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INFORMED CONSENT IN THE PROVISION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES TO ADOLESCENTS IN UGANDA

Advocacy for Policy Reform

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EXECUTIVE SUMMARY

Adolescents in Uganda face a number of challenges related to sexual and reproductive health rights (SRHR). They start having sexual intercourse at a young age, which results in early and unintended pregnancies, early and forced marriages, unsafe abortions, sexually transmitted infections (STIs) and HIV, ill health, dropping out of school, disability and even death. Adolescents need information on their sexuality and STIs, family planning and counselling services, contraceptives, HIV prevention and care services, maternal health services for adolescent mothers, post-abortion care, psychosocial support and other services, in order to smoothly transition to adulthood.

While many laws prescribe 18 as the age of majority (adulthood) the age at which an individual is presumed to have the capacity to consent — adolescents begin to demand for SRH services much earlier (that is, from the stage of puberty). The legal, policy and ethical frameworks regarding adolescents' consent to medical treatment generally and to SRHR information, services and commodities in particular, is not clear. It is possible that it is being applied by service providers, law enforcers and professional medical councils in a manner that does not promote access to SRHR services by young people.

Objective

The objective of this paper was to review the legal, policy and ethical frameworks on informed consent to medical treatment and assess their application in the provision of SRHR information, services and other commodities to adolescents.

Methodology

This assessment was designed as a qualitative process, relying mostly on a desk review of the laws, policies and codes of ethics relating to informed consent to medical treatment and how it applies to adolescents seeking sexual and reproductive health (SRH) services. This was supplemented by primary data from a rapid appraisal using personal interviews with policy makers, representatives of professional councils, service providers, young people and civil society.

Key emerging issues

1. There are inconsistencies in the laws in as far as the legal age of consent on different aspects such as age of majority, marriage, mature minors, gainful employment, above tender years, legal responsibility, HIV testing and counseling, HIV treatment, and assent, are concerned.
2. The policy is more progressive on the issue of informed consent to SRHR information and services than the law. For instance, SRHR policies and guidelines allow adolescents to access SRHR services and information without parental consent, and also emphasize confidentiality and privacy.
3. The legal and ethical duties of health service providers to disclose information to their patients is far from settled, as the Patients' Charter allows the practitioner to withhold information on diagnosis that they deem may harm the patient emotionally or physically.
4. In the provision of SRHR, the capacity to consent of adolescents can be assessed on the basis of age, but more importantly on the basis of maturity, in line with the concept of evolving capacities of the child.
5. Confidentiality and privacy are critical in the provision of SRHR information and services to adolescents.

RECOMMENDATIONS:

To Policy Makers

1. Harmonize laws and policies on informed consent for SRHR services to adolescents to improve access.
2. Provide a guidance document on the administration of informed consent to young people of different ages and for different SRHR services.
3. Develop criteria to guide service providers assess capacity to consent, considering all relevant parameters beyond that of the age of the client.

To Service Providers

4. Service providers that take on tasks outside their formal training should be trained in administration of informed consent in their new tasks.
5. The basic elements of informed consent should be defined for all SRHR services, and riskier procedures should have more rigorous processes.
6. Service providers should encourage parents to talk to their children about matters relating to their sexuality, including sex, and counsel them accordingly.

To Uganda Law Reform Commission

7. Train service providers on the concept of informed consent and its application in the provision of SRHR services to adolescents.
8. Revise existing laws on access to SRHR services to clarify how informed consent should be obtained from adolescents.

ABBREVIATIONS

AGYW	Adolescent Girls and Young Women
BCC	Behavioral Change Communication
CEHURD	Center for Health, Human Rights and Development
COC	Combined Oral Contraceptives
CRC	Convention on the Rights of the Child
GBV	Gender-Based Violence
GUSO	Get Up Speak Out
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
POP	Progesterone Only Pill
RAHU	Reach a Hand Uganda
REC	Research Ethics Committee
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UDHR	Universal Declaration of Human Rights
ULRC	Uganda Law Reform Commission
UMDPC	Uganda Medical and Dental Practitioners Council

DEFINITION OF KEY TERMS

Adolescent: A person in a stage of growth in which they are transitioning from childhood to adulthood. It is a phase in which an individual is no longer a child and not yet an adult.¹ According to the World Health Organization (WHO), an adolescent is a person between 10 and 19 years of age. During this stage, a person undergoes transition in physical and psychological development from puberty to adulthood.

Puberty: The period of life when a child transforms into an adult and becomes capable of sexual reproduction. On average, puberty in girls usually begins between 10-11 years and ends between 15-17 years. For boys, it starts between 11-12 years and ends between 16-17 years. The main sign of puberty in girls is the first menstruation, while in boys it is the first ejaculation.

Adolescent sexual and reproductive health: Adolescents achieve sexual and reproductive health (SRH) when they make a smooth transition to adulthood. However, many of them suffer sexual and reproductive ill-health or death when they experience sexual and gender-based violence (SGBV), including sexual coercion (defilement/rape). They may become pregnant at a nearly age, leading to unsafe abortion or to complications during childbirth and related undesirable health outcomes. They may get sexually transmitted infections (STIs) (such as HIV), life-long injuries (such as obstetric fistula), or debilitating or fatal mental ill-health (such as drug abuse and suicide).

Adolescent friendly services: Adolescents of different categories and from different parts of the world identify two priorities: 1) treatment with respect; and 2) protection of their confidentiality.² Health services, and especially SRH services targeting adolescents, should ideally meet these conditions for them to be considered adolescent friendly. For adolescents to easily access the health services they need, service providers should be non-judgmental and considerate in their dealings with this group of young people. They should have the competencies needed to deliver the appropriate health services in the right way. Health facilities should be equipped to provide adolescents with the health services they need and they should be appealing and friendly to adolescents. Adolescents should also be aware of the health facilities where they can obtain the services they need.

Child: Biologically, a child is a human being between the stages of birth and puberty, or between the developmental period of infancy (1-2 years) and puberty (12-13 years). However, a child is commonly equivalent to a minor, who is legally a person younger than the age of adulthood. According to Article 1 of Convention on the Rights of a Child, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier. In Uganda, the Children Act, Cap 59 (as amended) defines a child in section 2 as a person below the age of eighteen years.

Minor: A minor is a person under the legally established age of adulthood. Most countries, including Uganda, as well as the UN, have set the age of adulthood at 18 years.

Informed consent: Informed consent is defined as the permission a patient gives a doctor to perform a test or procedure after the latter has fully explained the purpose, benefits and risks.³ Medical practitioners are required to obtain permission from their clients before administering any medical treatment, procedure or examination on them. For consent to be valid, it must be voluntary and informed, and the person consenting must have the

1 WHO (1993). The Health of Young People: A Challenge and a Promise. WHO: Geneva.

2 WHO (2002). Global Consultation on adolescent-friendly health services: A Consensus Statement, Geneva, 7-9 March 2001, (WHO/FCH/CAH/02.18).

3 Richard A. Wagner (n.d). Informed consent. Retrieved from https://www.emedicinehealth.com/informed_consent/article_em.htm#what_is_informed_consent

capacity to make the decision – a person who can clearly appreciate and understand the facts, implications and future consequences of their decision. The consent should be informed, meaning that the person must be given all relevant information regarding what the treatment entails, including the benefits and risks, and information on alternative treatments to enable them make an independent decision, free from coercion or undue influence.

Assent: The agreement of someone, for example a child, not able to give legal consent. Working with children or adults not capable of giving consent requires the consent of the parent or legal guardian and the assent of the subject.

Counseling: The act of giving someone information about their potentialities, interests and abilities to help them overcome personal problems or difficulties and thereby achieve an optimal level of personal happiness and social usefulness. In the consent process, a subject is counselled to facilitate them to make an informed decision about a proposed medical treatment or procedure. The assumptions underlying the theory and practice of the concept of counselling is that each individual has the right to shape his own destiny and, that the role of the counselor is not to attempt to solve the client's problems for them, but instead to try to clarify the person's own thinking.

Emancipated minor: A minor who has been freed from control by their parents or guardians, and/or whose parents or guardians have been freed from any and all responsibility toward them. Children are considered legally incompetent to enter into contracts and to handle their own affairs. Emancipation overrides that presumption and allows emancipated children to legally make certain decisions on their own behalf. In the context of this work, emancipation applies in circumstances dictated by reality, for instance, if the child is married, pregnant or already a parent, institutionalized (e.g. in military service, rehabilitation), or is self-sustaining, among other reasons.

Mature minor: A doctrine that recognizes the evolving capacities of children, in the sense that older children (16-17 years) have the capacity to understand certain information and make some competent decisions, unlike the younger ones. This doctrine justifies the progressive rollback of parental control to nil by the time a child attains the age of 18. Hence, national health policies provide that mature minors may not need the consent of their parents to access SRHR services, and such services should be provided to them with privacy and confidentiality. However, a mature minor still does not have the right to consent to sex and her status as a mature minor does not absolve the perpetrator in such a case.

Health worker: A health professional, administrative, scientific and support staff employed in the health service, and designated by the Health Service Commission in consultation with the Public Service Commission.⁴ The officers who constitute the health service are the health professionals and such administrative, scientific and support staff appointed by the Health Service Commission for the efficient administration, management and delivery of health services.

Medical treatment: Medical treatment means the management and care of a patient to combat disease or disorder. Medical treatment includes the use of prescription medications, or non-prescription drug at prescription strength; wound closing devices such as surgical glue, sutures, and staples; devices with rigid stays or other systems designed to immobilize parts of the body; or administration of oxygen to treat injury or illness. Medical treatment, however, excludes the following: medical observation, counseling, diagnostic procedures, and first aid.⁵

Reproductive age: The average woman's reproductive years, usually considered between 15-49 years.

4 Health Service Commission Act 2001.

5 University of Wisconsin (n.d). Definition of medical treatment. Retrieved from <https://www.wisconsin.edu/workers-compensation/coordinators/osha-record/medical-treatment/> (accessed on 15th May 2019).

1. BACKGROUND

1.1 INTRODUCTION

Consent to medical treatment is based on the principle that a person must give permission before they receive any type of medical treatment, test or examination.⁶ Informed consent is the process by which the healthcare provider discloses appropriate information to a competent patient (a patient with capacity to consent) so that h/she may make a voluntary choice to accept or refuse treatment.⁷

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. For consent to be voluntary, the decision must be made by the person seeking medical treatment themselves without any influence of pressure from health workers, friends or family and the person must be capable of giving consent. Being capable to give consent means that one understands the information given to them and they can use it to make an informed decision.

Informed consent also requires full disclosure of what the treatment entails, including the benefits and risks, the available reasonable alternative treatments, if any, and the consequences for non-treatment.⁸ In the case of *Rogers v. Whitaker*,⁹ it was held that in providing information to patients for the purposes of obtaining consent, there is a duty to warn of a material risk inherent in a proposed treatment. Material risks are those that, in the particular circumstances, would significantly influence the likelihood of a “reasonable person in the patient’s position” consenting to the proposed treatment.¹⁰

In Uganda, obtaining consent to medical treatment from patients has long been viewed as a concern of medical ethics whilst providing medical treatment without first having obtained the patient’s consent is considered a form of battery. The principle of consent to medical treatment is also recognized in international instruments as an important part of medical ethics since patients have the right to receive information and ask questions about recommended treatments so that they can make well considered decisions about the care they are about to receive.

1.2 SRHR SITUATION FOR ADOLESCENTS IN UGANDA

Uganda has a predominantly young population, with over 56% of its population aged 18 and below, and about half (48.7%) under the age of 15. Nearly one-quarter of the country’s population are adolescents between the ages of 10 and 19.¹¹

Adolescents in Uganda face many challenges related to sexual and reproductive health rights (SRHR). They start to have sexual intercourse in the earlier years of their adolescence. In a study conducted by Uganda’s Ministry of Health (MoH) on adolescent health risk behaviour, almost 22% of adolescents reported experiencing some form of sexual activity.¹²

Teenage pregnancy is another major problem among adolescent girls, with many starting to bear children at an early age. According to the Uganda Bureau of Statistics (UBoS), 25% of adolescent girls start to have children at

6 <https://www.nhs.uk/conditions/consent-to-treatment/> (last visited on 26th February 2019).

7 Appelbaum, P.S. “Assessment of patient’s competence to consent to treatment.” 357(18) *New England Journal of Medicine* (2007).

8 <https://www.nhs.uk/conditions/consent-to-treatment/> (last visited on 26th February 2019).

9 (1992) 175 CLR 479.

10 See also, *Rosenberg v Percival* (2001) 205 CLR 434. For a patient’s consent to treatment, see Twinomugisha, B.K (2015). *Fundamentals of Health Law in Uganda*. Pretoria: Pretoria University Law Press, pp. 200-210.

11 Uganda Bureau of Statistics, 2016. *The National Population and Housing Census 2014 – Main Report*, Kampala: Uganda.

12 MoH et al (2017). *Adolescent Health Risk Behaviors in Uganda: A National Cross-sectional Survey, Final Study Report*, September 2017.

the age of 15-19, 19% have given birth while 5% are pregnant. Childbearing among adolescents rises rapidly with age. By the age of 15 years, 3% have had children. This percentage rises rapidly to 22% by the age of 17 years, and to 54% by the age of 19 years.¹³

Adolescents are also highly susceptible to sexually transmitted infections (STIs), including HIV, due to various reasons. In 2014, the HIV prevalence among young people aged 15-24 years was estimated at 3.72% for females and 2.32% for males.¹⁴ New HIV infections among adolescent girls and young women (AGYW) are substantially higher than their male counterparts of the same age because the virus is more commonly acquired from their male sexual partners who are a few or several years older.¹⁵ Findings from the Uganda AIDS Indicator Survey conducted by Ministry of Health revealed that 3% of adolescent girls aged 15-19 years live with HIV and that the prevalence rates double (7.1%) by the time they are 24 years.¹⁶ Estimates for the year 2015 show that the country registered an estimated 83,000 new HIV infections, 22% of which were among AGYW, among whom an average of 50 infections occurred on a daily basis.¹⁷

Sexual coercion among adolescent girls in Uganda manifests mainly as non-violent coercive sex, unwanted non-penetrative touching, verbal harassment, transactional sex and forced sex.¹⁸ Coercive sex exposes adolescent girls to unwanted pregnancy, unsafe abortion, HIV and other STIs, drop-out of school and other negative consequences.¹⁹ Sexual coercion and unwanted pregnancies are a common problem among adolescent girls in Uganda.²⁰

1.3 SRHR SERVICES FOR ADOLESCENTS

Adolescents are typically considered as minors with no legal control over their persons, actions and decisions, thus putting them under the control and legal responsibilities of their parents or guardian over them. The National Adolescent Health Policy 2004 outlines a range of sexual and reproductive health information and services for adolescents. These include: information on sexuality and STIs, family planning counselling and services, contraceptive use among sexually active adolescents, HIV prevention and care services; maternal health services for adolescent mothers, post-abortion care, and psychosocial support. To achieve and maintain good sexual and reproductive health, adolescents need access to accurate information related to sexuality and a choice of safe, effective, affordable contraception options are key. A human rights framework emphasizes access to information to empower individual freedom of choice with respect to: deciding whether to be sexually active or not (e.g. sexual debut); the pursuit of a satisfying, safe, and pleasurable sexual life; choosing a partner; consensual sexual relations and consensual marriage; protection from sexually transmitted infections (STIs); and family planning (e.g. whether or not, and when, to have children).²¹

1.4 STATEMENT OF THE PROBLEM

13 UBoS (2016). Uganda Demographic and Health Survey 2016, Kampala: Uganda.

14 Uganda AIDS Commission (UAC) (2015). Uganda HIV and AIDS Country Progress Report 2014, UAC: Kampala, Uganda.

15 UNAIDS (2016), HIV prevention among adolescent girls and young women: Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys. UNAIDS: Geneva.

16 MoH et al (2011), Uganda: AIDS Indicator Survey 2011. Retrieved from http://health.go.ug/docs/UAIS_2011_REPORT.pdf (last visited 3rd June 2019)

17 Office of the President of Uganda (2017), Presidential Fast Track Initiative on Ending AIDS as a Public Health Problem in Uganda: A Presidential Handbook, Kampala.

18 Wagman, J, et al. "Experiences of sexual coercion among adolescent women: Qualitative findings from Rakai District, Uganda", *J Interpers Violence* (2009), 24(12): pp. 2073-95.

19 Bott, S. 2010. "Sexual violence and coercion: Implications for sexual and reproductive health." In WHO. *Social determinants of sexual and reproductive health*. Pp. 133 – 157.

20 Guttmacher Institute (2013). *Unintended Pregnancy and Abortion in Uganda*.

21 Family Care International. "Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda." Retrieved from <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf>.

Establishing rules for minors' consent for medical treatment has been one of the more difficult issues that face policymakers.²² On the one hand, it seems eminently reasonable that parents should have the right and responsibility to make health care decisions for their minor child; on the other hand, it may be more important for a young person to have access to confidential medical services than it is to require that parents be informed of their child's condition.²³

While many laws prescribe the age of 18 as the age of majority (adulthood), and hence age at which an individual is presumed to have the capacity to consent, adolescents begin to demand for SRH services much earlier, from puberty. In the public sector setting, youth corners have been established to provide SRHR services to adolescents and young people with privacy and confidentiality. The reality of adolescents becoming sexually active early implies that they need SRH information and services, including surgical services in the case of caesarean section.

Most youth-serving agencies and medical professionals believe that access to confidential services is essential, because many sexually active adolescents will not seek care if they have to inform a parent or have their parent's consent.²⁴ The high prevalence of early pregnancies also implies that some parents are still minors themselves and would have to consent to medical treatment for their children.

At the same time, practitioners and law enforcers also continue to grapple with the ethical and legal dilemmas of providing SRH information and services to adolescents. The lack of clarity and consistence of the laws, policies and ethical codes has not helped the situation. In addition, the emergence of contemporary doctrines on the concept of capacity to consent, has rendered reliance on arbitrarily set age of adulthood irrelevant. So? You need a concluding statement clearly explaining the problem that the paper addresses (Is it the question of adolescents' ability to consent to sexual and reproductive health services?)

1.5 PURPOSE

This paper discusses the legal, policy and ethical frameworks as well as the best practices of capacity to consent to medical treatment, with a specific focus on adolescents and their ability to consent to sexual reproductive health services. The paper concludes with recommendations on the best practices of obtaining consent to medical treatment in the Ugandan context based on an analysis of the law, policies and interviews conducted with health practitioners and other stakeholders. The analysis made herein should in no way be construed as legal interpretations, but rather as commendations based on the analysis of the law, policy and best practices.

1.6 METHODOLOGY

This assessment was designed as a qualitative process, relying mostly on a desk review of the laws, policies and codes of ethics relating to informed consent to medical treatment, and how it applies to adolescents seeking sexual and reproductive health (SRH) services. Both national and international legal frameworks were reviewed and the domestic policy guidelines were also considered. Literature was reviewed to understand the evolution of the discourse on the concept of consent to medical treatment.

We also collected primary data from a rapid appraisal using personal interviews with policy makers, representatives of professional councils, service providers, young people and the civil society. Personal interviews were held with a total of 62 respondents, including young people in Kampala, Koboko, Wakiso, Mbarara, Iganga, Gulu, Mukono, and Mayuge districts. The interviews targeted youth networks of Reach a Hand Uganda (RAHU) and Voices for Health, both partners of CEHURD in the SRHR Alliance and the Get Up Speak Out (GUSO) program.

22 Boonstra, H.D and Nash, E (2000). "Minors and the Right to Consent to Health Care." Special Analysis, volume 3, Issue 4. Guttmacher Institute. Retrieved from <https://www.guttmacher.org/gpr/2000/08/minors-and-right-consent-health-care>.

23 Ibid.

24 Ibid.

Preliminary findings were discussed and enriched during a two-day residential report writing workshop attended by 15 experts in the field of SRHR and representatives of the Ministry of Health, the Association of Gynecologists of Uganda, service providers, legal experts, the civil society and academia.

2. CONCEPT OF CONSENT: A HISTORICAL PERSPECTIVE

The principle of informed consent is a relatively new concept in medical ethics. The concept first emerged in a court judgment in 1957 after evolving from rudimentary forms over the previous centuries when medical information was a matter of prudence and at the discretion of the healthcare provider.²⁵ The Hippocratic Corpus,²⁶ the first basis of medical ethics, implored physicians to provide medical benefits to their patients and to protect them from harm.²⁷ The focus was largely on minimizing harm through careful disclosure of medical information to ensure such disclosure did not harm patients by revealing their condition too abruptly and starkly.²⁸ Withholding medical information and even outright deception were justified as morally appropriate means of avoiding harm.²⁹

In the 18th and 19th centuries, the discourse gradually drifted to the importance of patient education in motivating them to adhere to physicians' recommendations. Thomas Percival held that the patient's right to the truth must yield to the obligation to benefit the patient in cases of conflict, thereby recommending "benevolent deception".³⁰ The American Medical Association (AMA) adopted the Percival paradigm in its 1847 "Code of Medical Ethics."

Worthington Hooker was the first champion of the right of patients to information, but fell short of prescribing informed consent as we know it today. Hooker was concerned with expediency in disclosure and truth-telling rather than with the promotion of autonomous decision making or informed consent.³¹

It should be noted that while the 19th century never saw an overt rule or practice of informed consent in clinical medicine, consent practices were not entirely non-existent. Pernick observes that records of surgery suggest a practice and rudimentary rules of obtaining consent in the second half of the 19th century.³² However, the consents obtained do not appear to have been meaningful or informed; they were based on a simple fact that it is physically difficult and interpersonally awkward to perform surgery on a patient without obtaining their permission. Such practices of obtaining permission do not constitute meaningful informed consent, but they nevertheless provided a modest grounding for the concept.³³

Informed consent has over time been shaped by the legal precedents set by court judgments, with *Schloendorff v. New York Hospital*³⁴ standing out prominently among the most influential ones in the earlier years. In January

25 Informed consent: History of informed consent. Encyclopedia of Bioethics. Retrieved from <https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/informed-consent-i-history-informed-consent>.

26 The Hippocratic Corpus is a collection of around 60 early Ancient Greek medical writings strongly associated with the physician Hippocrates and his teachings. Hippocrates began society's development of medicine through a delicate blending of the art of healing and scientific observations. The Hippocratic Corpus became the foundation for which all future medical systems would be built.

27 Encyclopedia of Bioethics, op. cit 25.

28 Ibid.

29 Ibid.

30 Jennifer Jackson. (2001). "Truth, Trust and Medicine". Routledge

31 The Gale Group, op. cit 25.

32 Pernick S. Martin. (1982). "The patient's role in medical decision-making: A social history of informed consent in medical therapy." In *Making Health Care Decisions: Studies on the Foundations of Informed Consent*, vol. 3, Washington D.C: USA.

33 Ibid.

34 105 N.E. 92, 211 N.Y. 125.

1908, Mary Schloendorff was admitted to New York Hospital where she was diagnosed with a fibroid tumor and the physician recommended surgery, which she declined. However, she consented to an examination under anesthesia. During the procedure, the doctors removed the tumor.

Schloendorff later developed gangrene³⁵ in the left arm, ultimately leading to the amputation of some of her fingers. Schloendorff blamed the surgery and filed a case against the hospital. The court found that the operation to which the plaintiff did not consent constituted “medical battery”, stating that:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained.

Schloendorff, however, had sued the hospital itself, not the surgeon, and for this reason court held that a non-profit hospital could not be held liable for the actions of its employees due to the principle of “charitable immunity” – a principle that came to be known as the “Schloendorff rule”.³⁶ This rule was, however, later rejected by court in the decision of *Bing v. Thunig*.³⁷ And, in the same year, the term “informed consent” appeared for the first time in the decision of *Salgo v. Leland Stanford Jr. University Board of Trustees*,³⁸ with court holding that failure to disclose risks and alternatives was cause for legal action on its own, reaching further than a case of battery.

In 1960, the Kansas Supreme Court, in the decision of *Natanson v. Kline*,³⁹ pioneered the use of the legal charge of “negligence” in informed-consent cases, rather than that of battery. The court established the duty of disclosure as the obligation “to disclose and explain to the patient in language as simple as necessary the nature of the ailment, the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforeseen conditions within the body.”

Later, in *Canterbury v. Spence*⁴⁰ in 1972, court in effect, defined a standard of disclosure requiring medical practitioners to disclose the risks that a reasonable patient would want to know, stating that “it is evident that it is normally impossible to obtain a consent worthy of the name unless the physician first elucidates the options and the perils for the patient’s edification.”⁴¹

While the courts of law made their contribution to the development of the concept of informed consent in clinical practice, other developments also contributed to the evolution of this doctrine. Following the adoption of the Universal Declaration of Human Rights (UDHR) in 1948, the civil rights movement emerged in the US in the mid-20th century, followed by feminists, consumerists, and bioethicists, which were all influential groups. The civil rights movement was a struggle for social justice that took place mainly during the 1950s and 1960s for blacks to gain equal rights under the law in the US. The first achievement of this Movement came in 1957 when the first major civil rights legislation — known as the Civil Rights Act — was enacted. Several successes were to come over the next two decades, including the adoption of the United Nations International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) in 1965. The civil rights movement emerged from, and actualized the embryonic interest in, and consciousness to, human rights and freedoms and civil liberties, especially of marginalized communities.

35 Gangrene is a condition resulting from peripheral artery disease that results into death of body tissue (usually hands or feet) when the disease cuts off blood supply to the affected part. Symptoms may include a change in skin color to red or black, numbness, swelling, pain, skin breakdown and coolness.

36 Faden, R. Ruth and Beauchamp L. Tom (1986). *A history and theory of informed consent*. Oxford: Oxford University Press.

37 2 N.Y.2d 656, 143 N.E.2d 3. (1957).

38 317 P.2d 170, 180 (Cal. App. 1957).

39 186 Kan. 393 (1960).

40 464 F.2d 772 (D.C. Cir. 1972).

41 Douglas S.T. Green and Ronald C. MacKenzie (2007). “Nuances of Informed Consent: The Paradigm of Regional Anesthesia.” *HSS*; 3(1): 115-118. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2504103/>.

The UN Charter and the UDHR emerged in response to the abuses and atrocities of the Second World War and has since shaped the human rights framework as we know it today. The human rights framework took shape in the subsequent decades, with the rights of patients, including the right to bodily integrity, the right to information, the right to informed consent being incorporated in several human rights instruments. In 1965, the ICERD provided for the right to security of person and protection by the State against violence or bodily harm, whether inflicted by government officials or by any individual, group or institution.⁴²

The civil rights movement inspired the second wave of the feminist movement in the 1960s-1980s, which broadened the demand for legal equality for women to include cultural equality, gender norms, and the role of women in society. The debate on the role of women in society highlighted women's reproductive rights.

At the same time, the consumer movement emerged in the US in 1960s whose main goals were to promote consumer rights, fight consumer exploitation and demand consumer protection. The concept of patient rights emerged in the framework of consumer rights.⁴³ Patients' bills of rights started to emerge in different countries, providing guarantees for people receiving medical care. In Uganda, the Ministry of Health published the Patients' Charter in 2009 with the objective of empowering health consumers to demand high quality health care, to promote the rights of patients and to improve the quality of life of all Ugandans and finally eradicate poverty nationwide. In addition, the Patients' Rights and Responsibilities Bill, 2017 has been tabled in Parliament to make the Patients' Charter law.

For consent to be valid, it must be given freely, willingly and when a patient is of sound mind. In this respect, the patient must be competent to consent and the information should be given to the patient in a language and terms that the patient can comprehend.⁴⁴ This means that for a patient's consent to be legally valid, the patient must be legally able to give consent. The law remains conflicted on the capacity of minors to consent, with varying positions given in different laws and policies which has affected access of minors to SRH services.

3. LEGAL AND POLICY FRAMEWORKS ON CONSENT TO MEDICAL TREATMENT

3.1 THE INTERNATIONAL AND REGIONAL LEGAL FRAMEWORK

The Universal Declaration of Human Rights (UDHR) recognizes in article 25(1) that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family.⁴⁵ Article 25(2) further provides that motherhood and childhood are entitled to special care and assistance. This, in essence, obliges the states parties to take special recognition of women performing the maternal function in society, including minors who are pregnant.

The right to health is specifically enshrined in the International Covenant on Economic, Social and Cultural

42 ICERD, Art. 5(b).

43 Jonathan Cohen and Tamar Ezer (2013). "Human rights in patient care: A theoretical and practical framework." *Health and Human Rights Journal*, vol. 15, No. 2. Retrieved from <https://www.hhrjournal.org/2013/12/human-rights-in-patient-care-a-theoretical-and-practical-framework> (Accessed on 1st July 2019).

44 Sylvester Onzivua (2019), *Medicine, the law and you: A critical analysis of forensic Evidence in the Courts of Law*– (1st edn.), Kampala, Uganda, p. 125.

45 Article 25(1) of the UDHR states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Rights (ICESCR) where in article 12 (1) it provides that the states parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It further expounds and provides in Article 12(2)(d) for the creation of conditions which would assure to all medical service and medical attention in the event of sickness. General Comment 14 of the Committee on Economic, Social and Cultural Rights takes special recognition of the right to maternal, child and reproductive health care⁴⁶ to be available, accessible, acceptable and of good quality and places an obligation on the states parties to respect, protect and fulfil the right to health for all, including minors

The Convention on the Rights of the Child (CRC) defines a child as a human being below the age of 18 years “unless under the law applicable to the child, majority is attained earlier”. It provides in Article 3 that in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be the primary consideration. States parties are called upon to ensure the child such protection and care as is necessary for their well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for the child.

Article 24(1) directs states to ensure access to essential health services for the child. The Convention goes on to link this with ensuring access to child-friendly information about preventive and health-promoting behavior and support to families and communities in implementing these practices. This demands that a child’s opinion prior to administering medical treatment should be sought, listened to and taken into consideration before any decisions are made. The CRC guarantees the rights and responsibilities of parents to provide direction and guidance to the child in a manner consistent with the evolving capacities of the child, and in Article 12 requires States Parties to assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

The African (Banjul) Charter on Human and Peoples’ Rights (African Charter) in Article 16(1) states that every individual shall have the right to enjoy the best attainable state of physical and mental health. Furthermore, the African Charter on the Rights and Welfare of the Child (African Children’s Charter) sets out rights and defines universal principles and norms for the status of children in Africa. The Charter does not have a direct provision on consent but defines a child as a human being below the age of 18 years. Also, the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol) defines “Women” in article 1(K) to mean persons of female gender, including girls. Article 14 enjoins States Parties to ensure that the right to health of women, including sexual and reproductive health, is respected and promoted.⁴⁷

The above Conventions guarantee children several rights that are relevant to the discussion of informed consent, including the right to enjoy the best attainable state of physical, mental and spiritual health, and the right to privacy. It provides that if children can voice their opinions, then those opinions should be heard and taken into consideration during legal and administrative proceedings; that every child who is capable of communicating his or her own views should be allowed to express his or her opinions freely; and that parents or other persons responsible for the child should always act in the best interest of the child. The highlight in these provisions is that the opinion of the child should be respected in decision making.

46 CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12).

47 Under Article 14(1) of the Maputo Protocol, the rights with a bearing to the right to health of women include: a) the right to control their fertility; b) the right to decide whether to have children, the number of children and the spacing of children; c) the right to choose any method of contraception; d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS; e) the right to be informed on one’s health status and on the health status of one’s partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; g) the right to have family planning education. Article 14(2) mandates States Parties to take all appropriate measures to: a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding; c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

The East African Community Sexual and Reproductive Bill section 12(1)(c) mandates partner states to ensure that every individual has the right to choose and consent to any method of contraceptives including sterilization, while section 6(1) guarantees every individual the right to seek and receive age-appropriate information on sexual and reproductive health.⁴⁸

3.2 THE NATIONAL LEGAL FRAMEWORK

Different laws in Uganda recognize that minors have evolving capacities and should be treated in such a way that their best interests are prioritized. Their engagement in society is based on the welfare principles and the same should be central while determining their capacity to consent to medical treatment; otherwise, they stand a chance of being arbitrarily denied health services due to their age.

The Constitution of the Republic of Uganda, 1995 provides for the age of marriage as 18 years and above.⁴⁹ This has been interpreted as the age determining the capacity to consent in Uganda. It has also been taken within the general medical practice as the age at which one can have capacity to consent to medical treatment. This is buttressed by the Penal Code Act which provides for defilement as an offence committed against a girl below the age of 18⁵⁰ and criminalizes child-to-child sex. The Act defines a child as one under the age of 18 years.⁵¹ Similarly, the Children Act, Cap 59 (as amended) also defines a child as a person below the age of 18 years.⁵²

There are also express provisions for consent to testing for HIV under the HIV Prevention and Control Act, 2014. This Act provides for voluntary testing of HIV if a person gives their consent.⁵³ A person who is incompetent of giving informed consent may be tested for HIV if his or her parent, guardian, next of kin, care taker or agent gives consent.⁵⁴ An incompetent person is one deemed to be unconscious, of unsound mind, a minor, and one suffering from an impairment that renders him or her incapable of giving informed consent.⁵⁵ However, the Act prohibits a minor from consenting to HIV treatment (anti-retroviral therapy or ART) in case they test HIV-positive.⁵⁶

These provisions are inconsistent with the Customary Marriage (Registration) Act, which provides that a customary marriage shall be void if the female party to it has not attained the age of 16 years.⁵⁷ This suggests that a female can get married customarily if they are 16 years and above. It can be inferred that with marriage comes sexual intercourse and probably pregnancy. The Marriage Act also provides for consent to marriage of minors and places the age of minors at 21 years and below.⁵⁸ It further provides that where there is no parent or guardian to consent

48 At the time of writing of this paper, the Bill had not yet been passed into law.

49 Article 31 provides that a man and a woman are entitled to marry only if they are each of the age of 18 years and above and are entitled at that age to found a family.

50 Section 129 of the Penal Code (amendment) Act, 2007 provides: (1) Any person who performs a sexual act with another person who is below the age of eighteen years commits a felony known as defilement and is on conviction liable to life imprisonment. (2) Any person who attempts to perform a sexual act with another person who is below the age of eighteen years commits an offence and is on conviction liable to imprisonment not exceeding eighteen years. (3) Any person who performs a sexual act with another person who is below the age of eighteen years in any of the circumstances specified in subsection (4) commits a felony called aggravated defilement and is, on conviction by the High Court, liable to suffer death.

51 In regard to child-to-child sex, section 129A of the Penal Code (amendment) Act, 2007 provides: (1) Where the offender in the case of any offence under section 129 is a child under the age of twelve years, the matter shall be dealt with as required by Part V of the Children Act. (2) Where an offence under section 129 is committed by a male child and a female child upon each other when each is not below the age of twelve years of age, each of the offenders shall be dealt with as required by Part X of the Children Act.

52 Children Act Cap 59 (amended), section 2(1).

53 HIV and Aids Prevention and Control Act 2014, sections 9 & 10.

54 Ibid, section 10.

55 Ibid, section 10(2).

56 Section 10(2)(c) HIV prevention and Control Act, 2014

57 Customary Marriage (Registration) Act Cap 248, section 11.

58 Section 17 of the Marriage Act Cap 251 states: "If either party to an intended marriage, not being a widower or widow, is under twenty-one years of age, the written consent of the father, or if he is dead or of unsound mind or absent from Uganda, of the mother, or if both are dead or of unsound mind or absent from Uganda, of the guardian of that party, must be produced annexed to the affida-

to marriage on behalf of the minor, then the responsibility rests with a high court judge.⁵⁹

The Ministry of Health Patients' Charter of 2009 provides for a patient's right to informed consent, where every patient has the right to be given adequate and accurate information about the nature of their illness, diagnostic procedures and the proposed treatment for one to make a decision.⁶⁰ It further provides that the information shall be communicated to the patient at the earliest possible stage in a manner that they are expected to understand in order to make a free, informed and independent choice

On informed consent, the Charter grants the clinician the prerogative to withhold the medical information from the patient concerning their condition if they strongly feel that divulging this information would likely cause severe harm to the patient's mental or physical health.⁶¹ Informed consent may be given verbally or in writing or demonstrated by the patient's behavior, and should be witnessed.⁶² In cases of emergency, informed consent should be given after the medical procedure.⁶³ The Charter requires the service provider to inform the patient if they intend to carry out or undertake human experimentation or some other educational or research project.⁶⁴ In this case, the patient has the right to accept or decline to participate in such activities.⁶⁵

The Charter defines a patient as a sick person or any person requesting or receiving medical care. It, however, does not provide any specifications on who has the capacity to consent to medical treatment. The Charter allows physicians to initiate treatment without prior informed consent in cases where the patient's physical or mental state does not permit obtaining such consent, or where it is impossible to obtain the consent of the patient's representative, his or her guardian, or where the patient is a minor or an incapacitated person.⁶⁶ In such situations, the physician should inform the patient at the earliest opportunity and obtain consent for ongoing treatment. This means that any patient seeking medical care must consent to it as long as they can understand the information being given to them. This applies to any patient, including those below the age of 18.

Whereas a medical practitioner can provide treatment to a minor or incapacitated patient without his or her consent, the patient however has freedom to refuse treatment as long as such refusal does not endanger the health of others.⁶⁷ Even then, the health provider may perform treatment against the patient's will if the facility management has confirmed that: 1) The patient has received information as required to make an informed choice; 2) The treatment is anticipated to significantly improve the patient's medical condition; and 3) There are reasonable grounds to suppose that after receiving treatment, the patient will give their retrospective consent.⁶⁸

The Evidence Act, 1909 applies to all judicial proceedings in or before the Supreme Court, the Court of Appeal, the High Court and all courts established under the Magistrates Courts Act. The Act provides that all persons shall be competent to testify unless the court considers that they are prevented from understanding the questions put to them, or from giving rational answers to those questions, by tender years, extreme old age, disease, whether of body or mind, or any other cause of the same kind.⁶⁹ In common law, a witness of "tender years" refers to one below the age of 14 years. This implies that evidence from a 14-year old child is directly admissible in

vit as required by section 10 before a license can be granted or a certificate issued."

59 Section 19 of the Marriage Act Cap 251 states: "If there is no parent or guardian of the party under twenty-one years of age residing in Uganda and capable of consenting to the marriage, then the Minister or a judge of the High Court may consent to the marriage in writing, upon being satisfied after due inquiry that the marriage is a proper one; and that consent shall be as effectual as if the father or mother had consented."

60 Patients' Charter 2009, section 10.

61 Ibid, section 10.

62 Ibid, section 10(a).

63 Ibid, section 10(b).

64 Ibid.

65 Ibid.

66 Ibid, section 11.

67 Ibid, section 12(a).

68 Ibid, section 12(b).

69 Section 117 Evidence Act, Cap 43.

court. Evidence from witnesses of tender age (below 14 years) is normally admissible after the witness has been subjected to a *voire-dire*, a procedure that enables court to determine if, as a witness, they know the difference between truth and falsehood, they understand the duty to tell the truth, and if they understand the nature of an oath.

The Health Service Commission Act, 2001 establishes the Health Service Commission and gives it powers to appoint persons to hold or act in any office in the health service, including the power to confirm appointments, to exercise disciplinary control over those persons, and to remove them from office. The Act provides a “code of conduct” to be observed by all health workers.⁷⁰ The code expressly requires a health worker to provide a patient or client with “relevant, clear and accurate information about his or her health and the management for his or her condition.”⁷¹ The Act prohibits the undertaking of treatment and other forms of medical intervention to a patient who has the capacity to consent without his or her full, free and informed consent. However, a patient may be subjected to treatment without his or her consent only in emergency situations when such intervention is in the best interest of the patient.⁷² In the case of a minor or other incompetent patients, consent shall be obtained from a parent or a relative or guardian.⁷³ The Act also requires the written consent of the patient or client in case a health worker has to disclose information relating to a patient.⁷⁴

The Medical and Dental Practitioners Act, Cap 272 establishes the Medical and Dental Practitioners Council to, among others, promote the maintenance and enforcement of professional medical and dental ethics, exercise general supervision of medical and dental practice at all levels, exercise disciplinary control over medical and dental practitioners, and protect society from abuse of medical and dental care and research on human beings.⁷⁵ The Act is silent about the principle of informed consent to medical treatment, but it empowers the Council to inquire into any allegation of professional misconduct on the part of a registered practitioner.⁷⁶

The Nurses and Midwives Act, Cap 274 establishes the Nurses and Midwives Council with a mandate to regulate the standards of nursing and midwifery in the country; and to regulate the conduct of nurses and midwives and to exercise disciplinary control over them.⁷⁷ In the interest of good practice and the welfare of patients, the Act prohibits nurses or midwives from carrying out procedures beyond common conditions and health problems and requires them to refer all cases beyond their ability to their professional seniors.⁷⁸ This Act, too, is silent on the issue of informed consent to medical treatment, but establishes a disciplinary committee within the Council with powers to handle cases of misconduct of registered and enrolled nurses and midwives that are alleged to have committed any scandalous act in respect of their professional calling.⁷⁹

The Allied Health Professionals Act, Cap 268 establishes the Allied Health Professionals Council with a mandate to regulate the standards of allied health professionals in the country and to regulate their conduct and to exercise disciplinary control over them.⁸⁰ The allied health professionals covered by this Act include medical clinical officers, laboratory technologists, dispensers, physiotherapists and public health dental officers. Like the Medical and Dental Practitioners Act and the Nurses and Midwives Act, this Act, too, is silent on the aspect of consent to medical treatment, but establishes a disciplinary committee within the Council to entertain and handle cases of professional misconduct on the part of any practitioner registered under the Act.⁸¹

70 Health Service Commission Act, 2001, section 29 – 35.

71 Ibid, section 30(3).

72 Ibid, section 30(4).

73 Ibid.

74 Ibid, section 30(5).

75 Medical and Dental Practitioners Act, 1998, section 3.

76 Ibid, Part VII.

77 Nurses and Midwives Act, 1996, sections 2-3.

78 Ibid, section 34.

79 Ibid, section 36.

80 Allied Health Professionals Act, 1996, section 2.

81 Ibid, section 37.

The Uganda Medical and Dental Practitioners Council Code of Professional Ethics 2013 is a legal document derived from the Medical and Dental Practitioners Act.⁸² The Code gives guidance to practitioners to promote and maintain the highest standards of ethical behavior in carrying out their duties. The Code acknowledges that practitioners operate in a society founded on human rights in which patients are entitled to good standards regarding the competence and conduct of practitioners, and that failure of a practitioner to observe the Code may result into a disciplinary sanction.

The Code provides that a practitioner shall observe the patient's confidentiality and privacy and shall not disclose any information regarding the patient except with the express consent of the patient; or in the case of a minor with the consent of a patient or guardian; or in the case of a mentally disadvantaged or unconscious or deceased patient, with the consent of their authorized next of kin – or to the extent that it is necessary to do so in order to protect the public or advance greater good of the community.⁸³

In regard to consent to medical treatment, the Code prohibits a practitioner from conducting any intervention or treatment without consent except where a bonafide emergency obtains.⁸⁴ It, however, does not prescribe a standard – and does not explicitly require that the consent be informed and voluntary. It only requires the practitioner to dispense with consent in emergency cases.

The Children (Amendment) Act, 2016 provides for the care, protection and maintenance of children. It embraces the concept of evolving capacities of the child as well as the welfare principle. The Act prescribes varying critical ages on different issues regarding children. Section 2 of the Act defines a child as a person below the age of 18 years. However, section 8 sets the minimum age of employment of a child at 16 years, implying that even when still a child, an individual has the capacity to be gainfully employed. Section 47(6) mandates a child of at least 14 years to give their consent to adoption. Section 88 of the Act sets the minimum age of criminal responsibility at 12 years.

The Act, in section 3, provides that the welfare of the child shall be of paramount consideration whenever any matter regarding a child has to be determined, and that any delay in determining a matter regarding a child will be regarded as prejudicial to the welfare of the child. In line with the concept of evolving capacities of the child, the Act provides that in determining matters regarding a child, their ascertainable wishes and feelings in line with their age and understanding shall be considered.⁸⁵ The Act, in section 4, guarantees the child the right to where capable, express their view, belief or opinion on any matter that affects their wellbeing. The Act also guarantees them the right to access any information to which a parent, guardian or other person in authority deems critical to the child's well-being; and to safety, privacy, information and access to basic social services.⁸⁶ The Act mandates the parent, guardian or any person having custody of a child to maintain the child and ensure the child receives medical attention and other basics.⁸⁷

The Contract Act, 2010 provides in section 11(1)(a) that a person has capacity to contract where that person is eighteen years or above. Section 11(2) further provides that a person of sixteen years or above has the capacity to contract as provided under Article 34 (4) and (5) of the Constitution.⁸⁸ The Employment Act, 2006 reiterates this

82 Section 34

83 Uganda Medical and Dental Practitioners Council (UMDPC), Code of Professional Ethics 2013, section 6.

84 Ibid, section 7(b).

85 Children (Amendment) Act, 2016, section 3(a).

86 Ibid, section 4(c) and (g).

87 Ibid, sections 5 and 6.

88 Article 34(4) of the Constitution of Uganda provides: Children are entitled to be protected from social or economic exploitation and shall not be employed in or required to perform work that is likely to be hazardous or to interfere with their education or to be harmful to their health or physical, mental, spiritual, moral or social development. Section 34(5) provides that for the purposes of clause (4) of this Article, children shall be persons under the age of sixteen years.

position in section 32(1) and (2) by allowing the employment of children from the age of 12 and above.⁸⁹ This provision recognizes the evolving capacities of the child to be able to provide for themselves in certain instances.

The general consensus on whether a child is able to exercise a right of autonomy and seek medical treatment without a parent's or guardian's consent largely depends on the maturity of an individual child. Where a child clearly lacks the competence to make a choice about his or her health care, the parent or guardian should give the consent. In the absence of a parent or guardian, the doctor may treat the child out of necessity.⁹⁰

3.3 THE NATIONAL POLICY FRAMEWORK

3.2.1 National Adolescent Health Policy 2004

The overall goal of the National Adolescent Health Policy 2004 is to mainstream adolescent health concerns in the national development process in order to improve the quality of life and standard of living of young people in Uganda. The objectives of the policy are: to create an enabling legal and socio-cultural environment that promotes provision of better health and information services for young people; to protect and promote the rights of adolescents to health, education, information and care; to promote the involvement of adolescents in conceptualization, design, implementation, monitoring and evaluation of adolescent health programs; to provide legal and social protections of young people especially the girl child against harmful traditional practices and all forms of abuse including sexual abuse, exploitation, trafficking and violence; and to train providers and reorient the health system at all levels to better focus and meet the special needs of adolescents.

The policy prioritizes the following categories of adolescents: those living in difficult circumstances (refugees, war zones, disaster, internally displaced, street children, etc.); the unemployed; those in hazardous employment (including commercial sex), fishing communities; those living with HIV; those with mental or physical disabilities and defects; those with violent behavior; those under conviction or incarceration; the orphans; those with substance abuse problems; the pregnant and mothers; and the institutionalized adolescents.

The policy sets a range of SRHR targets, including doubling contraceptive use among sexually active adolescents, increasing the number of adolescents abstaining from sex before marriage by 30%, increasing the age at first sexual intercourse to 18 years (from 16.7 years) in females, increasing the practice of protected/safe sex among sexually active adolescent by 30%, increasing the use of emergency contraception integrated in family planning programs targeting adolescents, among others.

The policy is to be implemented through a number of approaches. These include: advocacy, behavioral change communication (BCC), training of service providers, service implementation, resource mobilization for adolescent health, research and co-ordination. The policy is silent about adolescent consent/assent or the requirement for third party consent for adolescents to access any of the interventions in the policy.

3.2.2 Adolescent Health Policy Guidelines and Service Standards

The Adolescent Health Policy Guidelines and Service Standards, 2012 aim to rationalize the provision of adolescent-friendly health services and provide for a minimum package of services to be considered adolescent-friendly while at the same time ensuring national uniformity in their provision.

The policy guidelines and service standards recognize that for adolescents to achieve their full potential, they need to be provided with opportunities to live in a safe and supportive environment, acquire accurate information and values about health and development needs, build life skills they need to protect and safeguard their health,

⁸⁹ Section 32(1) of the Employment Act provides that a child under the age of twelve shall not be employed in any business, undertaking or workplace. Section 32(2) of the same Act prohibits the employment of a child under the age of fourteen years.

⁹⁰ Twinomugisha, op. cit 10, p. 209.

obtain counselling services, and have access to a wide range of services addressing their health needs.

The main components of adolescent friendly services include the following: Clinical care for sexual gender-based violence; prenatal care and maternity care for pregnant adolescents; HPV immunization; HIV counseling and testing; breast examination and information on cancer cervix; information and counselling on health especially growth and development; and information on their rights and responsibilities.

The policy guidelines and service standards require service providers to be adequately trained in the provision of adolescent/youth friendly services; to respect the sexual and reproductive health rights of the young people; and the health facilities to provide a comfortable environment for both visual and auditory privacy. The information and education materials are required to have information on body changes (secondary sexual characteristics), personal care and hygiene, nutrition, alcohol and substance abuse, reproductive health, STIs/HIV, life planning skills, and the abstinence, faithfulness and condom use (ABC) strategy. The policy guidelines and service standards encourage adolescents to involve their parents if they so choose (emphasis added).

In order to promote effective use of ARH, all adolescents shall be provided with adequate information about ARH services. The discussion between the adolescents and service providers shall be private and confidential to allow adolescents make informed decisions. Counselling will aim at promoting and encouraging continued use of ARH services.

3.3.3 The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights

The goal of the National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights, 2006 is to improve the sexual and reproductive health of everyone in Uganda. In the area of family planning and contraceptive service delivery, the policy guidelines and service standards aim to provide information and services to enable individuals and couples to decide freely and responsibly when, how often and how many children to have. It identifies adolescents among the “target and priority groups”, while stating that “Every individual who is sexually active can receive family planning and contraceptive services irrespective of age or marital status”.

The policy guidelines and service standards state that “No verbal or written consent is required from parent, guardian or spouse before a client can be given family planning service, except in cases of incapacitation (intellectual disability),” and recommends written consent only in cases of long-term and permanent family planning methods.

On eligibility for specific family planning methods, the policy guidelines and service standards recommend combined oral contraceptives (COC) for all women of reproductive age. The guidelines state that progesterone only pill (POP) has no age limitations; that injectable contraceptives can be used by women of any age including adolescents; and that spermicides and diaphragms can be used by women of any age and parity.

The policy guidelines and service standards further require that because male and female sterilization are permanent methods of contraception, thorough counselling procedures must be followed to ensure that the client fully understands their choice and to minimize chances of regret, adding that clients younger than 30 years old or with less than three children require particularly careful counselling and exploration of other long-term method options. The policy guidelines and service standards prescribe counselling and informed, written consent for tubal ligation and vasectomy.

The policy guidelines and service standards also require consent from the patient or legal guardian for PAC services, including evacuation for incomplete abortion, examination under general anesthesia, and any surgical interventions. For a client whose physical condition does not enable her to give a written consent, the policy guidelines and service standards recommend that the procedure be performed to save life.

3.3.4 The National Adolescent Health Strategy

The goal of the National Adolescent Health Strategy 2011-2015 is to improve the quality of life and well-being of young people in Uganda. It describes outputs and activities to be implemented at national, district and community levels in order to meet the strategic objectives.

The guiding principles of the strategy are: Respect for adolescents' rights; gender responsiveness; meaningful participation and involvement of adolescents; parental and community involvement and support; integrated and sustained delivery of adolescent friendly services; and partnerships.

The strategy's priority areas of action are identified as: The policy and legal framework; coordination, networking and partnerships; school health; adolescent friendly services; sexual abuse and GBV; psychosocial services; STI/HIV/AIDS; harmful traditional/cultural practices; etc.

The strategy establishes a minimum package for adolescent friendly services to be integrated in public, NGO and private service delivery points, and provides for the training of service providers in health needs of young people and delivery of adolescent friendly service. The policy commits to ensuring that services provided are conducive to the young people by making them accessible, affordable, acceptable, attractive, private and confidential to meet the standards of quality health care for adolescents and young people.

The strategy does not set the requirement of informed consent for adolescents to access SRHR services, but its use of the requirement of privacy and confidentiality can be interpreted to mean that adolescents do not need the consent of their parents or guardians to access the services.

3.3.5 National Sexuality Education Framework

The National Sexuality Education Framework 2018 was developed to guide the teaching of sexuality education and development and dissemination of related materials in schools. The Framework defines sexuality education as a lifelong process of acquiring, learning and teaching acceptable information that is age, cultural and religious appropriate. The Framework recognizes the SRHR challenges facing young people, including early sexual activity and marriage, teenage pregnancies and SGBV. It highlights statistics from the UDHS 2016 that show that 29% of primary school children and 50% secondary school children had ever used contraceptives. The Framework recognizes sexuality education as essential element in equipping young people with information about sexuality. By so doing, it aims to enable them make healthy choices about their sexual and reproductive health, and to utilize life-skills in developing values, attitudes and relationships that maximize their God-given potential.

The NSEF states the centrality of religious, cultural and national values as taught in the Bible and Quran and as stated in the Uganda National Culture Policy, 2000 and the National Ethical Values Policy, 2013, highlighting purity, morality, uprightness, virginity, faithfulness, respect for elders, obedience to parents, and others.

The NSEF is based on the principle of "age-appropriateness", providing that sexuality education messaging that will be age-appropriate with respect to content, context, communication, and the consumer (the child), adding for emphasis that "children are children, not small adults". It creates a cascade of content spread across the themes of human development, relationships, sexual behavior and sexual health for five different age-groups: Early childhood (3-5 years); for pre-primary learners in nursery; lower primary (6-9 years); upper primary (10-12 years); lower secondary (13-16 years); A-level and tertiary institutions (17+ years).

The Framework does not provide for consent of the learners to sexuality education in school settings, although it acknowledges the Eastern and Southern African (ESA) Ministerial Commitment on Sexuality Education of 2013

in which ministers of education and health from 20 countries in the region committed, among others things, to “Urgently review – and where necessary amend – existing laws and policies on age of consent, child protection and teacher codes of conduct to improve independent access to SRH services for adolescents and young people and protect children”; and to “initiate and scale up age-appropriate comprehensive sexuality education (CSE) during primary school education to reach most adolescents before puberty, before most become sexually active, and before the risk of HIV transmission or unintended pregnancy increases.”

3.3.6 National guidelines for research involving humans as research participants

The UNCT National Guidelines for Research involving Humans as Research Participants 2014 establish a system for carrying out research without compromising rights and welfare of individual research participants and communities. These Guidelines have the most elaborate consent process in the policy and legal framework. The overall objective of these Guidelines is to establish a coherent regulatory framework for conduct of research involving humans without compromising their rights and welfare.

The Guidelines provide for the rights of research participants, including: the right to decide on whether to participate in research or not, or withdraw at any time without penalty; be respected, including the right of their autonomy, culture, beliefs and values; the right to information about the research, highlighting the importance of communicating the information in understandable language, format and in a conducive environment at all stages of the research; protection against research related injuries, harm, exploitation, and any other forms of abuse; right to privacy and confidentiality of their participation, during and after the research; right to the standard of health care that is established nationally; right to treatment and management of research related injuries; and reimbursement for costs associated with their participation in the research.

In order to protect the rights and welfare of human research participants, the Guidelines require research to be conducted in accordance with four basic research ethics principles, namely: respect for persons, beneficence, non-maleficence and justice. Respect for persons means respect for autonomy and self-determination, while protecting those with impaired autonomy from abuse and exploitation; beneficence means maximizing benefits and minimizing harms; non-maleficence means that researchers should not deliberately inflict harm on research participants; while justice means to treat each research participant with what is morally right and to give them what is due to them, including the equitable distribution of benefits and burdens.

The Guidelines provide for an elaborate consent process. They prohibit any researcher from involving an individual person as a research participant unless the former has obtained informed consent of the latter or his or her authorized representative. A researcher is required to seek such consent only after ascertaining that the prospective research participant has adequate understanding of the relevant facts and of the consequences of participation. The Guidelines further require that the information provided should be adequate, clearly understood by the research participant with decision making capacity and the research participant should voluntarily decide whether or not to participate.

The Guidelines allow a Research Ethics Committee (REC) to waive the requirement for informed consent partially or fully for research that carries minimal risk; for research that cannot practically be carried out with informed consent; in circumstances where deception is needed to achieve the objectives of the research; where there is risk of harm in case of breached confidentiality; and if the participant presents in an emergency situation.

The Guidelines provide that assent to participate in research shall be obtained from all children aged 8 years and above, and from all persons incapable of self-determination. A child's assent is obtained after parental/guardian's consent. The child's assent or dissent takes precedence over the parent's or guardian's consent. Assent for all other persons incapable of self-determination is obtained after consent from their representatives.

The Guidelines further provide for consent of mature and emancipated minors. The Guidelines define mature

minors as individuals aged 14-17 years who have drug or alcohol dependency or STI, while emancipated minors are individuals below the age of majority who are pregnant, married, have a child or cater for their own livelihood. Mature and emancipated minors may independently provide informed consent to participate in research if: a) in the view of the REC, the research is not objectionable to parents or guardians (established by the REC with evidence from the community); b) the research protocols include clear justification for targeting mature and emancipated minors as participants; and c) a clear justification for not involving parents or guardians in the consent process.

4. CASE LAW ON THE CONCEPT OF CONSENT

There is a conspicuous shortage of jurisprudence on informed consent in Uganda. Only one case could be traced, and there has not been a case involving a child on the issue of informed consent.

4.1. FREDA KASAIRA AND OTHERS VS THE REGISTERED TRUSTEES OF NEBBI CATHOLIC DIOCESE OF 2016⁹¹

In the above case, the court found that doctors and other medical professionals have a duty to provide treatment that is in line with “the medical standard of care” defined as the level and type of care that a reasonably competent and skilled health care professional with a similar background and in the same medical community would have provided. Medical professionals have a duty to conduct their practice in accordance with the conduct of a prudent and diligent medical professional in the same circumstances.

Most medical procedures, treatments or tests involve some risk. However, except in cases of emergency or necessity, all medical treatment is preceded by the patient’s choice to undergo such. It is the medical professionals’ responsibility to give the patient information about a particular treatment or procedure so that the patient can decide whether to undergo the treatment, procedure, or test. Risks that are statistically likely enough to make disclosure worthwhile should be disclosed. In legal terms, the patient’s consent to the treatment may be valid once he or she is informed in broad terms of the nature of the procedure which is intended. But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. One of the factors relevant to, but not decisive of, the question of what a reasonable medical practitioner ought to have foreseen is the state of medical knowledge at the time when the duty should have been performed. A reasonable medical practitioner cannot be expected to have foreseen an event wholly un-comprehended by medical knowledge at the time. The law demands no more than what was reasonable in all the circumstances of the case.

If a patient is to undergo a surgical procedure, it is necessary for such patient to receive information from the medical team about the benefits and the risks of the procedure prior to the procedure being carried out. After having heard the possible risks and benefits, if the patient deems that they wish to go ahead with the surgical procedure they must sign a consent form, outlining the nature and range of the more or all significant risks involved in the suggested surgical procedure of which they have been fully advised, whereby their signature would then signify that they have understood and accepted the potential risks “inherent” in the procedure. This is what informed consent requires. Failure to fully brief a patient about the possible ill effects of the procedure prior to the surgery

91 H.C.C.S No. 0020, before Hon. Justice Stephen Mubiru. The facts of the case are that, the plaintiffs jointly and severally sued the defendants for the recovery of general and special damages for the wrongful death of Ms. Angucia Lucy which occurred on 12th September 2015 at Angal St. Luke Hospital alleged to have been caused by employees of the defendant. The deceased was admitted at the defendant’s said hospital on 8th September 2015 complaining of appendicitis. The deceased underwent surgery for that condition on 10th September 2015 during which a number of negligent acts occurred including failure to properly administer anesthesia, to ensure an effective and constant supply of oxygen to the patient during the operation, failure to monitor the vital signs of the patient during the operation, failure to install the monitoring equipment of those signs during the operation, lapses in handing over the patient to the ward staff and generally failure to exercise professional care and skill to the required standard. As a result, the deceased never regained consciousness and eventually died at the said hospital on 12th September 2015.

and thereby depriving the patient of the ability to give his or her full informed consent, could of its own be a basis for a claim of medical negligence.

Common law imposes a duty on a medical practitioner to warn a patient of material risks inherent in the proposed surgical procedure; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. This standard does not deal with the foreseeability of the risk in question, save to the extent that the risk must be "inherent" in the procedure. In this respect, the general law of negligence still applies. Once there is a risk which is generally known to the profession, there is a duty to warn. In the circumstances of this case, in the absence of any evidence — written or oral — as to the nature and range of the inherent risks involved in the surgical procedure of which the deceased is alleged to have been advised, there is no basis for the finding suggested by counsel for the defendants that by signing the consent form, she gave her informed consent to the surgical process or that she accepted the potential risks involved.

Moreover, even though the patient's informed consent dictates that the patient is aware that certain complications can occur, it does not mean that this covers negligent techniques or mistakes that occur during the surgery, that are not inherent in the procedure itself. The conduct of medical professionals must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence. The conduct of the procedure must reflect the current state of knowledge as to the risks involved in the use of that procedure. However, the standard to be observed by medical practitioners is not to be determined solely or even primarily by medical practice. Rather, it is for the courts to judge what standard should be expected from the medical profession.⁹²

In *Re: Akinyi Diana*⁹³ where a couple was seeking guardianship of an infant whose father and relatives were unknown, the mother is mentally ill and incapable of caring for the child and the child was abandoned in a child care home since 2011, court found that all decisions concerning a child should be in the best interests of a child. The welfare of a child is paramount in any decisions being made.

The Children (amendment) Act, 2016⁹⁴ provides for welfare principles; and criteria for decisions. In determining any question relating to circumstances affecting children, the court or any other person shall have regard in particular to;

1. The ascertainable wishes and feelings of the child concerned considered in the light of his or her age and understanding;
2. The child's physical, emotional and educational needs;
3. The likely effects of any changes in the child's circumstances;
4. The child's age, sex, background and any other circumstances relevant in the matter;
5. Any harm that the child has suffered or is at the risk of suffering;
6. Where relevant, the capacity of the child's parents, guardians or others involved in the care of the child in meeting his or her needs.
7. Rights of the child.

In the health care context, capacity refers to competence to make decisions with respect to medical treatment. The key question here is: does the patient have the competence to consent to or refuse treatment.⁹⁵ In *F v. West*

⁹² See, *Maynard v. West Midlands Regional Health Authority* [1985] 1 WLR 685, [1985] 1 All ER 635.

⁹³ Family Cause No. 004 of 2014 before Hon. Mr. Justice Henry I. Kawesa.

⁹⁴ Section 3(3) of the First Schedule.

⁹⁵ *Twinomugisha*, op. cit 10, p. 200.

Berkshire Health Authority, the court held that a patient is competent if he or she is able to understand the nature and purpose of the treatment. That he or she must be able to understand the risks and side effects as explained by the health care professional. In this case, the plaintiff, aged 36, had learning difficulties. She had been a voluntary in-patient at a mental hospital for over 20 years and had developed a sexual relationship with a male patient. Both the professionals and her mother thought that she should not have been pregnant and should be sterilised. Since she was unable to consent, a declaration was sought from court that the sterilisation would be lawful. Lord Brandon held that a doctor who operates on a patient without consent commits the actionable tort of trespass.⁹⁶

The question in obtaining consent then should not be limited to the age of a person but rather whether the person from whom the consent is being sought is capable of understanding the nature and purpose of the treatment proposed, appreciate the risks and make a decision fully aware of the information given.

In *Gillick v. West Norfolk and Wisbech Area Health Authority & Another*, Mrs Gillick objected to the provision of contraceptives to her daughters without her prior knowledge and consent so long as they were below 16 years. The court recognised the right of a 'mature minor' to consent to her own medical treatment. According to Lord Fraser:

It seems to me verging on the absurd to suggest that a girl or boy aged fifteen could not effectively consent, for example, to have a medical examination of some trivial injury to his [or her] body or even to have a broken arm set. Of course, the consent of the parents should normally be asked, but they may not be immediately available. Provided the patient, whether a boy or girl, is capable of understanding what is proposed, and of expressing his or her own wishes, I see no good reason for holding that he or she lacks the capacity to express them validly and effectively and to authorize the medical man to make the examination or give the treatment which he advises.⁹⁷

4.2 OTHER CASES

In *re Hudson*,⁹⁸ it was held that a court may not subject a child to a surgical operation over the objection of her parents. The common law rule is that minors are forbidden to consent to medical treatment. Still, "[t]he requirement that medical care be provided to a minor only with the consent of the minor's parent or guardian".

Powers v. Floyd,⁹⁹ concerned a case where an abortion was performed on a mentally challenged minor with the written consent of her mother, but without any information being given to the patient herself. A doctor was sued for performing an abortion on a 16-year-old girl without her knowledge. The court held that the doctor had no duty to even inform her of the procedure because her mother had already given informed consent. The court reasoned that even being told about the abortion could have been "disturbing to her".

In *Wallace v. Labrenz*,¹⁰⁰ it was held that it was no longer unusual for a court to order a state-appointed guardian to consent to medical care for children, even if the parents objected. Mature minors can be recognized as competent based upon a variety of factors, including their age, maturity, intelligence, and the nature and risks of the proposed treatment.¹⁰¹

In another case, a 17-year-old girl suffered from back pain and proceeded on her own to an osteopath, and as a result of the treatment had to be hospitalized, lost normal bladder control and some sensation in her buttocks and legs. The jury found no liability because she had the maturity, education, experience, ability, and judgment to knowingly consent to the treatment.

96 (1989) 2 All ER 545; (1990) 2 AC 1; (1989) 2 WLR 938.

97 *Twinomugisha*, op.cit 94 p. 209.

98 126 P.2d 765, 781 (Wash. 1962).

99 904 S.W.2d 713, 714 (Tex. Ct. App. 1995).

100 411 Ill. 618 (1952).

101 Fay A. Rozovsky, (December 11, 2014), "Consent to Treatment: A Practical Guide" Wolters Kluwer Law & Business; 5th edition

The application of these cases is persuasive as precedents in our court system and the Ugandan courts apply common law as per the Judicature Act Cap 13, but they all point out that it is essential that physicians have a clear understanding of: 1) How to adequately determine and record indications of the maturity and decisionmaking competence of minor patients; and 2) How to be assured that one has properly communicated with and obtained knowing and intelligent medical decisions from competent child patients.

For consent to be complete, the patient's comprehension of the information given should be reasonably attested to. For surgical or invasive procedures or treatment with potentially serious side effects, it is important that a patient is fully informed.¹⁰² When it comes to minors, the greatest reason given for their inability to consent is that they cannot understand the information given but this does not consider the true purpose of obtaining consent, especially given that minors have evolving capacities and different environments and situations. To deny them all the services because of their age ignores their different circumstances.

4.3 EXPERIENCES FROM OTHER COUNTRIES

This assessment also considered the experiences of other countries with informed consent in the provision of SRHR services to adolescents.

The case of South Africa

Section 134 of the Children's Act allows access of children to contraceptives starting from the age of 12 years. The Act prohibits the refusal to sell or distribute condoms to a child of at least 12 years.¹⁰³ The child is entitled to confidentiality when they obtain condoms, contraceptives or contraceptive advice.¹⁰⁴

In addition, under section 129(2) and (3) of the Children's Act, sufficiently mature minors can consent to the medical treatment and surgical operations for themselves or their children. In this instance, as long as the minor is 12 years and above, the test is "sufficient maturity." This means that besides age, a child must demonstrate maturity; otherwise they will need parental consent.¹⁰⁵

The case of Canada

In Canada, a child may give their consent to medical treatment but this is dependent on the legislation of the respective federal parts of Canada. In Quebec, the age of consent is 14,¹⁰⁶ while in British Columbia it is 16.¹⁰⁷ The Uniform Medical Consent of Minor's Act places the age of consent at 16.¹⁰⁸ Where the minor has not attained 16 years, they can consent to treatment where the medical practitioner, supported by the written opinion of one other practitioner, is of the view that the minor is capable of understanding the nature and consequences of the medical treatment and it is in the best interests of the minor.¹⁰⁹

The case of the United States of America

Although the United States Supreme Court has previously held that a State's prohibition against distribution of

102 Onzivua, op. cit 44, p. 125.

103 Section 134(2) of the Children's Act provides that contraceptives other than condoms may be provided at the request of the minor without parental consent if: a) the child is at least 12 years, b) there is proper medical advice given to the child, and c) a medical examination is carried out to determine whether such contraceptive should not be given.

104 Section 134 (3).

105 Section 129(5).

106 Loi sur la protection de la santé publique, section 42.

107 Infants Act, section 16.

108 Section 2.

109 Section 3.

contraceptives to persons under the age of 16 was not justifiable,¹¹⁰ and that the State of Missouri's statutory requirement for consent from a parent in the case of a minor to carry out an abortion was unconstitutional,¹¹¹ federal laws are still restrictive of the consent of minors to medical treatment.

A survey by the Alan Guttmacher Institute found¹¹² that only 25 American states and the District of Columbia have laws or policies that explicitly give minors authority to consent to contraceptive services. In the context of abortion, only Connecticut, Maine and the District of Columbia have laws that affirm a minor's ability to obtain an abortion on her own. Thirty-one states require the involvement of a guardian or a parent in the decision of a minor to have an abortion.¹¹³

5. FINDINGS FROM THE FIELD

5.1 ACCESS TO SRH SERVICES BY ADOLESCENTS AND PARENTAL DUTY

From the field interviews with young people, there were varied responses on whether young people below the age of 18 years should be accompanied by their parents or guardians to access SRHR services. The respondents who supported this position reasoned that parents have obligations towards the health of their children and therefore have a right to know the state of their children's life. It was also argued that children need their parents for guidance and support in treatment adherence and recovery process, as well as in meeting medical bills, where necessary. They argued that children are minors, without legal capacity to consent, and may even not precisely know what health problem they are facing, and are vulnerable and may not be able to protect themselves from the excesses of, or violations by, unethical health providers.

On the other hand, those opposed to the idea of parents accompanying their children argued that adolescents will fear to disclose their SRHR needs in the presence of their parent, and will have their confidentiality breached. Some parents have a negative attitude towards adolescents' access to family planning and contraceptives. It was also noted that adolescents are sexually active and some are already emancipated, as they were already pregnant, mothers, sex workers, employed, or married and may prefer to be accompanied by their spouses.

From the service providers, the study sought to find out whether they have handled clients below the age of 18 years seeking key SRH services, including HIV testing and counseling, HIV treatment and care, family planning and contraceptives (including condoms), antenatal care (ANC), abortion and post abortion care, and delivery (including by caesarean section). It also sought to establish how the service providers deal with such clients, particularly on issue of informed consent, and whether they were following any specific guidelines. It further sought to find out the adolescents' capacity to make sensible decisions.

According to the findings, service providers provide SRHR services to adolescents without conditionality. The practice has been influenced by the Ministry of Health policy that encourages access to SRHR information and services. The respondents emphasized that confidentiality and privacy is a paramount consideration in the provision of SRHR services to adolescents. Therefore, it is not a requirement that adolescents must come along with their parent to access SRHR services. However, service providers reported that they entertain parents who come along with their adolescent children, although at times they request a private session with the child to provide room for opening up. According to one respondent:

110 Carey v. Population Services International 431 U.S 678 (1977).

111 Planned Parenthood v. Danforth 428 U.S 52 (1976).

112 Heather Boonstra and Elizabeth Nash (2000), "Minors and the Right to Consent to Medical Care." The Guttmacher Report on Policy Analysis, vol. 3, Issue 4. Retrieved at www.guttmacher.org (accessed on 23rd June 2019).

113 Ibid.

These young people know what they want and you can't chase them away when they come for services... I think adolescents deserve to have their health needs addressed without discrimination considering that they are the future of the nation. So we need to put emphasis on them when we provide them SRH services, not their parents.¹¹⁴

According to the service providers, it is unnecessary to reveal information to the parents/guardians about their adolescent clients because the former are normally absent at the health facilities their children seek SRHR services and at times they never get to know when their adolescent children seek these services.

5.2 AGE AND THE CAPACITY TO CONSENT

Public policy discourse has centered on the need for SRHR information to be “age-appropriate” but the responses indicate that this concept has not been widely understood, and consensus is yet to be achieved. Respondents were divided on the “appropriate” age for the different categories of SRHR information and services.

There were varied responses with regards the age at which adolescents should access the different SRH services without parental influence. For HIV testing and counselling, the minimum age of 12 was considered the most appropriate to be exposed to such services. The same age was cited in at least one response as the bare minimum to access family planning and contraceptive services. However, while most of the respondents were of the view that SRHR services should be given to adolescents who are sexually active, others thought otherwise. The latter felt that some services and contraceptives are not appropriate for younger adolescents. For instance, in one case in Wakiso, a service provider stated that they declined to give an 11-year old boy condoms and instead chose to counsel him out of the decision. In another case, a 13-year old turned up with a grandparent for STI treatment, and the health provider counselled them and referred them to Mulago Hospital. Some service providers reported providing family planning to adolescents as young as 12 years, ANC to 12-year olds, post-abortion care to 13-year olds, and delivery to 13-year olds. One of the respondents expressed the dilemma of making reference to age-appropriateness to determine accessibility to SRHR services as follows:

I have not seen any formal restrictions on access to SRHR services but there is emphasis on age-appropriateness of SRHR information. Unfortunately, this is hard to define. Service providers and teachers also don't understand what policy makers mean by age-appropriate.¹¹⁵

Health providers argue that children are maturing more rapidly than ever before due to improved nutrition, to the extent that it is irrelevant to ask for their age. They should be availed information as early as possible because violence is rampant and many engage in sexual intercourse at an early age.

A limited number of service providers reported rarely asking their clients their age before providing SRHR services. A number of them reported doing so as part of history taking, but largely rely on their clients' responses without any means to verify the information. Some service providers, however, stated that they normally interrogate clients who appear too young or those who claim to be older to try to verify their age. One respondent observed as follows:

The nature of my work forced me to do it. I take her to a corner and counsel her... when were you born? Which class are you? When did you start school? How old is your elder brother? These are useful in estimating the age.¹¹⁶

The concerns expressed by the respondent in Wakiso district were not different from those from the other parts of the country. For example, a respondent in Iganga district expressed the same sentiments as follows:

114 Interview with a service provider in Kampala district, date of the interview 28th March 2019 in Kampala.

115 Interview with a civil society representative in Koboko district, date of interview 21st March 2019 in Koboko.

116 Interview with a service provider, private sector, Wakiso district, date of the interview 28th March 2019 in Kampala.

They don't usually tell you the correct age; you need to build rapport and talk to them in a friendly way for you to get honest answers. They lie about their age, the problem they are having, many things... To verify the age, we ask when they were born, and if she has someone accompanying her, we ask them.¹¹⁷

In regard to the capacity of the adolescents to make 'sensible' decisions, service providers reported that they are aware of what they need when they visit health facilities, and if listened to "they talk about the right things." This is affirmed by a respondent service provider who stated as follows:

I think they are able to decide except in extreme cases like surgery. And also when people are sexually active and they come for services then their consent is enough.¹¹⁸

Similar views on the capacity of the adolescents to make the right decisions were echoed by the other respondents. For example, a civil society respondent from Koboko district observed as follows:

I stay a lot with young people and many of them make sensible decisions in their relationships but some are reckless. They don't reflect on the consequences of their decisions that is why they make mistakes. For many of them, pregnancy takes them by surprise.¹¹⁹

A respondent in Iganga district noted that:

Most of the young people make good and sensible decisions based on the situation they are going through and the circumstances. I have seen many young mothers who go on to become very responsible mothers.¹²⁰

Another respondent reported as follows:

Experience teaches young people lessons. A 14-year old who had terminated a pregnancy insisted that she wanted an IUD which I gave her and she kept it for eight years until she had a stable partner and wanted to have a child.¹²¹

Most respondent service providers reported that they have never received a client who was too young for the service they were seeking.

In regard to the most appropriate age a child would make decisions about which SRH services they need, most service providers were of the view that this should be the case as soon as a child has become sexually active. On this issue, one respondent observed as follows.

Girls by the age of 9 start engaging in sex which sometimes is 'consensual'; reproductive health is for everyone. Older people talk about reproductive cancers while the 10-17 talk about STIs, unwanted pregnancy, unsafe abortion and the like.¹²²

117 Interview with a service provider in Iganga district, date of interview 25th March 2019 in Iganga.

118 Interview with a service provider in Kampala, date of the interview 28th March 2019 in Kampala.

119 Interview with a civil society representative in Koboko district, date of interview 21st March 2019 in Koboko.

120 Interview with a service provider in Iganga district, date of interview 25th March 2019 in Iganga.

121 Interview with a service provider in Kampala, date of the interview 28th March 2019 in Kampala.

122 Ibid.

The views from the respondent service providers suggest that the doctors' opinion is what really matters in emergencies and in cases requiring surgery; the consent process is more of a formality and it is not taken seriously. Some service providers feel that consent for SRH services is implied and capacity to consent is assumed. Responses indicated that by the mere fact that an adolescent has shown up at a facility looking for a service is indication enough that they have the capacity to consent and that they are seeking the service they have implicitly consented to use.

The responses further show that the Adolescent Health Policy Guidelines and Service Standards 2012 are not widely known by service providers and clients alike.

5.3 ADOLESCENT-FRIENDLY SERVICES AND CONSENT TO SRH SERVICES

Responses from young people show that they consider youth-friendly services to be those services that are provided free of charge, in a friendly way and are receptive to young people of all ages and are provided by fellow young people. They feel that young people need sexuality education before the age at which they usually "make mistakes".

Service providers felt that youth-friendly services should be in a separate space where they can have their privacy, but also such a place should be more of a "club" than a health facility with games, entertainment, peers and service providers who connect with young people. It was emphasized that youth-friendly services are not about space; it is about the service itself. While many public health facilities have established a youth corner, the services are not yet adolescent/youth friendly because of poor service delivery, lack of skills in dealing with young people, shortage of space and stock-outs of commodities. Also, games and entertainment are missing in youth corners, which would help keep the youth busy.

As a result, service satisfaction levels have been low among adolescent service users. Condom dispensers and community health workers have improved adolescent access to condoms. However, many young people have limited information about other contraceptives and their safety in young people. The youth corners rely on volunteers since there are no permanent staff. Service providers reported receiving feedback on the services they provide to adolescents mostly through suggestion boxes, peers and direct conversations with clients. A young respondent puts into perspective the challenges young people face at the health facilities.

Health workers take a long time to attend to people; you can even spend an entire day at the health facility. Health workers are few and don't give you much time.¹²³

The health service providers also face challenges of inadequate supplies at the facilities. Some clients who visit the facilities for services are, in some cases, unable to access the services appropriate to their situations. A respondent illustrates one of the instances below:

A girl of 13 years was raped by a 48-year old man. At the facility, she was given PEP and there was no emergency pill and she got pregnant. Sometimes health workers miss steps in giving health care.¹²⁴

The respondent further illustrates the complexity of ensuring male participation in maternal healthcare programs and its effect on a healthy pregnancy.

Male involvement is still too low. There is a requirement to go with a husband but most adolescents do not have husbands; men run away as soon as they discover that they have impregnated a young girl. So girls end up missing ANC and delivering in the community.¹²⁵

¹²³ Interview with a young person in Koboko district, date of interview 21st March 2019 in Koboko.

¹²⁴ Interview with a civil society representative in Koboko district date of interview 21st March 2019 in Koboko.

¹²⁵ Ibid.

6. DISCUSSION, EMERGING ISSUES AND RECOMMENDATIONS

6.1 DISCUSSION

Overall, the international and regional legal frameworks do not directly address the question of consent to medical treatment for children, but recognize the rights, responsibilities and duties of parents and guardians to protect their children, and to provide for them, including ensuring access to health care. Most importantly, the frameworks require states parties to respect the views of the child in making decisions that affect them, and recognize the concept of evolving capacities. The frameworks clearly show that in considering the views of children, age should be considered alongside maturity, implying that a higher age does not necessarily imply that an individual has matured. This is a recognition that some children mature earlier than others, and earlier than 18 years, and, as the Convention for the Rights of the Children commends, children who can form and express an opinion on any matter that concern them should be accordingly considered.

The age of majority is generally recognized in national and international law to be 18 years, and from the reading of the law, capacity to consent to medical treatment is a preserve of adults. However, the national policy framework is a lot more progressive than the law when it comes to consenting to SRHR information and services. It should be noted that individual laws have inconsistencies within themselves, with other laws as well as with policies.

To illustrate this, the national Constitution, the Children's Act, the Penal Code and the Convention on the Rights of the Child recognize 18 as the age of majority. However, the Penal Code differentiates defilement into simple defilement for children aged 16-17 years, from aggravated defilement for sex with children aged less than 16 years. The Customary Marriage (Registrations) Act recognizes that a child aged 16 can marry (and presumably have sexual intercourse), while the Marriage Act sets the minimum age for marriage at 21. On its part, the Evidence Act stipulates that anyone above tender years – that is, 14 and above – can testify in court. The Children's (Amendment) Act prescribes that a child can be gainfully employed at 16; can consent to adoption at 14; and criminal liability at 12. The HIV Prevention and Control Act prescribes 12 years as the minimum age for consent to HIV testing and counseling. The National Guidelines for Research Involving Humans as Research Participants sets the minimum age for assent to participate in research at 8, emphasizing that such assent or dissent, while it has to be accompanied by consent from a parent or guardian, it takes precedence.

The National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights (2006) emphatically states that no parental consent is needed for a client to access family planning. This is a total deviation from the provisions of the law that sets different ages for different responsibilities. In addition, the Guidelines recommend combined oral pills for adolescents who are sexually active and clarifies that oral pills have no age limitation. On its part, the adolescent health policy targets to increase contraceptive uptake among adolescents who are sexually active.

The practice in the judiciary of assessing the capacity of young witness for capacity to witness (*voire-dire*) is a practical illustration that children have the capacity to give views and make sensible decisions. This fact has also been confirmed by SRHR service providers that participated in this study. The findings suggest that age appropriateness is not widely understood or applied in the provision of SRHR information and services to adolescents. The more practical guide has been demonstrated to be service need, defined as sexual activity.

This argument is strengthened by the provisions of the law as well as of policy and practice. International law guarantees a child the right to privacy, while policy emphasizes the need for service providers to ensure confidentiality and privacy in the provision of SRHR services to young people, including adolescents.

It is also important to note that the law, policy and practice have legitimized the self-determination of mature and

emancipated minors in consenting to medical treatment, and by extension, including for fellow minors, at least in the case where minors are parents. As already noted, the law allows minors to get married provided they obtain parental consent which brings about a requirement for spousal involvement or consent before a woman can acquire reproductive services. This has been interpreted in case law as being unconstitutional as seen in the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*¹²⁶ where it was held that spousal notification laws place an “undue burden” on a woman’s ability to get an abortion, whereas parental involvement laws do not.

The practice is that service providers do not insist on adolescents coming with their parents as a precondition for accessing services, especially SRHR services. Indeed, many health facilities have a youth corner, where young people are attended to separately, away from the prying eyes of older people, some of whom may be their parents or in cases of child-child marriage where the husband or wife of the minor becomes the next of kin. This has been done to encourage young people to seek services without fear or stigmatization.

The findings suggest that in many cases, consent to even complicated and risky procedures is often neither informed nor voluntary. While many violations and procedures gone wrong seem to be widely known, these cases are not reported to the regulatory institutions, including professional councils. Consent is sometimes sought when the patient and caregivers are desperate for treatment and not in the best frame of mind to understand the potential risks. However, cases of violations of the right to informed consent and unethical practice related to breach of informed consent are not reported to the Uganda Medical and Dental Practitioners Council (UMDPC) for different reasons, including lack of awareness among patients, conflict in both public and private medical practice, difficulty in obtaining evidence of violations, and deliberate hiding of information by patients.

6.2 EMERGING ISSUES

- The law is inconsistent in its provisions on the legal age of consent on different aspects: age of majority (18 years); marriage (21 and 16 years); mature minors (16-17, and 14-17 years); gainful employment (16 years); above tender years (14 and above); legal responsibility (12 years); HIV testing and counseling (12 years); HIV treatment (18 years); assent (8 and above years); etc. This demonstrates how the laws are inconsistent and out of touch with reality.
- The policy is more progressive on the issue of informed consent to medical treatment – and in the case of SRHR information and services in particular – than the law. For instance, SRHR policies and guidelines outrightly reject the requirement for parental consent for adolescents to access SRHR services and information. Another example of the progressiveness of the policies is their emphasis on confidentiality and privacy in the provision of SRHR services to adolescents. Hence, the legal framework is a barrier to broader access to SRHR services by adolescents.
- The legal and ethical duties of health service providers to disclose information to their patients is far from settled, as the Patients’ Charter allows the practitioner to withhold information on diagnosis that they deem may harm the patient emotionally or physically. This paternalistic approach falls short of the human rights principles that promote self-determination of individuals.
- In the provision of SRHR, the capacity to consent of adolescents needs to be assessed not only on the basis of age, but more so on the basis of maturity, in line with the concept of evolving capacities of the child as recognized by the Convention on the Rights of the Child as well as the Children’s Act.

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This notion has been used to good effect by courts of law in assessing the capacity to testify of witnesses of tender years (below 14 years). Another example is that this concept has been applied to good effect in the case of mature and emancipated minors.

- Confidentiality and privacy are critical in the provision of SRHR information and services to adolescents. Many young people would wish their parents to know that they are sexually active as they would be judged to be immoral and health workers have a duty to ensure that they maintain the confidentiality of their patients including minors. It is also important to ensure that services are not provided in a judgmental manner if they are to be adolescent friendly.

6.3 RECOMMENDATIONS

6.3.1 Recommendations to policy makers

- Harmonize policies on informed consent for SRHR services to adolescents to improve access.
- Provide a guidance document on administration of informed consent to young people of different ages and for different SRHR services.
- Develop criteria to guide service providers assess capacity to consent, considering all relevant parameters beyond that the age of the client.
- Service providers that take on tasks outside their formal training should be trained in administration of informed consent in their new tasks.
- The basic elements of informed consent should be defined for all SRHR services, and riskier procedures should have more rigorous processes.

6.3.2 Recommendations to ULRC and law makers

- ULRC should undertake a legal review on the age of consent and recommend legal reform.

6.3.3 Recommendations to professional councils, trainers of service providers, program managers

- Train service providers on the concept of informed consent and how they should apply it in the provision of SRHR services to adolescents.
- Revise existing laws on access to SRHR services to clarify how informed consent should be obtained from adolescents.

6.3.4 Recommendations to service providers

- Service providers should encourage parents to talk to their children about matters relating to sex and counsel them accordingly. However, little information is available about the extent to which activities to promote parent-child communication have been adopted.

REFERENCES

1. Appelbaum, P.S., 2007. "Assessment of patient's competence to consent to treatment." *New England Journal of Medicine*, 357, 1834-1840.
2. Twinomugisha, B.K. 2015. *Fundamentals of Health Law in Uganda*. Pretoria University Law Press (PULP), Pretoria. Douglas S.T. Green and Ronald C. MacKenzie (2007). "Nuances of Informed Consent: The Paradigm of Regional Anesthesia." *HSS* 3(1): 115-118.
3. Faden R. Ruth and Beauchamp L. Tom (1986). *A history and theory of informed consent*, Oxford: Oxford University Press.
4. Family Care International. "Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda." Retrieved from <http://www.unfoundation.org/what-we-do/campaigns-and-initiatives/universal-access-project/briefing-cards-srhr.pdf> (accessed on 1st July 2019).
5. Guttmacher Institute (2009). *Unintended pregnancy and abortion in Uganda*.
6. Hooker, Worthington (1849). *Physician and Patient; or, A Practical View of the Mutual Duties, Relations and Interests of the Medical Professions and the Community*. New York: Baker and Scribner.
7. Jonathan Cohen and Tamar Ezer (2013). "Human rights in patient care: A theoretical and practical framework." *Health and Human Rights Journal*, vol. 15, No. 2. Retrieved from <https://www.hhrjournal.org/2013/12/human-rights-in-patient-care-a-theoretical-and-practical-framework/> (accessed on 1st July 2019).
8. Ministry of Health (MoH) (2011). *Uganda: AIDS Indicator Survey 2011*. Retrieved from http://health.go.ug/docs/U AIS_2011_REPORT.pdf (accessed on 1st July 2019)
9. MoH et al. (2017). *Adolescent Health Risk Behaviors in Uganda: A National Cross-sectional Survey, Final Study Report*, September.
10. Office of the President of Uganda (2017). *Presidential fast track initiative on Ending AIDS as a public Health Problem in Uganda: A Presidential Handbook*, Kampala: Uganda.
11. Richard A. Wagner. *Informed consent*. Retrieved from https://www.emedicinehealth.com/informed_consent/article_em.htm#what_is_informed_consent (accessed on 1st July 2019).
12. Sylvester Onzivua (2019), *Medicine, The Law and You: A Critical Analysis of Forensic Evidence in the Courts of Law*, Kampala: Uganda.
13. *Encyclopedia of Bioethics, Informed consent*. Retrieved from. <https://www.encyclopedia.com/science/encyclopedias-almanacs-transcripts-and-maps/informed-consent-i-history-informed-consent> (Accessed on 1st July 2019).
14. UBoS (2016), *Uganda Demographic and Health Survey 2016*, Kampala: Uganda.
15. Uganda AIDS Commission (2015). *Uganda HIV and AIDS Country Progress Report 2014*, UAC: Kampala, Uganda.
16. Uganda National Council for Science and Technology (UNCST) (2014). *National Guidelines for Research Involving Humans as Research Participants*. Kampala, Uganda: UNCST
17. UNAIDS (2016). *HIV prevention among adolescent girls and young women: Putting HIV prevention among adolescent girls and young women on the Fast-Track and engaging men and boys*. UNAIDS: Geneva.
18. University of Washington and Makerere University (2015). "Age of consent for HIV testing, counseling and treatment in Uganda." *AIDS Law Brief Background Paper*. September.

19. University of Wisconsin (n.d). Definition of medical treatment. Retrieved from <https://www.wisconsin.edu/workers-compensation/coordinators/osha-record/medical-treatment/> (Accessed on 1st July 2019).
20. Wagman J, Baumgartner JN, Geary CW, Nakyanjo N, Ddaaki WG, Serwadda D, et al. (2009). "Experiences of sexual coercion among adolescent women: Qualitative findings from Rakai District, Uganda." *Journal of Interpersonal Violence*, 24(12), 2073-95.
21. Bott, S. 2010. "Sexual violence and coercion: Implications for sexual and reproductive health." In WHO. *Social determinants of sexual and reproductive health*. 133 – 157.

Laws and policies reviewed

1. Adolescent Health Policy Guidelines and Service Standards 2012
2. African Charter on the Rights and Welfare of the Child CAB/LEG/24.9/49 (1990)
3. Allied Health Professionals Act, Cap 274
4. Children's (Amendment) Act 2016
5. Constitution of the Republic of Uganda, 1995
6. Convention on the Rights of the Child, 20 November 1989, 1577 UNTS 3
7. Customary Marriage (Registration) Act, Cap 248
8. East African Community Sexual and Reproductive Bill, 2017
9. International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966, GA Res 2200 (XXI) UN Doc A/6316 (1966) 993 UNTS 3
10. Health Service Commission Act 2001
11. Health Service Commission Act 2001
12. HIV Prevention and Control Act 2014
13. Marriage Act, Cap 251
14. Medical and Dental Practitioners Act 1998
15. Ministry of Health Patients' Charter of 2009
16. National Adolescent Health Policy 2004
17. National Adolescent Health Strategy 2011
18. National Policy Guidelines and Service Standards for Sexual and Reproductive Health and Rights 2006
19. National Sexuality Education Framework 2018
20. Nurses and Midwives Act, Act 268
21. Penal Code Act, Cap 120
22. The Evidence Act 1909
23. Uganda Medical and Dental Practitioners Council, Code of Professional Ethics 2013
24. Universal Declaration of Human Rights, adopted and proclaimed by the United Nations Assembly in Resolution 217 A (III) 1948

