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Chirkut, Shivani

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ETHICO-LEGAL CONCERNS IN RELATION TO ADOLESCENT SEXUAL INTERCOURSE

Shivani Chirkut

Student No. 9700671X

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the degree of Master of Science in Medicine in Bioethics and Health Law

Johannesburg, 2015

Declaration

I, Shivani Chirkut, student number 9700671X, declare the following information concerning my research report titled:
Ethico-legal Concerns in Relation to Adolescent Sexual Intercourse
submitted in partial requirement for the degree of MScMed (Bioethics and Health Law)

- I am aware that plagiariam (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the research report I submitted is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
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- I confirm that this research report has not been submitted to any other university or educational institution for the purposes of a degree.



01 March 2016

_____ _____

Signature Date

In memory of my father Dave Chirkut (1943-2002)

and my mother Dr. Sheila Chirkut (1945-2008).

Abstract

Generally, consensual adolescent sexual intercourse is fraught with a number of negative outcomes such as socio-economically, where unplanned pregnancies occur, and medically with the spread of sexually transmitted diseases that require treatment. The Sexual Offences and Related Matters Amendment Act 32 of 2007, hereunder referred to as the Sexual Offences Act ("SOA"), criminalised consensual sexual intercourse between adolescents aged from 12 to less than16 years.

Since the inception of the SOA in 2007, there seemed to have been relatively little evaluation of the practical effect of sections 15 and 16 of the SOA on society. This changed in 2011 when two non-profit organisations, The Teddy Bear Clinic for Abused Children and RAPCAN (Resources Aimed at the Prevention of Child Abuse and Neglect) who were the first and second applicants respectively, challenged the constitutionality of certain sections of the SOA. These sections are:

- section 15 – entitled "Acts of consensual sexual penetration with certain children (statutory rape)";
- section 16 – entitled "Acts of consensual sexual violation with certain children (statutory sexual assault); and
- section 56(2) – which deals with defences in respect of sections 15 and 16.

In October 2013, the Constitutional Court declared sections 15 and 16 inconsistent with the Constitution. That declaration was suspended for a period of 18 months to enable Parliament to correct the defects in the statute.

It is widely known that adolescents still engage in consensual sex with each other regardless of the law. The issues invite an evaluation of the current legislation in the context of the health and social issues that surround them. In addition, the impact of the current applicable legislation on the present realism needs to be scrutinised.

It is essential for alternative interventions to be established which will aid in reducing the negative impact of consensual adolescent sexual intercourse. This research report looks at interventions that could be introduced to prevent adolescent sexual intercourse and alleviate the negativity of outcomes. Furthermore, the report aims to suggest an ethical, structured approach to reduce the current negative outcomes of adolescent sexual intercourse. In order to accomplish this I first describe the legislation that applies to consensual adolescent sexual intercourse of children between the ages of 12 and 16 years old. This brought to the fore the health practitioner's practical experiences of problems associated with this legislation. In addition, I identify and discuss some ethical problems that health practitioners are confronted with in relation to consensual adolescent intercourse, in terms of having to balance their professional legal and ethical obligations.

Finally, I propose some recommendations that will inform educational organisations on the relevant information to be included in sexual and reproductive health education campaigns. Furthermore, recommendations are made to relevant national policy-making departments to make strategic decisions regarding health and social interventions for adolescent sexual and reproductive health services.

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Abbreviations

(in alphabetical order)

AIDS	Acquired Immunodeficiency Syndrome
CA	Children's Act 38 of 2005
CC	Constitutional Court
CJA	Child Justice Act 75 of 2008
CJS	Criminal Justice System
CToP	Choice on Termination of Pregnancy Act 92 of 1996
DoE	Department of Education
DoH	Department of Health
DoJCD	Department of Justice and Constitutional Development
FP	Family Planning
FEDUSA	Federation of Unions of South Africa
HCP	Healthcare Provider
HIV	Human Immunodeficiency Virus
HPCSA	Health Professions Council of South Africa
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
ISHP	Integrated School Health Programme
MDG	Millenium Development Goal
MTCT	Mother to Child Transmission
NGO	Non-governmental Organisation
NHA	National Health Act 61 of 2003
NRSO	National Register of Sex Offenders

NSHP	National School Health Policy
PID	Pelvic Inflammatory Disease
PoA	Programme of Action
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
SOA	Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexually Transmitted Infection
TLAC	Tshwaranang Legal Avocacy Centre
TOP	Termination of Pregnancy
UN	United Nations
UNCRC	United Nations Convention on the Rights of the Child
USA	United States of America
WHO	World Health Organisation
WLC	Women's Legal Centre
WMA	World Medical Association

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Chapter 1 – Introduction and Literature Review

1.1 Introduction

There are significant ethico-legal concerns in relation to adolescent sexual intercourse. This is largely due to the negative health and socio-economic consequences of early sexual intercourse. Unwanted pregnancies, the spread of sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV) and increased school drop-out rates are just some of the problems resulting from early sexual activity. On the one hand children must be safeguarded against these negative outcomes of their sexual explorations. On the other hand though, children are entitled to sexual and reproductive health rights (SRHRs) and these rights must be protected by the law.

This was highlighted in April 2012, when two children's rights organisations, the Teddy Bear Clinic for Abused Children and the Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) together with the Centre for Child Law, approached the North Gauteng High Court for an order that sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (SOA), which criminalized consensual sexual activity of adolescents between the ages of 12 and 16, be found to be unconstitutional. Accordingly, the argument put forward was that these sections infringed adolescents' constitutional rights to dignity, privacy, and bodily and psychological integrity, as well as the principle that a child's best

interests must be of paramount importance (1). The Tshwaranang Legal Advocacy Centre (TLAC), the Women's Legal Centre (WLC) and the Justice Alliance of South Africa all acted as friends of the court.

The respondents, the Minister of Justice and Constitutional Development and the National Director of Public Prosecutions, argued that the intention of sections 15 and 16 was to protect children from the risks associated with engaging in sexual activity, and were therefore legitimate limitations of these rights and not unconstitutional.

In January 2013, at the hearing in the North Gauteng High Court, Pretoria, it was contested that criminalisation of any consensual sexual contact between teenagers violates the constitutional rights of children. Judge Pierre Rabie held that "…criminalisation would constitute an unjustified intrusion of control into the intimate and private sphere of children's personal relationships, in a manner that could cause severe harm to them." (2) The judge's statement highlights that this issue showed a strong conflict between the criminal law and the sexual and reproductive health rights of adolescents.

Section 172(2)(a) of the Constitution provides that "an order of constitutional invalidity has no force unless it is confirmed by the Constitutional Court." Therefore, the outcome in the preceding paragraph was followed by an application for confirmation of the ruling to the Constitutional Court (CC) because the issues invited an evaluation of the current legislation in the context of the health and social issues that surround them. In addition, it

called for further scrutiny of the practical impact of the legislation on the present reality.

The Federation of Unions of South Africa (FEDUSA) is one of the largest national trade union centres in South Africa and is affiliated to the International Trade Union Confederation. It focuses its work on national and international representation in order to impact on policy formation, review and implementation (3). In keeping with the sentiments of the Applicants and several other children's rights organisations, Martle Keyter, FEDUSA Vice-President of the Gender Unit made a statement shortly after Judge Rabie's ruling saying that: "*It must be understood that FEDUSA does not conclusively condone penetrative sex between minors, but supports the ruling in its attempts to ensure that acceptable sexual activity between young people is not criminalised*." (4). What is required are interventions that empower these young people to make healthy decisions in terms of their sexual and reproductive health (SRH) needs.

On 30 May 2013, the CC heard the case. Judgment was handed down on 3 October 2013. The Court found that sections 15 and 16 are in fact unconstitutional in that they do infringe on several constitutional rights of adolescents. The Court also confirmed that in sections 15 and 16 of the SOA, developmentally normal adolescent behaviour was criminalised and that this impacted negatively on the very children that the Act aimed to protect.

I emphasise that Sections 15 and 16 of the SOA deal specifically with

consensual sexual acts only. Therefore, the ruling has no impact on non-consensual acts which are still criminalised such as rape, sexual assault or statutory rape. This research report will focus on issues related to consensual sexual intercourse primarily, not adolescent intercourse without consent, due to a word-count limitation.

Although the criminalisation of consensual sexual conduct between adolescents was pronounced invalid by the CC, the declaration was suspended for 18 months in order for Parliament to amend the necessary provisions of the SOA. Until then, the Court has placed a moratorium on all open cases in relation to sections 15 and 16 of the SOA, including investigations, arrests, prosecutions and other criminal proceedings. In addition, the criminal records of those adolescents already convicted of an offence in terms of these sections will be erased and their details will not appear in the National Register of Sex Offenders (NRSO) (see section 6.1.4). The suspension period was due to expire on 2nd April 2015. On 30th March 2015 the Acting Speaker of the National Assembly launched an urgent application to the CC to extend the period of suspension of the declaration of invalidity. The issue was heard on 7th May 2015 and the CC granted the requested extension to 5th August 2015. The respondents did not oppose this extension, but they made it clear that they would oppose any further application for extension beyond 5th August 2015. An Amendment Bill, (The Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Bill [B18-2014]), has now been produced to protect the privacy of adolescents in consensual sexual relationships with other adolescents who

are less than 18 years old.

As a result of the media exposing the apparent legal mishandling of adolescent sexuality as illustrated above, it left open a gap for contemplating a more sensitive and effective approach to reducing risky sexual behaviour in adolescents.

1.2 Importance of Sexual and Reproductive Health Rights

Women's rights to SRH are recognised internationally as being key to women's health. In terms of the South African Constitution (5), it is a right so broad as to encompass the rights of non-discrimination (section 9), life (section 11), freedom and security of the person (section 12); the rights to access health care services (section 27), education (section 29) and information (section 32).

Seeing that approximately 200 million women worldwide are unable to access family planning, the world's population is estimated to be increasing by about 70-80 million a year. Furthermore, a predicted 90% increase in population growth is expected to occur over the next 5 decades in the world's poorest countries (6).

In most of the developing world, reproductive health service utilisation falls well below desired levels (7). For women of child-bearing age, poor SRH accounts for about a third of the global burden of disease (6) (8). In

acknowledgement of this significant issue, in 2007 the United Nations (UN) General Assembly declared that universal access to reproductive health by 2015 must be included as an essential target for Millenium Development Goal (MDG) 5: improving maternal health (9). Bearing in mind that adolescents make up one fifth of the global population (10), and that they constitute the future work force of their nations, adolescents need to be healthy when they enter the labour market because a strong work force will raise economic productivity.

1.3 Adolescents in South Africa

In mid-2013, the total South African population was estimated to be almost 53 million, of whom almost 30% is under the age of 15 years and about 10% are between the ages of 10 and 14 years old (11).

Significant in South Africa is the long history of children not sharing the same home with their biological parents. This may be due to several factors including poverty, labour migration and educational prospects (12). The absence of a strong parental figure highlights the social vulnerability of South African children. Therefore, protecting their socio-economic and health rights is of utmost necessity.

Adolescents fall into a very special age group because they don't fit neatly into the clear categories of child or adult. Many become sexually active during adolescence (13). Consequently, adolescents have been given

particular legal consideration. South Africa has acknowledged the constitutional rights of adolescents to SRH by means of planning to amend necessary provisions of applicable legislation as mentioned above.

Generally, adolescent sexual intercourse is fraught with a number of negative outcomes. One major side-effect is unplanned pregnancy. The socio-economic effects of teenage pregnancy can be distressing for both the mother and child (see section 3.4). A further problem of adolescent sexual intercourse involves medical challenges such as the spread of HIV and STIs which are highly contagious via sexual activity (14). In order to prevent these negative consequences, I propose that adolescents need to be empowered with SRH knowledge and have access to appropriate healthcare. The issue is not merely whether adolescents may have consensual sex with each other or not. Adolescents are having consensual sex with each other anyway. The issue is how to effectively empower them to make responsible SRH decisions.

The role of health care providers (HCPs) provides an opportunity to intervene so that improved access to SRH can be achieved. Consequently, it is appropriate to consider how HCPs can promote SRH specifically targeting adolescents.

Accordingly, in light of the law applicable to adolescents and the ethical standard expected of HCPs, as well as their experiences of problems related to adolescent reproductive health, the question I intend to answer in this research report is: What interventions could be introduced to prevent

adolescent sexual intercourse and alleviate the negativity of the outcomes?

Chapter 2 – Aim, Objectives and Methodology

2.1 Aim

The aim of this study was to suggest an ethical, structured approach to reduce the current negative outcomes of adolescent sexual intercourse in South Africa.

2.2 Objectives

The first objective was to describe the current legislation that applies to consensual adolescent sexual intercourse of children between the ages of 12 and 16 years old in South Africa.

Secondly, to describe the health practitioner's practical experiences of problems associated with this legislation.

Thirdly, to describe the current ethical problems that health practitioners are confronted with in relation to consensual adolescent intercourse in South Africa.

2.3 Methodology

The study design was that of a descriptive analytical study employing normative and legal analysis.

This research was conducted using an extensive, but selective, systematic literature search strategy using health, legal and social science electronic databases to identify applicable relevant literature. These included Google Scholar, LexisNexis Academic, Butterworths, EBSCOHost, BioMed Central, Juta Online Publications, ProQuest Central, JSTOR, SABINET Online, ScienceDirect, Wiley InterScience, Taylor & Francis, Springer LINK and other search engines. Print media reports and documents of pertinent international and national sources were also used to substantiate the concerns raised on this topic. The literature obtained was used to support the proposed recommendations. Both ethical and legal concepts were used to explore the implications of current South African law related to consensual adolescent sexual intercourse.

An ethics waiver was requested from the Wits Human Research Ethics Committee and granted. (**See Annexure 1)**

2.4 Expected Outcomes

The following outcomes from the study are envisaged:

- Propose recommendations that will inform educational organisations on the relevant information to be included in educational campaigns as a method of improving the negative outcomes of adolescent consensual sexual intercourse.
- Make recommendations to the relevant national policy-making

departments, including the Department of Health, to make strategic policy decisions regarding more suitable health and social interventions for adolescents who engage in consensual sexual intercourse.

- Present the research report at national and international conferences and publish the research report in a peer-reviewed journal.

Chapter 3 – Law Related to Adolescents' Reproductive Health

This section makes mention of the pieces of national legislation that are of significance to adolescents and their SRH. Attention is drawn to the specific sections and subsections that are of particular relevance to this report.

3.1 Children and Rights

At an international level, the United Nations Convention on the Rights of the Child (UNCRC) (15) outlines the full range of human rights to which all children are entitled. The child is essentially a *subject* of rights and the fundamental principles enshrined in the UNCRC are:

- Non-discrimination
- Commitment to the best interests of the child
- The right to life, survival and development
- Respect for the views of the child

Since South Africa has ratified the Convention, it "has agreed to hold itself accountable for this commitment before the international community."(16)

Article 3 concerns the topic of the best interests of the child. Article 3(1) states: *"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 a primary consideration."* This concept is echoed throughout the document including in articles 9, 18, 20 and 21.

By inclusion of "*legislative bodies*" in Article 3(1), there is an obligation placed on governments to take into account the impact of legislation on the interests and well-being of children. The Committee on the Rights of the Child interprets the substance of the provisions of the Convention in the form of General Comments. **General Comment No. 5** (17) elaborates on this aspect of Article 3 in further detail.

Seeing that South Africa has ratified the UNCRC, the country has openly made a commitment to always consider the best interests of its children in its legislation as reflected in section 28(2) of the Constitution. One of my points of concern is whether or not South Africa had truly considered the child's best interest when sections 15 and 16 of the SOA was drafted. In addition, General Comment No. 5 draws attention to the fact that "*a continuous process of child impact assessment … and child impact evaluation*" must be conducted. I propose that since legislation is being reviewed, perhaps the time has come for South Africa to relook at the SRH needs of its adolescents from a more practical and realistic perspective.

General Comment No. 3 (18) requires States to refrain from "*censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and … must ensure that children … acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality.*" It is clear from this comment that children have a right to access information that is accurate and reliable, and that

governments must take suitable action to ensure this.

Paragraph 13 of **General Comment No. 7** (19) expands further on Article 3 in relation to the best interests principle. It maintains that the child's "*views and evolving capacities*" must be considered at all times. It further states that protecting children's rights requires "*active measures*" on behalf of State parties.

Article 12 takes into consideration the right of a child to express his/her view on any matters concerning him/herself. These views must be "*given due weight in accordance with the age and maturity of the child*." **General Comment No. 7** (paragraph 14) (19) clarifies that children are *active participants* "*in the promotion, protection and monitoring of their rights*." Research suggests that children certainly do want to be involved in discussions about their care (20). Listening to and genuinely considering the views of a child demonstrates value and respect for him/her, thereby increasing the effectiveness of interventions.

Article 24 of the UNCRC stipulates the necessity of states to develop preventative health care, support for parents and family planning (FP) education and services.

Articles 28 and 29 pertain to the rights of children to proper education. It goes further to mention aspects of children's development that education ought to be directed towards.

In summary, international guidance promotes that all professionals working with children must respect the child's autonomy and decision-making capabilities, while at the same time, taking into account the best interests of the child. Sometimes though, respecting the child's autonomy may be in conflict with the best interests principle and in these cases it is up to the professional to protect the child from him/herself. The mere existence of a right does not mean that the individual can stake a claim to the right without exercising the accompanying responsibilities that go with it. Practically, performing this balancing act is a huge challenge. Many practitioners have to make subjective judgments about the mental competency and maturity of a child. As a result, many children's views have been ignored or repressed under the acceptable guise of protection (20) from medical harms.

The Centre for Reproductive Rights, a global reproductive rights organisation based in New York, clearly states: "*Securing legal recognition of adolescents' reproductive rights is a crucial step in promoting government action to ensure adolescents' access to sexual and reproductive information and healthcare*, …" (21).

3.2 The South African Constitution (5)

South Africa's history of racial discrimination and segregation forms the background of the current highly regarded Constitution. A detailed description of the gross inequalities suffered by black South Africans is beyond the scope

of this report. However, it is sufficient to mention that this poignant past gave a very painful but proud birth to one of the most progressive pieces of legislation in the world. The Constitution came into force on 4th February 1997. Chapter 2 of the Constitution, the Bill of Rights, contains the list of "fundamental rights" that every South African is entitled to.

It is clearly affirmed that the State has a duty to "*respect, protect, promote and fulfill*" the rights in the Bill of Rights (section 7(2)). The State recognises that all people are equal and all rights and freedoms are to be enjoyed by all (section 9(1) and (2)). Everyone has inherent dignity and must be respected and protected (section 10). All people have the right to bodily and psychological integrity, and this includes the right to reproductive decision-making, as well as the right to security and control over their body (section 12(2)(a) and (b)). Everyone has the right to privacy, including the right not to have their communications infringed (section 14(1) (d)). Everyone has a right to access health care services. Specific mention is made of the right to reproductive health (section 27(1)(a)). Furthermore, the State must take measures to ensure that the right to access health care is progressively realised, and that this is done within available resources (section 27(2)).

Section 28(1) lists fundamental rights pertaining specifically to children who are defined as being under the age of 18 years. In keeping with international law, the Constitution mentions in section 28(2) that the best interests of the child are of "*paramount*" importance. Section 29 declares that everyone has the right to basic and further education. In addition, the State is compelled to

make education reasonably and progressively available and accessible.

The Constitution contains a host of other significant rights that are not mentioned here in view of the succinct nature of this report.

3.3 The Children's Act 38 of 2005 (CA) (22)

The Children's Act 38 of 2005 (as amended by the Children's Amendment Act 41 of 2007) and the associated Regulations came into force on 1 April 2010. The core objective of the CA is to give effect to children's constitutional rights to:

- parental care or alternative care when removed from the family environment;
- social services;
- protection from neglect and other abuse; and
- have their best interests considered in every matter concerning them.

Section 9 says that, in all matters concerning the care, protection and well-being of a child, "*the standard that the child's best interest is of paramount importance, must be applied*". Thus, the child's best interest is the most important factor always. Section 7 lists the factors to consider when deciding what the "*best interests of the child*" are. The following are some factors pertinent for consideration:

- child's age, maturity and stage of development;

- child's gender;
- child's physical and emotional security and intellectual, emotional, social and cultural development;
- disability or chronic illness;
- relationships with parents, family or care-givers;
- attitude of parents towards child;
- capacity of parent, or care-giver, to provide for child's needs;
- need for child to maintain connection with family, culture or tradition;
- need for child to develop within a stable environment; and
- need to protect child from physical or psychological harm.

The CA follows international child rights instruments to contain an express right of participation for children (section 10). Therefore, a child's opinion must be considered in any matter affecting the child. This ties in with the principle that the children must be informed of any decisions that are taken concerning them.

Section 12 protects all children against social, cultural and religious practices that are detrimental to their well-being. Some practices are banned completely, including female genital mutilation and forced marriages. Others are limited and regulated in order to prevent abuse. These include virginity testing and male circumcision for cultural reasons. Virginity testing for girls under the age of 16 years is prohibited (section 12(4)). For those over the age of 16 years, the procedure may be performed only under strict conditions that are specified in further detail in the Act and Regulations. One

requirement is the written consent of the child, after proper counseling and in a prescribed manner (section 12(5)). Circumcision of boys under the age of 16 years for social or cultural reasons is prohibited (section 12(8)). Circumcision for religious or medical reasons is excepted. For boys 16 years and older, circumcision may be performed under prescribed conditions which are specified further in the Act and Regulations. The boy himself must consent to the procedure after proper counseling and with the assistance of a parent or guardian.

Part 3 of Chapter 7 of the CA deals with protective measures relating to the health of children and stipulates legally acceptable ages of consent for various health-related interventions. Section 129(2) states that a child can consent to his or her medical treatment if over the age of 12 years and is of "*sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment*." In terms of surgical operations, an additional criterion to be met is that the child must also be assisted by a parent or guardian when making a decision (section 129(3)(c)). A child of any age may consent to HIV testing provided the child is of "*sufficient maturity to understand the benefits, risks, social and other implications of such a test*" (section 130(2)(a)). Section 134 pertains to children and contraception. According to section 134(1) any child over 12 years can have access to condoms on request where these are distributed free of charge. He or she may also legally buy condoms without parental consent. Other forms of contraception may be provided to a child who is at least 12 years old, under proper medical advice and after a full medical assessment by a HCP (section

134(2)). A child who accesses contraceptive services is entitled to confidentiality as clearly expressed in section 134(3).

All children therefore have a right to sufficient information about their health to enable them to make informed choices about disease testing, treatment and contraception.

The CA has increased the range of professionals who are legally obliged to report abuse of children (section 110). A report that a child has been abused or neglected must be substantiated and, if the report was made in good faith, the person reporting will not be liable to civil action. In section 6.1 of this report I discuss the implications of this clause for the HCP and the adolescent respectively.

3.4 Choice on Termination of Pregnancy Act 92 of 1996 (CToP Act) (23)

The preamble of the CToP Act recognises three fundamental aspects of the Constitution in terms of SRH. Firstly, that the Constitution protects the right of all persons to make decisions regarding their reproduction, and to security in and control over their bodies. Secondly, it identifies that universal access to reproductive healthcare services includes contraception, termination of pregnancy (TOP) , and sexuality education and counseling services. Thirdly, it accepts that the State has the responsibility to provide SRH to all, and to provide safe conditions under which the right of choice can be exercised without fear or harm.

Section 2 of the CToP Act sets out the circumstances in which and conditions under which pregnancy may be legally terminated. During the first 12 weeks of pregnancy, a TOP is available on request of the woman (section 2(1)(a)). From the 13th up to and including the 20th week, a TOP may be performed if a medical practitioner is concerned that the pregnancy may cause injury to the physical or mental health of the woman, if there is a risk of foetal abnormality, if the pregnancy is a result of rape or incest, or if the pregnancy is likely to have a negative impact on the woman's social or economic stability (section 2(1)(b)). After the 20th week, a TOP may be performed if the pregnancy places the woman's life in danger or if there is a risk of foetal injury or severe malformation (section 2(1)(c)). Therefore, a pregnancy may be terminated up to the foetal age of 20 weeks if a woman requests this for socio-economic reasons. This is not a very high bar to get over for a TOP in South Africa.

The CToP Act indicates who may legally perform a TOP (section 2(2)), as well as that surgical TOPs may only take place at designated facilities (section 3). Section 4 requires that pre- and post-procedure counseling must be provided by the State. Prior to the TOP, only the informed consent of the pregnant woman is required (section 5). If she is a minor, then the HCP must advise her to consult with a support person chosen by herself (section 5(3)). However, if she declines, the TOP may not be refused.

3.5 National Health Act 61 of 2003 (NHA) (24)

Section 27 of the Constitution guarantees South Africans the right to access healthcare services. The NHA gives effect to this constitutional right in that it sets the basis for the national health system. However, it is able to accomplish this only by working together with several other pieces of legislation that are discussed further in this report. Some legislation relevant to healthcare but not discussed in this report include the Health Professions Act 56 of 1974 (25), the Medicines and Related Substances Control Act 101 of 1965 (26), the Nursing Act 33 of 2005 (27) and the Traditional Health Practitioners Act 22 of 2007 (28).

Section 4(3) of the NHA indicates that the following people are eligible for free healthcare services at public health establishments:

- pregnant and lactating women;
- children under the age of 6 years;
- people requiring primary health care services; and
- services in relation to TOPs in accordance with the CToP Act.

3.6 Child Justice Act 75 of 2008 (CJA) (29)

This Act aims to establish a criminal justice system (CJS) specifically for children who are in conflict with the law. It provides a system for dealing with young offenders who lack criminal capacity. Since these offenders are minors, the Act attempts to divert these matters away from the formal CJS through which adult offenders are dealt with. In addition, it aspires to go the route of restorative justice as far as possible.

Section 7 of the CJA indicates that children up to the age of 10 years lack criminal capacity and therefore may not be prosecuted for an offence. Children over the age of 14 years have criminal capacity unless otherwise shown. Children from 11 to 14 years may be prosecuted if the prosecution can show that the child has criminal capacity. This is significant in terms of sections 15 and 16 of the SOA where adolescents engaging in consensual sexual acts with other adolescents were considered to be sexual "offenders."

3.7 Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (SOA) (30)

The SOA came into effect on 16th December 2007.

One of the greatest aims of this Act is to protect children from sexual abuse and exploitation. Section 54(1) states that a person who has knowledge that a sexual offence has been committed against a child must report such a case to a police official. This is in keeping with section 110 of the Children's Act (see section 3.3)

Section 15 aimed to criminalise acts of sexual **penetration** by a person with a child between the ages of 12 and 16 years, regardless of whether the child had consented. Section 16 criminalised acts of consensual sexual **violation** committed by a person with a child between the ages of 12 and 16 years. This research report involves issues of sexual penetration, and therefore

further detail regarding sexual violation will be avoided. For the purposes of sections 15 and 16, section 1 of the act defines a “child” as being a person 12 years or older but less than 16 years old. Section 15 is worded as follows (my emphasis added):

> **15**. (1) A person (“A”) who commits an act of sexual **penetration** with a child (“B”) is, **despite the consent** of B to the commission of such an act, **guilty of the offense of having committed an act of consensual sexual penetration with a child**.
>
> (2) (*a*) The institution of a prosecution for an offence referred to in subsection (1) must be **authorised in writing by the National Director of Public Prosecutions if both A and B were children at the time** of the alleged commission of the offence: Provided that, in the event of the National Director of Public Prosecutions authorises the institution of a prosecution, **both A and B must be charged** with contravening subsection (1).
>
> (*b*) The National Director of Public Prosecutions **may not delegate** his or her power to decide whether a prosecution in terms of this section should be instituted or not.

The SOA defines “**sexual penetration**” as :

…any act which causes penetration by any extent whatsoever by--

i. *(a)* the genital organs of one person into or beyond the genital organs, anus or mouth of another person;
ii. *(b)* any other part of the body of one person or, any object, including

any part of the body of an animal, into or beyond the genital organs or anus of another person; or

iii. *(c)* the genital organs of an animal, into or beyond the mouth of another person.

In October 2013, the CC judged that sections 15 and 16 of the SOA are unconstitutional since they infringe on a significant number of adolescents' human rights. The CC's declaration that the criminalization of consensual sexual activity between adolescents is invalid was suspended for 18 months so that Parliament may amend the relevant clauses of the SOA. The CC ordered that a moratorium be placed on all activities in relation to sections 15 and 16 until Parliament corrects the defects in the SOA. The period of suspension was due to expire on 2 April 2015. On 30 March 2015, the Acting Speaker of the National Assembly made an urgent application to the CC to further extend the period of suspension. After hearing the issue, the CC granted the extension until 5 August 2015. The respondents did not oppose the extension. However, they did make it clear that they would oppose any further applications of extension.

At the time of submission of this research report, an Amendment Bill has been published with ethico-legal changes which are significant. Consensual sexual activity between adolescents will no longer be criminalized. We therefore need to prepare ourselves from a healthcare ethics perspective in order to anticipate and deal with potential challenges.

In summary, chapter 3 highlighted that international instruments as well as pertinent pieces of South African legislation provide for the protection of children's human rights based on the underlying principle of the best interest of the child. SRHRs form an integral part of these human rights and HCPs therefore have a clear role in providing for the fulfillment of these rights. In light of the doctor-patient relationship being based on trust between the parties and the expectation that confidentiality will be maintained, besides other ethical standards that are required of the HCP by the Health Professions Council of South Africa (HPCSA), challenges with some of the laws will now be discussed.

Chapter 4 – Healthcare Practitioners' Potential Challenges associated with Current Legislation

The following chapter will consider challenges HCPs may encounter in dealing with adolescent sexual activity and how the management of these may be complicated by certain aspects of the legislation described in chapter 2. The problems associated with adolescent sex will first be highlighted, followed by a discussion of the problems with legislation in this context.

4.1 Problems Associated with Adolescent Sex

Bearing the law in mind, national studies show that a substantial number of South African youth are sexually active below the age of 16 (31). In a 2003 study in which the sexual behaviour of urban high school learners was evaluated, it was shown that by the age of 14 years, 23.4% males and 5.5% females admitted to having participated in sexual intercourse. By the age of 19 years, this had increased to 71.8% and 58.2% respectively (32). These figures are significantly higher than figures from an analogous study conducted in the same area several years prior to this (31).

It has been documented that adolescents are engaging in sexual activity at relatively early ages and with multiple partners (33). It follows that in this way they are opening themselves up to risky and harmful health practices. Taking this into consideration, young adolescents are particularly important targets for intervention efforts aimed at SRH education. South African statistics show

that in 2012 over 50 000 school attendees admitted to having given birth to a live child. Over 20 000 indicated that they were pregnant at the time of the survey. Furthermore, 2695 had had TOPs and 718 had experienced a miscarriage or stillbirth (34). This early sexual debut indicates that most young people become sexually active when still enrolled in school (35). It further indicates that the sexual education they are entitled to, including the opportunity to receive contraception from the age of 12, rather than opting for TOPs, is either non-existent or failing to protect them from risky behavior. It would therefore be sensible for educational and interventional SRH programmes to be especially targeted at school-going adolescents. Some researchers have even recommended commencing sexual health education at primary school level (32).

4.1.1 Pregnancy

Teenage pregnancy is a catastrophe in terms of health economics when a girl carries an unwanted pregnancy to term (36). In 2008 in the United States of America (USA), teen pregnancy and childbirth cost taxpayers almost US$ 11 billion for the year (37). The reasons for this included increased healthcare requirements, foster care and lost revenue because of lower education levels and income among young mothers.

According to the World Health Organization (WHO) (38), about 16 million girls between the ages of 15 and 19 years go through obstetric deliveries every year. This accounts for over 10% of all births worldwide. Sexually active

adolescents are at immediate risk for pregnancy and acquiring STIs, including the Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS). In both developed and developing countries, factors known to be associated with teen pregnancies include lower socio-economic status, early school-leaving, family disruption and early sexual initiation (39). Teenage mothers are more vulnerable to complications associated with pregnancy and childbirth (40). Up to 65% of women with obstetric fistulae develop these as adolescents (38), the consequences of which are dreadful for their entire lives, physically, socially and psychologically. Furthermore, stillbirths and death in the first week of life are 50% higher among babies born to teenage mothers than those born to older mothers (38).

The groundbreaking International Conference on Population and Development (ICPD) was held in Cairo in 1994. Here 179 governments signed up to the ICPD Programme of Action (PoA) which recognized the significance of sexual and reproductive health rights (SRHRs) and gender equality as being crucial to population and development programmes. It has been well stated in the ICDP PoA (41): *"Early child-bearing continues to be an impediment to improvements in the educational, economic and social status of women in all parts of the world. Overall for young women, early marriage and early motherhood can severely curtail educational and employment opportunities and are likely to have a long-term, adverse impact on their and their children's quality of life."*

The rate of unintended pregnancies is one of the most significant markers of a

country's reproductive health (42). A higher rate of unintended pregnancy would imply a deficient state SRH system. Studies have shown (38) that avoiding teen pregnancies, aside from improving adolescent health, could lead to far-reaching economic and social benefits. Many females who could die annually as a result of the complications of unintended pregnancy and childbirth may be saved by SRH involvement that is inexpensive and reliable.

4.1.2 Termination of Pregnancy

About 2.5 million adolescents have unsafe abortions every year (38). Complications of unsafe procedures affect adolescents more frequently than older women. Sometimes this could be because their bodies are not yet developed enough to handle a pregnancy. Another reason could be that due to the stigma associated with teen pregnancy, the girl wants to ensure complete secrecy and is more likely to go to a backstreet abortionist where the risk of complications would be greater.

4.1.3 Sexually Transmitted Infections (STIs) (including HIV/AIDS)

STIs are extremely common and most people are tragically unaware of the effects and consequences of these easily transmitted infections (43). The majority of STIs show no symptoms, and consequences of STIs may only become evident years after infection. Some consequences include pelvic inflammatory disease (PID), infertility and mother-to-child transmission (MTCT) of the STI. Furthermore, STIs may increase the risk of contracting

HIV by over three-fold (44).

4.1.4 Drugs and Alcohol

Early sex is associated with several high-risk behaviours including drug and alcohol use (45). A number of factors could contribute to this. Often peer pressure encourages adolescents to experiment with drugs and alcohol. Drugs and alcohol are also generally known to lower inhibitions (46), which may lead to adolescents engaging in risk-taking behavior, including unsafe sex.

4.1.5 School problems

The risks of adolescent learners having social and academic problems at school and engaging in delinquent deeds are significantly increased by early initiation of sexual activity (43). In 2012, research published by Cui et al showed a clear association between adolescents' romantic relationships and delinquency (47). Furthermore, the cumulative number of relationships in adolescence was also positively associated with delinquency. They offer various possible reasons for this association. However, due to the brief nature of this research report, I will not expand further.

Pregnancy and teen motherhood constitute major causes for girls dropping out of school (34). Moreover, regardless of whether or not pregnancy is involved, teenage sexual activity in school-going children is known to be a

factor associated with increased school drop-out rates (48).

4.1.6 Mental problems

Mental health challenges sometimes present in association with adolescent sexual activity, including primarily depression and suicidal tendancies. This may be due to psychosocial environmental deficiencies, exposure to drugs and alcohol, and exposure to violence and abuse. Peer pressure, risk-taking behavior and early sexual activity are also known to be risk factors for mental health problems (49). It's important to intervene early in order to avoid adult mental health problems later on.

After considering the range of problems associated with adolescent sexual activity discussed above, we can presume that the financial costs to the state of dealing with the consequences of teen sex is phenomenal in South Africa as it is running into tens of billions of dollars annually in the USA alone (43). It is indisputable that the negative social and economic consequences in South Africa are miserable, more so because many initiating factors are preventable.

Clearly, underage sex is a major public health issue. From my personal experience as a HCP in working with adolescents engaging in consensual sexual intercourse, I validate that HCPs in South Africa regularly experience similar problems as illustrated in the literature I have referred to.

4.2 The HCP's problems associated with current legislation

The CA states that any HCP who, on reasonable grounds, **suspects** that a child has been abused in any manner, is required to report that suspicion to the police or social worker (section 110). The SOA states that any person who **has knowledge** that a sexual offence has been committed against a child **must** report the matter to the police immediately (section 54(1)(a)). Since even consensual sexual activity between adolescents was seen to be an offence, HCPs were legally compelled to report these children to the police if, for example, the child approached the HCP for contraception. If the HCP did not report the child as required by the law, then according to section 54(1)(b) he or she could be guilty of an offence and liable to conviction.

In contrast to the SOA criminalising consensual sexual violation and penetration between certain groups of adolescents, the CA allows for a child older than 12 years to legally access condoms (section 134(1)). Children older than 12 years may also access hormonal contraception after a medical assessment (section 134(2)). It is significant to note that section 134(3) requires that a child who accesses FP is entitled to confidentiality in this regard. If a HCP discloses this information without the consent of the child then he/she would be in contravention of the SOA, thereby presenting the HCP with an ethico-legal dilemma.

Also at odds with the SOA, in terms of section 5(2) of the CTOP Act a girl of **any age** may request and consent to her own TOP without a parent/guardian's consent. Therefore, if a 13 year old girl falls pregnant after

having consensual sex with her 14 year old boyfriend, and soon thereafter approaches an appropriate facility for a TOP, the HCP may perform the TOP under specific and suitable conditions with the sole consent of the girl herself. (Note: The CTOP Act requires confidentiality to be protected by the HCP on pain of prosecution for a breach of confidentiality, too). Thereafter, however, this same HCP is required by law, in terms of the SOA, to notify the police about the case since the girl and her boyfriend are both guilty of an offence. By not reporting, the HCP puts him/herself in the precarious position of having knowingly committed an offence of his/her own, an act with legal and possibly disciplinary repercussions.

After consideration of the above pieces of legislation, it is clear that on the one hand, the law encourages young people to seek and use SRH services in the interest of their health and well-being. On the other hand, if that young person discloses that he or she is consensually sexually active, he/she could be prosecuted and possibly convicted. In addition, should HCPs not report knowledge of such, they too would be liable for prosecution and possible conviction. Therefore, the SOA's wording seems almost illogical and unreasonable considering the relevant sections.

Following the CC's judgment in the Teddy Bear Case, doctors are no longer obligated to report consensual underage sex in all instances. However, consensual underage sex must still be reported if the one partner is 16 or 17 years old (so still defined as children under the CA) or older, or the parties are more than 2 years apart in age. The judgment is very narrow and specific, and

still remains in conflict with the CA sections for accessing FP. Therefore, ethico-legal challenges for HCPs still exist in that there are some cases of consensual underage sex that are clearly not in the best interests of the child (50). In these circumstances it may be argued that these cases should remain reportable, but to a different entity such as a social worker, a state protection service or some other non-governmental organization (NGO), instead of to the police. The issues may then be screened and approached from a social angle rather than immediately involving the CJS.

Chapter 4 underscored some of the negative health and socio-economic consequences of adolescent sexual intercourse, followed by a discussion of the dilemmas faced by HCPs in fulfilling the legal duties of the profession. There is a clash between the legislation requiring reporting of adolescent sexual activity and the HCP's professional ethical duty to maintain patient confidentiality, which is also provided for in the law. This brings to the fore the intimate and complex relationship between ethics and the law. Merely following the law does not make one's behaviour ethical. Ethical responsibilities ideally supercede legal duties. In circumstances where the law seems to be unjust, unclear or ambiguous, ethical evaluation and reflection is required in order to guide and effect law reform.

Chapter 5 – Healthcare Practitioners' Ethical Challenges in relation to consensual adolescent sexual intercourse.

As described in chapter 4, the State's aim behind the law discussed is well intentioned but falls short of the ethical standards expected of a HCP, which will now be considered.

5.1 Ethical Theories

Ethics is essentially concerned with issues around how people ought to act. Furthermore, the domain of **normative** ethics is usually divided into the 3 main groups of Deontology, Consequentialism and Virtue Ethics (51).

5.1.1 Deontology

The Prussian philosopher Immanuel Kant (1727-1804) is considered to be the father of the theory of deontology. According to Kant, all rational beings (or persons) are bound by the "supreme moral law" that they each have intrinsic moral worth and are considered to be "ends in themselves". Therefore each individual person should be respected as such and ought not to be used as a means to an end, no matter how valuable that end may be (52). Kant was clear that this moral law applies categorically, without exception. The central idea behind Kant's philosophy is a person's autonomy (53).

As an example, in terms of the application of deontology to the healthcare

setting, Kant's philosophy therefore ties in with the ethical principle of "respect for persons" (see section 5.2). A HCP must take into consideration the thoughts and wishes of the patient (54). In order for a patient to divulge this information, the relationship between the HCP and the patient requires trust and confidentiality. When a patient trusts the doctor, he/she feels free to discuss matters of a private nature. The doctor, then, is able to provide better medical care that is appropriate to the case. In order for the doctor to perform expected duties well, he/she needs to gain the patient's trust, and this can be achieved by reassuring the patient of professional confidentiality.

In order for an adolescent to access quality sexual and reproductive healthcare from a HCP, he/she must trust that the HCP will respect his/her autonomy as well as maintain confidentiality.

5.1.2 Consequentialism

Consequentialism argues that the right action is the one that produces the best outcome or consequence. In addition, a sub-category of consequentialism is the theory of **Utilitarianism** which proposes that the right action is the one that leads to most happiness for the greatest number of people (51). This theory was advocated by the philosophers Jeremy Bentham (1748-1832) and especially John Stuart Mill (1806-1873) (55).

We can apply this theory to healthcare by realizing that a strong HCP-patient relationship would lead to a healthy, happy individual, ultimately leading to a

healthy and happy community. Therefore, maintaining strong HCP-patient relationships would ultimately lead to better medical consequences for the most people.

If young people are empowered to access quality SRH services early on during adolescence, they will be likely to maintain their own health as well as promote good health for their children. This will lead to a community that embraces good health and well-being.

5.1.3 Virtue Ethics

Virtue ethics focuses on the innate character of a person. It proposes that certain virtues, if practiced, will lead to the positive well-being of the person him/herself, thereby constituting a good life (51). The theory was advocated by Plato (429-347 B.C.E) and Aristotle (384-322 B.C.E).

Essentially, virtue ethics is an approach to *personal* morality (56) and in terms of healthcare, it encompasses the HCP's professional character and conduct. Examples of virtues that are essential for the HCP would be helping others, respect, compassion, patience and confidentiality. These virtues must be extended to all patients in dealing with all aspects of health, including adolescent SRH.

5.2 Ethical Principles

In the early 1980s, Thomas Beauchamp and James Childress (57) developed the “four-principles” approach to medical ethics (Principlism) that is based on the four *prima facie* moral principles of autonomy, beneficence, non-maleficence and justice.

5.2.1 Autonomy

We are obligated to respect the decisions of other people concerning their own health. Based on this principle, doctors are required to maintain patient confidentiality because health information belongs to that patient. Children have an evolving autonomy that the law does not fully recognise in terms of the contradictions with age regarding different actions. For example from 12 years old children can access contraception but only from 16 years can they consent to legal sexual intercourse. From 12 years they can be given condoms but only at 16 can they consent to circumcision, and at 18 years consent independently for surgical operations.

5.2.2 Beneficence

We must act in order to do good to others. Based on this principle, doctors ought to always promote their patients’ best interests at all times.

5.2.3 Non-maleficence

We must not harm others. Seeing that in healthcare practice a beneficial

outcome is often achieved with some degree of harm (e.g having to perform surgery on a patient in order to save his life), doctors ought to perform their duties of helping patients with the least amount of harm being done.

5.2.4 Justice

Limited resources must be allocated fairly. HCPs often need to make decisions regarding the allocation of scarce healthcare resources. This must be done after careful ethical consideration.

A study by Page aimed to test whether the principles can be quantitatively measured, and then whether they are actually used in the decision-making process by HCPs when faced with ethical dilemmas (58). She found that these principles are very highly valued, but often not strictly used in practical situations. Additionally, some valid reasons for this are postulated but not discussed further in this report.

Importantly, though, the principles provide an outline for many on how to organise their thoughts prior to approaching an ethical dilemma. It assists HCPs to think through issues and therein lies the attractiveness of principlism in the evaluation of ethical dilemmas.

5.3 Ethical Obligations of the HCP-Patient Relationship

Trust within the HCP-patient relationship is of crucial importance and forms

the basis of a therapeutic partnership. The HCP has an ethical duty to maintain the patient's confidentiality. The World Medical Association's (WMA's) International Code of Medical Ethics (59) gives clear guidance by stating that a patient's right to confidentiality must be respected. This is echoed in the ethical guidelines of the Health Profession's Council of South Africa (HPCSA) (54) as well as in various national law including the Children's Act, NHA and the CTOP Act.

One of the most widely known Greek medical texts is the **Hippocratic Oath (60),** representing the moral basis and values of ancient Greek medicine. It is thought to have been written in the fifth century B.C and is still regarded as the "cornerstone and foundation of the medical profession" (61). In recent years, several experts have reflected on and critically reviewed the application of the Oath in modern medicine (61-63). Today most medical schools have adopted versions of the Oath that are better suited to 21st century medical practice. Of significance is that privacy and confidentiality have remained one of the fundamental components of the Oath. The **Declaration of Geneva (64)**, the "modern day" physician's oath, was adopted in 1948 by the WMA and was last amended in 2006. The latest amendment states: *"I will respect the secrets that are confided in me."*

From both an ethical and legal perspective, people have a right to informational privacy and this ought to be respected. Divulging people's personal information could do them much harm. Non-maleficence should not solely be about avoiding physical harm, but ought to encompass avoiding

threats to a person's values and relationships. In order for HCPs to help a patient properly, they need to gain the trust of the patient by assuring them of maintaining confidentiality. This is especially so in cases involving SRH since these topics are sensitive and private. Disclosing personal information of this nature would therefore cause much emotional and social harm. South African case law clearly highlights the issue that for a HCP, maintaining a patient's confidentiality is both an ethical and a legal duty.(65)

Seeing that the law required HCPs to report consensual adolescent sexual acts, HCPs were placed in a position of ethical conflict. Lisa Vetten, director of the TLAC, succinctly states that HCPs were somewhat turned into the "surveillance arm of the law" in contravention of their ethical obligation to respect patient confidentiality (66).

Still, it is recognised by both the medical and legal professions, that in terms of healthcare, maintaining patient confidentiality is not absolute. In certain instances it is acceptable to break confidentiality such as in cases of sexual abuse, in order to protect the person from further harm (67). At other times, however, the line is not so clear, and that is where the conflict between ethics and law presents itself.

As mentioned in section 4.2, in spite of the new ruling that certain cases of consensual sexual activity of adolescents need not be reported, there are some cases that are clearly not in the best interests of the child and certainly must be reported by HCPs as this is a legal requirement, besides the ethical

requirement of what is in the best interests of the child. The ethical principle of beneficence demands that HCPs work in order to promote the well-being of their patients. One example of harmful adolescent consensual sex would be in cases of inter-generational sex, an extensively researched and well-documented situation in Sub-Saharan Africa in which sexual relationships especially between younger girls and older men are relatively quite common (68).

HCPs are ethically and legally required to report cases of inter-generational sex because the situation is clearly not in the best interests of the younger partner who is often an adolescent girl. Almost all studies in the field of inter-generational sex highlight material gain as the most direct benefit of age-disparate relationships for the young girl (68). Another benefit would include increased self-esteem which follows the feeling of being loved and wanted. Furthermore, there is a sense of increased social status among peers. The "illusion of romance" is highly attractive to girls, so being showered with luxuries by an older, more socially powerful male is very appealing. In urban areas of Southern Africa, these girls are referred to as the "three C girls" because they are generally out to obtain cash, cars and cellphones from their older partners (68).

Serious dangers with age-disparate sexual relationships arise because girls who are in relationships with much older partners often have little control in the relationship due to dependency. Furthermore, these girls are particularly vulnerable from a healthcare perspective because of the unequal power

distribution since they are more likely to engage in unsafe sex involving less use of contraceptives. Consequently, they are more likely to become pregnant, contract STIs and have an increased number of sexual partners (69), further exacerbating the health risks. It would therefore be ethically required for HCPs to intervene by reporting such cases.

5.4 Advocacy

The ethical obligations of HCPs extend to upholding and protecting children's rights, which are firmly established in the field of international human rights. Advocacy, social justice and children's rights are interrelated. It is appropriate that advocating for children's rights forms a part of the duties of all professionals involved in working with children (70).

Advocacy aims to:

> *Raise the status of children and increase the responsiveness and accountability of the institutions affecting them. Advocacy consists of social action on behalf of children whether to increase their self-determination or to enhance the social, educational and medical resources to which they are entitled. (71)*

Purely as a result of strong child rights advocacy in South Africa, SRHRs of adolescents have been addressed, which led to the successful review and challenge of applicable aspects of national law by the CC, as discussed in section 1.1.

This chapter looked at the main ethical theories and principles applicable to the ethical standards expected of a HCP in his/her relationship with a patient. The topics of trust, privacy and confidentiality seem to be the key matters of concern in the HCP's relationship with the sexually active adolescent requiring healthcare. In most cases HCPs are ethically obligated to protect patient confidentiality. At other times, however, it may be ethically required to break confidentiality. For the HCP, this is a big challenge in itself. Furthermore, when legal obligations are also placed on the HCP, the situation may become increasingly complicated.

Chapter 6 – Discussion

The last few decades have shown a clear shift in peoples' conceptualisations of adolescent sexuality. It is now accepted as a normative aspect of healthy development (72). This chapter explores the practical implications of this view on SRHRs, specifically in terms of the ethical and legal aspects of the HCP-patient relationship, as well as the need for adolescent SRH education.

Adolescence is a period of rapid development and sexuality is an important issue that adolescents must deal with. It is therefore imperative to appreciate the changing behaviour patterns of adolescents during this stage of life in order to better understand and assist them with challenges.

Although adolescent sexual experimentation is normal, in many cultures adolescent and pre-marital sexual activity is seen as "problem behaviour" (73) in that it is considered to be a social and cultural taboo. This is mainly based on fear, propaganda and people's need to guard customary norms (40). Interestingly, there are other cultures in which this is not the case at all. However, a discussion of these cultural trends is not within the scope of this research report.

6.1 Implications of Legislation on the Adolescent

It is probable that if adolescents are aware that they may be reported to the police if they disclose their sexual activities, they will be unlikely to approach

appropriate health services due to the fear of prosecution. They will therefore hesitate to form a trusting relationship with a HCP, thereby defeating the purpose of a SRH programme.

By sections 15 and 16 of the SOA criminalising consensual sexual activity between adolescents, it was thought by experts that this would lower the reporting of rape and other sexual crimes (4). This is probably because adolescents may not report sexual crimes against them because of their fear of being prosecuted themselves.

When a person is convicted of a sexual offence against a child or a mentally disabled person, section 50 of the SOA provides that the court must order that the particulars of the person be included in the National Register of Sex Offencers (NRSO) (74). However, there is no distinction made regarding the age of the offender. So young people who were prosecuted under sections 15 and 16 of the SOA would have been entered into the NRSO. This would be in the same category as criminals convicted of very serious sexual crimes including rape and paedophilia, crimes that cannot possibly be fairly compared with consensual adolescent kissing and petting. When the child offender grows up and seeks employment, he or she would never be able to work in situations that involve children. A child's name being added to the NRSO is a shameful situation and a humiliating occurrence that harms the child's dignity with potentially destructive consequences.

In February 2014, the Constitutional Court handed down another

breakthrough judgment declaring section 50(2)(a) of the SOA unconstitutional (75). In this case, the applicant who was 14 years old at the time of the offences, was convicted of the rape of a 7 year old boy and two 6 year old boys, as well as with the assault with intent to cause grievous bodily harm for stabbing a 12 year old girl. The CC held that section 50(2)(a) infringes on the right of child offenders to have their best interests considered of paramount importance in terms of section 28(2) of the Constitution. The declaration of invalidity was clearly limited to child offenders only and was suspended for 15 months to enable the Legislature to correct the defect.

It has been boldly submitted by critics that this NRSO is "poorly implemented (if at all)" by the Department of Justice and Constitutional Development (76). The reasons stipulated are that it is prohibitively expensive to keep up and secondly, without an effective CJS and child protection service, the NRSO is not likely to have much impact on protecting children by any means. It has been concluded then that the register seems to be a poor utilisation of limited resources without first implementing processes to strengthen the country's law enforcement and social development services (76).

While the CJA allows for restorative justice methods when dealing with offenders, it still requires the involvement of prosecutors, probation officers, defence lawyers and magistrates (77). It therefore directly exposes children to potentially traumatic and distressing experiences (4). In his judgment, Judge Rabie mentioned that: "*Despite many reforms to make the child justice system more child-friendly…exposure to the criminal justice system is still a*

dramatic and harrowing experience…" (1). For these children feelings of humiliation, indignity and stigmatisation will be inevitable. These experiences will be harmful in their further development. Child Rights Manager at the University of Cape Town's Children's Institute, Paula Proudlock, says that "…*police resources and the might of the law should be reserved for dealing with sexual offences against children, and not wasted on children who are exploring their sexuality together, consensually*." (78)

Moreover, people working with children, such as those in law enforcement and the courts, must be trained in the field of counseling and communication with children. A child being questioned in the same manner as an adult is not ideal and could be destructive to emotional and psychological development. This is clearly not in the child's best interests. Therefore, personnel ought to be properly trained in such delicate undertakings with children (79). Seeing that human resources in terms of numbers of staff and lack of skills are such a challenge, the practicality of these legal provisions are questionable.

6.2 Gender differences in adolescent sexual experiences and risk behaviour

SRH applies to males and females in different ways. Therefore, gender differences must be considered when discussing SRH. One way of illustrating gender differences in the context of health is to look at some relevant HIV statistics. HIV prevalence among South African women between the ages of 20 and 24 years was about 21% in 2010 (80). Among men in the same age

range, HIV prevalence was about 7%. This clearly highlights the disproportionate vulnerability of young women in terms of SRH issues. Subsequently, I propose that these figures may be used to illustrate a similar disproportion of vulnerability in the adolescent years of these young peoples' lives.

Biologically, considering female anatomy and physiology, women are more likely than men to be infected by STIs, including HIV, during heterosexual intercourse (81). This is often due to their relatively immature immune and reproductive systems (82). In addition, women are often fairly powerless to refuse sex or even discuss contraception. These general socio-cultural gender inequalities contribute considerably to poorer SRH in women and girls.

Girls bear a physical indication of sex in terms of pregnancy. Girls are therefore "easy targets" for stigmatisation and dishonour in some communities compared to boys. Again we see that by virtue of their female sex they are disproportionately affected by the consequences of sexual activity. It is important, therefore, to ensure strong SRH educational and health services especially for girls. A valuable lesson to be noted from previous SRH agendas at an international level is that effective programmes require particular emphasis on empowering young women and promoting their sexual rights (81).

An unfortunate consequence of pregnancy in school-going girls is that they often drop out of school during pregnancy or after delivery. These girls are

less likely to return to school afterwards in view of several barriers including child-rearing, financial constraints and stigmatization (83). This premature end to formal education results in poor outcomes for mother and child.

At a global level, a spotlight has been placed on issues surrounding maternal and child health. The international importance of gender equality is emphasized further by it being included as one of the major MDGs. The deadline for the achievements of the MDGs in 2015 is imminent and therefore South Africa too has renewed its focus on maternal and child health.

When the status of women is improved, then their decision-making capacities in all spheres of life will be enhanced (41). This would undoubtedly include the areas of sexuality and reproduction.

6.3 Sexual experimentation

Developmentally normal adolescents are curious about sex. For that reason adolescence necessitates a healthy exploration of sexual identity, values and behaviour. Sexuality is an ongoing developmental process that overlaps with various other facets of normal human development (73) (84). Behavioural patterns acquired and developed during adolescence tend to persist throughout the adult years (40). Therefore, influencing adolescents' sexual habits positively at the very beginning of adolescence will encourage healthy sexual practices later on. International SRH experts have analysed the content of educational programmes aimed at young people's sexuality.

Notably, however, there were no programmes identified to have included information regarding sexual pleasure or sexual activities as normative among young people (39).

The International Planned Parenthood Federation (IPPF) (85) is a NGO that promotes SRH advocating for peoples' rights to make their own choices regarding FP. Jacqueline Sharpe, President of the IPPF, concisely states: *"Sexuality is a natural and precious aspect of life, an essential and fundamental part of our humanity. For people to attain the highest standard of health, they must first be empowered to exercise choice in their sexual and reproductive lives; they must feel confident and safe in expressing their own sexual identity." (86)*

Considering that there is plenty of expert evidence that consensual adolescent sexual experimentation is a natural human phenomenon, the criminalisation of such in terms of sections 15 and 16 of the SOA seemed quite unreasonable. Since the CC has declared these sections unconstitutional, the time has certainly come for us to find effective ways of addressing adolescent sexual practices in order to ensure that children make healthy choices when it comes to their sexual behaviours.

6.4 Reasons for investing in adolescent health

International studies on adolescents show that peers were the most common source of SRH information (87). This was closely followed by a significant

number who received their information from sources of mass media (magazines, television, the internet, etc.). A few of the study participants stated that they received their SRH information from either parents or teachers. One may be justified in having concerns regarding the accuracy and reliability of the information being transferred to and amongst these children. Proper health education facilitated by the health sector is essential in ensuring that children, parents and teachers receive accurate and up to date health information.

Teenage mothers are recognized to be a large hurdle to South Africa's commitments in meeting the MDGs in that they are the greatest contributors to the maternal and newborn mortality rates (88). Therefore, focusing on the SRH needs of adolescents is clearly crucial to realising the MDGs.

Governments have a duty to empower adolescents to make informed and healthy choices (89). South Africa certainly seems to have accepted this responsibility quite openly. On 30th October 2013, South African Health Minister, Aaron Motsoaledi, told the Parliamentary Portfolio Committee on Health that the Department of Health (DoH) was preparing to launch a massive FP campaign aimed especially at preventing teen pregnancies. This was planned to occur within the following year (88). In the same statement he went on to explain that in South Africa about 8% of pregnancies involve girls under the age of 18. Unfortunately, these girls make up 36% of maternal deaths.

Many of the problems associated with adolescent sex are preventable. A key aspect of preventative healthcare is education. There are several countries in the world that have successfully decreased their national HIV prevalence rates. It is noteworthy that they have achieved this mostly by encouraging safer sexual behaviour in adolescents (90).

There are unquestionable benefits to investing in SRH and there have been many exceptionally strong cases made by Singh et al for allocating resources in this direction (8). The economic, social, cultural and political development of countries depend on the SRH of its young people (40). Conversely, denial of these rights have potentially devastating consequences (see section 4.1).

6.5 The necessity of sexual and reproductive health education for adolescents

South Africa is a signatory to the UNCRC, which plainly states that adolescents have the right to receive the health education and services they require in order not only to survive, but to grow and develop to their full potential.

It has been introduced earlier in section 6.3 that sexual curiosity and exploration is a feature of normal healthy adolescent development. However, a fine line divides healthy sexual exploration and sexual activity that significantly increases harm (73). This is understandable if we acknowledge that adolescents are faced with many life challenges and stressors that

contribute to their confusion and vulnerability. The key to assisting adolescents to clearly visualise this fine line is appropriate and relevant SRH education.

In western society, conventionally, pre-marital sex is viewed as socially unacceptable. The idea amongst several experts now, though, is that it should be looked at in a different light altogether. Perhaps it is merely a "shift in social norms," (39) the acknowledgement of which presents us with an opportunity to address health risks head on. Many adults believe that adolescents cannot be trusted with sexual information since they're perhaps too young or that they're too sexually pre-occupied to be responsible concerning sexual activity.

In today's socio-cultural climate, preventing young people from engaging in pre-marital sex is not a workable solution to avoid the damaging health outcomes of adolescent sexual intercourse. Rather, young people need to be provided with the necessary tools in order to make responsible choices regarding their sexual identity and relationships. As national studies have confirmed that the proportion of sexually active high school learners has increased, it has been recommended by researchers that sexual health interventions should start at primary school level (32).

Abstinence-only sex education programmes in both developed and developing countries almost always limit information regarding contraception and other facets of human sexuality (39). For this reason, youth advocacy

groups (91) have openly criticized abstinence-only interventions since these programmes ignore the youths' basic human right to receive accurate, balanced sex education. Besides, studies have shown that sex education does not increase sexual activity (87). Rather, it assists young people in making informed and healthy choices regarding their SRH.

In order to guide us in designing educational and interventional programmes, we need to ascertain and understand adolescents' motivations around sexual activity (39). There is certainly room to explore this understanding through conducting further research from a specifically South African viewpoint.

6.6 The media as a sex education tool

In a 2004 survey in the USA, it was revealed that "new media" like computers and the internet are being increasingly Accessed by children (92). In addition to this, children are still spending significant time on "regular" media like television, magazines and radio. Clearly then, children today take in vast amounts of information from various media sources. Furthermore, there is a very real risk of unfiltered information being disseminated by the media.

A follow-up survey in 2009, also in the USA, found that 8-18 year olds spend an average of greater than 7 hours a day using entertainment media (93). Research done within the South African context shows that local teenagers are also increasing their internet use, specifically mobile internet (94). The internet has revolutionised people's ease of access to information. World

Wide Web pages and links, game- and music-download sites and the various social network sites, all easily accessible on mobile phones, have an enormous influence on adolescents' behaviour and general outlook on life (33). Additionally, research has shown that in most cases adolescents' contact and experience with mass media does not occur under responsible adult supervision. Escobar-Chaves et.al. succinctly state: "*Effects of the mass media have been found to be far-reaching and potentially harmful in influencing the health-related behaviours of children and adolescents, many of whom are not yet mature enough to distinguish fantasy from reality, particularly when it is presented as 'real life'*." (33)

It has been observed by some experts that "given the popularity of the Internet, this may be the next most influential sex educator for American youth." (95) With the clear infiltration of computers and social networking sites into South African communities, even at a relatively rural level, this expectation of the Internet being a powerful ally in educating children about sex and reproduction, may be applied here as well.

One advantage of using online resources is that sex education can be disseminated privately and confidentially (95), thereby avoiding embarrassment and awkwardness for the adolescent. Internet access is generally available 24 hours a day 7 days a week. It is also relatively inexpensive and accessible.

As attractive as the prospect of media education may be, it is not without it's

disadvantages. One major problem is internet pornography. The amount of free internet pornography is staggering. The online pornography industry has very aptly been referred to as a "sexual-media giant." (96) There are a range of harms associated with inadvertant pornography exposure, including emotional and psychological disturbances (97). Considering the vulnerability of children and adolescents, the lifelong effects of these harms can be devastating. It is important then to have some means in place for control and monitoring of freely accessible sexual content.

Exposure to internet pornography is associated with higher sexual risk-taking behaviour (93). Naturally, this would have a negative impact on reproductive health. The spread of STIs and related dangers are an obvious consequence.

From the above discussion, we see that there is a link between the various forms of media and sexual health. The internet, together with all its available components, is obviously an important part of an adolescent's life and therefore plays a pivotal role in shaping their sexual attitudes. For that reason, it would make perfect sense to use this form of information transfer in order to instill in young people sexual attitudes that are acceptable and safe. In South Africa, the media industry is constitutionally assured of their right to freedom of expression, and so freedom of the press. Consequently, it may be seen as somewhat of a "watchdog". This could be an advantage when it comes to the country's efforts in improving SRH.

6.7 Educating adolescents through school health

There is debate surrounding specific elements of a successful sex education curriculum including who should teach it, how it should be taught, what information ought to be included or excluded, and the age groups of children that need to be exposed to such a syllabus (39).

A Nigerian study on school-based SRH programmes (98) showed that programmes that included more than just a single method of engaging learners, appeared to have increased effectiveness in relaying information. These mixed interventions often included teacher-led instruction combined with interactive peer education.

The 1997 WHO Technical Report on school health promotion states: "*School health programmes can be the most efficient and cost-effective way to improve students' health and, as a result, their academic performance. Thus for the student, school staff, the school as an institution, the family, community, and the nation, health promotion through schools is financially, educationally, socially and politically desirable*." (99) It is imperative that this statement is respected and implemented

6.7.1 The current South African school health policy

For the past 20 years, the WHO, through convening an Expert Committee on Comprehensive School Health in 1995 to encourage educational and health institutions to coordinate their efforts to promote health through schools, has

been firm in its efforts to promote health education programmes for school-going children. Based on international research (99), the Committee is adamant in its belief that school health programmes are crucial in improving public health and socio-economic development.

In 2010, in his State of the Nation Address, the South African President committed the government to reinstating health programmes in South African public schools. The numbers of school-going children are fortunately increasing, and targeting health interventions at this group is vital to the health of the entire nation. In 2012, more than 12 million learners were enrolled in public schools in South Africa (100). In 2013, the Minister of Health and the Minister of Basic Education jointly presented the Integrated School Health Policy (ISHP). It outlines the roles of both departments in addressing the health needs of learners. The ISHP is a revision of the 2003 National School Health Policy (NSHP). Reviewers and researchers were of the educated opinion that the NSHP was fraught with several shortcomings, and hence the great improvement in the new policy (101). This policy will continue to be analysed so that additional challenges can be underscored and addressed in order to allow ongoing changes for the better.

This ISHP, if implemented efficiently, has the potential to considerably improve the outcomes of SRH education for school-going children.

Chapter 6 explored adolescent sexuality and SRHRs as a changing concept in society in that it is a normative aspect of human development. The impact

of the changing legislation on the adolescent was explored. In addition, it was maintained that adolescent SRH education is the biggest contributing factor in eliminating the negative consequence of adolescent sexual intercourse. The next chapter looks at the contributions that can be made in this regard by various stakeholders.

Chapter 7 – Recommendations

It has been identified that the negative outcomes associated with adolescent sexual intercourse may be eliminated by effective SRH education programmes. These programmes must be directed to the appropriate audiences and must be a collective effort propagated by various stakeholders working together.

7.1 The target populations

In order for SRH strategies to be successful, programmes must be targeted towards specific populations. There would be differences in the nature of information transmitted, the manner of communication and the style of delivery based on the type of target audience. Specifically catering for each demographic would enhance the acceptance of SRH education among the general public.

7.1.1 Adolescents and youth

Essentially, regardless of whether school-attendees or not, empowering the youth is crucial to every aspect of a country's development.

In line with the UNCRC, ICPD PoA and the Children's Act, young people themselves must be actively involved in activities that have a direct impact on their lives. These would include the planning, execution and evaluation of

SRH education programmes. Their dynamic involvement would ensure that their needs are addressed since they would be given the opportunity to express what their needs actually are.

Older peers can play effective roles in mentoring younger youth and encouraging healthy SRH decision-making.

7.1.2 Focus on adolescent girls

In order for women to become equal partners in society, they must be targeted very early on in terms of education on gender equality.

In all societies, discrimination on the basis of sex and gender generally starts early in life (41). In view of this sad truth, greater equality for the female child is the first step in ensuring that women's full potential is realised.

Thereafter, young women can be expected to involve themselves in leadership roles in the designing and implementation of SRH services. As Leclerc-Madlala (57) expresses, "…*access to education remains a major route out of women's ongoing poverty and dependency*." Clearly, the key to empowerment is education and empowered girls form the foundation of a powerful nation.

7.1.3 Focus on men and boys

In nearly every realm of life, men seem to exercise more authority. Therefore, men and boys play a key role in bringing about changes in gender equality for the better (41). Leclerc-Madlala suggests that with respect to HIV prevention programmes, focus must be placed on changing men's behaviour and attitudes (68). I propose that this concept ought to pertain to SRH programmes as well. The time has come for this knowledge to be applied on the ground and awareness programmes must incorporate this message directly towards men and boys.

7.1.4 Learners v. non school-going children

Many children are completely missed by school health interventions since they cannot attend school. There are various reasons for this, but it may largely be due to socio-economic circumstances.

Worldwide, there are about 101 million children of primary school age who are not attending school and over 20 million of these children are from East and Southern Africa (102). Consequently, they are unlikey to be exposed to school-based interventions because they are not school-attendees. This is a staggering statistic and not incorporating these children into SRH campaigns could be devastating in view of the negative consequences of poor SRH knowledge (see section 4.1). It is therefore essential to ensure that SRH programmes include this set of young people.

7.2 The Stakeholders

7.2.1 Educating parents and other family members

Research has shown that adolescents who talk to their parents about sexuality and relationships are more likely to start sexual activity later, use contraception more often, communicate better with partners and have sex less often (103). This illustrates that parents and significant family members have a clear influence on whether or not their children make healthy decisions in life (104). However, many parents do not realise or admit that their teenage children are sexual individuals (105).

If parents are not adequately educated and supported in terms of adolescent sexuality, one major link in the chain of SRH education will be broken, potentially defeating the purpose of SRH education, thereby leading to a further waste of resources. In addition, other role-players including governments, teachers and HCPs will needlessly have to "*tread very carefully, concerned at not drawing the wrath of parents*…" (106).

In a statement by FEDUSA 's Vice President for the gender component Martle Keyter (4), it was stated that it is "…*essential that those of us who are parents question the extent to which we are willing to rely on the law of this country to instill in our children the values which we upheld individually and within our families*." Parents must realise that their role in educating children is critical. It is a responsibility that cannot be ignored, no matter how difficult it may be or how uneasy it may make them feel. Social challenges cannot be rectified by

the law alone (107).

Parents are confronted by many challenges that make it difficult for them to successfully control and monitor their children. They need to engage with their children and this is not a straightforward skill, especially when the child is an adolescent. Parents feel discomfort when having to talk to children about sexuality and this obviously impedes their efforts to provide guidance (48). Therefore, parents must be supported in the development of certain parenting skills. Facilitated workshops and seminars would go a long way in accomplishing this.

7.2.2 School educators

We cannot expect educators to enlighten children if they themselves are not trained. The ISHP identifies the categories of staff that require training so that effective health education can be implemented (100). Capacity-building strategies are fundamental to empower educators so that health education programmes are executed appropriately. Moreover, the programmes must be ongoing and information should be reviewed and updated regularly.

Schools must work together with the local community (108). Community values must always be respected and incorporated into health outreach programmes.

Rahman et.al. (87) suggests that sex education should be conducted

separately for boys and girls since the issues pertaining to SRH may be vastly different for boys as compared to girls, and preferably taught by teachers of the same gender to facilitate discussion and reduce embarrassment.

7.2.3 Community leaders

Leaders at all levels of society must campaign against gender discrimination (41). An essential adjunct to this is that they must also act and work dynamically in keeping with their discourses.

Community leaders and members must take into account the diverse home backgrounds of adolescents. In keeping with this, and in line with international guidance (41), the changing SRH requirements of young people must be acknowledged. Additionally, this ought to happen in ways that are sensitive to the circumstances and challenges faced by today's young people.

7.2.4 Government

Parliamentarians, with their political will and guidance, are fundamental to the support and promotion of effective SRH services (109). They are the spokespersons and role models of the public and are therefore critical to advancing gender equality and health rights. Their voices must be used to highlight the magnitude of SRH issues. Politicians are ideally positioned to promote health rights through policies and directives. They are also in a strategic position to influence the "allocation of budgetary, human and

administrative resources to help meet the needs" (41) of an effective and efficient SRH system.

Corresponding to international guidelines (41) governments can aid greater community participation in health services by decentralising public health programmes. Forming partnerships in cooperation with NGOs will support an improved SRH system. These bodies should include private healthcare providers, women's groups, youth programmes and religious groups. The more diverse the partnerships, the greater the variety and number of people reached in the awareness programmes.

Any health agenda requires the reliable and sustained provision of quality interventions (110) including both drug and non-drug items. Relevant examples applicable to SRH would be barrier and hormonal contraceptives. Furthermore, logistical systems that are required to secure the provision of these items must be strengthened at all levels (110).

Government must continue to be primarily responsible for SRH training of health providers, including health educators and managers. Both formal and informal instruction should be facilitated. Assistance from local and international NGOs and other stakeholders will further fortify the knowledge base of providers.

7.2.5 Private Sector

Over the past twenty years, the health systems of low- and middle-income countries have seen a growth in attention to the private sector's role in the industry (111). Resulting from this, a resolution was passed by the World Health Assembly in 2010 that encouraged countries to "*constructively engage the private sector in providing essential healthcare services*" (112). It should start at the top with policy makers who must openly and publicly acknowledge the private sector as having an important role to play in public health.

The investments of the private sector are crucial to the sustainability of health programmes. Corporate social responsibility is not just about financial charity or "cash hand-outs" but about investing sensibly in community development (113). On the other hand, it is also advised that it is not advantageous for the private sector to take over the responsibilities of government in the provision of basic social and health services (113). Obviously, this would not be sustainable. Their role is purely to supplement the activities of government.

7.2.6 International Aid

An effective SRH programme will involve an increase in the demand for relevant drug and non-drug items. International guidance documents advise (41) that the international community should help facilitate the procurement of contraceptives and other essential commodities for the SRH programmes of developing countries. One way of doing this could be by assisting with the logistical coordination of supply at global, regional and national levels.

Another significant method of contribution is the transfer of technology to developing countries to enable them to sustainably produce their own commodities like contraceptives. Facilitating capacity-building will reinforce the self-reliance of developing countries. In addition, developing countries must take advantage of assistance, and openly stipulate their requirements, whether material or advisory, so that aid is effective.

The 1994 ICPD in Cairo was a high point in the history of womens' rights and population development. There, all delegates agreed that "*population is not just about counting people, but making sure that every person counts*." Representatives also agreed that the empowerment of women is a global priority. At this ICPD, developed countries gave assurance that they would assist developing countries in their efforts of improving SRH services. About US$2,6 billion were provided by these developed countries for this purpose. However, this is less than half of what they had pledged at the ICPD for that year (8). Perhaps it is time for more affluent countries to live up to pledges made in the past.

7.2.7 Non-governmental Organisations (NGOs)

In the years since 1994, South Africa has made a substantial input towards its primary health improvement initiative (114). It has managed to do this through greater investment in resources allocated towards health programmes and infrastructure. However, there is still much to be desired in terms of a robust health system aimed at attaining the 2015 MDGs. The role

of NGOs here is critical.

For decades in South Africa, several NGOs have been instrumental in the lives of millions by facilitating improvements in health and quality of life (114). This must continue and the methods to do so must be continuously reviewed to ensure that interventions are effective and in keeping with global changes. Some methods I propose include:

- being strong advocates for healthcare development;
- utilizing marketing tools to promote health awareness;
- creating and maintaining effective management, coordination and administration systems;
- monitoring and evaluating the impact of programmes;
- facilitating training and education of HCPs; and
- collaborating with other stakeholders involved in similar pursuits.

7.2.8 Faith-based Organisations (FBOs)

There is often controversy when issues of faith and SRH overlap (115). However, there is also great opportunity for FBOs to contribute to the improvement of public health in terms of peoples' attitudes and beliefs and attention must be placed on using this avenue of influence. A broad array of beliefs, denominations and religious leaders acknowledge and accept that FP services are essential for women to protect their and their family's health and well-being (115).

At a global level, FBOs have played a prominent role in the United States Global AIDS Programme (The President's Emergency Plan for AIDS Relief (PEPFAR)). Even before this, FBOs have partnered with the United States Agency for International Development (USAID) in order to implement SRH programmes in the developing world (116).

It is therefore important that South Africa's civil society organisations, which include FBOs, collaborate with the health sector. This will guarantee that their interventions in SRH are informed and evidence based. They are able to penetrate deep into communities, thereby being effectively able to raise awareness and advocate for healthy SRH programmes (115).

7.3 Health research and marketing

Ongoing research and publication in the field of adolescent SRH is fundamental to the implementation of effective SRH programmes by making it available to institutions and individuals who are directly involved in SRH.

In a worldwide 2013 study, international experts on contraception were approached in order to identify the types of research that would be required in order to meet the global need for SRH services of which FP forms a crucial component (117). The three key categories are:

1) Policy implementation;
2) Addressing barriers to the use of FP services by the integration of services; and

3) Interventions targeting special groups, including adolescents.

Researchers should then consider these aspects first when designing future studies. This will ensure that appropriate and specific areas of SRH are targeted, thereby allowing for efficient use of limited resources too.

A relatively new area of practice is the field of **health marketing,** which draws from conventional marketing principles. Once health research is carried out, areas of SRH in which intervention is required may be identified, and then a health marketing framework can be initiated. In this way, further relevant interventions, campaigns and research projects can be designed.

7.4 Youth-friendly health services

WHO defines an **adolescent-friendly health service** as one that is accessible, acceptable, equitable, appropriate, and effective (14). Furthermore, the organization provides guidelines and toolkits for the implementation, monitoring and evaluation of youth-friendly health services.

The Centres for Disease Control and Prevention (CDC) also provide clear guidance on the elements of a youth-friendly SRH service (10). Special consideration must be given to:

- Privacy and confidentiality;
- Adolescents must be made aware of their rights e.g. to consent for themselves;
- The facility must be easily accessible – services are to be provided

during days or hours that are convenient for teens, and services should be free or of very low cost;

- Health staff must be non-judgemental; and
- Services must be culturally and linguistically appropriate.

Adolescents who have access to, and actually use, health and education services become a “powerful force for economic development” (84).

SRH education is crucial in equipping young people to make healthy lifestyle choices. Chapter 7 outlined the specific target populations that these education efforts ought to be targeted towards. Furthermore, these education outreach programmes must be a collaborative effort involving various identified groups. Recommendations were made specific to each stakeholder, as well as suggestions to incorporate further research, health marketing and youth-friendly health services.

Chapter 8 – Conclusion

In summary, South African legislation is currently undergoing revision so that consensual sexual intercourse between adolescents of a certain age is no longer a criminal offence. However, consensual adolescent sex is associated with a number of negative outcomes including unwanted pregnancies and STIs. There is a dire need to implement strategies to reduce these negative consequences.

This report has looked at aspects of South African legislation pertaining to SRHRs as well as international and local guidance documents associated with children's rights. The implications of the legislation have been discussed from the points of view of both the HCP and the adolescent, as well as highlighting several ethico-legal challenges for the HCP when working with adolescents and their SRH.

The literature supports the proposition that investing in adolescent SRH is a necessity in order to reduce negative consequences associated with irresponsible sexual behavior. The key to this is SRH education at various levels of society. Recommendations include programmes and interventions aimed at the target populations as well as towards stakeholders who have a responsibility to carry out their role in promoting SRH.

Attention has also been drawn to the overwhelming evidence of the benefit of educating girls in particular (98). Apparently, according to the Population

Council of New York in 2013, if a girl has just 5 years of school education, her children are 40% more likely to survive beyond the age of 5 years (118). Consequently, investing in and uplifting the social status of women and girls is one of the most cost-effective and efficient ways to advance population development (119).

As Hindin and Fatusi (47) state: "*Today's adolescents will determine the social fabric, economic productivity, and reproductive health and well-being of nations throughout the world in the coming decades.*" Sensibly designed interventional healthcare strategies that are put into effect during adolescence can have beneficial lifelong effects on health. In turn, this sets in motion an entire nation's journey towards quality healthcare.

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Human Research Ethics Committee (Medical)

Research Office Secretariat: Senate House Room SH10005, 10th floor. Tel +27 (0)11-717-1252
Medical School Secretariat: P V Tobias Health Sciences Building, 2nd floor Tel +27 (0)11-717-2700
Private Bag 3, Wits 2050, www.wits.ac.za. Fax +27 (0)11-717-1265

Ref: W-CJ-141020-1 20/10/2014

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigator: **Dr Shivani Chirhut. (Student no. 9700671X).**

Project title: **Ethico-legal concerns in relation to adolescent sexual intercourse.**

Reason: This study is an analysis of information in the public domain. There are no human participants.

UNIVERSITY OF THE WITWATERSRAND
PROF PE CLEATON - JONES
HREC (MEDICAL)
2014 -10- 20
JOHANNESBURG

Professor Peter Cleaton-Jones

Chair: Human Research Ethics Committee (Medical)

Copy – HREC (Medical) Secretariat : Zanele Ndlovu.