Robinson Gill Lawyers 'The meaning of parental responsibility' (2021) https://www.robinsongill.com.au/resource/the-meaning-of-parental-responsibility/ (accessed 4 September 2021)

Save the Children 'Protecting children in Zambia from violence, abuse, neglect and exploitation' (2011) https://resourcecentre.savethechildren.net/node/4444/pdf/4444.pdf (accessed 4 September 2021)

Smith, TM 'Pediatric decision-making: Help parents protect, empower kids' (26 December 2019) https://www.ama-assn.org/delivering-care/ethics/pediatric-decision-making-help-parents-protect-empower-kids (accessed 5 September 2021)

South African Human Rights Commission 'Children's rights and basic education' (2021) https://www.sahrc.org.za/index.php/focus-areas/children-s-rights-and-basic-education (accessed 29 September 2021)

UN Human Rights Office of the High Commissioner 'Committee on the Rights of the Child examines the report of Zambia' https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16987&LangID=E (accessed 18 September 2021)

UN Human Rights Treaty Bodies 'UN Treaty Body Database' (2021) https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=194&Lang=EN accessed 27 August 2021)

UN International Children's Emergency Fund 'Children in Africa: Key statistics on child survival and population' (2017) https://data.unicef.org/wp-content/uploads/2019/01/Children-in-Africa.pdf (accessed 27 August 2021)

UN International Children's Emergency Fund 'UNICEF's work in Zambia' (2021) https://www.unicef.org/zambia/what-we-do (accessed 16 September 2021)

US Department of Health and Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau 'Child neglect: a guide for prevention, assessment and intervention' (2006) https://www.childwelfare.gov/pubPDFs/neglect.pdf (accessed 18 September 2021)

University of Washington 'Parental decision making' (2018) https://depts.washington.edu/bhdept/ethics-medicine/bioethics-topics/detail/72 (accessed 5 September 2021)

Watch Tower Bible and Tract Society of Pennsylvania 'JW in Zambia' (2021) https://www.jw.org/en/jehovahs-witnesses/worldwide/ZM/ (accessed 18 August 2021)

Watch Tower Bible and Tract Society of Pennsylvania 'Medical alternatives to BT' (2021) https://www.jw.org/en/library/magazines/g201209/medical-alternatives-to-blood-transfusions/ (accessed 3 September 2021)

Watch Tower Bible and Tract Society of Pennsylvania 'What does the Bible say about BT?' (2021) https://www.jw.org/en/bible-teachings/questions/bible-about-blood-transfusion/ (accessed 27 August 2021)

Watch Tower Bible and Tract Society of Pennsylvania 'What does the Bible say about BT?' (2021) https://www.jw.org/en/bible-teachings/questions/bible-about-blood-transfusion/ (accessed 5 September 2021)

Watch Tower Bible and Tract Society of Pennsylvania 'Why don't JW accept BT?' (2021) https://www.jw.org/en/jehovahs-witnesses/faq/jehovahs-witnesses-why-no-blood-transfusions/ (accessed 4 September 2021)

Williams, SCP 'What's behind the decline in BT?' (2013) https://sm.stanford.edu/archive/stanmed/2013spring/article5.html (accessed 4 September 2021)

Woolley, SL 'The limits of parental responsibility regarding medical treatment decisions' (10 January 2011) https://pubmed.ncbi.nlm.nih.gov/21220259/ (accessed 27 August 2021)

World Health Organisation 'Sickle-cell anemia' 24 April 2006 https://apps.who.int/gb/ebwha/pdf_files/WHA59/A59_9-en.pdf (accessed 19 August 2021)

Yale Medicine 'BT for children' (2021) https://www.yalemedicine.org/conditions/child-blood-transfusions (accessed 27 August 2021)

Other sources

Good Hope Hospital 'Policy for treatment of JW adults & children' (2020) https://www.transfusionguidelines.org (accessed 18 August 2021)

Muyoba, P 'An ethical assessment of the relationship between the church and the state: a case of BT among the JW of Mpika and Lusaka districts' master's degree dissertation, University of Zambia, 2005

Stern, R ‘The child’s right to participation-reality or rhetoric?’ (2006) Doctor of Laws Dissertation, Uppsala University