PROTECTING THE REPRODUCTIVE RIGHTS OF CHILDREN AND YOUNG ADULTS WITH DISABILITIES: THE ROLES AND RESPONSIBILITIES OF THE FAMILY, THE STATE, AND JUDICIAL DECISION-MAKING[†]

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I. A GIRL'S STORY

Angela was an eleven-year-old girl with Rett's Syndrome, a progressive neurological disorder that results in severe intellectual and physical impairment and epilepsy.[1] Angela could not talk and had "neither the coordination or the mental faculties to be able to use sign language."[2] She acted "as a three month-old baby would."[3] In her ninth year, Angela's menstrual periods commenced, and while her epilepsy was controlled by medication, seizures could occur when she had a heavy menstrual period.[4] Excessive bleeding during these periods led to an "Implanon" medical procedure being performed, but this, together with oral contraceptive pills, proved to be unsatisfactory.[5] The

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1 Rett's Syndrome constitutes a failure of the neural pathways that impact the conscious actions of the person. BENJAMIN JAMES SADOCK & VIRGINIA ALCOTT SADOCK, KAPLAN AND SADOCK'S SYNOPSIS OF PSYCHIATRY: BEHAVIOR SCIENCES/CLINICAL PSYCHIATRY 1199–1200 (10th ed. 2007) ("The cause of Rett's disorder is unknown, although the progressive deteriorating course after an initial normal period is compatible with a metabolic disorder. . . . It is likely that Rett's disorder has a genetic basis. It has been seen primarily in girls.") Additionally, "[a]t 6 months to 2 years . . . these children develop progressive encephalopathy with a number of characteristic features." *Id.* at 1199 ("The signs often include the loss of purposeful hand movements, which are replaced by stereotypic motions, such as . . . the loss of previously acquired speech; psychomotor retardation; and ataxia. . . . All language skills are lost, and both receptive and expressive communicative social skills seem to plateau at developmental levels between 6 months and 1 year. Poor muscle coordination and an apraxic gait with an unsteady and stiff quality develop. All of these clinical features are diagnostic criteria for the disorder.").

2 *Re Angela* (*Angela's Case*) [2010] FamCA 98, para. 6 (Austl.).

3 *Id.*

4 *Id.* para. 11.

5 *Id.* para. 20.

bleeding caused Angela to become anemic and experience other problems.[6] Personal hygiene was also an issue.[7] Medical advice, supported by at least three medical practitioners, proposed that a hysterectomy be performed on the child, leaving the ovaries and tubes intact to provide her with normal hormones.[8] Therefore, "only the source of bleeding would be removed."[9] It was submitted that the effects on Angela would be relatively minimal and the menstrual problems would be resolved.[10] As the nature of her disability was "such that she would not have the psychological capabilities to consider a pregnancy into the future," this possibility would also have been taken care of.[11]

This recent case in the Family Court of Australia, *Re: Angela* ("*Angela's Case*"),[12] illustrates the tension between fundamental rights[13] and the need to address the roles and responsibilities of the family and state in the context of nonconsensual[14] sterilization of, specifically, girl children and female adolescents with disabilities. This case highlights the basic question of whether such matters are best catered to in the private or public domain.[15]

In *Angela's Case*, the Australian Family Court was satisfied that it had jurisdiction to grant an order in a case like this[16] and authorized the performance of a medical procedure removing Angela's uterus.[17] This was based on the majority decision of the Australian High Court in a similar case in

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[6] *Id.*

[7] *Id.* para. 9.

[8] *Id.* paras. 21, 30–32.

[9] *Id.* para. 21.

[10] *Id.* para. 23.

[11] *Id.*

[12] *Re Angela* [2010] FamCA 98 (Austl.).

[13] These fundamental rights include physical integrity, human dignity, and privacy, among others. See *Sec'y, Dep't of Health & Cmty. Servs. v JWB* (*Marion's Case*) [1992] 175 CLR 218, 265–68, 277 (Austl.), known as "*Marion's Case*," where the court sought to balance these rights. See Melinda Jones & Lee Ann Basser Marks, *Valuing People Through Law—Whatever Happened to* Marion*?*, 17 LAW CONTEXT 147 (2000), for an in-depth discussion of *Marion's Case* highlighting the articulation of the principle of inclusion by the High Court. Bates calls *Marion's Case* "[t]he most important case to be decided in Australian family law in 1992." Frank Bates, *Australian Family Law in 1992—The Year of the Loud Report?*, 32 U. LOUISVILLE J. FAM. L. 233, 239 (1993–1994).

[14] The Author uses this term to underline the fact that children with severe intellectual impairment, irrespective of age, are unable to consent to any form of medical treatment.

[15] *See generally Re Angela* [2010] FamCA 98 (Austl.).

[16] *Id.* paras. 46–47.

[17] *Id.* paras. 57–58. The court considered appointing an Independent Children's Lawyer (in terms of Sections 4 and 68L of the Family Law Act 1975) for the child but decided against it because Angela would not benefit from an appointment. *Id.* paras. 36–42.

1992, *Department of Health & Community Services v JWB* ("*Marion's Case*"),[18] and on the assumption that the invasive and irreversible medical procedure[19] would be in Angela's best interests[20] because the quality of her life would improve after the procedure.

Some analysts criticized the court's decision.[21] According to University of New South Wales disability scholar Leanne Dowse, the "'unusual' court ruling was the first in many years to side with parents seeking an invasive, irreversible medical procedure for their disabled child."[22] Dowse argues that, "[b]eyond raising the issue of who had the right to make a decision for a disabled child, the case highlighted an increasing lack of services for carers of people with a disability."[23] Dowse states that since the 1980s, governments had progressively reduced residential services without improving other community support, which had placed increased strain on families.[24] Referring to the

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[18] *Id.* paras. 44–47; *see also Sec'y, Dep't of Health & Cmty. Servs. v JWB* (*Marion's Case*) [1992] 175 CLR 218 (Austl.). Marion was a fourteen-year-old girl with mental disabilities (mental retardation, severe deafness, and epilepsy, with an ataxic gait and behavioral problems) who resided in the Northern Territory. *See* Kate Parlett & Kylie-Maree Weston-Scheuber, *Consent to Treatment for Transgender and Intersex Children*, 9 DEAKIN L. REV. 375, 377 (2004).

[19] *Re Angela* [2010] FamCA para. 48. One of the medical experts was adamant that the procedure was not a sterilization in this particular case. *Id.* However, the fact that the procedure was invasive and irreversible took it outside the ambit of normal parental responsibilities. *Id.*

[20] *Id.* para. 46 ("[T]he Court must regard the best interests of the child as the paramount consideration.").

[21] *Walk in Our Shoes*, AUSTRALIAN BROADCASTING COMPANY, http://www.abc.net.au/4corners/content/2003/transcripts/s880681.htm (last visited June 7, 2010).

[22] Courtney Trenwith, *Parents Win Bid To Sterilise Daughter*, BRISBANE TIMES (Mar. 9, 2010), http://www.brisbanetimes.com.au/queensland/parents-win-bid-to-sterilise-daughter-20100309-ptlf.html (quoting Leanne Dowse).

[23] *Id.* See Jones & Basser Marks, *supra* note 13, at 163–64 for the protocols and guidelines that have been developed for special medical procedures in Victoria following *Marion's Case*. These protocols establish a link between the Family Court, the Office of the Public Advocate, and Victoria Legal Aid, supported by the Department of Human Services. *Id.* Similar protocols have also been developed in Queensland. *Id.*

[24] Dowse continued:

> It means that something like menstruation for a family is just one more problem issue that they have to deal with in this massive set of unmet needs . . . .
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> . . . .
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> Decisions like [Angela's] have to be seen in that context; it's often for people who are at their wits end already.
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> . . . .
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> It's been a very difficult decision and I'm sure that nobody would take it lightly but . . . it's important to understand that those people are trying to make that decision in the context that their services [and] support needs are not being met. We see this increasingly in disability where there's an enormous amount of unmet need.
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> . . . .

Convention on the Rights of Persons with Disabilities ("CRPD"), she argues that "individuals with a disability have a right to respect for his or her physical integrity."[25]

II. HYPOTHESIS

The scenario outlined above brings, or seemingly brings, the best interests principle in conflict with other rights of children with disabilities, such as the right to physical integrity, the right to human dignity, as well as the right to retain fertility on an equal basis with others.[26] The main question is: What is in the best interests of a child in circumstances such as these? Secondary questions in this regard are whether the courts can assume, and even expand on, parental rights to decide what is in the best interests of a particular child or whether any other forum is better informed and equipped to do so. Finally, the strengths and weaknesses of different legal frameworks in addressing the issue of nonconsensual therapeutic sterilization of children with disabilities are considered and evaluated.[27] Recommendations are made to improve on the current South African framework in this regard.

The Family Court judgment referred to the earlier *Marion's Case*, which addressed these issues in a thought-provoking manner.[28] The majority view in *Marion's Case* was that the court's consent is required in cases of sterilization.[29] Furthermore, the "function of [the] court when asked to

> The issue is that it's probably a quick fix but it really is one of those things that probably almost definitely [is] covering up a whole range of other issues.

Trenwith, *supra* note 22 (quoting Leanne Dowse) (alterations in original) (internal quotation marks omitted).

[25] Paul Osborne, *Disabled Girl Can Be Sterilised: Court*, SYDNEY MORNING HERALD (Mar. 9, 2010), http://news.smh.com.au/breaking-news-national/disabled-girl-can-be-sterilised-court-20100309-pu6l.html; *see also* Convention on the Rights of Persons with Disabilities art. 17, *opened for signature* Mar. 30, 2007, 2515 U.N.T.S. 3 (entered into force May 3, 2008) [hereinafter CRPD]. Basic principles of international human rights law, such as human dignity and autonomy, are at the core of the CRPD. *Id.* pmbl. Although a person with mental disabilities "may not be deemed competent to consent to treatment . . . this does not mean that [he or she is] also incapable of objecting," which opens the door for considering veto rights. ANDREAS DIMOPOULOS, ISSUES IN HUMAN RIGHTS PROTECTION OF INTELLECTUALLY DISABLED PERSONS 178 (2010). German law provides for an absolute veto right. *Id.* at 163.

[26] *See* Marcia H. Rioux & Lora Patton, *Beyond Legal Smoke Screens: Applying a Human Rights Analysis to Sterilization Jurisprudence*, *in* CRITICAL PERSPECTIVES ON HUMAN RIGHTS AND DISABILITY LAW 243, 264 (Marcia H. Rioux, Lee Ann Basser & Melinda Jones eds. 2011); Kristin Savell, *Sex and the Sacred: Sterilization and Bodily Integrity in English and Canadian Law*, 49 MCGILL L.J. 1093, 1141 (2004).

[27] The question whether the nonconsensual procedure to be performed on the child in this case could amount to criminal assault is not addressed in this Article.

[28] *Re Angela* [2010] FamCA 98, paras. 44–45 (Austl.).

[29] *Sec'y, Dep't of Health & Cmty. Servs. v JWB* (*Marion's Case*) (1992) 175 CLR 218, 219 (Austl.).

authorize sterilization is to decide whether, in the circumstances of the case, that is in the best interests of the child."[30] However, Judge Brennan argued in his dissenting (minority) judgment that "the best interests approach does no more than identify the person whose interests are in question: it does not assist in identifying the factors which are relevant to the best interests of the child" and "offers no hierarchy of values which might guide the exercise of a discretionary power to authorize sterilization."[31] It also does not lay down "any general legal principle which might direct the difficult decisions to be made in this area by parents, guardians, the medical profession and courts."[32] Brennan referred to Professor Ian Kennedy, who criticized the best interests principle as follows:

> The best interests formula may be beloved of family lawyers but a moment's reflection will indicate that although it is said to be a test, indeed *the* legal test for deciding matters relating to children, it is not really a test at all. Instead, it is a somewhat crude conclusion of social policy. It allows lawyers and courts to persuade themselves and others that theirs is a principled approach to law. Meanwhile, they engage in what to others is clearly a form of '*ad hocery*'.[33]

Judge Brennan noted that, although the different circumstances of each case require judicial evaluation, "the power to authorize sterilization is so awesome, its exercise is so open to abuse, and the consequences of its exercise are generally so irreversible, that guidelines, if not rules, should be prescribed to govern it."[34] He continued:

> The test of therapeutic medical treatment recognizes the importance of personal integrity and of the maintenance and enhancement of natural attributes to the welfare of the child. By comparison, the best interests approach is useful only to the extent of ensuring that the first and paramount consideration is the interests of the child, not the

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[30] *Id.* at 259.

[31] *Id.* at 270 (Brennan, J., dissenting).

[32] *Id.*

[33] Ian Kennedy, *Patients, Doctors and Human Rights*, *in* HUMAN RIGHTS FOR THE 1990S: LEGAL, POLITICAL AND ETHICAL ISSUES 81, 90–91 (1991) (emphasis added).

[34] *Marion's Case*, 175 CLR at 272 (Brennan, J., dissenting); *see also* Alexandra George, Comment, *Sterilisation and Intellectually Disabled Children:* In the Matter of P & P, 18 SYDNEY L. REV. 218, 232 ("The elucidation of clear guidelines which focus on the best interests of the particular child" used by the full court in *P & P* is "preferable to the Family Law Council's recommendation that proscriptive rules be imposed.").

> interests of others. That approach furnishes no general guidance as to the factors which are relevant to the welfare of the child. [35]

III. SOUTH AFRICAN LAW

A. Children's Act 38 of 2005

In South Africa, the Children's Act 38 of 2005 ("Children's Act")[36]—hailed by some as the most progressive and comprehensive child law in Africa—contains a list of factors that should be taken into consideration when the best interests standard is applied.[37] This list includes factors such as the capacity of parents to provide for the emotional and intellectual needs of children, the need to protect the child from physical or psychological harm, any disability that a child may have, the child's intellectual, emotional, social, and cultural development, and many others.[38] The list is presented in a way that indicates factors that may have a bearing on a child's best interests. However, it provides no blueprint for determining such interests in a particular case, such as one involving the question of whether sterilization should be performed on a child with disabilities where the child does not have the ability to give consent.

The Children's Act provides the primary legal framework for the realization of every child's constitutional rights in South Africa, including the

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[35] *Marion's Case*, 175 CLR at 273–74 (Brennan, J., dissenting). The majority also notes that "the overriding criterion" of the child's best interests is itself a limit on parental power. *Id.* at 240 (majority opinion).

[36] Children's Act 38 of 2005 (S. Afr.). Some sections of the Children's Act, mainly those dealing with key child care and protection principles that do not require regulations to become operational, entered into force on July 1, 2007. Thalia Kruger, *Entry into Force of Parts of the Children's Act in South Africa*, CONFLICTOFLAWS.NET (Aug. 14, 2007), http://conflictoflaws.net/2007/age-of-majority-now-18-in-south-african-law. The remainder of the act entered into force on April 1, 2010. PRINSLEAN MAHERY, PAULA PROUDLOCK & LUCY JAMIESON, A GUIDE TO THE CHILDREN'S ACT FOR HEALTH PROFESSIONALS 3 (4th ed. 2010).

[37] Children's Act 38 of 2005 ch. 2, § 7(1) (S. Afr.). A similar list has been included in Namibia's as yet un-enacted Draft Child Care and Protection Act, as well as in Zanzibar's draft Children's Act. Draft Child Care and Protection Bill of 2009, http://www.lac.org.na/ccpa.html (Namib.); Shane Keenan, *Children's Act Provides New Tools for Protecting Child Rights in Zanzibar*, UNICEF, http://www.unicef.org/infobycountry/tanzania_59658.html (last visited Mar. 24, 2012).

[38] Children's Act 38 of 2005 ch. 2, § 7(1) (S. Afr.). Interestingly, the South African Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 seems to equate the position of mentally disabled persons in the sphere of sexual offenses against such persons, irrespective of age, to that of children. Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 §§ 23–26, 17–20 (S. Afr.). Sections 23–26 of the act, dealing with offenses against mentally disabled persons, mirror the provisions of Sections 17–20, dealing with offenses against children. *Id.*

principle that the best interests of a particular child are of "paramount importance in every matter concerning that child."[39] From the commencement of the Law Commission's endeavor to develop a new model for a children's code for South Africa, it was agreed that mention would be made of "children in especially difficult circumstances," such as children with disabilities.[40] Thus, it is an explicit objective of the act to recognize the special needs of children with disabilities.[41] It is therefore not surprising that the rights of children with disabilities are addressed upfront in Chapter 2 under the General Principles of the act.

The Children's Act dictates an approach upholding the basic principle of nondiscrimination. It therefore states unequivocally that a child must be protected "from unfair discrimination on any ground, including on the grounds of . . . the disability of the child or a family member."[42] Children with disabilities are extremely vulnerable and are particularly in need of an enabling environment due to the special needs they might have. The Children's Act mandates the creation of such an "enabling environment" to accommodate the "special needs" of children with disabilities.[43]

One section in the Children's Act is in toto dedicated to the rights of disabled children and children with chronic illnesses.[44] It provides for the provision of appropriate "parental care, family care or special care" for children with disabilities,[45] and places an obligation on the community to

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[39] *See* S. AFR. CONST., 1996 art. 28, cl. 2; Children's Act 38 of 2005 ch. 2, § 9 (S. Afr.). All references to sections will be to that of the Children's Act unless stated otherwise.

[40] SA Law Commission Issue Paper 13 The Review of the Child Care Act (Apr. 18, 1998) (S. Afr.) §§ 2.6, 4.2.6–4.2.7. This report is in line with Rule 15(3)(b) of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities (adopted by the UN General Assembly December 20, 1993), which provides for a duty on the state to create a legal basis aimed at achieving the objectives of full participation and equality. Standard Rules on the Equalization of Opportunities for Persons with Disabilities, G.A. Res. 48/96, Annex, U.N. Doc. A/RES/48/96, § 15 (Dec. 20, 1993). Disability matters pertaining to children have to be dealt with within mainstream legislation. *Id.*

[41] Children's Act 38 of 2005 ch. 2, § 2(h).

[42] *Id.* ch.2, § 6(2)(d).

[43] *Id.* ch 2, § 6(2)(f).

[44] *Id.* ch. 2, § 11.

[45] *Id.* ch. 2, § 11(1)(a). However, see *Ctr. for Child Law v. MEC Health & Soc. Dev., Gauteng* 2010 Case No. 37850/2010 (North Gauteng High Court) (unreported case) (on file with author), for an application to appoint a curator ad litem for a fifteen-year-old boy with psychiatric problems, attention deficit hyperactivity disorder, dysthymic disorder, severe mental retardation, and an abnormal EEG (electroencephalogram) for whom no suitable accommodation could be found after Weskoppies Hospital refused to admit him into their care as a mental health care user. *See* Trynie Boezaart & Ann Skelton, *From Pillar to Post: Legal Solutions for Children with Debilitating Conduct Disorder*, *in* ASPECTS OF DISABILITY LAW IN AFRICA 107–32 (Ilze

accept the participation of disabled children in "social, cultural, religious and educational activities, recognising the special needs that the child may have."[46] It also makes it obligatory to provide "the child and the child's care-giver with the necessary support services."[47] Most importantly, this section also makes it compulsory to provide "the child with conditions that ensure dignity . . . and facilitate active participation in the community."[48] Besides the right to life, the right to dignity is perhaps the most basic of all fundamental rights and one of the rights implicated when disabled children are subjected to sterilisation procedures. In this context, the last subsection of Section 11 of the Children's Act[49] becomes of utmost importance because it provides that "a child with a disability . . . has the right *not* to be subjected to *medical*, social, cultural or religious practices that are detrimental to his or her health, well-being or dignity."[50]

B. The Sterilisation Act 44 of 1998[51]

However, the Children's Act does not address children's nonconsensual sterilization. In South Africa, this is dealt with in the Sterilisation Act 44 of 1998 (the "Sterilisation Act").[52] In terms of this act, a person under the age of eighteen may only be sterilized if "failure to so would jeopardize the person's

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Grobbelaar-du Plessis & Tom Van Reenen eds., 2011) (discussing this case and how the legal system failed the children involved).

[46] Children's Act 38 of 2005 ch. 2, § 11(1)(b). However, see *W. Cape Forum for Intellectual Disability v. Gov't of the Republic of S. Africa* 2007 (5) SA 1 (WCC) (S. Afr.), on the lack of educational facilities for children with severe and profound intellectual disabilities.

[47] Children's Act 38 of 2005 ch. 2, § 11(1)(d) (S. Afr.). However, research studies in Gauteng and Mpumalanga revealed that more than fifty percent of children who are eligible for care dependency grants do not receive them. DEP'T OF SOC. DEV., INTEGRATED NATIONAL STRATEGY ON SUPPORT SERVICES TO CHILDREN WITH DISABILITIES 37 (2009), *available at* http://www.hsrc.ac.za/module-KTree-doc_request-docid-1672.phtml; *see also supra* notes 24–25 and accompanying text.

[48] Children's Act 38 of 2005 ch. 2, § 11(1)(c). See also *id.* ch. 2, § 10 (child participation) and § 13(2), which elucidate that information on health care, provided to children in terms of Section 13, "must be relevant and must be in a format accessible to children, giving due consideration to the needs of disabled children."

[49] Children's Act 38 of 2005 ch. 2, § 11(3).

[50] *Id.* (emphasis added); *see also* LUCY JAMIESON & PAULA PROUDLOCK, CHILDREN'S INST., FROM SIDELINES TO CENTRE STAGE: THE INCLUSION OF CHILDREN WITH DISABILITIES IN THE CHILDREN'S ACT 43 (2009).

[51] The Author adheres to the spelling of "sterilisation" as it is in the Sterilisation Act.

[52] Sterilisation Act 44 of 1998 (S. Afr.). It is interesting to note that legislation on the matter found favor after the Canadian case, *Re Eve*, [1986] 2 S.C.R. 388 (Can.); Dwight Newman, *An Examination of Saskatchewan Law on the Sterilization of Persons with Mental Disabilities*, 62 SASK. L. REV. 329, 340 (1999). However, the matter was left at the judicial level. *Id.* at 344. *See also* Amy Spady, *The Sexual Freedom of Eve: A Recommendation for Contraceptive Sterilization Legislation in the Canadian Post Re* Eve *Context*, 25 WINDSOR REV. LEGAL & SOC. ISSUES 33, 57–66 (2008).

life or seriously impair his or her health."[53] In this case, sterilization may be performed only with the consent of a person who is lawfully entitled to give consent (that is, the parent or guardian) and with a written opinion by an independent medical practitioner that the sterilization is in the best interest of the child.[54] The desirability of the sterilization must also be evaluated by a panel consisting of a psychiatrist (or a medical practitioner if a psychiatrist is not available), a psychologist or social worker, and a nurse.[55]

The Sterilisation Act also contains specific provisions regarding the sterilization of a person incapable of consenting, or incompetent to consent, due to mental disability.[56] In these cases, the sterilization may be performed only with the consent of the person's parents, spouse (or civil union partner),[57] guardian, or curator.[58] As in the case of children, the desirability of the sterilization must be evaluated by a panel consisting of a psychiatrist (or a medical practitioner if no psychiatrist is available), a psychologist or a social worker, and a nurse.[59]

The panel has to consider all relevant information, including:

(1) the person's age;

(2) whether there are other safe and effective alternatives to sterilization;

(3) the person's mental and physical health and well-being;

(4) the potential effect of sterilization on the persons health and well-being;

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53 Sterilisation Act 44 of 1998 § 2(3)(a).

54 *Id.* §§ (3)(1)–(2).

55 *Id.* § 3(2); *see also* § 2(3)(b). See BOBERG'S LAW OF PERSONS AND THE FAMILY 47 n.41 (Van Heerden et al. eds., 2d ed.1999), in connection with the lack of clarity in the act with regard to the precise function of the panel when the person is under the age of eighteen (explaining that, while the function is described in respect to people incapable of consenting, the same is not done in relation to people under eighteen). The editors suggest that the root of the problem is in the cross-referencing and suggests that clarity is required in this regard. *Id.*

56 Sterilisation Act 44 of 1998 § 3. Section 3(7) of the Sterilisation Act defines "severe mental disability" as "a range of functioning extending from partial self-maintenance under close supervision, together with limited self-protection skills in a controlled environment through limited self care and requiring constant aid and supervision, to severely restrained sensory and motor functioning and requiring nursing care." *Id.* § 3(7).

57 Civil Union Act 17 of 2006 § 13(2) (S. Afr.) (defining a marriage to include a civil union).

58 Sterilisation Act 44 of 1998 §§ 2(3)(b), 3(1)(a).

59 *Id.* §§ 2(3)(b), 3(1)(b), 3(2).

(5) the nature of the sterilization procedure to be performed;

(6) the likelihood that the person will become capable of consenting to sterilization;

(7) whether the sterilization is in the best interest of the person to be sterilized; and

(8) the benefit that the person may derive from sterilization.[60]

If the person is incapable of consenting, or is incompetent to consent owing to a mental disability, the sterilization may be performed only if he or she is incapable of: "(i) making his or her own decision about contraception or sterilization; (ii) developing mentally to a sufficient degree to make an informed judgement about contraception or sterilization; and (iii) fulfilling the parental responsibility associated with giving birth."[61]

In essence, South African law requires parental consent and a panel decision. In the case of children, there is one additional requirement, namely that an independent medical practitioner has to provide a written opinion to the effect that the sterilization is in the best interests of the child. His or her opinion is neither tested in a court of law nor guided by precedent, and no curator ad litem[62] is appointed to present any other view.

IV. INTERNATIONAL LAW

Angela's Case has been criticized for contravening the Convention on the Rights of Persons with Disabilities.[63] The CRPD[64] represents an international response to the long history of discrimination, exclusion, and dehumanization of persons with disabilities.[65] Although the CRPD applies to all persons with

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[60] *See id.* pmbl. § 3(1)(b).

[61] *Id.* § 3(1)(c). The person performing the sterilization must ensure that the method of sterilization used holds the least health risk to the person on whom sterilization is to be performed. *Id.* § 3(5). The sterilization of a person incapable of consenting may be performed only at a designated institution. *Id.* § 5(1).

[62] Nor is an independent children's lawyer or representative appointed to give the child a voice. *See supra* note 5.

[63] *See supra* notes 24–25 and accompanying text.

[64] The CRPD was adopted on December 13, 2006, and opened for signature on March 30, 2007. *Convention on the Rights of Persons with Disabilities*, UNITED NATIONS ENABLE, http://www.un.org/disabilities/default.asp?id=150 (last visited Mar. 30, 2012).

[65] It replaced the Standard Rules on the Equalization of Opportunities for Person's with Disabilities of 1993.

disabilities,[66] including children, the rights and protection of children with disabilities are specifically emphasized in various parts of the convention. The preamble, for instance, recognizes that children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children, while incorporating in Article 3, as a substantive principle, "[r]espect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities."[67] Article 7 is solely devoted to children and places additional obligations on state parties in the following terms:

> 2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
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> 3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.[68]

A range of other obligations are also imposed on state parties respecting children with disabilities, such as the adoption of "child-focused legislation and policies,"[69] the right of children to "be cared for by their parents,"[70] that children have "equal rights with respect to family life" and are not "separated from [their] parents against their will,"[71] ensuring that children are not "excluded from free and compulsory primary education" and that education is delivered "in the most appropriate languages and . . . means of communication,"[72] providing health services to children to "minimize and prevent further disabilities,"[73] and ensuring that children have equal access as other children to participation in recreation, leisure, and sporting activities.[74]

In addition to these rights, the rights of *girl* children with disabilities receive special emphasis in the preamble (which recognizes that "girls with

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[66] Article 1 of the CRPD denotes persons with disabilities as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." CRPD, *supra* note 25, art. 1.

[67] *Id.* pmbl., art. 3(h).

[68] *Id.* art. 7.

[69] *Id.* art. 16(5).

[70] *Id.* art. 18(2).

[71] *Id.* arts. 23(3)–(4).

[72] *Id.* arts. 24(2)(a)–(3)(c).

[73] *Id.* art. 25(b).

[74] *Id.* art. 30.

disabilities are often at greater risk, both within and outside the home of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation");[75] in Article 6 (requiring state parties to "recognize that . . . girls with disabilities are subject to multiple discrimination" and to "take measures to ensure the full and equal enjoyment by them of all human rights and fundamental freedoms");[76] and in Article 28 (an obligation "to ensure access by [girls] with disabilities . . . to social protection programmes and poverty reduction programmes").[77]

The principle of "[r]espect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons"[78] is inter alia augmented by the rights conferred on children with disabilities to

(1) have their best interests considered as a primary consideration;[79]

(2) respect for their "physical and mental integrity on an equal basis with others";[80] and

(3) "retain their fertility on an equal basis with others."[81]

The 1989 United Nations Convention on the Rights of the Child ("CRC")[82] was the first human rights treaty explicitly prohibiting discrimination against children on the basis of disability, thus affording children with disabilities all the other rights that children without disabilities are entitled to.[83] Some of these

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[75] *Id.* pmbl; *see also* Katarina Tomaševski, *Women's Rights*, *in* HUMAN RIGHTS: CONCEPT AND STANDARDS 231, 247 (Janusz Symonides ed., 2000) (discussing special protection for female children).

[76] CRPD, *supra* note 25, art. 6(1).

[77] *Id.* art. 28(2)(b).

[78] *Id.* art. 3(a).

[79] *Id.* art. 7(2).

[80] *Id.* art 17.

[81] *Id.* art. 23(1)(c).

[82] Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 3 (entered into force Sept. 20, 1990) [hereinafter CRC].

[83] *Id.* art. 2(1); General Comment No. 9: The Rights of Children with Disabilities, ¶ 2, U.N. Doc. CRC/C/GC/9 (Feb. 27, 2007) [hereinafter General Comment No. 9]; *see also* GERALDINE VAN BUEREN, THE INTERNATIONAL LAW ON THE RIGHTS OF THE CHILD 40 (1998). Van Bueren states that Article 2, Section 1, of the CRC prohibits discrimination "between adults and children and between different groups of children." VAN BUEREN, *supra*, at 40; *cf.* BRUCE ABRAMSON, ARTICLE 2: THE RIGHT OF NON-DISCRIMINATION: A COMMENTARY ON THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD 119–26 (2008); RACHEL HODGKIN & PETER NEWELL, IMPLEMENTATION HANDBOOK FOR THE CONVENTION ON THE RIGHTS OF THE CHILD 294 (2007).

"general rights" that are important in this context are inherent dignity,[84] the best interests standard,[85] access to services and facilities for care or protection,[86] life and development,[87] participation,[88] "appropriate assistance to parents and legal guardians,"[89] and education.[90] Over and above these general rights, Article 23 is specifically dedicated to the rights of children with disabilities.[91] The core message of this article is that children with disabilities have the right to enjoy a full life, and to access to special care and assistance to realize this objective.[92] They need special care and require state parties to ensure the extension of assistance in this regard.[93] "[C]hildren with disabilities should be included in . . . society."[94]

V. AUSTRALIAN LAW

Australia has ratified both the CRPD[95] and the CRC.[96] Neither has been incorporated into Australian law; however, many of the provisions of the

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84 CRC, *supra* note 82, pmbl.

85 *Id.* art. 3(1) ("[T]he best interests of the child shall be a primary consideration.").

86 *Id.* art. 3(3).

87 *Id.* art. 6(1).

88 *Id.* art. 12.

89 *Id.* art. 18(2).

90 *Id.* art. 28.

91 *Id.* art. 23. "The notion that positive measures should be taken to ensure that disabled children are integrated into the community, and thus made to feel as though they are full members, always enjoyed broad-based support." LAWRENCE. J. LEBLANC, THE CONVENTION ON THE RIGHTS OF THE CHILD: UNITED NATIONS LAWMAKING ON HUMAN RIGHTS 102 (1995).

92 *See* General Comment No. 9, *supra* note 83, ¶ 11.

93 *Id.*

94 *Id.* For a more detailed exposition of the international law pertaining to children with disabilities in Africa, see Trynie Boezaart, *The Children's Act: A Valuable Tool in Realising the Rights of Children with Disabilities* 74 TYDSKRIF VIR HEDENDAAGSE ROMEINS-HOLANDSE REG. (J. CONTEMP. ROMAN–DUTCH L.) 264, 265–71 (2011).

95 Australia ratified the CRPD on July 17, 2008. *Convention and Optional Protocol Signatures and Ratifications: Countries and Regional Integration Organizations*, UNITED NATIONS ENABLE, http://www.un.org/disabilities/countries.asp?id=166 (last visited Mar. 30, 2012).

96 Australia ratified the CRC on December 17, 1990. *Convention on the Rights of the Child*, UNITED NATIONS TREATY COLLECTION, http://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en (last visited Mar. 30, 2012). Australia has also ratified many other human rights instruments that oblige state parties to recognize the innate human right of disabled women to reproductive freedom, such as the International Covenant on Civil and Political Rights and the Universal Declaration on Human Rights. *See* International Covenant on Civil and Political Rights art. 23, *opened for signature* Dec. 19, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976); Universal Declaration of Human Rights art. 16, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948); *International Covenant on Civil and Political Rights*, UNITED NATIONS TREATY COLLECTION, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-4&chapter=4&lang=en (last visited Mar. 30, 2012); *Australia and the Universal*

CRPD are mirrored in the Disability Discrimination Act 1992.[97] In Australia, states and territories govern child protection matters.[98] Although Australia does not have a Bill of Rights, many of the basic values resonate in federal legislation,[99] such as Section 11(2) of the Human Rights Act 2004,[100] which provides that "[e]very child has the right to the protection needed by the child because of being a child, without distinction or discrimination of any kind,"[101] and in legislation of territories, such as the Charter of Human Rights and Responsibilities Act 2006.[102]

As is the case with the CRPD, many of the provisions of the CRC are also reflected in legislation.[103] When it comes to legislation dealing with sterilization of nonconsenting people, all the states have laws in place dealing with adults, but very few states have legislation relating to children.[104] In these

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Declaration on Human Rights, AUSTRALIAN HUM. RTS. COMMISSION, http://www.hreoc.gov.au/human_rights/UDHR/Australia_UDHR.html (last visited Mar. 30, 2012).

97 *Disability Discrimination Act 1992* (Cth) (Austl.).

98 Leah Bromfield & Daryl Higgins, *National Comparison of Child Protection Systems*, CHILD ABUSE PREVENTION ISSUES, Autumn 2005, at 1, 1, *available at* http://www.aifs.gov.au/nch/pubs/issues/issues22/issues22.pdf. ("As a federation of states and territories that each has responsibility for their own health and welfare issues, Australia does not have one unified system, but rather eight different child protection systems.").

99 *Protecting All Human Rights in Australia!*, 5 JUSTCOMMENT, no. 6, 2002, at 1, 1–2, *available at* http://www.erc.org.au/just_comments/pdf/1040270425.pdf.

100 *Human Rights Act 2004* (ACT) (Austl.), *available at* www.legislation.act.gov.au/a/2004-5/current/pdf/2004-5.pdf.

101 *Id.* s 11(2).

102 *See Charter of Human Rights and Responsibilities Act 2006* (Vic) ss 1, 10, 17 (Austl.), *available at* http://www.opi.vic.gov.au/file.php?251.

103 *See, e.g.*, *Family Law Act 1975* (Cth) ss 60CA, 60CB, 60CC (Austl.), http://www.austlii.edu.au/au/legis/cth/consol_act/fla1975114 (discussing the best interests of the child); *see also id.* s 60CD (discussing the views of the child); *id.* ss 68L, 68LA (discussing independent representation of the child's interests). The Children and Young Persons Act 2008 similarly discusses the paramount importance of the best interests. *Children and Young Persons Act 2008* (ACT) ss 8–9 (Austl.), *available at* http://www.legislation.gov.uk/ukpga/2008/23/pdfs/ukpga_20080023_en.pdf.

104 The states with legislation regarding sterilization of children are New South Wales, South Australia, and Queensland. Melanie Fellowes, *Australia's Recommendations for the Sterilisation of the Mentally Incapacitated Minor—A More Rigorous Approach?*, 2 WEB J. CURRENT LEGAL ISSUES (2000), http://webjcli.ncl.ac.uk/2000/issue2/fellowes2.html. "In New South Wales the age of the child will determine which statute governs" the envisaged sterilization. *Id.* In terms of the Children and Young Persons (Care and Protection) Act 1998, sterilization is regarded as a "special medical treatment" and can only be performed on a child under the age of sixteen with the consent of a Guardianship Tribunal. *Children and Young Persons (Care and Protection) Act 1998* (NSW) s 175 (Austl.), http://www.austlii.edu.au/au/legis/nsw/consol_act/caypapa1998442. If the child is over sixteen, the Guardianship Act 1987 applies, but once again the consent of the Guardianship Tribunal is necessary. *Guardianship Act 1987* (NSW) ss 34, 45 (Austl.), http://www.austlii.edu.au/au/legis/nsw/consol_act/ga1987136. In South Australia, the Guardianship and Administration Act 1993 applies. *Guardianship and Administration Act 1993* (S. Austl.), http://www.austlii.edu.au/au/legis/sa/consol_act/gaaa1993304. Sterilization is included in the term "prescribed treatment," *id.* s 3(1), and can only be

states, there are therefore two possible routes when applying for sterilization: either state legislation or use of the Family Law Act 1975.[105]

In both *Marion's Case* and *Angela's Case*, the applicant chose the Family Law Act 1975 route.[106] This act is effective in all the territories of Australia.[107] It confers jurisdiction on the Family Court[108] in matters relating to children.[109] It also vests the guardian with the responsibilities and rights for the welfare and decision-making regarding the child,[110] although the court retains the power to vary the decisions of a guardian.[111] These legislative provisions form the basis of the Family Court's jurisdiction to authorize sterilization. However, the court has no power under the act to enlarge the powers of the guardian so that he or she can consent to the sterilization of a child,[112] because the decision to sterilize a child with mental disabilities falls outside the ordinary scope of the guardians' responsibilities and rights as envisaged in the act.

It is noteworthy that there have been reports and recommendations in Australia condemning the current position.[113] Furthermore, there is a body of

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performed on individuals incapable of granting consent with the permission of the South Australian Guardianship Board, *id.* s 61. In Queensland, the Guardianship and Administration Act 2000 applies. *Guardianship and Administration Act 2000* (Qld) (Austl.), *available at* http://www.legislation.qld.gov.au/legisltn/current/g/guardadmina00.pdf. The consent of the Queensland Civil and Administrative Tribunal is required, and this tribunal may only grant consent "if the tribunal is satisfied the sterilisation is in the best interests of the child." *Id.* s 80C(1). Section 80D provides guidance when considering whether sterilization is in a child's best interests. *Id.* s 80(D). Section 80D(4) provides for the child's views and wishes to be expressed, *id.* s 80(D)(4), and Section 80L provides that a child representative *must* be appointed, *id.* s 80(L). For the position in Tasmania, see the Guardianship and Administration Act 1995, which requires the consent of the Guardianship and Administration Board. *Guardianship and Administration Act 1995* (Tas) s 46 (Austl.), http://www.austlii.edu.au/au/legis/tas/consol_act/gaaa1995304.txt.

105 *Family Law Act 1975* (Cth) (Austl.).

106 *See Re Angela* [2010] FamCA 98, para. 6 (Austl.); *Sec'y, Dep't of Health & Cmty. Servs. v JWB* (*Marion's Case*) (1992) 175 CLR 218, 265–68, 277 (Austl.).

107 *Family Law Act 1975* s 69ZG.

108 *Id.* s 31(1). The Family Law Act 1975 has been superseded many times since *Marion's Case*. *See id.* ss 31(1), 69H(1) (granting jurisdiction for any matter under the act).

109 *Id.* ss 60A–70Q.

110 *Id.* s 66(F).

111 *Id.* s 66(G).

112 *Id.* 69Z(2).

113 *Children with Intellectual Disabilities (Regulation of Sterilisation) Bill* 2006 (WA) (Austl.); FAMILY LAW COUNCIL, STERILISATION AND OTHER SPECIAL MEDICAL PROCEDURES FOR CHILDREN (1994); Fellowes, *supra* note 104 (discussing the recommendation that the Family Court of Australia should have exclusive jurisdiction and "that only specially trained judges should hear such applications"); R Martin & C Butler, *Sterilisation of People with Intellectual Disability*, (Intellectual Disability Servs. Council, Discussion Paper, 1997); Non-therapeutic Sterilisation of Minors with a Decision-Making Disability (Standing Comm. of Attorneys Gen., Issues Paper, 2004), http://www.wwda.org.au/scagpap1.htm; The Development of Legislation

case law in other jurisdictions that cannot be ignored.[114] These issues are most important when the positions in Australia and many other jurisdictions are compared with South African law.

VI. NO ANGELA, MARION, JEANETTE, OR EVE IN SOUTH AFRICA?

South Africa follows a dualistic system whereby international law has to be incorporated into national law before taking effect in any given case.[115] South Africa has as yet not incorporated the CRPD into national law.[116] However, the Children's Act professes to have done so with the CRC.[117]

To Authorise Procedures for the Sterilisation of Children with Intellectual Disabilities ¶ 5 (Women with Disabilities Austl., Policy & Position Paper, 2007), http://www.wwda.org.au/polpapster07.htm.

[114] English case law provides landmark decisions in this regard. In *In Re D (A Minor) (Wardship: Sterilisation)* [1976] Fam. 185 (Eng.), the court distinguished between therapeutic and non-therapeutic sterilizations. *See also Sec'y, Dep't of Health & Cmty. Servs. v JWB* (1992) 175 CLR 218, 269 (Austl.). "If pregnancy and childbirth can foreseeably cause serious injury to the girl then it is therapeutic." Kenneth McK Norrie, *Sterilisation of the Mentally Disabled in English and Canadian Law*, 38 INT'L & COMP. L.Q. 387, 390 (1989). In *In Re D*, the girl was eleven years old, and the mother and doctor decided on sterilization. [1976] Fam. at 187–88, 190–191, 194G. It was the consultant educational psychiatrist at the specialist school D attended that was opposed to the procedure. *Id.* at 189, 191–92. Thus D became a ward of court and a guardian ad litem was appointed. *Id.* at 192–94. The Official Solicitor was appointed as such in this case. *Id.* at 192. DIMOPOULOS, *supra* note 25, at 114, indicates that this judgment is in line with current developments in human rights law. He points out how the judgment evaluated the medical evidence in the light of the possibility of D getting married, or developing in maturity and understanding to be able to make informed choices regarding sterilization. *Id.* The judgment also made reference to a woman's basic right to reproduce, and her physical and mental condition allowing her the use of other contraceptives. *In Re D* [1976] Fam. at 195–96. See *In re D* for a discussion by Judge Heilbron explaining that nonconsensual, nontherapeutic sterilization violates a woman's basic right to reproduce. *Id.* at 193. In the case of *In Re S (Adult Patient: Sterilisation: Patient's Best Interests)*, the court was outspoken on the fact that the court, and not doctors, should have the final say in establishing whether sterilization is in the best interests of the person involved. [2001] Fam 15, 27–28 (Eng.). The court indicated that best interests include, in addition to medical considerations, also ethical, social, moral, and welfare considerations. *Id.* at 28. *See also In Re* B (A Minor) (Wardship: Sterilisation) [1988] 1 A.C. 199, 200. *Cf.* Rioux & Patton, *supra* note 26, at 243–71. On the difference of the Canadian and English approach resulting from *Re Eve* and *In Re B*, see Robert. S. Williams, *Pediatric Research and the* Parens Patriae *Jurisdiction in Canada and England*, 18 MED. & L. 525, 528 (1999). Additionally, see *Gillick v. W. Norfolk & Wisbech Area Health Auth.* [1986] 1 A.C. 112 (Eng.), on a child's right to seek contraceptive advice and treatment contrary to the parents' views and convictions. *See also* Children's Act 38 of 2005 § 134 (S. Afr.) (providing children with access to contraceptives). For a discussion on the application of the *Gillick* test to investigate the competence of the child in sterilization decision-making, see Melinda Jones & Le Ann Basser Marks, *Approaching Law and Disability*, 17 L. CONTEXT, no. 2, 2000, at 1, 5–6.

[115] Chrisje Brants & Stijn Franken, *The Protection of Fundamental Human Rights in Criminal Process*, 5 UTRECHT L. REV., no. 2, 2009 at 7, 9, 14.

[116] Tobias Pieter Van Reenen & Helene Combrinck, *The UN Convention on the Rights of Persons with Disabilities in Africa: Progress After 5 Years*, 8 SUR INT'L J. ON HUM. RTS., no. 14, 2012 at 133, *available at* http://www.surjournal.org/eng/conteudos/pdf/14/07.pdf.

[117] *Child Rights*, UNICEF, http://www.unicef.org/botswana/6705.html (last visited Mar. 31, 2012).

Sadly, the South African model for nonconsensual sterilization of children and female adolescents with disabilities does not comply with the directives of the CRC. It even ignores the four core principles of the CRC, which are nondiscrimination; the best interests of the child; the right to life, survival, and development; and respect for the child's views.[118]

In addition, the South African model for the nonconsensual sterilization of children with disabilities does not comply with the provisions of the Children's Act.[119] It is suggested that the procedures provided for in the Sterilisation Act 44 of 1998 concerning children will have to be revisited in light of these provisions and universally accepted human rights standards.

It is evident that South Africa lags far behind the rest of the world on the issue of nonconsensual therapeutic sterilization of children with disabilities. What does South Africa's position on this matter have to say for children as rights-bearers; or for the fact that children should be participants, to the extent of their capacity, in decisions affecting them?[120] In South Africa, it is left to parents to decide, and the medical professional to apply, the best interests standard. Medical professionals should not make the decision to sterilize a child because the consequences of sterilization are not merely medical, but at least also social and psychological.[121] However, parents should not make the decision either: not only are the best interests of the child at stake, but also the independent and possibly conflicting interests of the parents and other family members.[122] South Africa should follow global trends concerning the reproductive rights of children with disabilities that provides for independent judicial scrutiny.[123] Court involvement ensures, in the case of conflict, that the child's interests prevail.[124] The sterilization decision should be removed from the private realm of the medical practitioner and the family. The sterilization decision should be placed in the public arena under judicial scrutiny.

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118 *Convention on the Rights of the Child*, UNICEF, http://www.unicef.org/crc (last visited Mar. 31, 2012).

119 *See generally* 12 ESR REV.: ECON. & SOC. RTS. S. AFR., no. 3, 2011 at 1, *available at* http://www.communitylawcentre.org.za/clc-projects/socio-economic-rights/esr-review-1/previous-editions/ESR_Review12_3.pdf.

120 *See* Jones & Basser Marks, *supra* note 13, at 149–50 (stating that *Marion's Case* reflected a commitment made by Australia to promote children's rights).

121 *Sec'y, Dep't of Health & Cmty. Servs. v JWB* (*Marion's Case*) (1992) 175 CLR 218, 251 (Austl.).

122 *Id.*

123 *In re* Grady, 426 A. 2d 467, 475 (N.J. 1981); *see also* Mary Donelly, *Non-consensual Sterilisation of Mentally Disabled People: The Law in Ireland*, 32 IRISH JURIST 297, 320 (1997).

124 *Marion's Case*, 175 CLR at 252.