Haugli, T. & Martnes, M. (Eds.). (2025).
Perspectives on Children, Rights, and Vulnerability.
Scandinavian University Press.
DOI: https://doi.org/10.18261/9788215069500-25-12

11. The Right of Children to Make Healthcare Decisions – Balancing Vulnerability and Capability in Norwegian Law

Henriette Sinding Aasen

Abstract The chapter analyses provisions in the Norwegian Patient and User's Rights Act on the rights of children to consent to healthcare without parental involvement, with a focus on children between 12–16 years old. The regulation serves as a case study to explore the balancing of children's rights and parental responsibility. Theoretical perspectives on vulnerability and capability form the basis of the assessment of the legal balancing of children's and parents' interests and the role of health providers.

Keywords healthcare | vulnerability | capability | consent | parental responsibility | best interests of the child

11.1 INTRODUCTION

Children, especially the very young, are often portrayed as vulnerable and in need of protection. However, according to both international and domestic law, children are independent holders of rights, including autonomy and privacy rights according to age and maturity. Thus, children are to some extent seen as legal subjects capable of protecting their own interests and exercising rights on their own.[1]

---

[1] Kirsten Sandberg was early to point out the child's position as an independent rights holder in the health context and the underlying tensions in CRC provisions between respectively autonomy and protection: Kirsten Sandberg, "Children's Right to Participate in Health Care Decisions," in *Human Rights, Dignity and Autonomy in Health Care and Social Services: Nordic Perspectives*, eds. Henriette Sinding Aasen, Rune Halvorsen and António Barbosa da Silva (Intersentia, 2009), 71–89, 71–72. See also Anna Nylund, "Introduction to Children's Constitutional Rights in the Nordic Countries," in *Children's Constitutional Rights in the Nordic Countries*, eds. Trude Haugli, Anna Nylund, Randi Sigurdsen and Lena R. L. Bendiksen (Brill/Nijhoff, 2019), 3–19. She observes the potential dilemma between seeing children as holders of rights and the danger of treating children as adults and thereby neglecting their particular needs (3–4).

The Norwegian Patient and User's Rights Act[2] regulates children's right to access necessary healthcare and the extent of their right to make independent healthcare decisions. This act, and the Norwegian Constitution,[3] is inspired by provisions in the Convention on the Rights of the Child (CRC).[4] Both international and domestic regulations reflect notions of child vulnerability and capability, the challenge of balancing these perspectives and the competing rights and duties involved: children's rights, parental responsibility, and duties of health providers.

In this chapter, I explore provisions in the Norwegian Patient and User's Rights Act regarding children's right to be informed about and consent to healthcare. Particular attention is given to special provisions concerning children between 12–16 years old (adolescents). The analytical objective falls in to three related parts: 1) analysis of legal provisions concerning children's right to make healthcare decisions, 2) discussion of the relevance of theoretical perspectives on vulnerability and capability, and 3) reflection on whether vulnerability and capability arguments and perspectives contribute to and add new dimensions to the legal analysis of rights and duties.

11.2 CHILDREN'S HUMAN RIGHTS IN THE HEALTH CONTEXT – OVERVIEW

The protection of children's health, integrity and well-being is essential in all social settings of relevance for children, not least the healthcare service. Securing access to health services could have an impact on children's health and well-being not only at the time of intervention but also over the longer term.[5] Children's rights should be understood in a context of power, where powerful or influential actors may have great impact on children's enjoyment of their human rights, including the right to health.[6] Cathaoir asserts that rights of children "can reframe health as a shared responsibility of the state, parents and the child"[7] and that states should seek "to protect children's open future".[8] These are significant observations

---

[2] Act June 2, 1999 no. 63 on pasient- og brukerrettigheter [Norwegian Patient and User's Rights Act].

[3] Kongeriket Norges Grunnlov, May 17, 1814 [The Norwegian Constitution]. In May 2014, the Constitution was updated with a new chapter on human rights, including section 104 on children's rights.

[4] Adopted by the United Nations 20 November 1989.

[5] John Tobin, *The Right to Health in International Law* (Oxford University Press, 2012), 255–267.

[6] Katharina Q Cathaoir, *Children's Rights and Food Marketing: State Duties in Obesity Prevention* (Intersentia, 2022) 12–14.

[7] Ibid., 10–11.

[8] Ibid., 13, with reference to Joel Feinberg, "The Child's Right to an Open Future," in *Whose Child?*, eds. W. Aiken and H. LaFollette (Totowa, NJ: Rowman & Littlefield, 1980, 125).

relevant for the discussions in this chapter on the rights of children in the health context and the balancing of rights and responsibilities of, respectively, children, parents and health providers.

When revising the Norwegian Constitution in 2014, a special section on children's human rights was adopted (section 104), emphasising rights of children not covered by other constitutional provisions.[9] Section 104 contains overarching guarantees of children's rights in line with similar provisions in the CRC, which is given a semi-constitutional status by the Norwegian Human Rights Act.[10] As pointed out by the Law Commission preparing the constitutional reform, formal equality with adults does not necessarily address children's particular vulnerabilities and specific needs and therefore is no sufficient guarantee of substantive equality.[11] Section 104 guarantees children respect for their human dignity, a right to be heard in decisions affecting them according to age and development, and a general duty of protecting the best interest of the child in actions and decisions concerning them. Children are entitled to protection of their personal integrity,[12] and the state is obliged to facilitate the child's development and ensure necessary economic, social and health security, preferably within the family. These are general and overarching provisions protecting children as vulnerable human beings in need of social protection and assistance. Mentioning of children's right to be heard according to age and development, and their right to integrity protection, signifies state responsibility for securing children's autonomy and privacy rights.

Both adults and children have a constitutional right to privacy,[13] which includes autonomy and confidentiality in healthcare.[14] However, the right to privacy is not absolute and can be balanced against conflicting rights and interests. Children's

---

[9] Trude Haugli, "Constitutional Rights for Children in Norway," in *Children's Constitutional Rights in the Nordic Countries*, eds. Trude Haugli, Anna Nylund, Randi Sigurdsen and Lena R. L. Bendiksen (Brill/Nijhoff, 2019), 39–58, 43.

[10] Act May 21, 1999 no. 30 om styrking av menneskerettighetenes stilling i norsk rett [The Norwegian Human Rights Act], See sections 2 no. 4 and 3, stating that the CRC is to be seen as part of Norwegian law with priority over conflicting legislation.

[11] Doc. 16 (2011–2012), *Rapport til Stortingets presidentskap fra Menneskerettighetsutvalget om menneskerettigheter i Grunnloven* (December 19, 2011), sections 32.1, 32.5.1 and 32.5.2, and Recommendation from the Parliament committee no. 169 (2012–2013), *Innstilling fra kontroll- og konstitusjonskomiteen om rapport til Stortingets presidentskap fra Menneskerettighetsutvalget om menneskerettigheter i Grunnloven*, section 1.8.14.

[12] The right to privacy, as protected in Article 16 of the CRC, is covered by this provision.

[13] Section 102 of the Norwegian Constitution.

[14] Henriette Sinding Aasen and Mette Hartlev, "Human Rights Principles and Patient Rights," in *Health and Human Rights: Global and European Perspectives*, 2nd edition, eds. Brigit Toebes, Mette Hartlev, Aart Hendriks and Henriette Sinding Aasen (Intersentia, 2022), 53–91, 57–60 and 70–82.

rights are to be protected with regard for parental rights and responsibilities; cf. CRC Article 3 second paragraph and Article 18 first paragraph. Article 5 of the CRC proclaims that States Parties "shall respect the responsibilities, rights and duties of parents […] to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognised in the present Convention." This provision recognises parental rights as well as children's evolving capacities when it comes to exercising Convention rights.

11.3 VULNERABILITY AND CAPABILITY – THEORETICAL PERSPECTIVES[15]

11.3.1 Introduction

The discussion in this chapter concerns the right of adolescents to give consent to healthcare. The Norwegian Patient and User's Right Act contains 1) the main rule of entitling children to consent to healthcare from the age of 16, with the corresponding right of parents to consent on behalf of children below 16, and 2) special regulation entitling adolescents 12–16 years to consent on their own if certain conditions are fulfilled. Concepts of vulnerability and capability are informative for understanding the legislative objectives underpinning the regulation. Therefore, before turning to the specific legal provisions in the Patient and User's Rights Act, I briefly present the basic ideas of the vulnerability and capability theories and their implications for human rights and the legal issues discussed in this chapter.

11.3.2 Vulnerability and Human Rights

The term "vulnerable" originates from the Latin word *vulnus*, which means "wound".[16] As human beings, both children and adults are vulnerable. We may all be harmed in different ways: physically, emotionally, socially, financially and in our relations with others. We may be victims of violence, discrimination, accidents, natural disasters, pandemics, diseases, etc., and we are destined to become

---

[15] This section builds on my chapter: Henriette Sinding Aasen, "Vulnerability and Autonomy: Competing Perspectives in Human Rights," in *Health and Human Rights: Global and European Perspectives*, 2nd edition, eds. Brigit Toebes, Mette Hartlev, Aart Hendriks and Henriette Sinding Aasen (Intersentia, 2022), 221–255.

[16] Lourdes Peroni and Alexandra Timmer, "Vulnerable Groups: The Promise of an Emerging Concept in European Human Rights Convention Law," *International Journal of Constitutional Law*, vol. 11(4) (October 2013): 1056–1085, 1058.

old, lose physical and mental capacity, and depend more on caring relationships.[17] As pointed out by Fineman,[18] vulnerability is an inherent and constant aspect of the human condition, applying to all human beings in all social and political systems, calling for responsive legal and social structures. Mary Neal observes that "[w]ithout vulnerability, there would be no need for healthcare, or law, or ethics".[19] The Universal Declaration of Human Rights (UDHR) and the adoption of human rights conventions and monitoring bodies are founded on concerns regarding embodied (universal) vulnerability and particular vulnerabilities related to certain groups.[20]

Despite human beings' vulnerability – and not least that of children – the liberal idea and notion of free and independent subjects capable of pursuing their own interests is also strong in the human rights doctrine, with its historical roots in the Enlightenment and theories of the social contract:

> Society is constituted through a social contract, and autonomous and independent individuals interact with the state and its institutions, as well as with each other, through processes of negotiation, bargaining, and consent.[21]

Principles of respect for individual autonomy (consent) and privacy rights are strong in medical law protecting patient rights. These rights also protect children's interests in the health context.[22] Still, it is fair to say that the idea of liberal and independent subjects falls short in many situations, relations and contexts, not corresponding to the realities of many people,[23] including children.

---

[17] Jonathan Herring, "Ageing and Universal Beneficial Vulnerability," in *Embracing Vulnerability. The Challenges and Implications for Law*, eds. Daniel Bedford and Jonathan Herring (Routledge, 2020), 63–79. Herring observes that in old age, "we become most apparently what we always have been: vulnerable, frail and mutable" (75).

[18] Martha Albertson Fineman, "Equality, Autonomy, and the Vulnerable Subject in Law and Politics," in *Vulnerability. Reflections on a New Ethical Foundation for Law and Politics*, eds. Martha Albertson Fineman and Anna Grear (Ashgate, 2013), 13–29.

[19] Mary Neal, "The Idea of Vulnerability in Healthcare Law and Ethics: From the Margins to the Mainstream?" in *Embracing Vulnerability. The Challenges and Implications for Law*, eds. Daniel Bedford and Jonathan Herring (Routledge 2020), 91–114, 91. Neal challenges the idea that vulnerability is something harmful and undesirable to be reduced as far as possible (97–99). She points out that vulnerability traditionally has been understood "through the lens of the 'ideal' of the autonomous, self-determining patient, and seen as an obstacle to that ideal" (99).

[20] Peroni and Timmer, "Vulnerable Groups," 1056–1085.

[21] Fineman, "Equality, Autonomy," 13–29, 17.

[22] See section 11.4 below, where consent and privacy issues are discussed.

[23] Fineman, "Equality, Autonomy," 13–29, 17–24; Peroni and Timmer, "Vulnerable Groups," 1056–1085, with further references, 1061–1063.

Even if vulnerability is a common aspect of the human condition, certain individuals or groups are considered more vulnerable to human rights violations than others.[24] Individual and social factors may indicate that some people are particularly vulnerable to human rights violations. Over time, the international community has recognised the need to supplement the general human rights conventions[25] with more focused instruments targeting the vulnerabilities and needs of various groups. The CRC is a specific instrument addressing children's human rights and special vulnerabilities. The strategy of separate instruments for different groups, despite protecting the same basic rights, renders visible the great variations in the human condition and the different ways in and different reasons for which humans are vulnerable.[26]

Many factors may impact on children's vulnerability,[27] such as family environment and socio-economic situation, health and functioning, age, level of development and maturity, social support and relations. Some factors are of a structural nature, while other factors are associated with individual characteristics or behaviour, such as individual maturity or engaging in unsafe sex.[28] The vulnerability of children is especially due to their dependency on adults to take care of them and/or protect their interests, which makes them exposed to exploitation, violence, abuse and neglect.[29] Therefore, many of the CRC provisions oblige states to protect children against various harmful actions[30] and to ensure their basic needs through appropriate information and health and social services.[31] Children's dependency on parents makes them particularly vulnerable to human rights violations in the family setting. But even responsible and well-intended parents could make decisions with potential harmful consequences, e.g., if they fail to listen to

---

[24] Peroni and Timmer, "Vulnerable Groups," 1056–1085, 1060–1061 and 1063–1070, with references to ECtHR case law.

[25] International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR), both adopted by the UN on 16 December 1966.

[26] Fineman, "Equality, Autonomy," 13–29, 20–22.

[27] Mary Neal argues that vulnerability "is a prerequisite for, and a component of, the value of human dignity", in the same way as autonomy is only one aspect of dignity; Neal, "The Idea of Vulnerability," 91–113, 108.

[28] UN Committee, on the Rights of the Child, *General Comment no. 4 (2003), Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, CRC/GC/2003/4, (July 1, 2003), para. 34.

[29] CRC/GC/2003/4, para. 12. See also Doc. 16 (2011–2012), 191.

[30] See, for example, Articles 16, 19, 22 and 24(3).

[31] See Articles 13, 20, 23, 24, 26 and 27. See CRC/GC/2003/4, paras. 10, 26, 28, 35 and others.

the child and neglect their needs and perspectives. Also, in such situations, the child's dependency and lack of autonomy create vulnerability for damage.

However, a general assumption that all children are vulnerable and not able to protect their own interests creates risks of generalisations and victimisation which could be potential barriers for realising children's rights.[32] The overarching duty of securing the best interests of the child, the right to participate in decisions affecting them, and the right to make decisions according to age and maturity all require individual assessments of the particular circumstances, needs and capacities of each child, thereby counteracting dangers of generalisations.[33]

11.3.3 Capability and Human Rights

In the 1980s, the Indian economist and philosopher Amartya Sen,[34] followed by the American ethicist and legal scholar Martha Nussbaum, developed new knowledge on the importance of including human capabilities in the reasoning of welfare state economics, social choice theory and social justice ("the capability approach"). *Capabilities* are possible types and levels of individual functioning which are feasible for a person to achieve. Sen observed the close connection between human rights and human capability, asserting in his theory of justice that human rights values, freedoms and entitlements contribute to the enhancement of human agency and capability.[35] This approach indicates the perspective that human rights should be understood as instruments of enhancing and strengthening human capability, including the capability to live a healthy life.[36] Among the core capabilities which according to Nussbaum should be supported by all democratic societies are those connected to life, health and integrity, including the capability of survival and dignified existence, the ability to pursue a healthy life, the ability to make reproductive choices, and the ability to live free from violence and oppression.[37]

The capability approach, understood as a systematic approach of strengthening human capabilities to live dignified lives according to individual preferences,

---

[32] Peroni and Timmer, "Vulnerable Groups," 1056–1085, 1070–1073.

[33] Mona Martnes, "Barns autonomi og barnevaksinasjonsprogrammet," in *Menneskerettigheter i helse- og omsorgstjenesten*, eds. Henriette Sinding Aasen and Marianne Klungland Bahus (Universitetsforlaget, 2022), 329–351, 346–350, with further references.

[34] Amartya Sen, *Inequality Reexamined* (Clarendon Press, 1992).

[35] Amartya Sen, *The Idea of Justice* (Penguin Books, 2009), 321–388, 381.

[36] Brigit Toebes, "Synergies and Tensions in the Health and Human Rights Frameworks", unpublished manuscript.

[37] Martha Nussbaum, "Capabilities as Fundamental Entitlements: Sen and Social Justice," *Feminist Economics*, vol. 9(2–3) (2003): 33–59.

provides a quite different perspective than the focus on vulnerability. Rather, the capability approach is oriented towards strengthening individual capacities and is thereby more connected to individual autonomy and agency. Both vulnerability and capability perspectives and approaches are important to capture essential aspects of human rights values, principles and objectives. They should be seen as supplementary rather than contradictory in the human rights discourse.[38] The vulnerability and capability perspectives applied to children in the health field imply respectively adequate protective measures as well as the securing of avenues for individual empowerment and strengthening of individual capabilities.

Building on Rogers et al., Neal points out that when persons are both vulnerable and capable of autonomy, an appropriate balance must be found between protection and support for autonomy. Theories of *relational autonomy*, premised on human dependency but still recognising the human need for individual choice and autonomy, seem adequate in healthcare due to the intimate nature of the subject.[39] Rogers et al. argue that "a relational approach is committed to the view that the obligations arising from vulnerability extend beyond protection from harm to the provision of the social support necessary to promote the autonomy of persons who are more than ordinarily vulnerable".[40] In that sense, vulnerability and capability perspectives supplement each other.

In the following, I explore provisions mainly in the Norwegian Patient and User's Rights Act, using vulnerability and capability perspectives in the assessment of the balancing of rights and duties of adolescents, parents and health providers.

11.4 CHILDREN AND HEALTHCARE DECISIONS – THE NORWEGIAN REGULATION

11.4.1 Points of Departure

Generally, children have a right to receive care and consideration from their parents, while parents have a right to make decisions for children in personal matters, within limits specified by law.[41] Parental authority shall be exercised based

---

[38] Toebes, "Synergies and Tensions in the Health and Human Rights Frameworks."

[39] Neal, "The Idea of Vulnerability," 91–114, 108–109, with reference to Wendy Rogers, Catriona Mackenzie and Susan Dodds, "Why Bioethics Needs a Concept of Vulnerability," *International Journal of Feminist Approaches to Bioethics*, vol. 5(2) (Fall 2012): 11–38. See also Francesca Ippolito, *Understanding Vulnerability in International Human Rights Law* (Editoriale Scientifica, 2020), 12–15.

[40] Quoted from Neal, "The Idea of Vulnerability," 91–114, 108.

[41] Act April 8, 1981, no. 7 on barn og foreldre [Norwegian Act on Children and Parents], section 30 first paragraph.

on the interests and needs of the child and with regard for the child's right to participation and self-determination according to age and development.[42] Parents have a duty to recognise children's evolving capacities; cf. section 33 of the Act on Children and Parents, saying that parents shall give the child increasing self-determination in personal matters ("sjølvråderett") as he or she grows older, until majority is reached at the age of 18.[43]

When it comes to healthcare decisions, the Patient and User's Rights Act applies *lex specialis*. While the ordinary age of majority is 18, it is 16 in the health context, due to the recognition of health issues as particularly personal or intimate. The main rule is that adolescents *from the age of 16* are seen as generally capable of giving informed consent to or rejecting healthcare. Parents[44] are entitled to give informed consent or reject treatment on behalf of children below 16.[45] The right of adolescents to consent on their own from the age of 16 applies unless special legislation or the nature of the intervention (e.g., invasiveness or minor interventions) dictates or indicates otherwise.[46]

The Sterilisation Act[47] requires a capable person of sound mind who seeks *sterilisation* to be 25 years of age (section 2). A new provision in the Patient and User's Rights Act sets an age limit of 18 for cosmetic surgery or interventions without medical indication, not even with parental consent (section 4-5a). Moreover, only patients above 18 have a right to reject treatment with blood due to a serious conviction or to reject life-extending treatment.[48] In cases of *emergency*, health providers according to the Health Personnel Act[49] section 7 are under an obligation

---

[42] Sections 31 and 33. See parallel obligations in the CRC, Articles 3, 5, 12 and 18(1).

[43] See corresponding provision in Article 5 of the CRC.

[44] In the following, the term "parents" means persons with parental responsibility for the child, normally the mother and father, a legal guardian or the child protection service.

[45] Section 4-3 first paragraph litra (b) and section 4-4 first paragraph. Section 4-4 gives detailed regulations for situations when parents are divorced or disagree about proposed treatment, which will not be discussed here. See Trude Haugli and Randi Sigurdsen, "Om foreldreansvar og barns rett til helsehjelp" [On parental responsibility and children's right to healthcare], in *Likestilling, barn og velferd, rettsfelt i utvikling* [Equal rights, children and welfare], eds. Sigrid Eskeland Schütz, Ragna Aarli and Henriette Sinding Aasen (Gyldendal, 2020), 366–384.

[46] Section 4-3 first paragraph *litra* (b).

[47] Act June 3, 1977, no. 57 om sterilisering [Norwegian Act on Sterilisation].

[48] Norwegian Patient and User's Rights Act section 4-9 first and third paragraph. Concerning complex issues related to life/death decisions involving children, see Marianne Klungland Bahus, "Beslutningskompetanse og barnets beste ved liv/død- avgjørelser til barn" [Life/Death Decisions Involving Children], in *Menneskerettigheter i helse- og omsorgstjenesten* [Human Rights in Health and Care Services], edited by Henriette Sinding Aasen and Marianne Klungland Bahus (Universitetsforlaget, 2022), 351–379.

[49] Act July 2, 1999, no. 64 om helsepersonell [Norwegian Health Personnel Act].

to provide healthcare irrespective of age or consent, with a few exceptions. Parents are entitled to give informed consent on behalf of patients between 16 and 18 years *without consent capacity*, as long as the patient does not oppose the treatment.[50] If a patient aged 16–18 opposes treatment, the treatment must be allowed by particular legislation.[51] The alternative *nature of the intervention* in Patient and User's Rights Act section 4-3 first paragraph *litra* (b) concerning patients between 16 and 18 is typically applicable in case of a serious procedure, such as a risky or potential life-changing or threatening operation, which a 16- or 17-year-old child is not seen as competent to consent to alone. The above-mentioned legislation will not be discussed further in this chapter.

All children are entitled to information necessary for meaningful participation in the decision-making process concerning healthcare.[52] They have a right to age-appropriate information according to the individual child's capacity, maturity, language, etc.,[53] and a right to express their views about proposed healthcare. The child's right to be informed and participate does not depend on a particular age but rather on the ability of each child to give and receive information. Children who are able to form their own opinions shall receive information and be heard. Their views shall be taken into account in accordance with age and maturity.[54] According to section 4-4 last paragraph (last sentence), the opinion of a child who has reached 12 years *shall* be given great weight.

This absolute requirement could be somewhat problematic if the child is clearly immature for their age. Even younger children's opinions should be given great weight if the understanding and maturity of the child indicate so. Previous experiences could play a significant role and in fact be more important than age.[55] The reference to a particular age could hide the most essential aspect of child participation, namely, that the child understands what is at stake and is able to make up their own mind.[56] Neither the Constitution Section 104 nor the CRC Article 12 mentions a particular age for when the opinion of the child should have great

---

[50] Norwegian Patient and User's Rights Act section 4-5 first and last paragraph.

[51] Ibid., last paragraph. For psychiatric healthcare, the Act July 2, 1999, no. 62 om etablering og gjennomføring av psykisk helsevern [Norwegian Act on Psychiatric Healthcare] applies concerning consent and requirements for coercive interventions. These provisions will not be discussed further.

[52] Norwegian Patient and User's Rights Act sections 3-1 first paragraph and 3-2 first paragraph.

[53] Ibid. section 3-5.

[54] Norwegian Patient and User's Rights Act sections 3-1 first paragraph last sentence and 4-4 last paragraph.

[55] Haugli and Sigurdsen, "Om foreldreansvar," 366–384, 383.

[56] Sandberg, "Children's Right to Participation," 71–89, 88.

influence on decisions. Age limits are not in direct conflict with the CRC;[57] however, referring to evolving capacities would be more in line with Article 5 in the CRC.[58]

In the following, we will concentrate on the special rules in the Norwegian Patient and User's Rights Act regarding adolescents aged 12–16.

11.4.2 Special Regulation for Adolescents Aged 12–16 Years

Overview

The term "child" includes individuals from 0–16 years of age in the health context (cf. section 4–3 of the Patient and User's Rights Act),[59] thereby covering a broad range of ages and stages of development. Maturity is a gradual phenomenon and with great individual variations. Adolescents, in contrast to younger children, will often be able to make rational and reasonable choices and decisions for themselves. Furthermore, certain healthcare decisions may be of a particular sensitive or personal nature. This is why the Patient and User's Rights Act has special regulations in sections 3–4 and 4–3 concerning information and consent for adolescents between 12 and 16 years of age. The regulation indicates the view that parental involvement in some situations may conflict with the wishes and even the best interests of a young person. In the following, the focus will mainly be on children aged 12–16, although younger children will be mentioned a few times when relevant.

Overall Legislative Objective: Securing the Right to Health

The Norwegian regulation is, in line with Article 24 of the CRC, motivated by the objective of securing children's right to health. More specifically, the legislative intention is to enable persons between 12 and 16 years of age to access healthcare, information and advice, for example, from the school nurse or a community doctor, without fearing that parents will be automatically informed.[60] The assumption is that adolescents may choose not to use the health service if they fear parental

---

[57] The CRC Committee states that "laws or regulations should stipulate an age […] or refer to the evolving capacity of the child," UN Committee on the Rights, *General Comment No. 4: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, CRC/GC/2003/4, (July 1, 2003) para. 29.

[58] Sandberg, "Children's Right to Participation," 71–89, 88.

[59] For the purposes of the CRC, a child means "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier" (Article 1).

[60] Draft resolution no. 75 (2016–2017) 86.

involvement. Securing accessibility to all is a leading principle in health service provision.[61] A related objective is to secure trust in the health service, which is a fundamental principle in securing that people use the health service,[62] also emphasised in the Norwegian Patient and User's Rights Act.[63] Thus, despite the main rule that parents have a right to consent on behalf of their children below the age of 16, in situations where the consequence could be that young people will not use the health service, or not be open about health issues and therefore not receive adequate care, priority is given to adolescents' privacy.[64] The balancing of parental rights versus the rights of adolescents is formulated in the Patient and User's Rights Act section 3–4 second paragraph in the following way: information *shall not be given to parents* when the child for *reasons that should be respected* ("av grunner som bør respekteres") is against it.

"Reasons That Should Be Respected"

All healthcare provision must be based on valid consent from the patient or a legal representative.[65] One consequence of entitling adolescents to give informed consent and not involving parents is that parental informed consent is not obtained.[66] Section 4–3 first paragraph *litra* (c) entitles adolescents to give informed consent without parental involvement in situations covered by section 3–4 second paragraph, i.e., when the young person expresses *reasons that should be respected* for not involving parents. In such situations, the law acknowledges that a person between 12 and 16 years of age may have sufficient personal capacity to give informed consent, given that age-appropriate information and support from the health service are provided. If there is reason to believe that parents should not be involved, the child must as soon as possible be informed about 1) parents' right to information and 2) the exceptions from the main rule.[67] The preparatory work stresses the importance of informing children that what they tell will not automatically be shared with

---

[61] Committee on Economic, Social and Cultural Rights, *General Comment no. 14, The Right to the Highest Attainable Standard of Health (Art. 12)*, E/C.12/2000/4 (August 11, 2000) paragraph 12 *litra* (b).

[62] See statements in the European Court of Human Rights, *Case of Z v. Finland* (Application no. 22009/93, Strasbourg: Judgment February 25, 1997).

[63] Section 1-1 second paragraph.

[64] Draft resolution no. 75 (2016–2017) 23.

[65] This is established in case law by the European Court of Human Rights and put forward in the Norwegian Patient and User's Rights Act sections 4-1, 4-4, 4-5, 4-6 and 4-7.

[66] This is stressed several times in the preparatory work; see Draft resolution no. 75 (2016–2017) 27, 28, 32.

[67] Section 3-4 fifth paragraph.

parents. Such assurance should be given as early as possible to establish necessary trust and security for children to talk about their concerns.[68]

The preparatory work emphasises that the alternative *reasons that should be respected* supplement the *nature of the intervention* alternative (in the same provision in section 4–3) which would typically allow children aged 12–16 to consent to minor, non-serious and non-controversial interventions, e.g., in the school setting. An example given for *reasons that should be respected*, however, reflects a far more serious situation where cultural norms are involved: a young girl seeking healthcare due to a previously performed genital mutilation, requesting confidential healthcare.[69] Female genital mutilation is strictly forbidden in Norway.[70] Despite the fact that such mutilations often happen before the girls arrive in Norway,[71] they are still controversial and stigmatising for both victims and parents. Healthcare will naturally aim to reduce pain and problems for the patient as much as possible. Involving parents could lead to additional problems for the girl. Therefore, her wish not to inform them should be respected.

The alternative *reasons that should be respected* apply in situations where parents would prefer to be contacted, or ideally should be involved in assisting their child, but where the young person for legitimate reasons does not want this. The preparatory work mentions mistreatment, parents' strong convictions, the need for advice on contraceptives or abortion, and non-serious psychological problems due to bullying as examples of such legitimate reasons.[72] The wording (reasons that should be respected) indicates some kind of assessment of the child's expressed wishes. The preparatory work indicates the same, e.g., by using the formulation that parents should not *automatically* be contacted[73] and stressing that this is a special case or an exception from the main rule of parental consent for children below 16.[74]

The child must be perceived as sufficiently competent to understand relevant age-appropriate information necessary for valid consent. If the child clearly does not understand the situation, for example, the seriousness of his/her health condition or the implications of a particular health intervention, parents must be

---

[68] Draft resolution no. 75 (2016–2017), 86.

[69] Ibid., 28.

[70] Act May 20, 2005, no. 27 om Straff [Norwegian Act on Criminal Offences], sections 284 and 285.

[71] Official Norwegian Reports (NOU) *2024: 13 Lov og frihet: Negativ sosial kontroll, æresmotivert vold, tvangsekteskap, kjønnslemlestelse, psykisk vold og ufrivillig utenlandsopphold – juridiske problemstillinger og forslag til* regelverksendringer [Law and freedom: Negative social control, forced marriage, genital mutilation, psychological violence and involuntary stay abroad – legal issues and suggested legislative changes], 222.

[72] Ibid., 17, 86.

[73] Ibid., 26, 86.

[74] Ibid., 17, 29, 32.

contacted to ensure informed decision-making and valid consent. Parents are entitled to the information they need to fulfil their parental responsibility.[75] Likewise, if the adolescent is seen as incapable of safeguarding his/her best interests in a reasonable manner, the health provider must contact the parents. This would be the case if the child needs to go to hospital, e.g., due to life-threatening or serious illness, risk of suicide or serious injury. Injury after drinking and driving is an example where parents should be contacted even if the child has reason to be afraid of strict reactions. Serious mental conditions, danger of self-harm, use of illegal drugs and serious physical injuries due to involvement in criminal activities are also examples where parents should be contacted to be able to fulfil their parental responsibilities, unless the child protection service should be contacted.[76] Another situation could be a 14-year-old girl having a sexual relationship with a much older man or a child who it seems is being abused or mistreated in a relationship. Parental involvement may be urgent to take care of the child and prevent further harm. However, if the parents are themselves abusive or seriously neglect the child, health staff must contact the child protection service.

The preparatory work refers to a statement by the Health Directorate saying that in a situation where the child is found to be capable of handling its own interests in a sensible manner, *and* it is questionable whether parents are acting in the best interest of the child, the justification for the rights of parents lapses.[77] This statement could indicate that if the health provider, after having listened to and discussed with the child, is not convinced that the parents will behave inadequately, the conditions are not fulfilled. Thus, if the health provider finds that it would most likely be in the best interest of the child to contact parents after having considered the situation carefully, the justification for leaving the decision to the child seems to be lacking, according to statements in the preparatory work. This understanding is supported by statements[78] referring to the right and duty of parents to make decisions on behalf of their children in personal matters and that in most situations parents are in the best position to take care of their children's best interests, given that the child's evolving capacities are acknowledged. In section 4.2.5 below, we will come back to the question of how to balance the different considerations and interests at stake in these situations.

---

[75] Norwegian Patient and User's Rights Act section 3-4 fourth paragraph.

[76] Draft resolution no. 75 (2016–2017) 17, 86. According to the Health Personnel Act section 33, health staff are obligated to report to the child protection service immediately if there is reason to believe that a child is mistreated, seriously neglected, or suffering from a life-threatening illness or injury which is not taken care of or if a child shows serious behavioural problems.

[77] Draft resolution no. 75 (2016–2017), 28.

[78] Draft resolution no. 75 (2016–2017), 23.

"Weighty Regard to the Child"

Irrespective of the child's age, health personnel may not inform parents in situations where weighty regard for the child ("tungtveiende hensyn") speaks against it. The provision is meant to be a narrow exception from the main rule of parental consent. The preparatory work mentions serious neglect and intimate issues such as gender identity, sexuality, psychosocial problems or other severe problems experienced by the child.[79] The main concern is to include situations where the child is either below 12 years old or is not capable of expressing particular reasons for not involving parents, but where the health personnel have evidence (e.g., due to earlier contact with the parents) to conclude that it would not be in the child's best interest to involve parents. This could be the case if informing parents would put the child in danger or in a more difficult situation, in cases of parental abuse or serious neglect, or if parental involvement would prevent the child from giving information that could help the child to access necessary healthcare.[80]

If the child is below 12, health personnel are entitled to make decisions about strictly necessary interventions which are not intrusive regarding nature or duration. Such decisions may only be taken for a limited period until a valid consent from a legal representative can be obtained.[81] If the child is between 12 and 16, and parents are not to be involved, the child should consent alone, or the child protection service must be contacted if the conditions in the Health Personnel Act section 33 are fulfilled.[82] In the following, the difficulties of balancing rights and duties will be further discussed.

Balancing Rights and Duties

The preparatory work emphasises that both the second and third paragraphs in section 3-4 aim at balancing considerations of, respectively, young patients' autonomy and parental care and responsibility, stressing the importance of securing parents' information necessary for fulfilling their parental responsibility.[83] The *reasons that should be respected* alternative in the second paragraph is rather vague and could open up for different practices, for example, more liberal in certain areas and more restrictive in others. The preparatory work and administrative guidelines provide some direction, especially by giving examples (see above). But still,

---

[79] Draft resolution no. 75 (2016–2017), 85.

[80] Ibid., 86.

[81] Section 3-4 third paragraph of the Norwegian Patient and User's Rights Act.

[82] See note 76 above.

[83] Ibid., 17-18.

the legal situation is not clear and predictable regarding when it is justified to leave parents out. What about situations where there is no reason to believe that parents are neglecting the child or are otherwise problematic parents? How far should health providers go in respecting the wishes of adolescents not to inform parents when they are below the age of 16? And how should health staff act if the child opens up in confidence that parents will not be contacted, but the health provider after all finds that parents should be involved?

Regarding the alternative *weighty regard to the child* (see above), the preparatory work emphasises that in a situation where a child opens up about his/her problems, and the health personnel find that worries are exaggerated and that it would be best to involve parents, they should explain why and try to convince the child to agree to inform the parents.[84] This strategy should also be used in situations where adolescents aged 12–16 express legitimate views for why parents should not be involved according to *the reasons that should be respected* alternative, i.e., where the consultation reveals that worries seem exaggerated and that non-involvement of parents may not be in the child's best interest. Clearly, these situations require a concrete and thorough assessment of the information available, and health personnel might experience difficulties in finding the right solution.[85]

However, if the child is above the age of 12, and the child has opened up trusting that parents will not be contacted, it is essential to preserve the child's trust and secure her/him access to professional care. Health personnel cannot first encourage the child to open up under the promise of confidentiality and thereafter contact the parents. This would be a breach of the promise and a violation of the Patient and User's Rights Act section 3-4 second paragraph.[86] The dilemma confronting health personnel is at the same time an illustration of the child's dependency and vulnerability due to insecurity of how health personnel will respond.[87]

An example illustrating this dilemma is if a 14-year-old girl who is being sexually active with her boyfriend of the same age[88] contacts the health service for

---

[84] Draft resolution no. 75 (2016–2017), 24, and Health Directorate, *Regulation: Patient and User's Rights Act with comments*, updated November 16, 2021, https://www.helsedirektoratet.no/rundskriv/pasient-og-brukerrettighetsloven-med-kommentarer (visited November 23, 2022).

[85] Henriette Sinding Aasen, "Barnets rett til medvirkning, selvbestemmelse og privatliv ved helsehjelp" [The Child's Right to Participation, Self-Determination and Privacy in Relation to Healthcare], in *Barnekonvensjonen i norsk rett. Prinsipper og praksis*, eds. Ingun Fornes, Anna Nylund and Kari Sperr (Gyldendal, 2023), 141–165, 158.

[86] Ibid., 159.

[87] See section 11.5 below.

[88] In Norway, sexual intercourse with a person below 16 is illegal according to the Norwegian Act on Criminal Offences, May 20, 2005 No. 28 section 302. Sexual intercourse or relations with a person below 14 is defined as rape (section 299).

contraceptives. The penalty for sexual intercourse may according to the Act on Criminal Offences lapse[89] when "victim" and "offender" are of the same age and maturity[90] and the relationship is obviously voluntary. If the partner is much older, sexual intercourse or activity will be a criminal offence. In that case, health personnel cannot avoid reporting to parents, and even to the police if necessary, in order to prevent serious harm.[91] If the relationship is with a partner of the same age and maturity, and no exploitation or pressure is suspected, reporting to parents, the child protection service or police may conflict with both confidentiality rights and the best interests of the child. Respecting the needs of the child would involve securing access to contraceptives and guidance from health professionals on safe sex and other relevant issues brought up in a confidential setting. In this situation, the girl has *reasons that should be respected* for not involving parents, if she is clearly worried that contacting them could lead to punishment or other harsh reactions.

If the girl is below 14, however, according to the law she is not capable of giving consent to sexual intercourse or relations.[92] However, in 2020, section 196 in the Act on Criminal Offences on the general duty to avert such relations – e.g., by reporting to parents or police – was amended. The situation now is that the duty to avert sexual relations does not apply when the children are of the same age and maturity, specified in the preparatory work as around two years' difference.[93] The Supreme Court has specified that when the parties are of the same age and maturity, only particular reasons (abuse, exploitation) can justify punishment. If the child is below 14, an age difference greater than three to three and a half years will be seen as punishable.[94] Holmboe points out that for health personnel it could be challenging to apply section 196 in the Act on Criminal Offences.[95]

When it comes to sexuality, the legal regulation clearly presumes a close examination by health personnel of the nature of intimate relations, maturity and age of partner when young patients seek assistance to avoid unwanted pregnancies.

---

[89] The formulation signals that the sexual relationship could be a criminal offence, which views adolescents as potential criminal offenders when they are sexually active.

[90] Norwegian Act on Criminal Offences, section 308.

[91] Norwegian Health Personnel Act, section 31.

[92] Morten Holmboe, "Taushets- og opplysningsplikt i helsesektoren – menneskerettighet mot menneskerettighet" [Confidentiality and Information in Healthcare – Human Rights in Conflict], in *Menneskerettigheter i helse- og omsorgstjenesten* [Human Rights in Health and Care Services], eds. Henriette Sinding Aasen and Marianne Klungland Bahus (Universitetsforlaget, 2022), 96–122, 111.

[93] Ibid., 119.

[94] Ibid. with reference to Norwegian Supreme Court Judgement, Rt. 2003, 342 and HR-2017-579.

[95] Ibid.

The potential threat of punishment makes the situation unpredictable, and young persons in need of contraceptives – also those above 14 – may choose to stay away from the healthcare service to avoid unwanted infringements by parents or even the police.

The CRC Committee emphasises the right of adolescents to give informed consent according to their maturity and the importance of schools and other venues to help the child develop a healthy lifestyle and to provide adolescents with essential information on safe sexual behaviour.[96] Youth-specific services tailored to the needs of young persons have proven to improve accessibility to young persons.[97] In Norway, municipalities have established health services for young persons to meet the need for information and advice. In Bergen, for example, there is a free-of-charge drop-in service for persons between 13–25, where they can get advice from a nurse or doctor about contraceptives, pregnancy and abortion. Moreover, issues like eating problems, depression, sorrow, loneliness, difficulties in the family, drugs, violence, abuse and bullying are emphasised.[98] These are issues where parents ideally should be involved, especially if the child is below 16. However, as described, parents are not always in a position to assist their children, and it is therefore necessary to provide confidential services for young people, in line with the requirements and limits outlined above.

As mentioned, the preparatory work to the Patient and User's Rights Act concerning the regulation of consent leaves the impression that the exceptional rule for adolescents aged 12–16 is somewhat linked to the notion of an irresponsible parent, situations of conflict between the child and their parent(s) or parents with strong convictions that are likely to be a barrier to the child's access to particular health services.[99] But what about the situation where none of these reasons exists? A girl aged 14/15 wants contraceptives to avoid pregnancy, and at the same time explains that her parents most likely would support her, but she does not want to bother them due to other social problems in the family, and she is also embarrassed and expresses the view that it is her body and she should be able to make that decision herself, especially since the outcome could be an unwanted pregnancy. It seems clear that she will continue to have sex with her boyfriend(s), and she seems able to protect herself from abusive relations. Most parents would

---

[96] CRC/GC/2003/4, paras. 17, 28, 30 and 32.

[97] Tobin, *The Right to Health*, with further references.

[98] "Helsestasjon for ungdom, et gratis dropin-tilbud" [Health Center for adolescents, free of charge drop-in offer], Bergen Kommune, https://www.bergen.kommune.no/innbyggerhjelpen/helse-og-omsorg/helsetjenester/helsestasjon-og-skolehelsetjeneste/helsestasjon-for-ungdom-et-gratis-dropin-tilbud (Visited January 30, 2024).

[99] See above in this section.

probably be worried about their child being sexually active at an early age with several partners. However, both parents and children often find it difficult to be open about sexuality and to discuss the matter in detail.

The overall objective of the legal regulation is to ensure that young persons have access to necessary health services, including sexual and reproductive care. Children have a right to necessary health services,[100] and girls have a right to seek abortion,[101] which implies the necessity of legal protection from infringements which could imply barriers to access services. When it comes to intimate health concerns such as sexuality and reproduction, adolescents' right to autonomy, privacy and confidentiality is strongly emphasised by the CRC Committee:

> In accordance with their evolving capacities, children should have access to confidential counselling and advice without parental or legal guardian consent, where this is assessed by the professionals working with the child to be in the child's best interests … States should review and consider allowing children to consent to certain medical treatments and interventions without the permission of a parent, caregiver, or guardian, such as HIV testing and sexual and reproductive health services, including education and guidance on sexual health, contraception and safe abortion.[102]

The conditionality following from "to be in the child's best interests" in the quote must be related not only to leaving parents out but also to the potential outcome that the young person will not use the healthcare service when needed in the future. This could mean a breach of the right to health; cf. CRC Article 24. This is clearly not in the best interest of the child, and should be a main consideration when interpreting the provisions in the Norwegian Patient and User's Rights Act section 3-4.

Vaccination is another theme which could potentially create conflict between children and parents. If a child is mature and expresses convincing reasoning for wanting a particular vaccination, which is also recommended by health authorities, but fears serious conflict or negative reactions from parents, it seems reasonable to assert that a child below 16 should be entitled to give informed consent

---

[100] Norwegian Patient and User's Rights Act sections 2-1 a) and 2-1 b).

[101] Act June 13, 1975, no. 50 om svangerskapsavbrudd [Norwegian Act on termination of pregnancy]. If the girl is under 16, parents are entitled to give a statement ("uttale seg") unless special reasons speak against it (section 4).

[102] UN Committee on the Rights of the Child, *General Comment no. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24)*, CRC/C/GC/15, (April 17, 2013), para. 31.

independently.[103] In this situation, parents are acting against general advice from the health authorities, and in that regard could be seen as not fully living up to the ideal of a responsible parent. According to the logic in the preparatory work (the child's right to consent is justified when parents are not trusted to act in the best interest of the child), such a failing, though small, could justify that a mature and informed child is entitled to consent. However, if the parents are generally responsible but strongly against vaccination due to fear of potential health risks, such resistance should not be held against them. They could even be seen as very responsible parents. Such resistance is clearly within what must be accepted in a democratic society. The right of the child to consent to vaccination should therefore be justified not with reference to parental irresponsibility but rather with reference to child capability and autonomy. Sandberg seems to have a similar understanding based on the CRC, saying that if parents to a normally capable 14–15-year-old child object to a doctor-recommended and non-controversial treatment "without reasonable grounds", the decision should be left to the child.[104] If parental objection is based on strong convictions not shared either by the health service or by the child, respect for the child's evolving capacity is in best harmony with the CRC and section 104 of the Norwegian Constitution.[105]

The overall duty of health personnel and other public servants is to secure the best interests of the child in terms of health, well-being and future development. An important assumption also stressed by the CRC Committee is that responsible healthcare personnel will assist the child in making the best possible decision, by providing objective and age-appropriate information and professional advice and support. The health worker must assess the entire situation, including the age of the patient, maturity, scope of treatment and family relations, and consider what would be the best solution for the child under the circumstances. The health worker does not need to fully agree with the choices made by the child, but must, however, make sure that the child is protected from criminal offences and that the child is able to make reasonable and voluntary decisions, e.g., by using contraception when having sex with different boys of her own age. The doctor or nurse may find that the child's behaviour is not ideal or completely safe, but still believe after conversing with the child that it is in her best interests to have a safe place to receive proper advice on safe sexual behaviour and contraception rather than contacting parents against her will and with the potential outcome that she will stay away from the health service in the future. Such an assessment is within the

---

[103] Martnes, "Barns autonomi."

[104] Sandberg, "Children's Right to Participate," 71–89, 88.

[105] See section 11.2.

discretionary space left to health personnel according to the Patient and User's Rights Act.

11.5 VULNERABILITY AND CAPABILITY – FINAL REFLECTIONS

While children are traditionally seen as inherently vulnerable and dependent on the care of others, especially that of parents, Norwegian law acknowledges that respect for children's autonomy and privacy rights in certain situations is the most adequate way of protecting essential health and welfare interests. Children (adolescents) are thus seen as both vulnerable and capable. These perspectives complement each other insofar that by securing autonomy and privacy rights, they may reduce the young person's vulnerability to ill health. The regulation implies that an adolescent's rights to autonomy and privacy are prioritised over parental rights when this is considered the most adequate way of securing the child's best interests in terms of facilitating access to necessary health services. The best interests of the child, put forward in the CRC and the Constitution, are thus the balancing principle in the regulation, even though this principle is not mentioned in the Patient and User's Rights Act.

The legal term "free informed consent" is the gateway for accepting the consent as a legal basis for effectuating healthcare.[106] The right reflects the notion of an independent legal subject assumed capable of handling his/her own interests. When a child is put in the position of giving informed consent, the child is as all patients entitled to receive information adapted to individual prerequisites. The child is given responsibility for taking care of his/her own interests with assistance from a professional health provider, which could be called "relational autonomy" due to the assumed dependency on the healthcare worker.[107] As emphasised by Rogers et al., "relational autonomy" implies that "the obligations arising from vulnerability extend beyond protection from harm to the provision of the social support necessary to promote the autonomy of persons who are more than ordinarily vulnerable".[108] The quote captures the essence of this chapter, seeing the notions of vulnerability and capability as mutually interdependent, which supplement and reinforce each other. Persons in vulnerable situations need additional assistance to strengthen their autonomy and capability to make sensible decisions in difficult life situations.

---

[106] Norwegian Patient and User's Rights Act section 4-1.

[107] See Rogers, Mackenzie and Dodds, "Why Bioethics," quoted in section 11.3.2.

[108] Ibid.

The terms “capacity” and “competency”, used to determine whether the young person is capable of making healthcare decisions, do not equate with the word “capability” as used in Sen’s theory. Capability theory is a theory about how human rights, generally and at the individual level, could enable human beings to achieve better functioning and more dignified lives, including health and well-being. In relation to children’s rights in the health setting, capability theory implies that children’s right to health should be respected and protected to ensure their optimal functioning and quality of life. This is also the overall objective of protecting children’s autonomy and privacy rights at the expense of parental rights: to secure access to necessary health services in situations where children’s dependency on parents could imply barriers to service accessibility. This could be the case even if parents are responsible and supportive, typically if the adolescent for various reasons does not want them to be involved in personal and sensitive matters at a given time. Capability theory provides an argument for respecting children’s autonomy and privacy rights as long as they have capacity to make reasonable decisions and involvement of parents could prevent them from receiving necessary healthcare.

Children’s capacity is not necessarily linked to a particular age, although age is often an indicator of the level of maturity. The 12–16 age range as specified in the Patient and User’s Rights Act section 3-4 second paragraph covers a wide scope of development stages, which in fact could occur both before and after the mentioned ages. The intention is to acknowledge children’s evolving capacities, which is in line with Article 5 of the CRC; however, the specification of ages may blur the most important issue: the individual child’s personal capacity and maturity. Section 104 of the Constitution protects the integrity of children without linking this to particular ages. This could imply that autonomy and privacy rights of children should primarily be protected in accordance with their personal capacity and maturity. Integrity protection is especially important in relation to personal and intimate issues such as healthcare.[109]

Capability theory reflects the basic objective of the legal regulation, i.e., to empower children and make them less dependent and vulnerable, with the overall goal of securing access to necessary health services. In the situations covered by section 3-4 in the Patient and User’s Rights Act, there is not necessarily a conflict between respecting the child’s autonomy and privacy rights on the one hand and the protection of the child’s life, health and/or development on the other. Rather, these rights reinforce each other in securing the assumed best interests of the child. This may be the case even when the adolescent makes decisions that are not seen as the best lifestyle or relational choice. If the involvement of parents could

---

[109] Haugli and Sigurdsen, “Om foreldreansvar,” 366–384, 382.

lead to a worsened situation, such as a more serious mental or physical condition, it is in the best interests of the child to receive necessary care without parental involvement. The vulnerability perspective is inherent in the assessment of the child's situation with the overall purpose of securing the child adequate support in a difficult life situation.

One problem with the legislation is the wording's discretionary nature, creating legal insecurity for children, parents and health professionals alike. Haugli and Sigurdsen point out that children's right to health is linked to the rights of parents to make decisions on their children's behalf and that consent issues are seldom discussed in publicly available cases.[110] Regarding the regulation of consent issues for adolescents, formulations like "nature of the intervention", "reasons that should be respected", "weighty regard to the child", as well as the "best interests of the child", are all open for a range of views, opinions and priorities which could lead to different interpretations and outcomes. Since all human rights of children aim at securing their best interests, while parents are children's primary caretakers, it is difficult to balance the various rights and duties, even for lawyers and experienced health staff.[111]

Physical and mental health belong to the personal and intimate sphere of all individuals. Especially sexual and reproductive health issues and sexual behaviour of young people are typical areas of taboo, diversity, and tension between adolescents and parents, and even among health providers in different social contexts and with different backgrounds. The balancing of rights and interests is a challenging task, and practice may vary across the country among different health facilities and providers. In this situation, national administrative guidelines explaining the legal provisions for health providers are essential. One clear guideline should be that the child's own views must always be the starting point for establishing his/her best interests.[112] The capability approach is a helpful reminder that protection of autonomy and privacy rights of adolescents in the health context is the best way of securing trust and service accessibility. Moreover, the capability approach may contribute more to the notion of individual responsibility than the emphasis on child vulnerability.

---

[110] Haugli and Sigurdsen, "Om foreldreansvar," 366–384, 380–381.

[111] Ibid., 381, concerning the Patient and User's Rights Act section 4-4.

[112] Sandberg, "Children's Right to Participate," 71–89, with reference to John Eekelaar, "The Interests of the Child and the Child's Wishes: The Role of Dynamic Self-Determinism," *International Journal of Law and Family*, vol. 8 (1994): 42–61.

BIBLIOGRAPHY

Aasen, Henriette Sinding, and Mette Hartlev. "Human Rights Principles and Patient Rights." In *Health and Human Rights: International and European Perspectives*, 2nd edition, edited by Brigit Toebes, Mette Hartlev, Aart Hendriks and Henriette Sinding Aasen, 53–91. Intersentia, 2022.

Aasen, Henriette Sinding. "Barnets rett til medvirkning, selvbestemmelse og privatliv ved helsehjelp." In *Barnekonvensjonen i norsk rett. Prinsipper og Praksis*, edited by Ingun Fornes, Anna Nylund and Kari Sperr, 141–165. Gyldendal, 2023.

Aasen, Henriette Sinding. "Vulnerability and Autonomy: Competing Ideas in Human Rights." In *Health and Human Rights, International and European Perspectives*. 2nd edition, edited by Brigit Toebes, Mette Hartlev, Aart Hendriks and Henriette Sinding Aasen, 221–255. Intersentia, 2022.

Act April 8, 1981 no. 7 om barn og foreldre [Norwegian Act on Children and Parents].

Act July 2, 1999 no. 62 om etablering og gjennomføring av psykisk helsevern [Norwegian Act on Psychiatric Healthcare].

Act July 2, 1999 no. 64 om helsepersonell [Norwegian Act on Health Personell].

Act June 2, 1999 no. 63 om pasient og brukerrettigheter [Norwegian Patient and User's Rights Act].

Act June 3, 1977 no. 57 om sterilisering [Norwegian Act on Sterilisation].

Act June 13, 1975 no. 50 om svangerskapsavbrudd [Norwegian Act on Termination of Pregnancy].

Act May 20, 2005 no. 28 om straff [Norwegian Act on Criminal Offences].

Act May 21, 1999 no. 30 om styrking av menneskerettighetenes stilling i norsk rett [The Norwegian Human Rights Act].

Bahus, Marianne Klungland. "Beslutningskompetanse og Barnets beste ved liv/død-avgjørelser til barn." In *Menneskerettigheter i helse- og omsorgstjenesten*, edited by Henriette Sinding Aasen and Marianne Klungland Bahus. Universitetsforlaget, 2022.

Bedford, Daniel, and Jonathan Herring, eds. *Embracing Vulnerability: The Challenges and Implications for Law.* Routledge, 2020.

Bergen Kommune. "Helsestasjon for ungdom, et gratis dropin-tilbud." https://www.bergen.kommune.no/innbyggerhjelpen/helse-og-omsorg/helsetjenester/helsestasjon-og-skolehelsetjeneste/helsestasjon-for-ungdom-et-gratis-dropin-tilbud (Visited January 30, 2024).

Cathaoir, Katharina Q. *Children's Rights and Food Marketing: State Duties in Obesity Prevention*. Intersentia, 2022.

Committee on Economic, Social and Cultural Rights. *General Comment no. 14 on the Right to the Highest Attainable Standard of Health*. E/C.12/2000/4.

Doc. 16 (2011–2012). *Rapport til Stortingets presidentskap fra Menneskerettighetsutvalget om menneskerettigheter i Grunnloven.* December 19, 2011.

Draft resolution no. 75 (2016–2017). *Endringar i pasient- og brukarrettslova, helsepersonellova m.m. (styrking av rettsstillinga til barn ved yting av helse- og omsorgstenester m.m.)*

European Court of Human Rights. *Case of Z v. Finland.* Application no. 22009/93. Strasbourg, February 25, 1997.

Fineman, Martha Albertson. “Equality, Autonomy, and the Vulnerable Subject in Law and Politics.” In *Vulnerability. Reflections on a New Ethical Foundation for Law and Politics*, edited by Martha Albertson Fineman and Anna Grear, 13–29. Ashgate, 2013.

Haugli, Trude, and Randi Sigurdsen. “Om foreldreansvar og barns rett til helsehjelp.” In *Likestilling, barn og velferd. Rettsfelt i utvikling*, edited by Sigrid Eskeland Schütz, Ragna Aarli and Henriette Sinding Aasen, 366–384. Gyldendal, 2020.

Haugli, Trude, Anna Nylund, Randi Sigurdsen and Lena R. L. Bendiksen, ed. *Children’s Constitutional Rights in the Nordic Countries.* Brill Nijhoff, 2019.

Haugli, Trude. “Constitutional Rights for Children in Norway.” In *Children’s Constitutional Rights in the Nordic Countries*, edited by Trude Haugli, Anna Nylund, Randi Sigurdsen and Lena R. L. Bendiksen, 39–58. Brill Nijhoff, 2019.

Health Directorate. *Regulation: Patient and User’s Rights Act with Comments*. Updated November 16, 2021. https://www.helsedirektoratet.no/rundskriv/pasient-og-brukerrettighetsloven-med-kommentarer (Visited November 23, 2022).

Hendriks, Aart. “The Council of Europe.” In *Health and Human Rights: Global and European Perspectives*. 2nd edition, edited by Brigit Toebes, Mette Hartlev, Aart Hendriks, Henriette Sinding Aasen, 119–163. Intersentia, 2022.

Herring, Jonathan. “Ageing and Universal Beneficial Vulnerability.” In *Embracing Vulnerability: The Challenges and Implications for Law*, edited by Daniel Bedford and Jonathan Herring, 63–79. Routledge, 2020.

Holmboe, Morten. “Taushets- og opplysningsplikt i helsesektoren – menneskerettighet mot menneskerettighet.” In *Menneskerettigheter i helse- og omsorgstjenesten*, edited by Henriette Sinding Aasen and Marianne Klungland Bahus, 96–122. Universitetsforlaget, 2022.

International Covenant on Economic, Social and Cultural Rights (ICESCR). Adopted by the UN December 16, 1966.

International Covenant on Civil and Political Rights (ICCPR). Adopted by the UN December 16, 1966.

Ippolito, Francesca. *Understanding Vulnerability in International Human Rights Law.* Editoriale Scientifica, 2020.

Kongeriket Norges Grunnlov, May 17, 1814 [The Norwegian Constitution].

Martnes, Mona. “Barns autonomi og barnevaksinasjonsprogrammet.” In *Menneskerettigheter i helse- og omsorgstjenesten*, edited by Henriette Sinding Aasen and Marianne Klungland Bahus, 329–351. Universitetsforlaget, 2022.

Neal, Mary. “The Idea of Vulnerability in Healthcare law and Ethics: From the Margins to the Mainstream?” In *Embracing Vulnerability. The Challenges and Implications for Law*, edited by Daniel Bedford and Jonathan Herring, 91–114. Routledge, 2020.

Nussbaum, Martha. “Capabilities as Fundamental Entitlements: Sen and Social Justice.” *Feminist Economics*, vol. 9(2–3) (2003): 33–59. https://doi.org/10.1080/1354570022000077926.

Nylund, Anna. “Introduction to Children’s Constitutional Rights in the Nordic Countries.” In *Children’s Constitutional Rights in the Nordic Countries*, edited by Trude Haugli, Anna Nylund, Randi Sigurdsen and Lena R. L. Bendiksen, 3–19. Brill Nijhoff, 2019.

Official Norwegian Reports (NOU) 2024: 13 Lov og frihet: Negativ sosial kontroll, æresmotivert vold, tvangsekteskap, kjønnslemlestelse, psykisk vold og ufrivillig utenlandsopphold

– juridiske problemstillinger og forslag til regelverksendringer [Law and freedom: Negative social control, forced marriage, genital mutilation, psychological violence and involuntary stay abroad – legal issues and suggested legislative changes],

Peroni, Lourdes, and Alexandra Timmer. "Vulnerable Groups: The Promise of an Emerging Concept in European Human Rights Convention Law." *International Journal of Constitutional Law*, vol. 11(4) (October 2013): 1056–1085. https://doi.org/10.1093/icon/mot042.

Recommendation from the Parliamentary Committee no. 169 (2012–2013). *Innstilling fra kontroll- og konstitusjonskomiteen om rapport til Stortingets presidentskap fra Menneskerettighetsutvalget om menneskerettigheter i Grunnloven.*

Rogers, Wendy, Catriona Mackenzie and Susan Dodds. "Why Bioethics Needs a Concept of Vulnerability." *International Journal of Feminist Approaches to Bioethics*, vol. 5(2) (Fall 2012): 11–38.

Sandberg, Kirsten. "Best Interests of the Child in the Norwegian Constitution." In *Children's Constitutional Rights in the Nordic Countries*, edited by Trude Haugli, Anna Nylund, Randi Sigurdsen and Lena R. L. Bendiksen, 133–159. Brill Nijhoff, 2019.

Sandberg, Kirsten. "Children's Right to Participate in Health Care Decisions." In *Human Rights, Dignity and Autonomy in Health Care and Social Services: Nordic Perspectives*, edited by Henriette Sinding Aasen, Rune Halvorsen and António Barbosa da Silva, 71–89. Intersentia, 2009.

Sen, Amartya. *Inequality Reexamined.* Clarendon Press, 1992.

Sen, Amartya. *The Idea of Justice.* Penguin Books, 2009.

Tobin, John. *The Right to Health in International Law.* Oxford University Press, 2012.

Toebes, Brigit, and Katharina Q. Cathaoir. "The Right to Health: Central Concepts." In *Health and Human Rights. Global and European Perspectives*. 2nd edition, edited by Brigit Toebes, Mette Hartlev, Aart Hendriks, Henriette Sinding Aasen, 23–53. Intersentia, 2022.

Toebes, Brigit. "Synergies and Tensions in the Health and Human Rights Frameworks." Unpublished manuscript.

UN Committee on the Rights of the Child. *General Comment no. 4 (2003), Adolescent health and Development in the Context of the Convention on the Rights of the Child.* CRC/GC/2003/4. July 1, 2003.

UN Committee on the Rights of the Child. *General Comment no. 14 (2013) on the Right of the Child to Have His or Her Best Interests Taken as a Primary Consideration (Art. 3, para. 1).* CRC/C/GC/14. May 29, 2013.

UN Committee on the Rights of the Child. *General Comment no. 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24).* CRC/C/GC/15. April 17, 2023.