

Obesity amongst children

Child Abuse or Parental Neglect?

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Dedication

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with you these past years.

Kindest regards,
Lyla Mclachlan

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CHAPTER 1: INTRODUCTION

1.1. BACKGROUND

Childhood obesity is one of the most serious public health challenges of the 21st century. This problem, which has been described as an epidemic by some, is a global problem and is increasing at an alarming rate.¹ The obesity rate of children worldwide has increased from 4.2% in 1990 to 6.7% in 2010.² Globally, in 2010 it was estimated that over 42 million children under the age of five were overweight.³ Of the estimated 42 million, close to 32 million of these children are living in developing countries.⁴ In 2020 the prevalence of childhood obesity is expected to reach 91% or, in other words affect 60 million children.⁵ In Africa, childhood obesity was at 8.5% in 2010 and is predicted to reach 12.7% by 2020.⁶

South Africa is by no means unaffected by this global health issue. According to world health statistics South African children are rated as the fifth most obese in the world.⁷ Up to 5% of boys and an astounding 25% of girls in South Africa are obese or overweight.⁸ Only the United Kingdom, Canada, United States of America and Mexico outdo South Africa's childhood obesity statistics.⁹ These numbers are a cause of great concern, as studies have shown that overweight or obese children are two times more likely to be obese adults.¹⁰ Obese adults in turn face a series of serious health consequences such as cardiovascular disease, type-2 diabetes,

¹"Global: Childhood obesity rate higher than 20 years ago"

<http://www.procor.org/prevention_show.htm?doc_id=1367793> (accessed on 12 November 2012).

²Van Heerden (2011) "Many SA kids obese" 14 April 2011<http://www.health24.com/dietfood/weight_centre/15-51-2954,18609.asp> (accessed on 12 November 2012).

³*Id.*

⁴"Childhood overweight and obesity on the rise" <http://www.who.int/dietphysicalactivity/childhood/en/> (accessed on 12 November 2012).

⁵"Global: Childhood obesity rate higher than 20 years ago"

<http://www.procor.org/prevention_show.htm?doc_id=1367793> (accessed on 12 November 2012).

⁶*Id.*

⁷Van Heerden "SA kids 5th most obese in the world"

http://www.selfmed.co.za/full_story.aspx?nid=13534 (accessed on 12 November 2012).

⁸*Id.*

⁹*Id.*

¹⁰*Id.*

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musculoskeletal disorders, gall-bladder diseases and some cancers.¹¹ These conditions cause premature death and substantial disabilities.¹² It goes without saying that overweight and obese children are also faced with the emotional trauma of teasing, bullying, victimization and social embarrassment in their schools.

1.2 RESEARCH PROBLEM

The problem of obesity and the diseases caused by being obese, result in a secondary problem. This problem places a further unnecessary burden on the already overstretched South African public health sector as obesity is a highly preventable disease. While the problem of obesity causes many threats to the public health sector, the issue of obesity has largely been viewed as a medical issue only. The legislature and legal world has not yet joined the obesity bandwagon that the medical world has been on for some time.

In South Africa there is clearly a need for the state to intervene and curb the childhood obesity problem faced by children today, as childhood obesity has serious and far reaching consequences. Considering the fact that in today's society there is a huge amount of information available about healthy diets and lifestyles, there is almost no excuse for a parent to allow their children to become obese. This is especially true when one considers that the vast majority of children of a young age are generally not in control of their diets and that it is primarily the parent's responsibility to ensure the well-being and health of the child.

Furthermore, just as most people know that being overweight is an unhealthy condition, it can also be said that most people know that being "too thin" is also unhealthy. Being "too thin" or anorexic or starved also poses various health threats to a person's well-being and these consequences will also be explored. Purposefully starving a child is globally considered a severe form of child abuse because of the

¹¹*"What are the health consequences of being overweight?"*

<http://www.who.int/features/qa/49/en/index.html> (accessed on 12 November 2012).

¹²*Id.*

extremely dangerous effects. Childhood obesity has not been given the same label. Only in recent years has it been considered by the courts in a handful of federal states in America as worthy of state intervention into the family unit, and then only in extreme cases where the child was morbidly obese.¹³

1.3 RESEARCH QUESTION AND OBJECTIVES

The question which is therefore faced is how should the state intervene to curb the obesity problem amongst children? Should childhood obesity be classified as a form of child abuse or parental neglect so that the state can intervene when it is appropriate?

There clearly is a need for some form of intervention on the part of state with regard to childhood obesity, as childhood obesity poses an enormous problem, not only to children's health and welfare, but also to society as a whole, because of the secondary problems that childhood obesity can create, as discussed above.¹⁴ Therefore this research aims to examine whether child obesity is a form of child abuse or parental neglect which can be regulated by legislation.

1.4 METHODOLOGY

This research is a literary study. Use of literary sources pertaining to childhood obesity or related topics, such as newspapers, textbooks, journal articles as well as opinions of academics and authors and relevant legislation will be examined and discussed. All the sources used appear in the bibliography. A comparative study will also be undertaken by on one hand, examining the laws concerning childhood obesity in America and the stance that the courts of several federal states have taken and on the other hand South African law concerning children and how the

¹³Mitgang "Childhood obesity and state intervention: An examination of the health risks of paediatric obesity and when they justify state involvement" 2011 *Columbia Journal of Law and Social Problems* 559.

¹⁴See para 1.1.

legislature could incorporate the principles arising from American laws concerning childhood obesity into South African child law.

1.5 PLAN OF DEVELOPMENT OF RESEARCH

In Chapter 2 the causes as well as the consequences, physiological and psychological, of childhood obesity will be examined. The consequences of starving a child will be briefly examined to demonstrate that while both starvation and obesity cause serious and sometimes similar health issues that can ultimately lead to death, only deliberately starving a child is considered abuse.

In Chapter 3 an examination of the relevant concepts pertaining to this research and the international legal framework will be undertaken. Concepts such as child abuse and parental neglect will be looked at, as well as how these concepts have been recognised in terms of international child law. International laws such as the United Nations Convention on the Rights of the Child, 1989 and the African Charter on the Rights and Welfare of the Child, 1990 will be examined in this regard, as South Africa has ratified these international instruments and therefore has an obligation to introduce them into our domestic law.

In Chapter 4 the Constitution of the Republic of South Africa, 1996 and the rights pertaining to the topic of childhood obesity as contained in section 28 of the Bill of Rights, as well as relevant legislation will be examined. Finally South African case law will be examined to determine the judicial interpretation of the concepts of child abuse and parental neglect and the meanings that relevant sections of legislation have been given. Chapter 4 is ultimately aimed at determining whether there is a possibility that childhood obesity can fall under the definitions of child abuse or parental neglect or some other form of child maltreatment so that the legislature does not need to enact new laws, but merely needs to expand on the current law.

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In Chapter 5 American case law from various federal states pertaining to childhood obesity will be looked at to establish how different federal states have interpreted their legislation pertaining to children and how the prevention of child abuse or neglect has been applied to cases of obese children.

Finally, Chapter 6 deals with the conclusion and recommendations with respect to possible intervention and preventative measures that can be introduced into the South African law.

1.6 DELIMITATIONS

This research will not be looking at starvation as a form of child abuse *per se*. Only the medical consequences of starvation in comparison to the medical consequences of childhood obesity will be examined in order to determine if childhood obesity is as dangerous or serious as starvation.

Malnutrition amongst children will also not be covered in this research as the majority of the population in South Africa is poverty stricken and such person's staple diet consists mainly of maize meal which lacks sufficient nutrients. Therefore the majority of the population is malnourished due to their economic status. Parents in such circumstances should thus not be punished merely because they are unable to afford to provide nutritious meals for their children.

CHAPTER 2: IS BEING OBESE SUCH A SERIOUS MEDICAL CONDITION?

2.1. INTRODUCTION

In today's day and age it is very hard to ignore the fact that being overweight is unhealthy to a person. One merely has to open a magazine or turn on a television to be bombarded with numerous advertisements, articles and documentaries about diets, being overweight or obese and lifestyle changes a person should make if he or she is overweight. In fact, one could go as far as to say that it is impossible to avoid this type of information. So while the vast majority, if not every person, knows that being overweight or obese is unhealthy, the question that must be asked is whether people realise that being overweight or obese actually poses various serious negative medical consequences and threats, or do most people simply view being overweight as unhealthy because of the stigma that society has attached to it in recent years?

This chapter will explore the definition of obesity, the causes of obesity as well as the medical consequences of being obese, paying particular attention to the physiological and psychological consequences an obese child would potentially face. Furthermore this chapter will also briefly look at the opposite end of the spectrum, starvation, in order to demonstrate that both conditions have serious and life-threatening consequences, yet only starvation is currently considered as abuse.

2.2. THE DEFINITION OF CHILDHOOD OBESITY

The World Health Organisation (WHO) defines obesity or being overweight as an abnormal or excessive fat accumulation that may impair health.¹ The generally accepted method which is used to determine whether a person is underweight,

¹World Health Organisation "*Obesity and overweight: Fact sheet N 311*"
<http://www.who.int/mediacentre/factsheets/fs311/en/> (accessed on 29 August 2013).

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within the normal range or overweight is by calculating the individual's Body Mass Index (BMI). This method consists of a simple calculation of a person's weight in kilograms divided by height in square meters.² The WHO classifies a person as being overweight if he or she has a BMI between 25 and 30, while a person is classified as obese if he or she has a BMI which is between 30 and 35. A person, who has a BMI of above 35 is classified as being morbidly obese.

2.3. CAUSES OF CHILDHOOD OBESITY

The National Institutes of Health and National Heart, Lung and Blood Institute describe obesity as:

“A complex multi factorial chronic disease that develops from an interaction of genotype and the environment.”³

On a basic level the cause of obesity is an imbalance between the body's caloric intake and output and it happens when a person eats more than he or she uses.⁴ In general the majority of the global population has in recent years followed an increasingly sedentary lifestyle with the development of technology.⁵ For example people would rather drive to the local grocery store instead of walking, or make use of online shopping instead of going to a store. Instead of choosing physically demanding jobs like agriculture or mining, career choices which place people in offices have become increasingly popular. Furthermore, instead of having to participate in physical activities such as sports and outdoor games as a means of entertainment, people now tend to stay indoors to enjoy the development of televisions, computer games, the internet and video games.

²Girela “Law and obesity” 2006 *European Food and Feed Law Review* 210.

³National Institutes of Health & National Heart, Lung and Blood Institute “*Clinical guidelines on the identification, evaluation and treatment of overweight and obesity in adults: The Evidence Report*” (1998), available at http://www.nhlbi.nih.gov/guidelines/obesity/ob_gdlns.htm (accessed on 29 August 2013).

⁴Montgomery “The American obesity epidemic: Why the U.S government must attack the critical problems of overweight & obesity through legislation” 2008 *Journal of Health & Biomedical Law* 379.

⁵Krautmanis “Filling the gap: A call for legislative action and community mobilization to implement physical education requirements in colleges and universities” 2013 *The Scholar* 804.

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This sedentary lifestyle is compounded by the increasing popularity of what is termed as “junk food”. Food such as candy, chips, fast food like McDonalds, takeaways and sodas are all defined as unhealthy and energy dense food sources which result in an excessive intake of calories and weight gain.⁶ These types of foods are perceived as being more accessible and convenient than healthier food which is not as easily accessible and usually must be cooked before consumption.⁷ At the same time these types of foods are also cheaper than healthier foods.⁸

Additional factors which contribute to the cause of obesity are genetics, metabolic disorders and rare ailments.⁹ For instance studies have shown that 80% of children are more likely to be obese should the child’s parent be obese.¹⁰ However, these studies are disputed by critics because there is no evidence that the genetic makeup of the population has changed in the last 30 years although obesity in school-going children has almost tripled during the same period of time.¹¹ Thus these critics question whether the rise in childhood obesity can be attributed to genetics, or simply because children tend to develop the same lifestyle patterns as their parents.¹² Medical conditions such as metabolic disorders or hypothyroidism can also be a factor which plays a role in a person becoming obese.¹³ These factors merely increase an individual’s risk of becoming overweight or obese. Ultimately it is the eating habits and lifestyle of an individual which causes him or her to become overweight or obese.¹⁴

⁶Benjamin “Public health approaches to obesity: litigation, legislation, and lessons learned” 2007 *Pittsburgh Journal of Environmental and Public Health Law* 132.

⁷*Ibid* at 133.

⁸*Id.*

⁹Sciarani “Morbid childhood obesity: The pressing need to expand statutory definitions of child neglect” 2010 *Thomas Jefferson Law Review* 316.

¹⁰*Id.*

¹¹*Id.*

¹²*Id.*

¹³*Id.*

¹⁴*Id.*

2.4. THE LINK BETWEEN CHILDHOOD OBESITY, PARENTS AND SCHOOLS

2.4.1. The role parents play in childhood obesity

Children, particularly young children, often aren't able to control their eating habits. Generally it is their parents who plan their meals, provide them with money to buy food at school and do the shopping for food.¹⁵ Parents also have some influence over their children's physical activity and sedentary behaviours.¹⁶ Because parents directly influence their children's eating habits and weight when considering the factors which contribute to childhood obesity, the parents' role in the child's lifestyle must be considered. For example, if a parent allows his or her child to eat unhealthy or healthy food in excessive quantities or allows the child to watch an excessive amount of television or play video games all day long, this can cause the child to become obese.

2.4.2. The role of schools in childhood obesity

Parents can be said to be the main contributing factor to their child becoming overweight. However, parents are not constantly with their child, as most children attend school for roughly seven hours a day, five days a week. At school a child is exposed to a large variety of unhealthy "junk food" which is made available to them by access to vending machines or school tuck shops. Healthy alternatives are often not available as most children would rather have candy and soda instead of carrot sticks and water.¹⁷

¹⁵George "Parents super-sizing their children: Criminalizing and prosecuting the rising incidence of childhood obesity as child abuse" 2010 *DePaul Journal of Health Care Law* 50.

¹⁶*Id.*

¹⁷Larson "The American childhood obesity epidemic: Probable causes and the legislative and judicial responses" 2008 *Children's Legal Rights Journal* 2.

2.5. THE EFFECTS OF CHILDHOOD OBESITY

Childhood obesity goes hand in hand with a large variety of illnesses and medical conditions, some of which can be fatal.¹⁸ The effects of childhood obesity can be divided under two headings namely physiological effects and psychological effects of obesity.

2.5.1. Physiological effects of childhood obesity

Type-2 diabetes is a common side-effect of being obese. This disease is traditionally considered a disease of adulthood. However, with the rise in childhood obesity, type-2 diabetes has been diagnosed more and more often in children, some as young as eight years old.¹⁹ If untreated type-2 diabetes can result in heart disease, stroke, limb amputation, kidney failure and blindness.²⁰ Furthermore type-2 diabetes is a life-long condition as there is no cure although the disease can be managed through medication, diet and exercise.

Obese children are at an increased risk of asthma, regardless of other factors such as age, sex, ethnicity, socio-economic status and exposure to second hand smoke. Studies have shown that the more obese the child is, the more severe the condition becomes.²¹ Asthma, like type-2 diabetes cannot be cured although the condition's symptoms can be controlled.²² These symptoms include shortness of breath, chest pain or tightness, trouble sleeping due to shortness of breath and coughing or wheezing attacks which are aggravated by the flu, colds or other respiratory viruses.²³

¹⁸Mitgang 2011 *Columbia Journal of Law and Social Problems* 571.

¹⁹*Id.*

²⁰*Id.*

²¹*Ibid* at 572.

²²Mitgang 2011 *Columbia Journal of Law and Social Problems* 573.

²³*Id.*

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Sleep apnoea, which is a condition in which breathing frequently starts and stops during sleep, is also associated with childhood obesity.²⁴ The condition steadily progresses from snoring to Obstructive Sleep Apnoea (OSA), and finally to pulmonary hypertension and cor pulmonale which in extreme cases can cause sudden unexpected death.²⁵ OSA occurs when a person's airway collapses during sleep and causes irregular breathing, snoring and disruptive sleep patterns and is linked to hyperactivity and adverse cardiovascular effects.²⁶ Because OSA causes disruptive sleep patterns, it also affects a persons' academic performance as a persons' ability to absorb and retain new information is substantially lowered.²⁷ In children who suffer from obesity, this side effect of OSA is particularly serious, as childhood obesity is already associated with considerably lower academic performance in mathematics, and literacy skills compared to children who have healthy weight.²⁸ Thus OSA results in even lower academic performance. OSA, like asthma is exacerbated by obesity and in fact the degree of OSA is proportional to the degree of obesity.²⁹ If OSA is not treated, the condition can result in pulmonary hypertension which in turn can lead to cor pulmonale³⁰ and eventually will result in the right ventricle failing from the extra strain placed on it.³¹

Childhood obesity can also lead to liver disease namely cirrhosis and ultimately can result in end-stage liver disease and failure. Cirrhosis is a liver disease which causes scarring of the liver tissue. The more advanced the cirrhosis is, the less the liver functions.³²

²⁴*Id.*

²⁵*Id.*

²⁶*Id.*

²⁷*Ibid* at 574.

²⁸Mitgang 2011 *Columbia Journal of Law and Social Problems* 574.

²⁹*Id.*

³⁰Taber's Medical Dictionary Online defines cor pulmonale is defined as an alteration in the structure and function of the right ventricle caused by a primary disorder of the respiratory system. Available at <http://www.tabers.com> (accessed on 3 September 2013).

³¹Mitgang 2011 *Columbia Journal of Law and Social Problems* 575.

³²*Id.*

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Childhood obesity also places a child at serious risk of heart diseases and conditions when they reach adulthood.³³ Obese children are at an increased risk of hypertension, high cholesterol, atherosclerosis (the hardening of the arterial walls) and left ventricular hypertrophy.³⁴ These conditions can ultimately lead to heart disease, namely a heart attack or a stroke.³⁵ Childhood obesity is also a risk factor for metabolic syndromes, which also lead to a variety of risk factors for cardiovascular diseases.³⁶

Finally, obesity is also linked to Blount's disease, which is characterised by the bowing of the tibia during which the lower leg takes on a bowed appearance and leads to an abnormal posture.³⁷ Obese children are also at a higher risk of a condition known as slipped capital femoral epiphysis (SCFE). Of the children who are diagnosed with SCFE 50 to 70% are obese.³⁸ This condition causes the femur to rotate externally from under the growth plate and causes an extreme amount of pain, often resulting in the person being unable to walk and requiring surgery.³⁹

2.5.2. Psychological effects of childhood obesity

With the stigma that society has attached to being overweight and the constant pressure one feels in today's world to be thin, it comes as no surprise that children who are obese are often the targets of taunts, harassment and intolerance. This stigma attached to being overweight can be traced back to the early Christian Church, when gluttony was considered as one of the seven deadly sins and where being overweight was viewed as a manifestation of the sin of overindulgence.⁴⁰ Today people are still mocked for being overweight and are often ridiculed and looked down upon. It is argued by some that the psychological effects of being

³³ *Ibid* at 577.

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Ibid* at 578.

³⁷ Mitgang 2011 *Columbia Journal of Law and Social Problems* 579.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

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overweight are even more severe than the physiological effects.⁴¹ Children who are overweight complain of being repeatedly bullied and subjected to verbal abuse at school, by their neighbourhoods and even in their own home by their siblings. The verbal abuse consists of being called names like lazy, greedy, clumsy, and fatty and so forth.⁴²

Children who are obese generally report on having a negative school experience.⁴³ They are especially embarrassed doing physical activities and playing sports and many are ashamed or embarrassed at being overweight or being “the fat one” in class.⁴⁴ Furthermore they feel that they have fewer friends and that they are unpopular.⁴⁵ Obese children have trouble maintaining friendships, report significantly lower health related quality of life than their healthy weight peers and show decreased degrees of self-esteem related with feelings of sadness, loneliness, nervousness and high-risk behaviours.⁴⁶ In addition, because of the various medical conditions that arise from obesity, obese children may end up missing school four more times than normal weight children, which often leads to lower school performance and will further add to the child having a negative self-image and lower self-esteem.⁴⁷ A study conducted by Schwimmer⁴⁸ found that when a large, random sample of children was asked to rate their quality of life, the obese children in the sample rated their quality of life to be equal to that of a child with cancer undergoing chemotherapy.

⁴¹Pierce & Wardle “Cause and effect beliefs and self-esteem of overweight children” 1997 *Journal of Child Psychology and Psychiatry* 645.

⁴²*Id.*

⁴³Pierce & Wardle 1997 *Journal of Child Psychology and Psychiatry* 648.

⁴⁴*Ibid* at 649.

⁴⁵*Id.*

⁴⁶Mitgang 2011 *Columbia Journal of Law and Social Problems* 580.

⁴⁷*Id.*

⁴⁸Schwimmer “Health-related quality of life of severely obese children and adolescents” 2003 *Journal of the American Medical Association* 1813.

Finally some people argue that they have been discriminated against because of their weight in their personal and professional lives.⁴⁹

2.6. THE OTHER END OF THE SPECTRUM – STARVATION

It is common knowledge that deliberately starving a person, whether an adult or child, is not only abuse, but an extreme form of abuse. One could even go as far to say that starving a person is a form of inhumane treatment. The facts in the case of *Her Majesty the Queen v E.B. and N.K.* demonstrate how cruel and inhuman starving a person is.⁵⁰

EB and NK were the grandparents and primary caregivers of their four grandchildren, M born 2 June 1994; JB (2) born 4 December 1995, JB (1) born in January 1997; M born 2 June 1994; JB (2) born 4 December 1995 and J, born 9 July 1998. While M and J were well cared for JB (1) and JB (2) were subjected to horrific abuse. JB (1) and JB (2) were confined to a locked, barren and unheated room and were left to live in utter squalor in a room which reeked of urine and faeces as neither child was toilet trained. JB (1) was not allowed to go to school and indeed, the neighbours of the appellants did not even realise that he existed, while JB (2) was allowed to go to school part-time. School reports stated that she was always hungry, filthy and lice infested. Both children were forced to eat what little food they were given by EB and NK from a bowl which was placed on the floor. JB (1) died in November 2002 at the age of five years, ten months. Death was caused by terminal septicaemia brought on as a complication of prolonged starvation. At the time of his death he weighed 9.68 kg's, less than what he weighed when his grandparents took custody of him when he was 15 months old.⁵¹ JB (2) showed obvious signs of maltreatment and malnutrition. A professor in paediatrics and nutritional sciences, Dr Zlotkin, who also examined JB (1), testified that the malnutrition began when JB (1) was about 18 months old and described the boy's appearance as stunted and

⁴⁹Patel "Are we too darn fat? Trying to prevent and treat obesity with health care reform" 2004 *Quinnipiac Health Law* 144.

⁵⁰*Her Majesty the Queen v E.B. and N.K.* (2011) 232 CRR (2d) 18.

⁵¹*Ibid* at para 17 to 20.

wasted caused by gradual, long-term starvation.⁵² The trial judge summarised the evidence of Dr Zlotkin in his judgement by stating:⁵³

“It was the evidence of Dr Zlotkin that JB (1) would not have been able to interact with his environment in any meaningful way for weeks, even months before he died. As his death approached JB (1) would have been unable to walk or climb stairs, the preceding months, he would have limited physical capacity and would tire easily because he lacked muscles.”

The appellants in this matter were convicted of second degree murder and forcible confinement. The trial court sentenced EB to life imprisonment without eligibility of parole for 22 years and a concurrent sentence of 8 years for forcible confinement and NK to life imprisonment without eligibility of parole for 20 years and a concurrent sentence of 8 years for forcible confinement. The appellants appealed against the sentence. The appeal was dismissed and the sentence was upheld. When justifying the conviction of murder and the sentence imposed, the trial judge described the murder as a crime of “inordinate cruelty and inhumanity which clearly fell in the worst group of offences”, and that there were many aggravating factors such as:⁵⁴

- JB (1) died a slow and painful death as a result of protracted abuse and starvation;
- His body was wasted and stunted and was covered in bruises and sores when he died;
- The appellants’ conduct towards JB (1) was an appalling breach of trust, made worse by the fact that the appellants had voluntarily sought the custody of the children;
- The extreme differences in the appellants’ behaviour towards M and J and JB (1) and JB (2); and
- The intense trauma suffered by M and J as a result of witnessing the protracted murder of JB (1) and abuse of JB (2).

⁵²*Ibid* at para 25.

⁵³*Ibid* at para 26.

⁵⁴*Ibid* at para 115.

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The trial judge stated that the conduct of the appellants involved “the relentless pursuit of a course of unyielding inhumanity and degradation, which stemmed from the unremitting denial of adequate nutrition and medical care.”⁵⁵ The appellant court agreed with the trial judge’s assessment on the behaviour and treatment of the appellants.

One can understand, by simply looking at the effects of starvation, why starvation can be considered as extreme abuse and why courts take such a strong stance against persons who starve children.

2.7 AN EXAMINATION OF STARVATION

Starvation is defined as the condition of being without food for a long period of time or when everything but air and water is withheld.⁵⁶ Essentially starvation means starving the body of the vital nutrients it needs to function and survive.⁵⁷

Any time that the body is depleted of vital nutrients and liquids there are several physical side effects. Eventually these side effects become irreversible and death can occur.⁵⁸ Some of the effects of starvation will now be briefly examined.

The case of *R v BW & SW*⁵⁹ further demonstrates the extreme consequences of starvation and why it is considered as an extreme form of child abuse. In this case SW and BW were the mother and father of a seven year old girl, Ebony, who died as a result of starvation. SW and BW were both tried for murder and the Supreme Court

⁵⁵ *Ibid* at para 117.

⁵⁶ Taber’s Medical Dictionary <http://www.tabers.com/tabersonline/view/Tabers-Dictionary/759139/0/starvation?q=starvation> (accessed on 03 September 2013).

⁵⁷ Boehlke (2011) “*The Side effects of Starvation*” 21 March 2011 <http://www.livestrong.com/article/35040-side-effects-starvation/> (accessed on 3 September 2013).

⁵⁸ *Id.*

⁵⁹ *R v BW & SW* (No 3) (2009) NSWSC 1043.

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of New South Wales, Common Law Division convicted SW of murder and BW of manslaughter.

The forensic pathologist who conducted Ebony's post mortem examination, Dr Nadesan, described Ebony as:⁶⁰

“A little child dead ... in an extreme degree of emaciation ... wasted and dehydrated. It looked almost like a mummy to me.”

At the time of Ebony's death her body only weighed 9 kilograms and Dr Nadesan noted that her hair was heavily matted and dirt and layers of white and brown solid particles, including faecal matter, was trapped in it. Furthermore due to very little blood in her body, as a result of extreme dehydration, there was no post mortem lividity and because Ebony's body had virtually no muscles no rigor mortis occurred. He also observed that her face was distorted, her eyes were sunken and there was only skin stretched over the skull, with no fatty tissue underneath. Her brain had begun to waste away as a result of chronic, long-term malnourishment and the soles of her feet appeared to have been soaked in urine and other body fluids over a long period of time. He further noted that although her body was in a poor state of hygiene, with an offensive body odour, there were no physical injuries on Ebony's body, and no evidence of physical violence or natural disease.⁶¹ Dr Nadesan concluded that Ebony died as a result of starvation and neglect, and further stated that:⁶²

“The terminal stage of her state, as severe malnutrition, emaciation, usually they go into some sort of semiconscious state and then finally become comatose before they pass. So it is very likely that she (*Ebony*) would have been in a stuporous, semiconscious or even unconscious state during the last few days. Maybe semiconscious or drowsy, sort of, during the last weeks.”

⁶⁰*Ibid* at para 39.

⁶¹*Ibid* at para 42 and 43.

⁶²*Ibid* at para 46.

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Dr O 'Loughlin, a specialist gastroenterologist confirmed that Ebony died as a result of chronic malnutrition caused by starvation which was a result of profound neglect. He further testified as to her likely behaviour before she died, and testified to the following.⁶³

“In [Ebony’s] circumstances her distress induced by hunger, grossly amplified by any containment in the room of the house, would have been manifested by crying, tantrums, extreme behaviour disturbance and clear distress. Anxiety and distress also accompany the biochemical changes in the body due to falling levels of available energy, essential for brain function. It would have been very obvious to any adult who saw her that she was in extreme distress. As the degree of malnutrition worsened, lethargy, sleepiness and disinterest in her surroundings would have set in. She would have been very withdrawn and largely unresponsive to her environment – a very abnormal situation for any child.”

The court convicted BW to imprisonment comprising of a non-parole period of 12 years and a balance of the term of the sentence of four years, while SW was convicted to imprisonment for life.

The facts of Ebony’s case demonstrate the physiological and psychological consequences of starvation and further explain why starvation is viewed as such an extreme form of abuse.

⁶³*ibid* at para 53.

2.7.1. The effects of starvation

One of the very first side effects that occur (and one of the most obvious) is drastic weight loss. This initial weight loss will quickly result in one becoming emaciated.⁶⁴ In order for the body to maximise efficiency, the body protects its insulating fats by using muscle stores instead in order to make up for the lack of calorie intake.⁶⁵ Dehydration also occurs as the body begins to use fluids and water that is being stored in the body.⁶⁶ When dehydration occurs the first organs to be affected are the kidneys, which could begin to fail and stop working altogether.⁶⁷ Dehydration can also lead to irregular heartbeat. Lack of vital proteins can also lead to the development of edemas, which appear as large swollen areas.⁶⁸ This drastic weight loss can lead to fatigue, decreased capacity for activities and mental sluggishness.⁶⁹

Starvation causes a lack of concentration, loss of motor skills and an increased likelihood of anxiety and depression.⁷⁰ As the starvation becomes more severe, brain function decreases until eventually the person may no longer be able to attempt to find food or survive.⁷¹ Another common side effect of starvation is an electrolyte imbalance in the body.⁷² Electrolytes play an important role in healthy heart function, muscle and nerve impulses and the flow of oxygen throughout the body. When electrolyte levels are disrupted a person can even become comatose.⁷³

⁶⁴"The effects of starvation"<http://www.wisegeek.com/what-are-the-effects-of-starvation.htm> (accessed on 3 September 2013).

⁶⁵*Id.*

⁶⁶Boehlke "The Side effects of Starvation" <http://www.livestrong.com/article/35040-side-effects-starvation/> (accessed on 3 September 2013).

⁶⁷*Id.*

⁶⁸"The effects of starvation"<http://www.wisegeek.com/what-are-the-effects-of-starvation.htm> (accessed on 3 September 2013).

⁶⁹*Id.*

⁷⁰*Id.*

⁷¹*Id.*

⁷²Boehlke "The Side effects of Starvation" <http://www.livestrong.com/article/35040-side-effects-starvation/> (accessed on 3 September 2013).

⁷³*Id.*

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Severe muscle atrophy occurs in the final stages of starvation.⁷⁴ Muscle atrophy is when the body of a person starts to literally feed itself, by using its own muscle mass to provide energy to prevent organs from shutting down. As the body consumes its muscle mass, nerve cells degenerate, mainly in the spinal cord area where movement is controlled.⁷⁵ As the condition worsens a person may not be able to move freely, or in severe cases, not at all.⁷⁶ Another side effect of muscle atrophy is muscle spasms and twitches caused by low potassium levels in the body.⁷⁷

A person who is starved can also experience attacks of low blood pressure or hypertension, as well as drops in body temperature.⁷⁸ In some cases a person's blood pressure can fall so low that it can cause shock, which is a potentially fatal condition as the body begins to shut down as a final attempt to survive.⁷⁹ If hypertension is not treated it can lead to a comatose state or death.⁸⁰

2.8. SUMMARY

It is evident that the side effects of childhood obesity and that of starvation are equally extreme. Both situations pose very serious medical threats to a person and ultimately death can occur. The question thus remains if child obesity should not also be considered a form of child abuse.

⁷⁴*Id.*

⁷⁵*Id.*

⁷⁶*Id.*

⁷⁷*Id.*

⁷⁸Boehlke "The Side effects of Starvation" <<http://www.livestrong.com/article/35040-side-effects-starvation/>> (accessed on 3 September 2013).

⁷⁹*Id.*

⁸⁰*Id.*

CHAPTER 3: INTERNATIONAL LAW PERTAINING TO CHILDREN

3.1. INTRODUCTION

In this chapter the United Nations Convention on the Rights of the Child, 1989, will be examined in the context of childhood obesity and the duty which it places on parents and the state to ensure the well-being, development and general health of the child. Furthermore the African Charter on the Rights and Welfare of the Child, 1990, will also be briefly examined.

3.2. THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD, 1989

The United Nations Convention on the Rights of the Child (hereinafter referred to as the CRC) was adopted on 20 November 1989 by the United Nations General Assembly and entered into force on 2 September 1990.¹ The CRC is the first legally binding international instrument which creates international standards for states to meet in their domestic legislation to address children's rights comprehensively. It is also the most widely celebrated human rights treaty in history.² One hundred and ninety two nations have now acceded or ratified this ground-breaking Convention with the exception of only two states, the United States of America and Somalia.³

The CRC is by no means the first international document that recognised children's rights.⁴ While various international documents recognised children's rights, the only one that focused on children in particular was the United Nations Declaration of the Rights of the Child (1959) which has been described as the foundation document of the CRC.⁵ However, the principles enshrined in this Declaration were not legally

¹Todres, Wojcik & Revaz (eds) *The U.N. Convention on the Rights of the Child: An Analysis of Treaty Provisions and Implications of U.S. Ratification* (2006) 12.

²*Ibid* at 9.

³*Id.*

⁴Mahery in Boezaart (ed) *Child Law in South Africa* (2009) 310.

⁵*Id.*

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binding and merely served as guidelines.⁶ Unlike the Declaration the CRC established legally binding principles and norms which create international standards for states to meet in their domestic legislation.⁷

When interpreting the CRC a holistic approach is required due to the manner in which civil and political rights are interwoven with social, economic, humanitarian and cultural rights. All the rights and principles in the CRC are indivisible, interdependent and interrelated with one another. In other words, one right is dependent on the realisation of another and *vice versa*.⁸

At its core the CRC has four general principles that are fundamental to the implementation of the entire Convention.⁹ These four principles are the following:

- The best interests of the child shall be a primary consideration in all decisions or actions affecting the child;¹⁰
- The child must not be discriminated against for any reason;¹¹
- The child has the right to survival and development in all aspects of the child's life;¹² and
- In all matters affecting the child, the child has the right to be heard, and to freedom of expression.^{13 14}

The two general principles that can be used in the context of childhood obesity are the best interests of the child and the child's right to survival and development.

⁶Sloth-Nielsen "Ratification of the United Nations Convention on the Rights of the Child: Some implications for South African Law" 1995 *South African Journal on Human Rights* 401.

⁷*Ibid* at 402.

⁸*Ibid* at 404.

⁹Mahery in Boezaart (ed) *Child Law in South Africa* (2009) 315.

¹⁰Art 3.

¹¹Art 2.

¹²Art 6.

¹³Art 12.

¹⁴Todres, Wojcik & Revaz (eds) (2006) 9.

These two general principles will be explained in greater detail later on in the chapter.¹⁵

For the sake of clarity it must be mentioned that the CRC defines a child as any person under the age of 18 years unless under the law applicable to the child majority is attained earlier.¹⁶ In South Africa, the Constitution in section 28(3), defines a child as any person under the age of 18 years. Section 17 of the Children's Act¹⁷ reiterates section 28(3) by providing that a child becomes a major at the age of 18 years.

3.2.1. Articles in the CRC that pertain to childhood obesity

Admittedly, when the CRC was drafted, it is unlikely that childhood obesity was considered because at that time childhood obesity was not the epidemic it is today. Nonetheless the articles that were incorporated in the CRC can be interpreted to apply to obesity in children. Furthermore, there are several articles in the CRC that pertain to parental rights and responsibilities, state obligations in ensuring the welfare and well-being of children as well as specific rights that children have, all of which can be interpreted to address the problem of childhood obesity. These articles are discussed hereunder.

3.2.1.1. Article 24: The right to health

Article 24(1) obliges state parties not only to recognise the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health, but also to ensure that no child is deprived of his or her right to access of such health care services. Subsection 2 goes further and places, amongst others, an obligation on state parties to take measures

¹⁵See para 3.2.1.2 and 3.2.1.3.

¹⁶Art 1.

¹⁷The Children's Act 38 of 2005.

Hereinafter referred to as the Children's Act.

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to educate children and parents in basic knowledge on children's health and nutrition and to combat disease and malnutrition.

The Committee on the Rights of the Child (hereinafter referred to as "the Committee") in its introduction of General Comment 15 (2013), to serve as a guideline to state parties when interpreting Article 24, states the following:

"The importance of approaching children's health from a child-rights perspective that all children have the right to opportunities to survive, grow and develop, within the context of physical, emotional and social well-being to each child's full potential."

The Committee has interpreted children's right to health to be an inclusive right. It does not only include the child's right to grow and develop his or her full potential and live in conditions that enable him or her to attain the highest standard of health through the implementation of programmes that address the underlying determinates of health. The right also includes the state's obligation to provide timely and appropriate prevention, health promotion, curative, rehabilitative and palliative services.¹⁸

In the Constitution of the WHO, states have agreed to regard health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Therefore one should not consider the right to health in the traditional sense, namely that a person does not have an illness or disability, but rather should consider health as an all-inclusive concept which includes all the various factors which result in a person being a well-rounded individual.

¹⁸General Comment 15 (2013) "On the rights of the child to enjoyment of the highest attainable standard of health" *CRC/C/GC/15* United Nations Documents.

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The Committee recognised the fact that children's health is affected by numerous factors, which change as society evolves and therefore intentionally made its comments generic in order to ensure that the comment was relevant to the wide range of children's health problems.¹⁹

With regard to Article 24(1) the Committee stated that a child's right to health contains a set of freedoms and entitlements, such as the right to control one's own health and body and the right to quality health services including prevention, promotion, treatment, rehabilitation and palliative care services.²⁰

What is interesting to note is that the Committee expressly stated, in the context of Article 24(2)(c)²¹ that state parties should address obesity in children because of all the health risks associated with the condition as discussed in Chapter 2 of this dissertation. It went further to state that a child's exposure to so-called "junk food" should be limited and that the marketing of such foods and drinks should be regulated and their availability in schools should be controlled.²² Thus it is evident that there is a growing awareness of the dangers associated with childhood obesity and the need to curb this growing global epidemic.

The Committee furthermore not only placed emphasis on the state's obligation to provide health related information and support programmes to all segments of society, but also emphasised the role that parents play in the health of their children. The Committee recognised that parents are the most important source of early diagnosis and primary care for small children in particular and that they play a central role in promoting healthy childhood development.²³ Children are primarily influenced

¹⁹General Comment 15 (2013).

²⁰*Ibid.*

²¹Art 24 (2)(c) provides that state parties have an obligation to combat disease and malnutrition, including within the framework of primary health care, through, *inter alia*, the application of readily available technology and through the provision of adequate nutritious foods and drinking-water, taking into consideration the dangers and risks of environmental pollution.

²²*Ibid.*

²³General Comment 15 (2013).

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by their parents, family and other caregiver's behaviours and therefore parents and caregivers should nurture, protect and support children to grow and develop in a healthy manner. As parents were recognised as being the primary factor to regulate the child's health status, states were urged to provide information about children's health to all parents and their families and other caregivers, such as teachers, through a variety of methods such as health clinics, parenting classes, public information pamphlets and leaflets, community organisations and the media. The Committee also mentions the role that the media and private companies can play in promoting children's health by limiting the advertisement of "junk food" and promoting health and healthy lifestyles amongst children while refraining from propagating health related stigmas.²⁴

As mentioned previously Article 24 can be interpreted to include the issue of childhood obesity by considering the terms "highest attainable standard of health"²⁵ and "basic knowledge of child health and nutrition".²⁶ As demonstrated in Chapter 2, the consequences of being obese are severe and undesirable, especially in the case of children and most certainly does not place a person in a good state of health. Considering that obesity is primarily caused by over-feeding²⁷ and lack of exercise, simply by making a few lifestyle changes such as introducing healthy eating and implementing exercise into a person's daily regime, a person's health would improve. Thus if state parties were to start applying educational programmes on healthy lifestyles aimed at combating childhood obesity to parents and children, as suggested by the Committee, not only would states be fulfilling their obligation under Article 24, but the child's right to the highest attainable standard of health would also be respected. Even in South Africa, where the majority of the population is living in poverty, combating childhood obesity in this manner is possible because childhood

²⁴ *Ibid.*

²⁵ Art 24(1).

²⁶ Art 24(2)(e).

²⁷ It should be noted that incorrect feeding can also lead to obesity. As incorrect feeding also encompasses an unbalanced diet which leads to malnutrition, it will not be discussed as it is a delamination for the purposes of this dissertation as was discussed in para 1.5. Furthermore the argument can be made that incorrect feeding, for example only eating fast foods for meals, is a form of over-feeding. Should a person only eat fast foods once or twice a month, instead of every day, that person may not necessarily become overweight.

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obesity is not the result of the parents' lack the resources to feed their child, but rather one of parents over-feeding their child.²⁸

Finally the Committee recognised the interdependence and equal importance of all rights that enable a child to develop his or her mental and physical abilities to the fullest extent possible and that the realisation of the right to health was a prerequisite for a child to benefit from all the other rights afforded to him or her by the CRC.²⁹ This principle of interdependence is best demonstrated by considering Article 6, which provides children with the right to survival and development³⁰ and Article 24. Obviously, one cannot survive and develop without being healthy and *vice versa*.

3.2.1.2. Article 3: The best interests of the child

Article 3, which is a fundamental general principle to the CRC, sets out the best interests of the child standard as a primary consideration in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies. This article further places a duty on state parties to ensure that children receive the required protection and care necessary for their well-being by taking into account all appropriate legislative and administrative measures with due consideration of the rights and duties of parents, legal guardians, or other individuals legally responsible for a child.

This concept of the “child’s best interests” was already included in the Declaration of the Rights of the Child, 1959³¹; The Convention on the Elimination of All Forms of Discrimination against Women³² as well as various regional instruments and national and international laws.

²⁸“Poverty Trends in South Africa” Press statement 3 April 2014 <http://www.beta2.statsa.gov.za/?p=2591> .

²⁹General Comment 15 (2013).

³⁰Discussed in para 3.2.1.3.

³¹Para 2 of the Declaration of the Rights of the Child.

³²Art 5(b) and 16 (1)(d).

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In General Comment 14 of 2013,³³ which concerns the best interests of the child principle, the Committee on the Rights of the Child highlighted the fact that the principle is a threefold concept, namely:

1. **A substantive right:** A child has the right to have his or her best interests assessed and taken into primary consideration when conflicting interests are being considered in order to make a decision.
2. **A fundamental, interpretative, legal principle:** If a legal principle can be interpreted in more than one way, the interpretation which most successfully serves the best interests of the child should be followed.
3. **A rule of procedure:** When a decision has to be made that will either affect an individual child or children in general, an evaluation of the possible impact of the decision on the child or children in general must be included in the decision-making process. Furthermore, the justification of the decision must explicitly show that the right has been taken into account.

The term “in all actions concerning” was explained by the Committee to mean that a child’s best interests must be taken into account in every action concerning a child or children in general, which does not only include decisions, but also acts, conducts, proposals, services, procedures and other measures, which directly or indirectly affect the child.³⁴ In General Comment 5 the Committee further stated that every legislative, administrative and judicial body or institution is required to apply the best interests principle by considering how children’s rights and interests will be affected by their decisions or actions.³⁵

³³General Comment 14 (2013) “On the right of the child to have his or her best interests taken into consideration as a primary consideration” *CRC/C/GC/14* GE.13-44189 United Nations Document.

³⁴General Comment 14 (2013).

³⁵Mahery in Boezaart (ed) *Child Law in South Africa* (2009) 318.

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Although the CRC does not contain a definition for the concept of “the best interests of the child” and no definition exists in any prior human rights document,³⁶ the principle has been explained by the Committee to be flexible and adaptable and the content thereof must be determined on a case-to-case basis. The concept should be defined and adjusted on an individual basis, taking into consideration the child’s personal circumstances and needs.³⁷ It therefore appears that there is no hard and fast rule when determining the best interests of the child as each child’s best interests must be determined on the merits of the facts in that specific matter. The best interests of the child principle has been examined extensively by the courts in South Africa. It will be examined in more detail in Chapter 4.

The CRC is rather clear on the fact that in all matters concerning the child, the child’s best interests shall be a primary consideration. This places a strong obligation on state parties in that they are not entitled to exercise any discretion as to whether they need to assess the best interests of the child in any action. State parties must always make such an assessment.³⁸ The best interests’ standard exceeds traditional concepts of protection as the standard should be applied to all the provisions of the CRC, including legislative, administrative acts and judicial decisions.³⁹ While Article 3 of the CRC appears to contain the general principle of the best interests of the child, there are other articles in the CRC which also require that the best interests of the child to be considered, such as Article 24 which concerns a child’s right to health, Article 9 which deals with the separation of a child from the family environment and Article 18 which concerns parental rights and responsibilities. This has been interpreted to mean that Article 3(1) acts as a general principle, as in certain circumstances the child’s best interests must be considered alongside other interests, and can be trumped while in other circumstances the child’s individual best interests are the overriding consideration and can trump other interests. As an example Article 18 provides that the best interests of the child shall be the basic

³⁶Sloth-Nielsen 1995 *SAJHR* 409.

³⁷General Comment 14 (2013).

³⁸*Id.*

³⁹*Id.*

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concern of the parents or legal guardians of the child, or Article 21 which concerns adoptions.⁴⁰

In the context of childhood related obesity, the child's right to health⁴¹ and the child's right to have his or her best interests taken into consideration are closely related. As explained in Chapter 2, because obesity leads to serious physical and mental consequences in children, particularly in the case of the morbidly obese child, clearly an obese child's right to health and a child's right to have his best interests considered are not being upheld. Thus should a state institution be faced with the question of whether or not to intervene in the case of an obese child it is clear that intervention would be in the child's best interests.

3.2.1.3. Article 6: The right to life, survival and development

This article concerns the right to life. The first part of the article provides that state parties must recognise that every child has the right to life. This article goes beyond addressing the physical continuation of existence by introducing a dynamic aspect to the right to life in the provisions contained in the second part of the article.⁴² It obliges state parties to ensure, to the maximum extent possible, the survival and development of the child.

Article 6 contains the rights to life, survival and development.⁴³ Other provisions in the CRC⁴⁴ such as Article 24 give effect to the right to survival and development.⁴⁵ These provisions incorporate all the basic needs that a child has in order to develop and survive, such as the right to an adequate living standard, nutrition, shelter and

⁴⁰ *Id.*

⁴¹ Art 24.

⁴² Sloth-Nielsen 1995 *SAJHR* 410.

⁴³ Mahery in Boezaart (ed) *Child Law in South Africa* (2009) 320.

⁴⁴ As discussed below.

⁴⁵ *Id.*

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the right to access to medical services.⁴⁶ In General Comment 5 the Committee on the Rights of the Child explains that:

“Development should be looked at in the broadest sense, embracing the child’s physical, mental, spiritual, moral, psychological and social development.”⁴⁷

Therefore the right to survival and development encompasses all the steps necessary to ensure the healthy development of children, and furthermore places an obligation on state parties to take these steps. This right expands on a range of positive measures to be adopted by state parties to further ensure the health of a growing and developing child, like growth monitoring, disease control, immunisation, education programmes about child spacing, nutrition and female literacy amongst others. All of these fields have been identified by the WHO as factors which affect children’s development and in turn their survival.⁴⁸

A child who is obese is clearly not a healthy child and thus his or her right to survival and development is being threatened. Obesity poses not only physical threats to a child, which if left untreated can lead to death, but also mental and psychological threats as discussed in Chapter 2. Furthermore their social development can be stunted. As the CRC clearly places an obligation on state parties to ensure a child’s right to healthy development, coupled with the best interests’ principle, states are obliged in the case of obese children to take measures to intervene and prevent childhood obesity.

⁴⁶*Id.*

⁴⁷General Comment 5 (2003) “General measures of implementation of the Convention on the Rights of the Child” *CRC/GC/2003/5* GE.03-45514 (E) 281103 United Nations Document.

⁴⁸Sloth-Nielsen 1995 *SAJHR* 410.

3.2.1.4. Article 9: The right of a child to not be separated from his or her parents against his or her will and Article 18: Parents have the primary responsibility for the upbringing and development of the child

Article 9 obliges state parties to ensure that a child is not separated from his or her parents against their will, except where such separation would be in the best interests of the child by reason of, for example abuse or neglect of the child by a parent, guardian or care-giver.⁴⁹ Although this article indirectly provides state parties with the obligation to remove children from their home, it limits this obligation by clearly providing that the state cannot remove children from their homes for arbitrary or minor reasons. Children, in terms of Article 9, can only be removed from their homes for real and serious reasons, when the child's living circumstances are harmful, extreme or life-threatening.

Closely related to this provision is Article 18(1) which awards both parents the common and primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern. Article 18(2) obliges state parties to render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and to further ensure the development of institutions, facilities and services for the care of children.

Article 18 must also be read with Article 6 of the CRC as it is an expansion of the right to survival and development. Article 18(1) provides that the parents, guardians or caregivers have the primary responsibility in the upbringing and development of their child and that the best interests of the child must be their basic concern. This merely means that parents, guardians or caregivers, whichever the case may be, are the first parties responsible in ensuring that a child develops into a healthy adult and in doing so the child's best interests should be their main concern. Subsection 2 of this article reiterates the obligation of state parties to intervene and provide assistance to parents, guardians or caregivers that are failing in their obligation to ensure the healthy development and survival of their child.

⁴⁹*Id.*

3.2.1.5. Article 19: The right of the child to be protected from all forms of violence

Article 19 entrenches the right of a child to protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of the parent, legal guardian or any other person who has the obligation to care for the child.

This article is of particular interest as it recognises the fact that children can, and sadly are, abused or neglected in their own homes by the very people that are meant to protect and care for them. This prevention of intra-familial harm has never featured in a binding international instrument until the CRC was drawn up. The reference to parents and legal guardians indicates that the primary focus is on intra-familial harm, however, by including the term “and any other person” broadens the application of this article to include private and public institutions, like schools and hospitals.⁵⁰

Article 19(2) also places a duty on state parties to establish and provide the necessary support for the child as well to those who have to care for the child. Furthermore it obliges state parties to establish procedures to be followed when identifying, reporting, referring, investigating and treating instances of child abuse or parental neglect.

Therefore, while subsection 1 provides the child with the right to be protected from abuse or neglect, subsection 2 places the duty on the state to ensure that the child’s right is respected, protected and enforced by the state.

General Comment 13 of 2011 the Committee on the Rights of the Child, when interpreting Article 19 of the CRC, explored the meaning of this article. In the

⁵⁰Detrick (ed) *A commentary on the United Nations Convention on the Rights of the Child* (1999) 321.

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Comment the Committee referred to the term “violence” which in context was understood to mean:

“All forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse as listed in Article 19, paragraph 1, of the Convention.”

The Committee stated that the term “violence” as referred to above, was chosen to represent all forms of harm to children as listed in Article 19, although reference to other terms used to describe harmful behaviour carries equal weight.⁵¹ Therefore, for purposes of this subsection of this paper, when the term “violence” is referred to all aspects of harm as encompassed in Article 19 are included. When examining Article 19 (1) the phrase “... all forms of ...” has been interpreted by the Committee to mean that all forms of violence, however trivial, are equally important.⁵²

Neglect was defined by the Committee to mean:

“The failure to meet the children’s physical and psychological needs, protect them from danger, obtain medical, birth registration or other services when those responsible for children’s care have the means, knowledge and access to services to do so.”

The Committee went further and explained that neglect also includes all forms of physical neglect, psychological or emotional neglect, the neglect of children’s physical or mental health, educational neglect and abandonment.

⁵¹General Comment. 13 (2011) “The right of the child to freedom from all forms of violence” *CRC/C/GC/13* GE.11-42387 United Nations Document.

⁵²*Id.*

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Physical violence (abuse) was explained to include all fatal and non-fatal physical violence such as all corporal punishment and all other forms of torture, cruel, inhuman or degrading treatment or punishment and physical bullying and harassing by adults and other children.⁵³

Maltreatment was not assigned a meaning by the Committee. However, the WHO defines child maltreatment as a term “which includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that results in actual or potential harm to the child’s health, development or dignity.” It further provides that within this definition of maltreatment five subtypes of maltreatment can be distinguished: physical abuse; sexual abuse; neglect and negligent treatment; emotional abuse; and exploitation.⁵⁴ The definition that the WHO provides for “maltreatment” is in all likelihood the definition that is to be used when interpreting this article as the WHO is the public health arm of the United Nations. Furthermore, from the definition provided by the WHO, it appears that maltreatment is a so-called “umbrella” term for various forms of harmful behaviour as it encompasses several individually defined forms of abuse or neglect.

State parties have been placed under the strict obligation to undertake all appropriate measures to fully implement the right of children to be protected from all forms of harm. States, similar to that of the right of the child’s best interests to be taken into consideration, have no discretion in this regard. They must take all appropriate measures to protect children from harm.⁵⁵ Prevention was further highlighted by the Committee in that states have an obligation to adopt all measures necessary to ensure that adults who are responsible for the care, guidance and upbringing of children, will respect and protect children from harm. This can be achieved through the adoption of proactive preventative measures and policies, which include public health and other measures to promote respectful child-rearing.⁵⁶

⁵³ *Id.*

⁵⁴ http://www.who.int/topics/child_abuse/en (accessed on 1 May 2014).

⁵⁵ General Comment 13 (2011).

⁵⁶ *Id.*

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In the context of childhood obesity if states consider it a form of abuse or parental neglect, the CRC places an obligation on such states to intervene and assist those children. States should also implement proactive measures to prevent children from becoming obese, such as nutritional programmes aimed at children and their parents, guardians or caregivers, limiting a child's access to unhealthy foods in schools and promoting physical activities amongst children.

3.2.1.6. Article 27: Right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development

Article 27(1) recognises the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development. Subsection (2) once again states that the parent or others responsible for the child have the primary responsibility to secure the conditions of living necessary for the child's development within their abilities and financial capacities. Subsection 3 provides that state parties are obliged, in accordance with national conditions and within their means, to take appropriate measures to assist parents and others responsible for the child to implement the right in subsection (1) and to provide material assistance and support programmes, particularly with regard to nutrition⁵⁷, clothing and housing in cases where it is needed.

Article 27 is intertwined with Articles 6, 18 and 24. Once again a child's right to survival and healthy development is reiterated, as well as the fact that parents, guardians or caregivers have the primary responsibility of raising a healthy child. It is expressly stated in subsection 3 that state parties have an obligation to intervene in cases where parents fail to provide their child with the conditions necessary for the healthy development of the child by providing assistance and support programmes. The nutrition of the child is again emphasised as one of the main focuses of state parties.

⁵⁷Own emphasis.

3.3 IMPLICATIONS OF THE CRC FOR SOUTH AFRICA

South Africa became a signatory to the CRC on 29 January 1993 and ratified the Convention on 16 June 1995. Once a state has ratified a treaty, it is under an obligation to ensure and fulfil the rights contained in a treaty by bringing its national laws in line with the principles of the treaty.⁵⁸ States are also obligated to refrain from acts which would defeat the purpose of the treaty.⁵⁹ South Africa has done this by enacting the Children's Act⁶⁰ which has given effect to specific articles in the CRC,⁶¹ and which will be further discussed in Chapter 4.

The CRC also impacts on the decisions of the judiciary because of the Constitution of the Republic of South Africa, 1996.⁶² The Constitution contains provisions that determine the status of international law in South Africa.⁶³ Section 39 of the Constitution requires that courts and tribunals must consider international law when they interpret rights contained in the Bill of Rights, while section 233 states that when national legislation is interpreted, courts and tribunals should prefer the interpretation that is in line with international law.⁶⁴ Consequently when interpreting the rights contained in the Bill of Rights in matters concerning children, or when interpreting the Children's Act, the courts must consider the CRC and favour the interpretation that is in line with the spirit and principles of the CRC. Section 28 of the Constitution also contains a brief summary of some of the principles contained in the CRC, one of which is the best interest standard, which has been incorporated as a general standard in South African law pertaining to children.⁶⁵

⁵⁸ Mahery in Boezaart (ed) *Child Law in South Africa* (2009) 324.

⁵⁹ Sloth-Nielsen 1995 *SAJHR* 417.

⁶⁰ Act 38 of 2005.

⁶¹ Mahery in Boezaart (ed) *Child Law in South Africa* (2009) 324.

⁶² Hereinafter referred to as the Constitution.

⁶³ Mahery in Boezaart (ed) *Child Law in South Africa* (2009) 323.

⁶⁴ *Id.*

⁶⁵ Sloth-Nielsen 1995 *SAJHR* 417.

3.4. THE AFRICAN CHARTER ON THE RIGHTS AND WELFARE OF THE CHILD, 1990

The African Charter on the Rights and Welfare of the Child, 1990 (henceforth referred to as the ACRWC) is relatively new to the international community.⁶⁶ Even though it was adopted by the then Organisation of African Unity (hereinafter referred to as the OAU) in 1990, it only came into force on 29 November 1999 when the Charter was finally ratified by the required fifteen state parties to the OAU quorum. South Africa ratified the ACRWC on the 7 January 2000.

Even though the CRC was already in existence, the OAU felt the need to adopt the ACRWC because many African states felt that they had been marginalised or excluded from the drafting process during the drafting of the CRC.⁶⁷ Furthermore, it was perceived by OAU that the CRC had failed to adequately address some of the unique problems facing children in Africa such as amongst others, harmful traditional cultural practices and customs, the situation of children living under Apartheid and socio-economic conditions amongst the poverty stricken population of African states.⁶⁸ The three main principles of the ACRWC are the following:

- The best interests of the child;
- Non-discrimination; and
- The primacy of the Charter over harmful cultural practices and customs.

Despite the concerns of the OAU regarding the lack of certain provision in the CRC, the majority of the articles in the ACRWC are very similar to those of the CRC and ultimately provide the same protection or rights to the child. For example Article 5 of the ACRWC and Article 6 of the CRC both refer to the child's right to life, survival and development.

⁶⁶Viljoen in Boezaart (ed) *Child Law in South Africa* (2009) 331.

⁶⁷*Ibid* at 335.

⁶⁸*Ibid* at 336.

It would be superfluous to explore each article of the ACRWC which could be interpreted to pertain to childhood obesity as the articles would be interpreted to mean more or less the same as those articles from the CRC listed above. The slight differences of the various articles pertaining to childhood obesity in the Charter and the Convention can merely be pointed out.

3.4.1. Articles in the ACRWC similar to that of the CRC provisions

Just as Article 1 of the CRC states that a child is a person under the age of 18, so does Article 2 of the ACRWC. However, the ACRWC's provision seems to be absolute, as it does not provide that the age of majority can be attained at an earlier date in accordance with the law applicable to the child.

Article 4 of the ACRWC provides for the best interests of the child to be the primary consideration in all matters concerning the child. While Article 3 of the CRC also contains the best interests' principle, the use of the word "the" in the Charter instead of the word "a" as in the Convention has led to the interpretation in the case of the ACRWC that the best interests of the child is the overriding factor in matters concerning a child, and other considerations cannot override it.⁶⁹

Article 5 of the Charter and Article 6 of the Convention both refer to the survival and development of children. In the context of childhood obesity the meanings of both articles can be perceived to be the same. Health rights, like those in Article 24 of the CRC are provided for in Article 14 of the ACRWC. Articles 19 and 20 of the Charter refer to parental care and protection, as well as parental responsibilities as do Articles 9, 18 and 27 of the Convention. Finally Article 16 of the ACRWC and Article 19 of the CRC both provide for protective measures that state parties must take in order to protect children from abuse and neglect.

⁶⁹Viljoen in Boezaart (ed) *Child Law in South Africa* (2009) 342.

3.5. SUMMARY

It is evident that there are several provisions in the CRC and the ACRWC, both which have been ratified by South Africa, that can be used when addressing the issue of childhood obesity.

CHAPTER 4: SOUTH AFRICAN LAW PERTAINING TO CHILDHOOD OBESITY

4.1. INTRODUCTION

South Africa has in recent years showed a commitment to promote and protect children's rights by ratifying the CRC and ACRWC and adopting the Constitution.

Section 2 of the Constitution declares that the Constitution is the supreme law of South Africa and any law or conduct which is inconsistent with the Constitution is invalid. Section 7(2) also obliges the state to respect, protect, promote and fulfil the rights in the Bill of Rights.¹ Section 8 further provides that the rights contained in the Bill of Rights bind natural persons if the right is of such a nature that it is required. While children in South Africa are entitled to all the rights contained in the Bill of Rights except those rights that have age restrictions attached to them like the right to vote, the Bill of Rights also contains an entire section solely dedicated to the rights of children, namely section 28.² Taking into account sections 7 and 8 of the Constitution this means that section 28 places an obligation not only on the state to promote, protect, respect and fulfil the rights of children but also on natural persons such as parents and care-givers.³

4.2 A BRIEF EXAMINATION OF SECTION 28 OF THE CONSTITUTION

4.2.1 Section 28(1)(b): The right of every child to parental or family care

Section 28(1)(b) of the Constitution provides that every child has the right to parental or family care, or when removed from the family environment, to appropriate alternative care. Section 28(1)(b) is a reflection of the spirit contained in Articles 9

¹Chapter 2 of the Constitution.

²Skelton in Currie & de Waal (eds) *The Bill of Rights Handbook* (2013) 599.

³*Ibid* at 600.

and 18 of the CRC, in that children have a right, firstly, to parental or family care, and only a secondary right to alternative state-provided care, if removed from their family home. Essentially this section defines who is responsible for providing a child with care being, first the parent or family of the child, and only if they are unable to do so the state has an obligation to provide care.⁴ The right to parental or family care also includes the right of the child to be cared for by the extended family.⁵

4.2.2 Section 28(1)(c): The right of every child to basic nutrition, shelter, basic health care services and social services

Section 28(1)(c) further provides that every child has the right to basic nutrition, shelter, basic health care services and social services. It is an established common law principle that parents are obliged to provide food, shelter, clothing and medical care to their children, alternatively the essential things required by people to live.⁶ This section makes it clear that when parents fail to provide their children with these essentials, the state has a duty to step in and support the child.⁷ This right is also embodied in Article 24(2)(c) and (e) and Article 27(3) of the CRC.⁸

For the purpose of this dissertation the right to basic nutrition is important. Looked at in the context of obesity and the numerous health consequences that come with it, a child who is obese is being deprived of his or her right to basic nutrition. No medical practitioner will be able to honestly state that an obese child is a healthy child and considering that the definition of nutrition⁹ includes the element of health, such a child's constitutional right is being infringed.

⁴*Government of the Republic of South Africa and Others v Grootboom and Others* 2000 (11) BCLR 1169 (CC) at para 1174.

⁵Skelton in Currie & de Waal (eds) *The Bill of Rights Handbook* (2013) 605.

⁶Bonthuys in Currie & de Waal (eds) *The Bill of Rights Handbook* (2005) 611.

⁷*Id.*

⁸*Id.*

⁹Oxford Online Dictionary [http:// www.oxforddictionaries.co/definition/english/nutrition](http://www.oxforddictionaries.co/definition/english/nutrition) (accessed on 15 September 2014). Definition of nutrition: "The process of obtaining the food necessary for health and growth."

In the case of *Grootboom*¹⁰ the Constitutional Court stated that section 28(1)(c) must be read together with section 28(1)(b) in that the person/s responsible for ensuring the implementation of section 28(1)(c) is firstly the parents or family of the child, and only when they are unable to do so, does the state have an obligation to do so. Thus, in the context of the obese child, if the parents fail to or refuse to control their child's weight, then the state is obliged to do so. This concept will be discussed in detail later on in this chapter.

4.2.3 Section 28(1)(d): The right of every child to be protected from maltreatment, neglect, abuse or degradation

This section of the Constitution provides every child with the right to be protected from maltreatment, neglect, abuse or degradation. This right could not be put more plainly and is clear in its aim. It places a positive obligation on the state to protect children from maltreatment, neglect, abuse or degradation. The Children's Act expands on this right in great detail and thus will be explored in greater detail later in this chapter. It is sufficient to say for now, that the state must, in terms of the constitution, take every measure possible to protect children from such detrimental treatment.

4.2.4 Section 28(2): A child's best interests are of paramount importance in every matter concerning the child

Section 28(2) of the Constitution provides that "A child's best interests are of paramount importance in every matter concerning the child."

The Constitutional Court has interpreted the meaning of the best interests' principle through various judgements. In *Minister of Welfare and Population Development v Fitzpatrick and Others* the court interpreted section 28(2) of the Constitution to be a right in itself and not just a guiding principle, furthermore that the best interests of the

¹⁰2000 (11) BCLR 119 (CC) at para 1174.

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child right works with and strengthens other rights.¹¹ Despite this the Constitutional Court has also found that section 28(2) must be applied in the same manner as any other right in the Bill of Rights, being that it can be limited if the limitation is reasonable and justifiable in terms of section 36 of the Constitution.¹² With regard to the wording of the section 28(2) in particular the words “paramount importance” Justice Sachs expounded the meaning of “paramount importance” rather eloquently in the judgement of *S v M (Centre of Child Law as Amicus Curiae)*¹³ by stating the following:

“The paramountcy principle, read with the right to family care, requires that the interests of children who stand to be affected receive due consideration. It does not necessitate overriding all other considerations. Rather, it calls for appropriate weight to be given in each case to a consideration to which the law attaches the highest value, namely the interests of children who may be concerned.”

The best interests of the child principle can be summarised in the following four points.

- In all matters concerning the child, the best interests of the child must be considered.
- The best interests of the child is a right as well as a guiding principle.
- Section 28(2) functions in the same manner as all other rights in the Bill of Rights, namely it is not an absolute right, and it can be limited.
- The best interests of the child can be overridden by another factor.

This being said, while in all matters and actions concerning a child the best interests of the child are always considered, the vast majority of the time the best interests of the child is the overriding factor when making a decision. This is best demonstrated

¹¹*Minister of Welfare and Population Development v Fitzpatrick and Others* 2000 (3) SA 422 (CC) at para 17.

¹²*De Reuck v Director of Public Prosecutions* 2004 (SA) 406 (CC) at para 55.

¹³*S v M (Centre of Child Law as Amicus Curiae)* 2007 (2) SACR 539 (CC) at para 42.

by the judgement made in *S v M*.¹⁴ This case concerned the sentencing of a mother who had been convicted of 38 counts of fraud and had been sentenced to four years of imprisonment. The mother was the primary caregiver of her three young sons. On application to the Constitutional Court the court decided that amongst other factors, it was in the best interests of her children that she not be imprisoned for four years and sentenced her to four years imprisonment, 45 months of which were conditionally suspended as well as three years of correctional supervision, which included community service, counselling and repayment of the people she had defrauded. A case which not only demonstrated how the child's best interests can be an overriding right in making a decision, but also how section 28(2) can strengthen other rights is that of *Hay v B*.¹⁵ In this case the parents of a child who required a blood transfusion were refusing the necessary medical treatment to save the child's life on the grounds of section 31 of the Constitution, namely religious reasons. The court overruled the parents' refusal by deciding that the child's best interest was to survive and furthermore that the child's right to life¹⁶ outweighed the parents' right to religion.¹⁷

4.3 THE CHILDREN'S ACT 38 OF 2005

The Children's Act was enacted as a result of the adoption of the Constitution and the ratification of the CRC and the ACRWC. The Children's Act can be viewed as not only as a manner in which the legislature introduces the obligations created under the CRC and the ACRWC into South African law, but also as an extension of the constitutional principles and rights contained in section 28 of the Bill of Rights. Section 8 of the Children's Act which concerns the application of the Children's Act makes this clear by stating the following in subsection 1:

¹⁴*Id.*

¹⁵*Hay v B* 2003 (3) SA 492 (W).

¹⁶S11.

¹⁷S129(10) of the Children's Act provides that no parent, guardian or care-giver of a child may withhold consent to medical treatment or surgical operation of the child by reason of religious or other beliefs unless the parent or guardian can show that there is a medically acceptable alternative choice to the proposed medical treatment or surgical operation.

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“(1) The rights which a child has in terms of this Act supplement the rights which a child has in terms of the Bill of Rights.”

The Act further sets out its objectives in section 2, which encompasses the aims of the Act. In total section 2 lists nine objectives. The objectives of the Act are the following:¹⁸

- To preserve and strengthen families;
- To give effect to the following constitutional rights of children:
 - Right to family care or parental care or appropriate alternative care when removed from the family environment;
 - Right to social services;
 - Right to be protected from maltreatment, neglect, abuse or degradation; and
 - The best interests of the child are of paramount importance in all matters concerning the child;
- To give effect to South Africa’s obligations concerning the well-being of the child under international instruments which are binding on South Africa;
- To make provision for the structures and tools necessary to promote the sound physical, psychological, intellectual, emotional and social development of children;
- To develop community based structures which can provide care and protection for children;
- To protect children from discrimination, exploitation and any other physical, emotional or moral harm or hazards;
- To provide care and protection to children who need it;
- To recognise the special needs disabled children may have; and
- In general to promote the protection, development and well-being of children.

¹⁸S2(a) – (i) of Act 38 of 2005.

When examining South African law pertaining to children in the context of childhood obesity it is best to examine the Constitution together with the Children's Act. The abovementioned sections in the Constitution must be considered in combination with certain sections of the Act as discussed in this chapter.

4.4. THE BEST INTERESTS OF THE CHILD

The best interests of the child principle can be considered as the foundation of modern child law. In South Africa this principle is firmly entrenched in the law, not only in the Constitution¹⁹ but also in the Children's Act. This principle is reiterated in section 9 of the Children's Act which provides that:

“In all matters concerning the care, protection and well-being of a child the standard that the child's best interest is of paramount importance, must be applied.”

The Children's Act in section 7 further provides numerous factors which must be taken into account when determining what the child's best interests are. The factors which are most relevant in the context of childhood obesity are the following:

- The attitude of the parents, or any specific parent, towards –
 - The child; and
 - The exercise of parental responsibilities and rights in respect of the child;
- The child's physical and emotional security and his or her intellectual, emotional, social and cultural development;
- The child's –
 - Age, maturity and stage of development;
 - Gender;
 - Background; and

¹⁹See para 4.2.4.

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- Any other relevant characteristics of the child;
- Any chronic illness from which a child may suffer; and
- The need to protect the child from any physical or psychological harm that may be caused by –
 - Subjecting the child to maltreatment, abuse, neglect, exploitation or degradation or exposing the child to violence or exploitation or other harmful behaviour.²⁰

The best interests of the child is so essential to the interpretation and application of all matters concerning a child that it has been termed as the “golden thread” that runs through laws relating to children.²¹ What a child’s best interests are is a factual question that has to be determined according to the circumstances of each individual case.

When considering the problem of childhood obesity and whether the courts should intervene when appropriate, the best interests of the child must be considered on a case to case basis. When considering the appropriate provisions in the Children’s Act the best interests of the child can serve as a guiding factor and should be borne in mind.

4.5. PARENTAL RESPONSIBILITIES AND RIGHTS

As stated above section 28(1)(b) of the Constitution provides that every child has the right to family care or parental care, or to appropriate alternative care when removed from the family environment. The Children’s Act has supplemented section 28(1)(b) of the Constitution through its Chapter 3 which covers a wide variety of matters concerning parental responsibilities and rights, ranging from the elements of parental responsibilities and rights, to acquiring and terminating parental responsibilities and rights, as well as sharing parental responsibilities and rights.

²⁰Davel & Skelton (eds) *Commentary on the Children’s Act* (2013) 2-5.

²¹*Ibid* at 2-6.

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The concept of “parental responsibilities and rights” was introduced by the Children’s Act. Prior to its enactment the term “parental authority” was used. The law pertaining to parental authority was largely found in common law and through case law.²² The Children’s Act incorporated parental responsibilities and rights into its ambit through Chapter 3.²³ The structure of the term “parental responsibilities and rights” is very interesting. The emphasis is on parental responsibilities and not rights, thus emphasising that parents have a responsibility to their children first, and then have parental rights over their children.²⁴

Section 18(2) of the Children’s Act provides that the concept of parental responsibilities and rights consist of four elements, namely:

- (a) To care for the child;
- (b) To maintain contact with the child;
- (c) To act as guardian of the child; and
- (d) To contribute to the maintenance of the child.

For the purposes of this paper only one element is relevant when considering whether parents should be held responsible for their child’s obesity, namely the element of care.

4.5.1. Care

The previously used common law term “custody” has been replaced by the concept of care through section 18(2)(a) of the Children’s Act.²⁵ Custody referred to a person’s capacity to physically have the child with him or her and to control and supervise the child’s daily life. Thus it includes caring for the child, supporting and guiding the child and assuming responsibility for the child’s upbringing, health, education, safety and welfare.²⁶ Care is a far broader concept and custody is now

²²Skelton in Boezaart (ed) *Child Law in South Africa* (2009) 63.

²³*Id.*

²⁴*Id.*

²⁵Skelton in Boezaart (ed) *Child Law in South Africa* (2009) 63.

²⁶*Id.*

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one of several elements of care.²⁷ Section 1 of the Children’s Act provides the following definition of care:

“**care**, in relation to a child, includes, when appropriate-

- (a) Within available means, providing the child with-
 - (i) A suitable place to live;
 - (ii) Living conditions that are conducive to the child’s health, well-being and development;²⁸ and
 - (iii) The necessary financial support;
- (b) Safeguarding and promoting the well-being of the child;²⁹
- (c) Protecting the child from maltreatment, abuse, neglect, degradation, discrimination, exploitation and any other physical, emotional or moral harm or hazards;
...
- (j) Generally, ensuring that the best interests if the child is the paramount concern in all matters affecting the child.”

4.5.1.1. Heath, well-being and development

The terms “well-being” and “development”, while being used in section 1(a)(ii) and 1(b) of the Children’s Act, are not defined as individual concepts in section 1 of the Children’s Act.

As demonstrated in the previous chapter, however, the Committee on the Rights of the Child has said that “health” and “development” should be given broad meanings, embracing the child’s physical, mental, spiritual, moral, psychological and social development. Because of sections 39 and 233 of the Constitution concerning the rules of interpretation when interpreting the Bill of Rights or international law, it can

²⁷ *Id.*

²⁸ Own emphasis.

²⁹ Own emphasis.

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be presumed that South African courts will apply the same meaning to the term “development” as the Committee on the Rights of the Child has done.

As the legislator failed to provide a definition for the terms “well-being” and “development” the ordinary meanings of the words must be considered. The Oxford Dictionary defines “well-being” as “The state of being comfortable, healthy or happy”³⁰ and “development” as “The process of developing or being developed” or “A specific state of growth or advancement”.³¹

It is clear from the definition of care and the subsequent definitions of well-being and development that parents have a responsibility to their children to ensure that their children are healthy, to the best of the parents’ financial abilities. Considering the numerous negative physical, emotional and mental consequences for a child who is overweight, part of this responsibility of parents to care for their child includes managing their child’s weight. Failure to do so and to allow their child to become obese, or even worse morbidly obese, is a failure to exercise their responsibility of care correctly. As explained in Chapter 2, even though some people are predisposed to become overweight, being overweight or obese is primarily caused by overeating and an unhealthy lifestyle. So although section 18(2) of the Children’s Act takes into consideration the financial status of the parents, those parents who come from a low income bracket that have obese children cannot be considered as faultless. Put differently, there is a difference between those parents whose children are underweight because they cannot afford food and those parents who have overweight or obese children because they provide their children with too much food.

³⁰Oxford Online Dictionary <http://www.oxforddictionaries.com/definition/english/well-being?q=well-being> (accessed on 2 January 2014).

³¹Oxford Online Dictionary <http://www.oxforddictionaries.com/definition/english/development> (accessed on 15 September 2014).

4.5.1.2. Protection against maltreatment, abuse and neglect and any other form of harm as an element of care

It was established above that when parents fail to prevent or address their child's overweight issues, they are failing in their parental responsibility of care because the child's health, well-being and development are being jeopardised. However, are they also failing in their responsibility to protect the child against maltreatment, abuse, neglect or any other form of harm?

A child's right to be protected from harm such as maltreatment, abuse, neglect or degradation is also provided for in the Constitution in terms of section 28(1)(d) which provides that "Every child has the right to be protected from maltreatment, neglect, abuse or degradation."

While a definition for the terms "abuse" and "neglect" are provided for by the Act, no such definition for the term "maltreatment" is provided even though it is used often in the Act. As already discussed maltreatment is defined by the WHO as being:³²

"A term which includes all forms of physical and emotional ill-treatment, sexual abuse, neglect, and exploitation that result in actual or potential harm to the child's health, development or dignity. Five subtypes of maltreatment can be distinguished: physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation."

Maltreatment appears to refer to any form of harmful behaviour towards a person. Considering the fact that the definition of maltreatment therefore seems to refer to both neglect and abuse, the courts, when interpreting the meaning of the term, will more than likely take the position that maltreatment was intended by the legislature

³²World Health Organisation http://www.who.int/topics/child_abuse/en (accessed on 1 May 2014).

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to be used as an umbrella term for the terms “abuse” and “neglect”, in other words the term “maltreatment” can be used to denote either abuse and/or neglect.

The Children’s Act provides definitions for the terms “abuse” and “neglect” in section 1. **Abuse** is defined as:

“Any form of harm or ill-treatment deliberately inflicted on a child and includes-

- (a) Assaulting a child or inflicting any other form of deliberate injury to a child;
- (b) Sexually abusing a child or allowing a child to be sexually abused;
- (c) Bullying by another child;
- (d) A labour practice that exploits a child; or
- (e) Exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally.”

While **neglect** is defined as:

“A failure in the exercise of parental responsibilities to provide for a child’s basic physical, intellectual, emotional or social needs.”

This duty on parents to protect their children from harm is broad and open ended. By using the words “and any other forms of harm” the legislature ensured that the definition was open ended and would be interpreted to include all other types of behaviour or actions that are harmful to children, even if such behaviour is not within its normal definition considered to be harmful. The behaviour associated with obesity in children demonstrates this point perfectly. Normally feeding your child is not considered as harmful behaviour, in fact it is considered to be a hallmark of a good parent. However, should you overfeed your child to the point where the child becomes obese or morbidly obese, then the behaviour becomes harmful and is no longer acceptable as it can be considered as a failure in a person’s parental responsibility and rights.

4.6. CAN THE DEFINITIONS OF “ABUSE” AND “NEGLECT” BE USED IN RELATION TO CHILDHOOD OBESITY?

As indicated abuse refers to “any form of harm or ill-treatment deliberately inflicted” while neglect specifically refers to a “failure in the exercise of parental responsibilities.” Ultimately both refer to some form of action or behaviour which is harmful to the child in some way or another.

The only real difference between neglect and abuse is motive, or the mind-set of the person performing the harmful action or behaviour in question towards the child. In the case of neglect it is the failure to do something or in other words negligence, while in the case of abuse it entails the deliberate or intentional harmful action towards a child.

In South African criminal law, in terms of the common law, negligence is when a person’s conduct does not comply with a certain standard of care required by the law.³³ In the context of child law the standard of care required from all persons is that of the best interests of the child.³⁴ The test for determining negligence is the following:³⁵

“A persons’ conduct is negligent if:

1. A reasonable person in the same circumstances would have foreseen the possibility;
 - a. That the particular circumstance might exist; or
 - b. That his conduct might bring about a particular result;
2. The reasonable person would have taken steps to guard against such a possibility; and
3. The conduct of the person whose negligence has to be determined differed from the conduct expected of the reasonable person.”

³³Snyman (ed) *Criminal Law* (2008) 208.

³⁴S28(2) of the Constitution read together with s9 of the Children’s Act.

³⁵*Ibid* at 209.

Intention on the other hand is defined in South African criminal law as:³⁶

“A person commits an act:

1. While his will is directed towards the commission of the act or the causing of the result;
2. In the knowledge of the existence of the circumstances mentioned in the definitional elements of the relevant crime; and
3. In the knowledge of the unlawfulness of the act.”

Perhaps the best method to demonstrate the difference between neglect and abuse is by way of an example.

In scenario 1:

A is the mother of the child B. While B is playing one afternoon, he falls and breaks his arm. A then fails to seek medical treatment for B because she is too busy at work.

Here A’s conduct fell short of the standard of care that is expected of her, namely to act in the best interests of the child. A reasonable person in the same circumstances would of immediately take B to the doctor in order to treat his broken arm. A failure to do so can be considered negligence.

In scenario 2:

A is the mother of child B. While B is playing one afternoon he manages to break one of A’s ornaments which is in the house. As punishment A breaks B’s arm on purpose to teach him a lesson.

³⁶Snyman (ed) *Criminal Law* (2008) 181.

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In scenario 2 A deliberately broke B's arm with the aim of teaching him a lesson. She purposefully causes B pain and harm and acts with the intention of teaching him a lesson, which is abuse.

The question is whether the conduct of the parents who allow their children to become obese can be seen as abuse or neglect. The answer to this question lies in the motive or mind-set of the parents. It has already been proven that childhood obesity has harmful consequences for children, physically and emotionally and can even in severe cases lead to death. Being obese is clearly not in the best interests of the child. Furthermore the definition of "care" requires parents to see to the health, well-being and development of the child. Therefore it is rather simple to link obesity in a child with neglect on the part of the parents of the child. In cases where a child is obese, the parents are acting against the best interests of child and are also failing to exercise their responsibility of care correctly. A reasonable person would either take steps to prevent their child from becoming obese or if the child becomes obese, would take proactive measures such as placing the child on a diet and making the child exercise, to return the child to a healthy weight. Parents who simply do nothing to control their child's weight or fail to address their child's weight are acting contrary to what the reasonable person would do and thus can be found guilty of neglect due to their negligent actions.

In the case of abuse, in order to find a parent guilty of abusing their child due to their child's obesity the parent must act with intention. Abuse in the context of childhood obesity can arise when the parent deliberately ignores a medical practitioner's advice or order to place their child on a diet. In such a case the parents would have been informed that their child's weight poses serious medical threats to the child. Should the parent then deliberately fail to act on the medical practitioner's advice or order and continue to feed their child as they always have, they would do so in full knowledge that their behaviour is harming their child.

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Therefore it is evident that a parent can be found guilty of abuse or neglect in the case of their child being obese.

4.7. STEPS THAT CAN BE TAKEN IF IT IS ESTABLISHED THAT AN OBESE CHILD IS BEING ABUSED OR NEGLECTED

What can be done once it is established that obese children are indeed being neglected or abused by their parents' failure or refusal to address their weight problem? The answer to this question will briefly be examined.

Chapter 9 of the Children's Act provides appropriate steps that can be taken in such situations. Chapter 9 of the Act provides the grounds on which a child can be found in need of care and protection as well as various intervention measures that can be taken in such cases.

Section 150 provides the grounds on which a child can be found in need of care and protection. The relevant grounds with regard to a child which is obese are the following:³⁷

“150. Child in need of care and protection:

(1) A child is in need of care and protection if, the child –

...

(f) lives or is exposed to circumstances which may seriously harm that child's physical, mental or social well-being;

(g) may be at risk if returned to the custody of the parent, guardian or care-giver of the child as there is reason to believe that he or she will live in or be exposed to circumstances which may seriously harm the physical, mental or social well-being of the child;

³⁷S150(1)(f)-(i) of Act 38 of 2005.

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- (h) is in a state of physical or mental neglect; or
- (i) is being maltreated, abused, deliberately neglected or degraded by a parent, care-giver, a person who has parental responsibilities and rights or a family member of the child or by a person under whose control the child is.”

It is unnecessary to explain how each ground is relevant in the case of an obese or morbidly obese child, as the negative physiological and psychological effects of obesity on a child have been explained in Chapter 2, as well as the legal obligation which rests on persons with parental responsibilities and rights to prevent such effects from occurring. Thus it is sufficient to state that the grounds listed above can be interpreted to include a child who is obese and such a child will be found in need of care and protection.

Just because a child is in need of care and protection due to his or her weight would not necessarily immediately require the removal of the child from his or her home. Each case would have to be individually evaluated. The Act provides that before a child is removed from his or her home and placed into alternative care, an investigation by a social worker must occur and the Children’s Court will decide on whether the child needs to be placed into alternative care with consideration to the social worker’s report.³⁸ However, the Act requires that removal should be considered as a last resort and only when a child is in immediate or imminent danger. For this reason there are many other intervention measures that can be put into place by the Children’s Court or social worker. This principle underlying removal would also apply to children who are obese. In the case of childhood obesity, removal should only be utilised when a child’s weight has reached a life-threatening level or the parents or caregivers of the child refuse to address the child’s weight after other intervention measures have failed. Such measures are described as prevention and early intervention programmes and are contained in Chapter 8 of the

³⁸S155 and 156 of Act 38 of 2005.

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Act. In terms of section 46 of the Act a Children's Court is empowered to make the following orders which can be utilised when dealing with a child that is obese:

“46 Orders children's court may make:

(1) A children's court may make the following orders:

(a) Alternative care order, which includes an order placing a child-

...

(f) A supervision order, placing the child, or the parent or care-giver of the child, or both the child and the parent or care-giver, under the supervision of a social worker or other person designated by the court;

(g) An order subjecting a child, a parent or care-giver of a child, or any person holding parental responsibilities and rights in respect of a child, to-

- (i) Early intervention services;
- (ii) A family preservation programme; or
- (iii) Both early intervention services and a family preservation programme;

(h) A child protection order, which includes an order-

- i. That a child remains in, be released from, or returned to the care of a person, subject to conditions imposed by the court;
- ii. Giving consent to medical treatment of, or to an operation to be performed on, a child;
- iii. Instructing a parent or care-giver of a child to undergo professional counselling, or to participate in mediation, a family group conference, or other appropriate problem-solving forum;
- iv. Instructing a child or other person involved in the matter concerning the child to participate in a professional assessment;

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- v. Instructing a hospital to retain a child who on reasonable grounds is suspected of having been subjected to abuse or deliberate neglect, pending further inquiry;
 - vi. Instructing a person to undergo a specified skills development, training, treatment or rehabilitation programme where this is necessary for the protection or well-being of a child;
- ...”

Section 156 of the Act provides the court with even further possible orders a court can make when a court finds that a child is in need of care and protection. This section provides for a range of possible orders, ranging from removing a child from his current living environment, retaining a child in his current living environment under supervision to ordering the child to attend medical care.

What can be seen from section 46 and section 156 of the Act is that the court is empowered to make just about any order which it deems to be in the best interests of the child, as the wording of the section is not specific and open to interpretation. The intervention measures which can be utilised are wide, ranging from educational programmes and supervision by a social worker to removal of a child from the family household and placing the child in alternative care, either on a temporary basis or permanently.

Should a court be faced with the question as to what to do with a child that is obese, the court would be able to order the family be placed under supervision; the child to receive treatment for his or her weight which would include a diet and exercise plan; the parents of the child and the child to attend educational programmes and skills development programmes or even to impose any other conditions that the court deems fit.

4.8. SUMMARY

What can be concluded from this chapter is that the state is under an obligation, in accordance with international law, to provide for the well-being and development of the obese child. In addition it has to take measures to protect the obese child. South Africa has also through the Children's Act 38 of 2005, provided the state and the courts with the means to ensure that the obligation to protect, assist and provide support to obese children is met.

CHAPTER 5: FOREIGN LEGISLATION

5.1. INTRODUCTION

To date America has one of the most comprehensive legal systems in place aimed at combating childhood obesity amongst its population. Various federal states in the United States of America have begun to combat childhood obesity by passing bills that are aimed at preventing obesity in children. Furthermore the courts of several federal states have started to use the current legislation concerning child abuse and neglect to intervene in cases where the child's weight has become life-threatening. Interestingly, it appears that the American legal system is not only concerned with preventative measures, but also with intervention and punishment methods when parents fail to regulate their child's weight and allows their child's weight to become life-threatening.

5.2. PROGRAMMES AND LEGISLATION AIMED AT PREVENTION

Federal states in America have begun to address the childhood obesity epidemic through either school board proceedings or at local government levels.¹

The governor of New York signed a bill into law in 2004 which established a childhood obesity prevention programme within the state's Department of Health.² The programme is aimed at reducing obesity amongst children as well as the prevalence of diabetes and other medical conditions associated with obesity.³ The state of Massachusetts has also taken steps to prevent obesity by implementing a school-based healthy-weight programme.⁴ This programme keeps track of elementary school pupils' BMIs and also keeps parents informed of their children's

¹George "Parents super-sizing their children: Criminalizing and prosecuting the rising incidence of childhood obesity as child abuse" 2010 *DePaul Journal of Health Care Law* 48.

²*Id.*

³*Id.*

⁴*Id.*

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weight by sending report cards home with the child's weight and fitness scores.⁵ The government of Texas has similarly initiated a school-based healthy-weight programme to curb the childhood obesity.⁶ The Texas government currently monitors the nutritional content of school provided meals and the legislature has introduced educational programmes, including advertisements through various mediums, aimed at promoting awareness of healthy lifestyles.⁷

California passed three bills in 2005 aimed at childhood obesity prevention by regulating the food and beverages that are made available in public schools.⁸ Chapter law 237 regulates the type of beverages that may be sold at all levels of the schooling system, from elementary to high schools by providing that only drinks that contain a certain percentage of sugar can be sold in schools.⁹ Chapter law 235 creates a pilot program wherein participating schools are restricted in the types of competitive foods that may be sold.¹⁰ The law imposes strict calorie requirements that are allowed in each meal, the type of food which may be served or snacks which are made available, how meals must be prepared as well as the quantity of food allowed per meal.¹¹ Finally, Chapter law 236 also creates a pilot program which requires that fresh fruit and vegetables must be provided at breakfast and that participating schools include a sampling of fresh fruit and vegetables as part of their nutrition education programs.¹²

School-based efforts aimed at preventing childhood obesity, such as the above examples, will most likely prove to be the most successful method of prevention because each federal state requires that children attend school. Furthermore a child spends the majority of his or her day in school, therefore most of his or her meals or snacks are eaten at school. Once the child can be educated on a healthy lifestyle

⁵*Id.*

⁶*Ibid* at 49.

⁷George 2010 *DePaul Journal of Health Care Law* 49.

⁸Neal "Childhood obesity prevention: Is recent legislation enough?" 2006 *Journal of Juvenile Law* 115.

⁹*Id.*

¹⁰*Ibid* at 116.

¹¹*Id.*

¹²*Ibid* at 117.

and the school provides healthy meals, the childhood obesity epidemic should decrease.

5.3. THE CHILD ABUSE PREVENTION AND TREATMENT ACT

The Child Abuse Prevention and Treatment Act of 1974 (henceforth referred to as the CAPTA) was the first and most significant piece of federal legislation enacted to combat child abuse and neglect.¹³ The CAPTA was designed by congress to chiefly focus on physical abuse cases involving children by providing states with federal funding to investigate and prevent child maltreatment.¹⁴ In order for the states to receive this federal funding for programmes aimed at preventing, identifying and treating abuse and neglect, they were required to enact a state statute defining child abuse and neglect, which all 50 states have since done.¹⁵

Although the definitions of child abuse and child neglect differ from federal state to federal state, there are commonalities between the various definitions.¹⁶ In almost every state the concept of child maltreatment incorporates four categories, namely sexual abuse, physical abuse, emotional abuse and neglect.¹⁷ The categories that are most relevant to morbid childhood obesity are physical abuse and medical neglect.^{18 19}

Physical abuse can be broadly defined as “non-accidental physical injury as a result of caretaker acts.”²⁰ While this definition does provide some guidance to the courts

¹³Sciarani “Morbid Childhood Obesity: The pressing need to expand statutory definitions of child neglect” 2010 *Thomas Jefferson Law Review* 318.

¹⁴Garrahan & Eichner “Tipping the scale: A place for childhood obesity in the evolving legal framework of child abuse and neglect” 2012 *Yale Journal of Health Policy, Law and Ethics* 350.

¹⁵Sciarani 2010 *Thomas Jefferson Law Review* 318.

¹⁶Garrahan & Eichner 2012 *Yale Journal of Health Policy, Law, and Ethics* 351.

¹⁷*Id.*

¹⁸Medical neglect occurs when parents fail to either take their children to a medical practitioner when the child clearly requires medical assistance, or when the parents fail to follow medical practitioners’ directives with regard to the child’s treatment. This definition is broad and varies from state to state.

¹⁹*Ibid* at 352.

²⁰*Id.*

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as to the type of behaviour that constitutes physical abuse, it focuses on the type of act that causes injury and not on whether the intent of the person accused of physical abuse was justified or unjustified.²¹ For example if a caregiver pushes a child who falls on the ground and breaks his nose it is unclear whether the action of the caregiver constitutes physical abuse until the intention of the caregiver is established. If the caregiver pushed the child with malicious intent, then clearly it is a case of physical abuse. However, if the caregiver pushed the child in order to prevent him from being hit by a vehicle, then the act would be justified and not be abusive. A similar approach would have to be used when determining whether the child's morbid obesity is physical abuse by firstly establishing the underlining causes of the child's condition and then asking whether the parent's response to the child's condition is reasonable and justified.²²

Neglect is a concept which is particularly difficult to define because of the numerous ways in which a child can be neglected.²³ Neglect is often defined as “the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child's health, safety, and well-being are threatened with harm.”²⁴ Traditionally the removal of a child from the parental home is only warranted when the level of neglect has reached that of starving the child, but some courts have started to acknowledge that a failure to care for those aspects of a child's physical well-being that are related to obesity is also a form of neglect.²⁵ Most of the courts that have come to this realisation have classified this form of neglect as medical neglect.²⁶ Medical neglect, just like neglect and physical abuse, has no universal definition; however some states have defined medical neglect to be “a failure to provide any special medical treatment or mental health care needed by the child.”²⁷

²¹*Id.*

²²*Id.*

²³*Id.*

²⁴Garrahan & Eichner 2010 *Yale Journal of Health Policy, Law and Ethics* 353.

²⁵*Id.*

²⁶*Id.*

²⁷*Id.*

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The lack of a universal definition for physical abuse or neglect within the United States of America has made it somewhat difficult for the courts to intervene in the case of a morbidly obese child. Despite this, courts in several federal states in America have begun to develop its existing child abuse and neglect statutes to intervene in such cases. The underlying rationale for the courts' decisions is that the physical, emotional and mental well-being of the child has been endangered by the parent's failure to address their child's morbid obesity.²⁸

5.4. A LOOK AT VARIOUS COURT DECISIONS CONCERNING CHILDHOOD OBESITY IN AMERICA

Morbid obesity in a child has been recognised by courts in California, Indiana, Iowa, Michigan, New Mexico, New York, Pennsylvania, South Carolina and Texas as a justified reason for state intervention into the family unit.²⁹ Some of these cases will now be briefly examined.

5.4.1. California

A case which clearly demonstrates not only the dangers of childhood obesity and the need for state intervention when a child is morbidly obese is that of Christina Corrigan.³⁰ In 1996 the 13 year old Christina died of heart failure in the living room of her home, weighing 680 pounds (about 308,4 kg).³¹ She was wearing a bed-sheet, her body was covered in bedsores and there were faeces in the folds of her body.³² Furthermore she had not been to school in a year, had not been out of her home for three months and had been in the position where she eventually died for days.³³ Even though her mother was convicted of misdemeanour child abuse in the

²⁸ *Id.*

²⁹ Mitgang 2011 *Columbia Journal of Law and Social Problems* 559.

³⁰ La Ganga M (1997) "For Obese Girl, Battle of Blame Comes Too Late" 26 December 1997 Los Angeles Times.

³¹ *Id.*

³² *Id.*

³³ *Id.*

California Superior Court; the fact remains that the state failed to take any action to assist Christina while she was alive.^{34 35}

5.4.2. Iowa

One of the first major decisions concerning state intervention in the case of a morbidly obese child was that of *In re L.T.*³⁶ The case revolved around a ten year old girl, Liza who weighed 290 pounds (about 131,5 kg). As a result of her weight Liza had become depressed to the point that immediate medical intervention was required. She had a severe yeast infection which was out of control and growing in the folds of her body, while producing an extremely strong body odour. The court had previously tried to avoid removing her from her mother's custody by ordering the mother to place Liza in a treatment facility and to schedule regular appointments with a dietician who had recommended a dietary program.³⁷ However, Liza's mother failed to comply with the court's order and the court then ordered that Liza be placed into foster care after finding that Liza was a child who was in need of assistance. A child in need of assistance is defined in terms of the Iowa Code³⁸ as:

“An unmarried child who is in need of medical treatment to cure or alleviate serious mental illness or disorder, or emotional damage as evidenced by severe anxiety, depression, withdrawal or untoward aggressive behaviour towards self or others and whose parent, guardian, or custodian is unwilling or unable to provide such treatment.”

An Iowa Court of Appeal confirmed the decision of the trial court to have Liza immediately removed from her mother's care and placed in a treatment facility. While

³⁴*Id.*

³⁵One should consider the similarities of the case of Christina and Ebony as described in para 2.7. In both cases the child died as a result of serious eating disorders; had been unable to move for days or weeks prior to their death and their bodies were covered in bodily waste and fluids at the time of death.

³⁶*In re L.T.*, 494 N.W. 2d 450 (Iowa App.1992).

³⁷Mitgang 2011 *Columbia Journal of Law and Social Problems* 563.

³⁸Iowa Code 232.2 (6)(f)(2010).

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the court did not go so far as to state that the mothers actions amount to child abuse, the court reasoned its decision by stating that Liza's obesity was a potentially life-threatening condition that shortened her life expectancy and that it had interfered with her socialization. As a result Liza was a child in need of assistance. The court also considered the long term physical effects of her obesity on her health and mental well-being, not just the short term effects.³⁹ It also took note of the fact that Liza's mother worsened her obesity by encouraging her to overeat as a method of coping with stress as well as using food as a reward system.⁴⁰

5.4.3. Michigan

The Court of Appeals in Michigan applied the "best interests of the child" standard to confirm the decision of the trial court to terminate the parental rights in a case concerning a morbidly obese four year old named Jered.⁴¹ ⁴² The Family Independence Agency first intervened when Jered weighed 106 pounds (About 48,8 kilograms) at the age of three years by offering his mother various services.⁴³ However his mother refused to accept the Agency assistance and five months later he weighed a shocking 120 pounds and required the use of a wheelchair because he had trouble walking.⁴⁴ In addition to his morbid obesity Jered also had ten cavities, head lice, scabies, infections caused by improper cleaning and also suffered from delayed physical and verbal skills development.⁴⁵ He was then removed from his mother's custody by court order and was placed into foster care where he lost 60 pounds.⁴⁶ Eventually the Agency approached the court to have his mother's parental rights terminated and at the trial the state produced evidence that showed that Jered's mother had continued to feed him fast food during parenting time, even after completing a nutritional program, had failed to attend his occupational therapy sessions and did not have a close bond with her son.⁴⁷ Because of these reasons

³⁹ *Id.*

⁴⁰ Garrahan & Eichner 2012 *Yale Journal of Health Policy, Law and Ethics* 359.

⁴¹ *Id.*

⁴² *In re Ostrander*, No 247661, 2004 WL 515561 (Mich. Ct. App. Mar. 16, 2004).

⁴³ Garrahan & Eichner 2010 *Yale Journal of Health Policy, Law and Ethics* 359.

⁴⁴ *Ibid* at 360.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

the trial court found that it was in the best interests of the child that his mother's parental rights be terminated, and the Appeal court confirmed the finding.⁴⁸

5.4.4. New Mexico

Under New Mexico's child neglect statute a neglected child is, amongst other causes, one "who is without proper medical care necessary for the child's well-being because of the faults or habits of the child's parent, or refusal of the parent to provide them".⁴⁹ The New Mexico Abuse and Neglect Act also provides for the removal of a neglected child until fact-finding hearings can be held to determine the future placement of the child.⁵⁰ The case of Anamarie Martinez-Regino demonstrated the application of this Act.

In 2000 Anamarie was removed from her home by officials when her parents were charged with medical neglect as they had failed to follow a doctor's instructions to treat their daughter's obesity.⁵¹ At the time of her removal Anamarie weighed 131 pounds (about 59,4 kg) at the age of three years.⁵² She had previously been hospitalised for respiratory problems at the tender age of nine months as a consequence of her obesity.⁵³ In June 2000 she was hospitalised once again for three weeks for obesity related issues and was placed on a liquid diet where she lost ten pounds.⁵⁴ She was discharged from the hospital and her parents were given strict instructions to continue with the liquid diet and exercise plan until she had achieved a healthy weight.⁵⁵ However, her parents, Adela and Miguel failed to follow her doctor's instructions and by August 2000 she had gained more weight and was once again hospitalised for a fever and irregular breathing where she remained until her weight had dropped to 117 pounds (about 53,7 kg).⁵⁶ The hospital notified New

⁴⁸ *Id.*

⁴⁹ Arani "State intervention in cases of obesity-related medical neglect" 2002 *DePaul Law Review* 876.

⁵⁰ *Id.*

⁵¹ *Ibid* at 877.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ *Id.*

Mexico's Children, Youth and Families Department of Anamarie's continued condition. The department agreed with the hospital that her condition was life-threatening and that she needed to be removed from her home to protect her from neglect.⁵⁷ The Children's Court found that the state had probable cause to remove Anamarie from her parent's custody and further ordered that she was to remain in foster care until a more permanent custody arrangement could be found.⁵⁸

5.4.5. Pennsylvania

In *In re D.K.*,⁵⁹ the Pennsylvania Court of Common Pleas placed continued legal and physical custody of a morbidly obese 16 year old boy who weighed 451 pounds (about 204,5 kg) with the county's Children and Youth Services despite his and his mother's objections.⁶⁰ Records show that even though the child had been overweight since infancy, his parents had never taken him to a dietician or any other specialist and that in the previous year alone he had gained 100 pounds, putting his health in a life-threatening situation.⁶¹ The doctors examined him after school officials submitted him for a medical examination when they grew concerned about his health and academic performance. The doctors found that he suffered from an enlarged liver, hypertension, insulin resistance, sleep apnoea, depressive disorder, respiratory problems so severe he was required to wear an oxygen mask at night and knee pain, all of which were attributed to his morbid obesity.⁶² The Northumberland County Children and Youth Services Department (CYS) initially obtained a voluntary entrustment agreement from the child's mother that placed him in the custody of CYS as a dependent child as a result of the medical examination.⁶³ Under Pennsylvania Law a dependent child, whose welfare the court is authorised to protect is defined as "one who is without proper parental control, subsistence, education as required by law, or other care or control necessary for his physical,

⁵⁷ *Id.*

⁵⁸ *Ibid* at 878.

⁵⁹ *In re D.K.*, 58 Pa. D. & C. 4th 353, 358 (Pa. Com. Pl. 2002).

⁶⁰ Mitgang 2011 *Columbia Journal of Law and Social Problems* 560.

⁶¹ Larson 2008 *Children's Legal Rights Journal* 6.

⁶² *Id.*

⁶³ *Id.*

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mental or emotional health or morals”.⁶⁴ Despite the fact that the child had lost 50 pounds in three months while in CYS custody, both he and his mother challenged his designation as a “dependent child” and approached the court for his return.⁶⁵

The court found that D.K.’s mother was not capable of providing adequate care for his physical needs as she had failed to take any steps to address his morbid obesity and therefore he was a “dependent child”.⁶⁶ The court noted:⁶⁷

“If a child does not receive necessary medical care for a health problem, there is usually no difficulty in a court making a finding of dependency and especially in the situation where a child was malnourished to the point of near starvation. This situation here is on the other end of the nourishment spectrum, but it is no less dangerous to the child’s physical and mental well-being.”

Although the court ordered the child’s removal it did make provision for the child to be reunited with his mother in the future should she become able to address his morbid obesity.⁶⁸

5.5. SUMMARY

Even though these cases originate in different states, each with their own child abuse and child neglect laws, there are similarities in the approaches that the courts and social departments took. Firstly, family based intervention and education of the parents was attempted in all these cases. Secondly, only when intervention methods had completely failed and it was clear that the child’s weight had reached a level that was life-threatening were the courts approached and the child was removed from the

⁶⁴Mitgang 2011 *Columbia Journal of Law and Social Problems* 561.

⁶⁵Larson 2008 *Children’s Legal Rights Journal* 6.

⁶⁶Garrahan & Eichner 2010 *Yale Journal of Health Policy, Law and Ethics* 357.

⁶⁷*Ibid* at 358.

⁶⁸*Id.*

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family home. Finally provision was made by the courts for reintegration of the child into the family home. The parental rights of the children concerned were only terminated after it became clear that the parents were unwilling or unable to control their children's weight.

It is interesting to observe that even though the American legal system and South African legal system differ in almost all aspects, the approach employed by the above-mentioned courts when dealing with a child who is morbidly obese is exactly the same as the approach used in South African child protection methods in certain cases. Intervention and education is always the first step, followed by removal of the child should intervention fail. The reintegration of the child into the family home is always the ultimate goal once a child has been removed. Termination of parental rights and responsibilities is the last resort the courts will take, only after all other attempts to reintegrate the child has failed.

CHAPTER 6: CONCLUSION

6.1. BACKGROUND

The epidemic of obesity and specifically childhood obesity remains a critical public health issue. Obesity alone directly affects 5% of our male children and a quarter of our female children.¹ Furthermore the impact of obesity is far reaching, having a negative effect on a country's economy and society.

The purpose of this dissertation was to discover whether childhood obesity can be considered as a form of child abuse or parental neglect. This dissertation investigated current legislative frameworks to determine if the interpretation of the current laws can be applied to protect children from the harmful effects of obesity, or alternatively whether new laws needed to be enacted in order to regulate the issue of childhood obesity.

The specific research question posed in this dissertation was: Is childhood obesity a form of child abuse or parental neglect?

6.2 CONCLUSION REACHED

Chapter 2 illustrates the direct role parents play in causing childhood obesity and the lesser role schools play in exacerbating the problem. It is clear that the role parents play should be considered and examined with the overall consequences caused by childhood obesity. Furthermore Chapter 2 shows that childhood obesity can result in an overabundance of medical conditions – all of them serious and any one of the diseases or conditions negatively affecting the quality of the child's life. The psychological effects obesity has on a child is well documented, but the Schwitter

¹Van Heerden "SA kids 5th most obese in the world"
http://www.selfmed.co.za/full_story.aspx?nid=13534 > (accessed on 12 November 2012).

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study clearly puts it into perspective when obese children equate their life to those of children undergoing chemotherapy. The ultimate medical and psychological effect of obesity on the child can be death – the same potential outcome as starvation.

In light of the very serious medical consequences of obesity, Chapter 3 and 4 explored the obligations that South Africa has towards children through the application of international and domestic laws. In reviewing current South African legislation to determine who is responsible for preventing or reversing obesity in a child, the concept of parental responsibilities and rights as stated in the Children's Act, it can be deducted that an obese child is not given the best care possible. The adverse effects of childhood obesity as stated in Chapter 2, makes it clear that obese children are not given the care they require in order for them to develop optimally.

When investigating legislation related to the right of the child to be protected against abuse and neglect as an element of care, it is clear that all manners of actions or behaviour against a child that can be harmful are included. Obesity in children is physically and psychologically harmful and, as determined in Chapter 2, can be equated as the opposite extreme of starvation.

Therefore it is clear that in light of the international laws pertaining to children, to which South Africa is bound, and South Africa's own domestic legislation pertaining to children, childhood obesity can be considered as a form of child abuse or parental neglect.

Against the backdrop of the consequences of obesity in children as described in Chapter 2 and the determination that the state has ultimate responsibility, there is a clear need for additional legislation or clarity on legislative interpretation that will protect children against obesity. It is thus clear that if the state does not step in to take care of the obese child where the primary caregivers fail to do so, or where the

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state fails to implement measures to protect the obese child, the state is also guilty of neglecting its responsibility to step in and take over the care of the child where such child is deprived of the right to care and protection under section 150 of the Children's Act.

The influence of international law in the interpretation of the Bill of Rights should compel the legislature to take into consideration various efforts around the globe to address and curb childhood obesity as highlighted in Chapter 5. Chapter 5 demonstrates how the state can interpret current laws pertaining to the protection and prevention of child abuse, neglect or any other form of harm to also include childhood obesity. Either educational programmes or stricter regulations with regards to food in schools can be implemented or the courts can be approached for relief.

South Africa needs similar programmes to be implemented to educate primary caregivers to stop the epidemic of childhood obesity. The legislature must clarify the interpretation and application of the law to include childhood obesity as affecting the child's best interests and clarify the duty of care as it relates to obesity.

Unfortunately, while the judiciary is empowered to interpret the current laws applicable to children to include the issue of obesity, the likelihood of a court determining that a child is being abused or neglected due to the child's obesity is highly unlikely. It is more likely that the courts will only do so once a case similar to that of Christina Corrigan is placed before them.² Similarly, it is doubtful whether a social worker or other state institution will be willing to intervene in such a case until the legislature clarifies the interpretation and application of the law to include childhood obesity.

²See para 5.4.1.

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One can only hope that something is done in South Africa to address the issue of childhood obesity amongst its children before a child dies as a result of obesity.

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