

**CONDOMS?** YES!

**SEX?**

**NO!**

**Conflicting Responsibilities  
for Health Care Professionals  
under South Africa's  
Framework on  
Reproductive Rights**

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# List of Abbreviations

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CTPA	Choice on Termination of Pregnancy Act
NHA	National Health Act
RHC	Reproductive Healthcare Clinic
SOA	Criminal Law [Sexual and Related Matters) Amendment Act / The Sexual Offences Act
TOP	Termination of Pregnancy

# Introduction

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This project was conceived following training workshops on the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2007<sup>1</sup> [hereafter referred to as the SOA/The Act] conducted in 2010 by the Gender, Health and Justice Research Unit for a group of health care workers employed by the Provincial Department of Health in the Western Cape, South Africa. During discussions, workshop participants reported different experiences in implementing the new SOA provisions which criminalise consensual sexual intercourse between teenagers under the age of 16 and require anyone with knowledge of such an offence to make a police report. Practitioners who worked in a labour ward in one rural hospital, for example, reported that police officials had actually visited the ward and demanded to see a list of teenage patients. Other health care workers were not familiar with the relevant obligations and had received no instructions from their facility managers regarding the obligation to report consensual sex among teenagers under the age of 16 years. Some workshop participants wanted to know whether the Act actually meant that health care providers are required to report all pregnant teenage patients to the police. Health workers also expressed different levels of approval or concern over these provisions, suggesting a range of experiences and attitudes regarding teenage sexuality and reproductive rights. The discussion that ensued highlighted what appeared to be an obvious flaw in the legislation and a real concern for health care workers who considered patient confidentiality to be an essential condition for effective healthcare.

Existing provisions of the Choice on Termination of Pregnancy Act 1996<sup>2</sup> [the CTPA], and the new provisions of the Children's Act, 2005<sup>3</sup> have increased teenagers' autonomy over reproductive health care decisions and added another layer of complexity to the issues introduced by the Sexual Offences Act. How could the legislature protect the right of a 12- year- old girl to confidentiality when accessing a termination of pregnancy, while simultaneously requiring the nurse who provides this service to report the girl's sexual activity to the police? There was clearly much to be understood about how these conflicting provisions were being implemented in practice.

The Gender, Health and Justice Research Unit (the GHJRU) therefore embarked on the present study in order to explore how health care workers who provide reproductive health care to teenagers manage these seemingly conflicting legal rights and duties. The report consists of three parts. Part I of the report contextualises the study both in terms of the policy framework and existing research. It also describes the methodology used in the study. The first section of Part I sets out the legal framework within which teenage sexuality and reproductive rights are regulated and protected, and highlights those aspects of the legislation that appear internally inconsistent or counter-productive. The second section of Part I reviews the local and international

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<sup>1</sup> Act 32 of 2007.

<sup>2</sup> Act 92 of 1996.

<sup>3</sup> Act 38 of 2005.

<sup>4</sup> Act 38 of 2005.

<sup>5</sup> Sections 12(2), 27(1)(a) of the South African Constitution.

<sup>6</sup> Section 28 (1)(c) of the Constitution.

literature that has been written on some of the issues that emerge from this research in order to provide a context for the interpretation and analysis of the findings. The third section sets out the methodology used in the study.

The findings of the study are described in Part II of the report. The first and second sections provide background on the participants and findings on health care workers' knowledge of some of the legal rights and duties that are relevant to the provision of reproductive health care to teenagers. The final section of Part II looks at health care workers' implementation of their legal duties. Throughout this presentation of the findings, the report highlights the multiple roles that the legal framework assigns to reproductive health care nurses; the roles that health care workers perceive for themselves and carry out in practice; and the ways in which these roles are fulfilled. Part III of the report discusses the findings of the research and begins with a discussion of the impact that the current legal framework has had on the provision of reproductive health care to teenagers. This is followed by a discussion of the legal framework itself, which is seen as a manifestation of some of the difficulties inherent in the attempt to regulate teenage sexuality, and of the problematic nature of the multiple roles that nurses are expected to fulfil as a result.

### **Post-Script: Changes in the Law (2013)**

As is noted in various places in the text, at the time of the fieldwork and writing of this report the constitutionality of sections 15 and 16 of the Sexual Offences Act were being challenged in *The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35. The applicants argued that the sections in question harmed the children that they intended to protect – exposing minors to the harshness of the criminal justice system and damaging the development of healthy attitudes and behaviours in terms of their sexuality. The case centred on whether it is constitutional to criminalise children in order to achieve the aims of the Act: deterring early sexual behaviours and reducing the risks of such activity (for example, teenage pregnancy).

In a unanimous judgment on 3 October 2013 Judge Sisi Khampepe determined that the provisions were indeed unconstitutional as they infringe on the rights of adolescents to dignity and privacy. Non-consensual sexual acts with or between children of any age remain illegal and are prosecutable under the law.

The matter has now been referred to the legislature to amend the law within a timeframe of 18 months. In the meanwhile a moratorium has been placed on investigations, arrests, prosecutions and proceedings in relation to these sections of the Act and the Minister of Justice is required to remove all details of children who were convicted under the impugned provisions from the National Register for Sex Offenders and expunge their records, at the cost of the state.

# PART I: Context and Methodology

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## The Legal Framework on Sexual and Reproductive Rights

South Africa's 1996 Constitution,<sup>4</sup> internationally acclaimed for its comprehensive and progressive Bill of Rights, protects the individual's right to make decisions regarding reproduction and the right to access health care services, including reproductive health care.<sup>5</sup> These provisions, like all other rights in the Bill of Rights, also apply to children. In addition, the Constitution stipulates that every child (i.e., person under the age of 18 years) has the right to basic health care services.<sup>6</sup> Furthermore, the Constitution requires that in *every matter* concerning a child, his or her best interests are paramount.<sup>7</sup>

Since the enactment of the Constitution, several laws have been passed to breathe life into these constitutional protections, including the Children's Act (Act 38 of 2005), the Choice on Termination of Pregnancy Act (Act 92 of 1996), the National Health Act (Act 61 of 2003) and the Criminal Law (Sexual Offences and Related Matters) Amendment Act (Act 32 of 2007). All of these laws regulate or affect certain aspects of teenagers' sexual and reproductive rights. The following section provides a brief overview of relevant provisions of these laws and highlight potential areas of conflict between them.

## The Choice on Termination of Pregnancy Act

Under the Choice on Termination of Pregnancy Act, 1996 any pregnant woman or girl can request a termination of pregnancy [TOP]<sup>8</sup> up to 12 weeks of gestation, without consultation or approval by a doctor or nurse.<sup>9</sup> The Act explicitly states that its provisions apply to 'any female person of any age'.<sup>10</sup> The courts have imposed only one limitation on access to terminations of pregnancy, which requires that the child be able to provide informed consent.<sup>11</sup>

While health care professionals should advise minors to consult their parents before having an abortion, they may not deny the termination of the pregnancy where the

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<sup>4</sup> Act no. 108 of 1996

<sup>5</sup> Sections 12(2), 27(1)(a) of the South African Constitution.

<sup>6</sup> Section 28 (1)(c) of the Constitution.

<sup>7</sup> Section 28 (2) of the Constitution.

<sup>8</sup> The terms 'abortion' and 'termination of pregnancy' are used interchangeably in this report.

<sup>9</sup> Section 2(1)(a) of the Choice on Termination of Pregnancy Act.

<sup>10</sup> Section 1 of the Choice on Termination of Pregnancy Act.

<sup>11</sup> *Christian Lawyers Association v Minister of Health and Others (Reproductive Health Alliance as Amicus Curiae)* 2005 (1) SA 509 (T) at 516.

minor chooses not to consult them.<sup>12</sup> One of the reasons for not requiring parental consent in the law is that pregnant minors may have been sexually abused by their father or guardian.<sup>13</sup> Requiring parental consent could therefore “pose a barrier to seeking help.”<sup>14</sup> Under the law, pre- (and post-) abortion counselling should be made available to patients, but use of service is not mandatory in order to access an abortion.<sup>15</sup> The law is thus very clear that abortions in the first trimester are the autonomous decision of the pregnant woman or girl and are not subject to any conditions or requirements other than the pregnant woman’s or girl’s informed consent.

Under certain conditions, females can request a TOP beyond the 12 weeks gestation period (up to 20 weeks), for instance if the pregnancy is the result of a rape; if the foetus is at risk for severe mental or physical abnormality; or if there is a substantial risk for the physical or mental health of the pregnant woman or girl.<sup>16</sup> Whereas abortions in later trimesters can only be carried out by medical doctors, first trimester abortions can be carried out by doctors as well as sufficiently trained midwives and nurses. Abortions are available at health care facilities that are equipped in terms of staffing, equipment and facilities and that have been designated by the Minister of Health.<sup>17</sup> Since an amendment of the law in 2008, abortions can also be carried out at facilities that have not been designated as long as they are sufficiently equipped and have a 24-hour maternity service.<sup>18</sup>

The CTPA protects clients’ confidentiality by stipulating that the identity of a woman who has requested or obtained an abortion shall remain confidential at all times unless she chooses to disclose that information herself.<sup>19</sup> Facilities that provide terminations of pregnancies are only required to keep records of the number of abortions they perform and to forward this information to the national Department of Health on a monthly basis.<sup>20</sup> The CTPA is a very progressive abortion law because it protects women’s and girls’ right to make autonomous reproductive health decisions by granting them the ‘right to choose’ for the first 12 weeks of pregnancy and providing a high level of protection of patient confidentiality.

## The National Health Act

The National Health Act, 2003 [the NHA], deals with a wide range of health-related issues ranging from structural matters, including human resource planning and the

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<sup>12</sup> Section 5(3) of the Choice on Termination of Pregnancy Act.

<sup>13</sup> Mhlanga R.E. 2003. Abortion: developments and impact in South Africa. *British Medical Bulletin*. 67(1):115–126.

<sup>14</sup> Ibid.

<sup>15</sup> Section 4 of the Choice on Termination of Pregnancy Act.

<sup>16</sup> Ibid at Section 2(1)(b).

<sup>17</sup> Ibid at Section 3.

<sup>18</sup> Ibid at Section 3(3)(a).

<sup>19</sup> Ibid at Section 7(5).

<sup>20</sup> Ibid at Section 7.



set-up of the health care system, to specific matters such as health care workers' duties and patients' rights. The NHA states that informed consent is required for the provision of health care services,<sup>21</sup> thereby recognising that an informed decision about a medical procedure can only be made if the patient has been given all relevant information on the procedure's benefits and potential risks.<sup>22</sup> The requirement of informed consent reflects the provisions in the CTPA.

The Act upgraded the ethical principle of patient confidentiality to a binding statutory principle.<sup>23</sup> Confidentiality and informed consent are key principles of medicine; they form the pillars of a trusting relationship between the health care provider and the patient. The protection of confidentiality is therefore essential for ensuring that patients come forward and access both preventative or curative health services and health information. Failure to access health care services out of fear that confidentiality will be breached has negative ramifications not only for the patient's own health, but may also put others at risk, especially where conditions are communicable.

A trusting relationship between doctors and patients is particularly important when it comes to stigmatised health issues such as HIV/AIDS or (other) sexual and reproductive health issues. Teenagers are an especially difficult target group when it comes to addressing these topics, because at that age sexuality and reproductive health issues are considered 'secret'. The protection of teenage patients' confidentiality, therefore, seems particularly important in order to encourage them to make use of available reproductive health services.

Although confidentiality is protected under the NHA, this law also stipulates that where a court order or any law requires that information of a particular patient be disclosed, such disclosure is lawful.<sup>24</sup> Accordingly, under the NHA a patient's right to confidentiality may be limited where a law allows or requires the disclosure of his or her medical information. This is different from the CTPA which does not provide for limitations of patient confidentiality.

## The Children's Act

The Children's Act, 2005, was finally promulgated in its entirety, along with the accompanying Regulations, in 2010. The Act sets out a framework for providing the social services necessary for the protection and care of children (i.e. persons under the age of 18 years), including protective measures relating to children's health. In particular, the Children's Act has comprehensively reformed the age of consent for medical procedures. Lawmakers recognised the need to strengthen the autonomy of children in making decisions that affect them and, therefore, along with enacting their

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<sup>21</sup> Section 7 of the National Health Act.

<sup>22</sup> Knobel, G. J. 2006. Consent, with particular reference to HIV and AIDS. *CME SA Journal of CPD: Forensics* 1(24), 79-82.

<sup>23</sup> Section 7 of the National Health Act.

<sup>24</sup> Section 14(2)(b) of the National Health Act.

right to participate in such decisions,<sup>25</sup> dropped the age of consent for most health-related decisions to 12 years.<sup>26</sup> In line with this approach, the Children's Act further aims to protect children's sexual and reproductive health by regulating children's access to contraceptives.<sup>27</sup> The establishment of these rights by Parliament was in part based on recognition of the fact that children become sexually active at a young age and that "a sexually active child may be a child in need of care."<sup>28</sup> The intention of the legislature was, therefore, to protect sexually active children, particularly teenagers, from unprotected sex and sexually transmitted diseases including HIV. The Department of Social Welfare has also said that "access to contraceptives should go hand in hand with appropriate sexuality education."<sup>29</sup> The legislation assumes that healthcare workers are well placed, and adequately trained, to detect these needs and to provide the requisite care and education.

Section 134 of the Children's Act carries a strong public health message that it is in the best interests of children that condoms be provided, and sets out stringent penalties of a fine and/or imprisonment for up to ten years for anyone refusing to do so.<sup>30</sup> The Act further stipulates that '*contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or care-giver of the child if the child is at least 12 years of age*', on the conditions that the child received medical advice<sup>31</sup> and a medical examination to ensure there are no medical reasons not to provide the contraceptives.<sup>32</sup> Aside from these physical health precautions there is no requirement that the child undergo any further counselling before being issued with the contraceptives.

Children's right to confidentiality regarding their health status is protected by the Act<sup>33</sup> and specifically, with regard to accessing contraceptive services, the Act states: '*[a] child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality in this respect*'.<sup>34</sup> This confidentiality provision is limited, however, as it is subject to section 110 of the Act which creates a reporting obligation for certain professionals, including medical professionals, when they conclude on reasonable grounds or reasonably believe a child is a victim of abuse. In such cases, a report must be made to either the provincial department of social development, a

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<sup>25</sup> Section 10 of the Children's Act.

<sup>26</sup> Sections 129-134 of the Children's Act.

<sup>27</sup> Section 134 (1) on access to contraceptives states that: (1) *No person may refuse (a) to sell condoms to a child over the age of 12 years; or (b) to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge.*

<sup>28</sup> The Department for Social Development notes that, 'given HIV and AIDS, especially amongst teenagers, it would be unwise to deny children access to condoms' – 'Clarity on clauses in the Children's Act, Act No 38 of 2005', Statement issued by the Department for Social Development, 6 July 2007, accessed at <http://www.info.gov.za/speeches/2007/07070615151001.htm> on the 10th December 2012.

<sup>29</sup> Ibid.

<sup>30</sup> Section 305 (1) (c) and (6) Subject to subsection (8), a person convicted of an offence in terms of subsection (1), (2), (3), (4) or (5) is liable to a fine or to imprisonment for a period not exceeding ten years, or to both a fine and such imprisonment.

<sup>31</sup> The Children's Act Section 134 (2) (b).

<sup>32</sup> The Children's Act Section 134 (2) (c).

<sup>33</sup> Section 13 (1) (d) of the Children's Act.

<sup>34</sup> Section 134(3) of the Children's Act.

designated child protection organisation, or a police officer in order for the matter to be investigated and, where necessary, for the appropriate measures to be taken to protect the child from further harm.<sup>35</sup> Failure to make such a report is an offence under the Act and a person in contravention of this provision is liable to a fine and/or to imprisonment for a maximum of ten years.<sup>36</sup> It is therefore important that all professionals who are burdened with the reporting obligation under section 110 (1) are clear of their duty in terms of reporting underage consensual activity.

'Abuse' is defined in the Children's Act as: "*any form of harm or ill-treatment deliberately inflicted on a child*"<sup>37</sup> and includes: assault, bullying, exploitation, behaviour that may psychologically or emotionally harm the child and sexual abuse.<sup>38</sup> The Children's Act is silent as to whether consensual sex between teenagers above the age of 12 years but under the age of 16 years – which is an offence under sections 15 and 16 of the SOA – constitutes sexual abuse.<sup>39</sup> If, however, the term '*sexual abuse*' as used in the Children's Act is referring to or includes '*sexual offences*' as defined in the SOA,<sup>40</sup> then the duty to report would include consensual sex between teenagers. Given that consensual sex between teenagers above the age of 12 but under the age of 16 is considered a sexual offence under the SOA it seems that, when read in conjunction with the SOA, health care professionals have to provide contraceptives, including condoms, to children aged 12 years and older, but at the same time must report them to the authorities if those workers believe the children are having sex. There is a risk that the reporting requirement may lead to a decline in the numbers of teenagers accessing reproductive health services due to a fear their confidentiality may be breached, or worse, that they may face reprisals from authorities for their criminal behaviour, and this result would undermine the protective purpose of the Act in relation to children's sexual and reproductive health.

This raises the question of whether such an obligation to report complies with the Constitutional rule, also enforced by the Children's Act, whereby '*a child's best interests are of paramount importance in every matter concerning the child*'.<sup>41</sup> Section 9 of the Children's Act is clear that this standard must be applied in all matters concerning the care, protection and well being of a child. Section 7 of the Children's Act expands on

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<sup>35</sup> In terms of Section 110 of the Children's Act, officials must complete Form 22, Reporting of Abuse or Deliberate Neglect of Child (Regulation 33).

<sup>36</sup> Children's Act Section 305 (1) (c) and (6).

<sup>37</sup> Section 1(1) of the Children's Act.

<sup>38</sup> Section 1(1) of the Children's Act; "**abuse**" in relation to a child, means any form of harm or ill-treatment deliberately inflicted on a child, and includes - (a) assaulting a child or inflicting any other form of deliberate injury to a child; (b) sexually abusing a child or allowing a child to be sexually abused; (c) bullying by another child; (d) a labour practice that exploits a child; or (e) exposing or subjecting a child to behaviour that may harm the child psychologically or emotionally.

<sup>39</sup> Section 1(1) Children's Act, "**Sexual abuse**" in relation to a child means – (a) sexually molesting or assaulting a child or allowing a child to be sexually molested or assaulted;(b) encouraging, inducing or forcing a child to be used for the sexual gratification of another person; (c) using a child in or deliberately exposing a child to sexual activities or pornography; or (d) procuring or allowing a child to be procured for commercial sexual exploitation or in any way participating or assisting in the commercial sexual exploitation of a child.

<sup>40</sup> Criminal Law (Sexual Offences and Related Matters) Amendment Act (Act 32 of 2007). Note "**Sexual offences**" are defined in section 1 (1) of the Act to "include any offence in terms of Chapters 2, 3 and 4 and sections 55 and 71(1), (2) and (6) of this Act".

<sup>41</sup> Section 28(2) of the Constitution.

this duty by setting out the factors that should be considered when making such a decision. While needing to evaluate all the factors, considerations such as the nature of the relationship between the child and their parents or care-giver,<sup>42</sup> the child's age, maturity and stage of development,<sup>43</sup> gender,<sup>44</sup> background<sup>45</sup> and other relevant characteristics of the child,<sup>46</sup> may be especially relevant to decisions related to the administration of reproductive health services to teenagers. Likewise, the child's physical and emotional security and his or her intellectual, emotional, social and cultural development<sup>47</sup> may also be apposite. When balancing the reporting obligation introduced by the Children's Act with the constitutional principle of the 'best interest of the child' as expanded by the Children's Act, it is unlikely that health professionals would always consider reporting consensual sexual activity between children over the age of 12 and under the age of 16 as being in the best interest of the children in question. Rather, such action may result in significant disadvantage to the individual child by involving them in the stigma and consequences of the criminal justice system. The 'best interests' framework under the Children's Act allows discretion for health care workers to exercise their professional judgment in this regard.

## The Criminal Law (Sexual Offences & Related Matters) Amendment Act

The Sexual Offences Act, 2007, not only protects adults and children from non-consensual sexual acts, but also criminalises *consensual* sexual acts between children of a certain age and between children and adults. For children under the age of 12 years, the SOA is straightforward: A child under the age of 12 cannot give legally valid consent to sexual acts.<sup>48</sup> Any sexual acts with a child under the age of 12 years are therefore regarded as *non-consensual*. This is why 'consensual' penetrative sex with children under the age of 12 years is regarded as a more serious offence (i.e. rape) than 'consensual' sex with children between 12 years and 15 years (i.e. statutory rape). Sex with a child over 12 years old but *under* the age of 16 also constitutes an offence, even when consensual in a non-legal sense, because children can only *legally* consent to sex once they are 16 years old.<sup>49</sup> Engaging in consensual sexual acts with a child between 12 and 15 years of age is thus a crime (either statutory rape or statutory sexual assault), even when both parties are children in this age group.<sup>50</sup> The offence of statutory sexual assault covers multiple forms of non-penetrative sex with children in this age group, including direct or indirect contact between the mouth of one person

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<sup>42</sup> Section 7(1)(a) of the Children's Act.

<sup>43</sup> Ibid at section 7(1)(g)(i).

<sup>44</sup> Ibid at section 7(1)(g)(ii).

<sup>45</sup> Ibid at section 7(1)(g)(iii).

<sup>46</sup> Ibid at section 7(1)(g)(iv).

<sup>47</sup> Ibid at section 7(1)(h).

<sup>48</sup> Section 57 of the Sexual Offences Act.

<sup>49</sup> Section 15 of the Sexual Offences Act.

<sup>50</sup> See sections 1(1)(b), 15 and 16 of the Sexual Offences Act.

and the genital organs, anus, female breasts, or mouth of another person.<sup>51</sup> Thus if, for example, two 15-year old children consensually kiss or the boy touches the girl's breasts with her consent, both children commit the crime of statutory sexual assault. Where the conduct involves penetrative sex (vaginal, anal or oral penetration), the charge is statutory rape.<sup>52</sup> Due to the definition of sexual penetration,<sup>53</sup> statutory rape also includes the penetration of the genital organs with objects (e.g. sex toys) and body parts other than the penis (e.g. finger).

Where the children involved in the consensual sexual conduct are both between 12 and 15 years old, both of them have committed a crime and both would need to be prosecuted. The SOA includes a safeguard, however, against hasty prosecutions by requiring that children in this age group may only be prosecuted with the written authorisation of the National Director of Public Prosecutions (DPP).<sup>54</sup> The SOA thereby suggests that the primary objective of these offences is not to penalise children for exploring their sexuality, but to protect them from sexual exploitation by others. But this remains ambiguous and therefore potentially subject to the individual discretion of police officers. Where both parties are children, prosecutors also have the option of using diversion programmes.<sup>55</sup> Even if the prosecutor decides to use diversion rather than prosecution, children would still be exposed to a criminal investigation and the 'stigma' of having committed a crime when engaging in consensual sex with another teenager.

The SOA also creates a defence for the offence of statutory sexual assault. Accordingly, it is a valid defence to a charge of statutory sexual assault if both accused persons were children at the time of the offence, and the age difference between them was not more than two years at the time of the offence.<sup>56</sup> Thus if a 14 year old and a 12 year old consensually kiss, the accused could use the defence provided by s 54(1)(b) of the SOA. This defence, however, only applies to non-penetrative forms of sexual conduct and does not, therefore, provide a defence for statutory rape. Furthermore, the availability of a defence may not protect the child from a criminal investigation as the decision of whether or not to prosecute can only be made by the National Director of Public Prosecutions, who 'may not delegate his or her power to decide whether a prosecution ... should be instituted or not' and would only be able to make such a decision once a police investigation has taken place.<sup>57</sup>

The SOA further establishes an obligation to report sexual offences against children. The reporting obligation under the SOA is, however, different from the reporting obligation under the Children's Act. According to the SOA, *any person* who knows of a sexual offence having been committed against a child must inform the police

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<sup>51</sup> The key element of sexual assault, including statutory sexual assault, is 'sexual violation' which is defined very broadly. See Section 16(1), 1 of the Sexual Offences Act.

<sup>52</sup> Section 15(1) of the Sexual Offences Act.

<sup>53</sup> Section 1 of the Sexual Offences Act.

<sup>54</sup> Section 15(2), 16(2) of the Sexual Offences Act.

<sup>55</sup> Diversion is authorised for offences of statutory rape and statutory sexual assault, under section 15 and 16 of the SOA, by the Child Justice Act 2008 (Act number 75 of 2008) at Section 51 and Schedule 1 of the Act, section 15.

<sup>56</sup> Section 56(1)(b) of the Sexual Offences Act.

<sup>57</sup> Section 15 and 16 (2) (b) of the Sexual Offences Act.

immediately.<sup>58</sup> This provision is broadly drafted and applies to all sexual offences against children, including rape,<sup>59</sup> sexual assault,<sup>60</sup> child pornography,<sup>61</sup> sexual exploitation<sup>62</sup> and sexual grooming.<sup>63</sup> Thus, any person who knows that a child has been raped or sexually assaulted must report this knowledge to the police. The reporting obligation also applies to consensual sexual acts between teenagers that constitute statutory rape or statutory sexual assault under the SOA. Failure to report the commission of a sexual offence against a child constitutes an offence, which can result in a fine or imprisonment of up to five years.<sup>64</sup>

While the purpose of the SOA was to encourage the protection of children by placing everyone under an obligation to report abuse, the broad application of the current provisions may encourage interference with the privacy of children for reasons other than those that could be construed as being in the child's best interests.

## The Relationship between Acts

The various laws governing teenage sexual and reproductive rights serve different purposes, which they strive to achieve by imposing rights and obligations that sometimes appear internally inconsistent or counter-productive. While some of these inconsistencies can be overcome by legal analysis, others cannot be so easily resolved.

The aim of the CTPA, for example, is to make abortions accessible to women and girls of all ages. The CTPA therefore protects patients' privacy 'unconditionally' and only requires the consent of the pregnant woman or girl for the abortion. Mhlanga argues that the CTPA does not require parental consent for the termination because such consent may 'pose a barrier to seeking help' particularly where the pregnancy is a result of sexual abuse by the father or guardian.<sup>65</sup> The child's pregnancy or the fact that she has been sexually active does not have to be reported to the authorities under the CTPA. According to McQuoid-Mason, the CTPA thus 'accepts that young girls may fall pregnant'.<sup>66</sup> Under the SOA, however, a health care worker who terminates the pregnancy of a girl under the age of 16 is obligated to report the patient to the police because, as mentioned above, sex with a girl under the age of 16 constitutes a sexual offence against a child and must consequently be reported to the police immediately so that the matter can be criminally investigated. This reporting duty under the SOA runs contrary to the purpose of the CTPA.

Mandatory reporting of a teenager who had an abortion may, however, be justified

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<sup>58</sup> Section 54(1)(a) of the Sexual Offences Act.

<sup>59</sup> Section 4 of the Sexual Offences Act.

<sup>60</sup> Section 5 of the Sexual Offences Act.

<sup>61</sup> Sections 19, 20 of the Sexual Offences Act.

<sup>62</sup> Section 17 of the Sexual Offences Act.

<sup>63</sup> Section 18 of the Sexual Offences Act.

<sup>64</sup> Section 54(1)(b) of the Sexual Offences Act.

<sup>65</sup> Mhlanga (2003). See footnote **Error! Bookmark not defined.** above.

<sup>66</sup> McQuoid-Mason, D. (2011) Mandatory reporting of sexual abuse under the Sexual Offences Act and the 'best interests of the child'. *South African Journal of Bioethics and Law*, 4(2):76.

under certain circumstances if such reporting serves the 'best interest of the child' principle protected under the Constitution and the Children's Act. For instance, one could argue that for children under the age of 12 years reporting the TOP is in the best interest of the child because 12 year olds are not sufficiently mature to consent to sex. In other circumstances, however, violating the child's privacy may not be justified by the 'best interest of the child' principle. Where, for instance, two teenagers between 12 and 15 years have engaged in 'consensual' sex and the age difference between them is not more than two years, McQuoid-Mason argues that the reporting obligation under the SOA undermines the purpose of the CTPA which is to encourage safe and legal terminations of pregnancy.<sup>67</sup> In his opinion, the reporting obligation for children in this age group would compel in teenagers towards procuring unsafe back-street abortions and therefore is not in the best interest of the child.<sup>68</sup>

Similarly, the reporting obligation under the SOA may be inconsistent with the purpose of the Children's Act, which is to make contraceptive services and condoms available to children from the age of 12 years in order to protect girl children from unwanted pregnancies and all children from sexually transmissible diseases such as HIV/AIDS. This results in the paradoxical situation whereby it is illegal to have sex before the age of 16, but contraception is available from the age of 12. This difficulty was recognised by the Department of Social Development, who explained that the need to provide access to contraceptives for children over 12 years in the Children's Act was 'in realisation of the fact that children are sexually active at a very young age, even though the legal age of consent is 16'.<sup>69</sup> The Children's Act therefore operates in a context which recognises that children who engage in consensual sexual activity between the ages of 12 and 15 years of age are breaking the law, yet it expressly prioritises the need to protect their health. This approach fits within a recognised public health framework, and medical bodies recognise the need to ensure confidentiality when providing reproductive health service in this context.

Research from the United Kingdom has highlighted that: '[y]oung people under 16 are the group least likely to use contraception and concern about confidentiality remains the biggest deterrent to seeking advice'.<sup>70</sup> The UK General Medical Council warns that this 'in turn presents dangers to young people's own health and to that of the community, particularly other young people'.<sup>71</sup> The General Medical Council, therefore, advise that in situations where health care workers believe the child has the capacity to have consented freely to sexual intercourse, the confidentiality of young patients who request contraception should only be breached in cases of concern for their welfare,<sup>72</sup> for example: if there are big differences in age, maturity or power between

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<sup>67</sup> Ibid.

<sup>68</sup> Ibid at 76.

<sup>69</sup> Department of Social Development, (2007). Clarity on issues in the Children's Act, 6 July 2007. <http://www.info.gov.za/speeches/2007/07070615151001.htm>.

<sup>70</sup> Department of Health (UK) 2004, *Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under the age of 16 on contraception, sexual and reproductive health*. Accessed [http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4086914.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4086914.pdf).

<sup>71</sup> General Medical Council, (2007). *0-18 years: guidance for all doctors*, at paragraph 64.

<sup>72</sup> Ibid at paragraph 68.

sexual partners;<sup>73</sup> if one partner is in a position of trust;<sup>74</sup> or force or the threat of force, emotional or psychological pressure, bribery or payment, either to engage in sexual activity or to keep it secret has been used or suspected;<sup>75</sup> drugs or alcohol are used to influence a young person to engage in sexual activity when they otherwise would not;<sup>76</sup> or where a person is known to the police or child protection agencies as having had abusive relationships with children or young people.<sup>77</sup> Arguably, this system of discretion, which is similar to the provisions in the Children's Act, provides safeguards in cases of abuse but otherwise allows health care professionals to maintain patient confidentiality and prioritise the public health goals of ensuring access to reproductive health care for children and teenagers.

In contrast, as pointed out above, the reporting obligation under the SOA does not differentiate between children under the age of 16 years who engaged in consensual versus non-consensual sex and does not provide the health worker with discretion as to whether to report the child to the police. It is worth remembering that children aged between 12 and 15 years who request contraceptives or condoms have not necessarily engaged in sex. Health care workers who hand out contraceptives or condoms can therefore not be sure whether a sexual offence against the child has been committed and thus do not automatically have to make a report to the police. If, however, the health care worker conducts a proper assessment before administering contraceptives to his or her patient, he or she will ask the teenager about their sexual relationship(s) and previous or planned sexual activity. If the teenager admits to having had consensual sex with another teenager or an adult partner, the health care worker would be obligated to report this behaviour to the police to comply with the reporting duty under the SOA. Health care workers who see pregnant teenage patients – either for pre-natal care, a TOP or at the time of giving birth – would also have to report these cases if the pregnant patient is under the age of 16 years.<sup>78</sup>

The implications for sexually active children who are reported to the police are illustrated in a recent case in Limpopo. Amid media reports of the high rate of teenage pregnancy at schools in the province, five pupils, including one who was pregnant, appeared in court charged with consensual sexual penetration while under the age of 16.<sup>79</sup> Authorising the prosecutions, the National Prosecuting Authority reportedly hoped to deter underage sexual activity and unprotected sexual intercourse, which it alleged was fuelled by alcohol consumption.<sup>80</sup> Although all five children avoided criminal records because they were subsequently placed on diversion programmes, they nonetheless endured a police investigation, faced the stigma of being charged in

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<sup>73</sup> Summary of guidelines, *ibid* at paragraph 68 (b).

<sup>74</sup> *Ibid* at 68 (c).

<sup>75</sup> *Ibid* at 68 (d).

<sup>76</sup> *Ibid* at 68 (e).

<sup>77</sup> *Ibid* at 68 (f).

<sup>78</sup> In patients who give birth the reporting would apply to patients above 16 years who fell pregnant when they were under 16 years of age. Possibly, health care workers would have to calculate how old the teenager was at the time of conception.

<sup>79</sup> Swart, H. 2012. Teen Sex Laws Challenged in Court. *Mail & Guardian* (11 May 2012). Accessed at <http://mg.co.za/article/2012-05-11-teen-sex-laws-challenged-in-court>.

<sup>80</sup> *Ibid*.



court and suffered the discomfort of very personal information being publicly disclosed by the nature of the charge.<sup>81</sup>

McQuoid-Mason argues that, under certain circumstances, imposing a reporting obligation on health professionals who are consulted by teenagers for contraceptive advice undermines the purpose of the Children’s Act.<sup>82</sup> For teenagers between the ages of 12 and 15 years who engage in consensual sex with another teenager who is less than two years older, the reporting obligation violates the ‘best interest of the child’ principle by potentially discouraging young girls from seeking contraceptive advice and thereby putting them at risk of pregnancy. This argument also applies to a girl who engages in consensual sex with a boy who is more than two years older than her, for instance a 13-year old girl who engages in consensual sex with a 16-year old boy, depending on what one understands to be the impact of underage sex between children in this age group.

Furthermore, it is unclear whether health workers have to follow the mandatory reporting obligations under the Children’s Act or under the SOA. Both laws include provisions on reporting of child abuse and sexual offences against children, respectively, but these provisions are inconsistent in terms of *who* has a duty to report, *what* needs to be reported, *under which circumstances* a report needs to be made, and *to whom* the report must be made. The following table illustrates these differences.

	<b>Sexual Offences Act</b>	<b>Children’s Act</b>
<b>Who must report?</b>	Any person	Certain professionals
<b>What must be reported?</b>	<i>Knowledge of a sexual offence against a child or a mentally disabled person</i> <sup>83</sup>	<i>Reasonable belief that a child has been physically abused, sexually abused or deliberately neglected</i>
<b>To whom must the report be made?</b>	Police	Department of Social Development Designated child protection organisation Police
<b>Penalty for non-reporting</b>	A fine or imprisonment of up to five years	A fine and/or imprisonment for up to ten years.

Under the Children’s Act, only a group of certain professionals, including health care professionals, have to report *child abuse*. As discussed, child abuse is different from a sexual offence, although it includes *“any form of harm or ill-treatment deliberately*

<sup>81</sup> See also Malan, M. 2011. Criminalising sex is not the answer. *Mail & Guardian* (September 23 to 29 2011).

<sup>82</sup> Ibid at 77.

<sup>83</sup> Although the SOA also requires the mandatory reporting of sexual offences against persons with mental disabilities, this is beyond the scope of this report and therefore not discussed in this report.

*inflicted on a child" and sexual abuse.*<sup>84</sup> A report needs to be made if the health care worker reasonably concludes or has a *reasonable belief* that a child is being abused.<sup>85</sup> The standard of 'reasonable belief' is not defined in the Children's Act, but professionals are required to substantiate the grounds of their suspicion when making a report to the authorities. As noted above, in this case the health care worker needs to make a report to the provincial Department of Social Development, a designated child protection organisation or a police official.<sup>86</sup> The provincial Department of Social Development must then assess and investigate the truthfulness of the report and decide how to proceed in the matter.<sup>87</sup>

Under the SOA *any* person who has *knowledge* of the commission of a sexual offence has to report this knowledge *immediately to the police*. The Children's Act thus not only gives health care professionals greater discretion in terms of when to report, and to whom, but also whether a certain case should be reported based on the best interest of the child principle.

As noted above, it is arguable that the obligation on health care workers in the SOA to report consensual sexual activity between children aged 12 to 15 years of age is incompatible with the public health intention of the Children's Act. In addition, the SOA reporting provision risks outcomes which are not in the best interests of the child and further undermines the Constitutional principle and the provisions of Children's Act. Health care workers are therefore left in an unenviable position of deciding whether to reporting their patient – and risk real harm to both the individual child and others who may subsequently be deterred from seeking medical care – or whether to put themselves at risk of a fine and/ or criminal prosecution if they decide not to report.

Given the heavy penalties for non-reporting under both the Children's Act and the SOA it is important that health workers are informed and trained on the implications and requirements of the new legislation. When legal rights and duties are assigned by an Act of Parliament to a particular class of people and/or to particular service providers, the relevant departments of the executive branch must take steps to ensure that these rights and duties are enforced and implemented. Key steps in this process are informing service providers (and those entitled to services) of their new obligations (and rights), and providing clear guidelines for implementation. Service providers also require on-going professional development to maintain and update their skills, and specialised training for new or specialised practice areas, or areas in which practical guidelines or the approach to service provision has changed.

Research from South Africa<sup>88</sup> suggests that there is a danger that nurses who have not been consulted on policy development or on their subsequent implementation responsibilities will allow their personal discretion and moral values to affect the level

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<sup>84</sup> Section 1(1) of the Children's Act.

<sup>85</sup> Section 110(1) of the Children's Act.

<sup>86</sup> Section 110(1) of the Children's Act.

<sup>87</sup> Section 110(5)(b) and (c) of the Children's Act.

<sup>88</sup> Walker L. & Gilson, L. 2004. 'We are bitter but we are satisfied': Nurses as street-level bureaucrats in South Africa. *Social Science & Medicine* 59, 1251–1261.

of policy implementation that actually takes place. Knowing how and to what extent health care workers have received information, guidelines and training on the new framework of reproductive health rights and obligations under the Children's Act, the CTPA and the SOA, helps to understand and assess the knowledge they have about their legal duties and the manner in which they implement, or fail to implement them.

## Existing Literature

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This section discusses the existing research and literature which have informed our current study, both as a frame of reference and to highlight where data and policies are missing. We examine the high levels of teenage pregnancy in South Africa and consider the barriers to teenagers accessing effective reproductive health services which have been identified in prior studies. The analysis then reflects on the political and moral justifications for controlling teenage sexuality, and finally, focuses on the roles and responsibilities of nurses as stakeholders in tackling teenage pregnancy and providing reproductive health services.

## Teenagers, Pregnancy and Reproductive Knowledge

Although teenage fertility (i.e. the number of live births per 1000 women aged 15-19 years<sup>89</sup>) has been declining in South Africa, this decline has occurred at a slower pace than the decline in fertility among the overall population.<sup>90</sup> Teenagers aged between 17 and 19 years account for the vast majority of teenage births,<sup>91</sup> and figures from a 2002 study show that, whereas only 2% of 15-year-old girls had given birth, this rose to 30.2% of girls by the age of 19.<sup>92</sup> However, the fertility rate does not include those teenagers who have become pregnant but have not had a live birth, either due to miscarriage or as a result of terminating the pregnancy. It is therefore difficult to fully measure the rate of pregnancy – a fact that is exacerbated by the fact that data is not available from TOP facilities.<sup>93</sup> Research from Europe suggests, however, that rates of TOPs may be higher among younger teenage girls (aged 15-17 years) than among those

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<sup>89</sup> Panday, S., Makiwane, M., Ranchod, C. & Letsoalo, T. 2009. *Teenage Pregnancy in South Africa – With a Specific Focus on School-Going Learners*. Pretoria: Department of Basic Education, at 26.

<sup>90</sup> Ibid at 10 and 105. Note also that the Community Survey 2007 quoted in Panday et al. found the teenage fertility rate had continued to fall; the decline was recorded as a rate of 54 per 1000.

<sup>91</sup> A 2003 study found 93% of teenagers aged 15 to 19 who had given birth to a live child were aged between 17 and 19. RHRU survey (2003), quoted in Panday et al. Ibid at 35.

<sup>92</sup> Department of Health, Medical Research Council & Measure DHS+. 2002. *South Africa Demographic and Health Survey 1998* [Full Report]. Pretoria: Department of Health, quoted in Panday et al. Ibid at 35.

<sup>93</sup> As Panday et al. comment: "Fertility rates refer only to pregnancies that have resulted in live births while pregnancy rates include both live births and pregnancies that have been terminated... Trends in pregnancy rates in SA cannot be accurately estimated for two reasons. First, it is not known whether pregnancies that were terminated early on are well captured in survey data and school record systems. Second, a comprehensive national register of abortion is not maintained in SA", ibid, at 105.

aged between 18 and 19 years.<sup>94</sup> The 1998 Demographic and Health Survey found that 16.4% of 15 to 19 year old girls in South Africa had been pregnant at least once.<sup>95</sup> A representative study in 2003 reported that 15% of girls in the same age group had been pregnant.<sup>96</sup> By the time young South African women are 24 years old, half of them have been pregnant.<sup>97</sup> In addition to the risk of early pregnancy, unprotected sex puts teenagers at risk of HIV infection. With an HIV prevalence of 16.9% among young females aged 15 to 24 years, HIV/AIDS presents the primary reproductive health concern for teenagers in South Africa.<sup>98</sup>

Despite the high rate of fertility and HIV among female teenagers in South Africa, the sexual decision-making of teenagers, their knowledge of contraceptive services and their ability to access reproductive health care services have not garnered much attention. Although a few studies do exist, these focus primarily on teenage pregnancy and its effect on girls' education.<sup>99</sup> What these studies do show is that pregnant teenagers have relatively low levels of knowledge about modes of contraception and protection from sexually transmitted infections. These findings support international research<sup>100</sup> which shows that only 40% of young people aged 15-24 have accurate knowledge about HIV and transmission.<sup>101</sup> For example, Ehlers' study of 250 teenage mothers aged 19 years or younger found that 76% of the participants did not know what emergency contraception was, and only half of them (55.6%) knew about (general) contraceptives.<sup>102</sup> Further, fewer than 50% had used contraceptives themselves.<sup>103</sup> One of the main reasons respondents gave for not using contraceptives was the fear that their mothers would find out about the clinic visit.<sup>104</sup>

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<sup>94</sup> Darroch, J.E., Singh, S., & Frost, J.F. 2001. Differences in teenage pregnancy rates among five developed countries: the roles of sexual activity and contraceptive use. *Family Planning Perspectives*, 33, 244-250.

<sup>95</sup> 1998 Demographic and Health Survey as quoted in Panday et al. (see note 89 above at 33).

<sup>96</sup> Pettifor, A.E., Rees, H.V., Steffenson, A., Hlongwa-Madikizela, L., MacPhail, C., Vermaak, K., et al. 2004. *HIV and Sexual Behaviour among Young South Africans*. Johannesburg: Reproductive Health Research Unit, WITS.

<sup>97</sup> MacPhail, P., Pettifor, A.E., Pascoe, S. & Rees, H.V. 2007. Contraception use and pregnancy among 15–24 year old South African women: a nationally representative cross-sectional survey. *BMC Medicine*, 5(31).

<sup>98</sup> Department of Health, Medical Research Council & Orc Macro (2007) *South Africa Demographic and Health Survey 2003*. Pretoria: Department of Health; Panday et al. (see note 89 above) at 5; Dorrington, R et al. (2006) *The Demographic Impact of HIV/AIDS in South Africa – National and Provincial Indicators*, at 8.

<sup>99</sup> See for instance: Panday et al. (note 89 above); Chigona, A. & Chetty, R. (2008) Sexuality out of control: an analysis of the educational policy of schooling teen mothers in the Western Cape. *Child Abuse Research*, 9(1),15-26; Chigona, A. & Chetty, R. (2007) Girls' education in South Africa: special consideration to teen mothers as learners. *Journal of Education for International Development*, 3(1), 1-17. For a compilation of studies see Ngcobo, B. (1997) *Directory of Health System Research: Reproductive Health Research in South Africa*, Health Systems Trust available at <http://www.hst.org.za/publications/directory-health-systems-research-reproductive-health-research-south-africa>.

<sup>100</sup> UNAIDS (2008) *Global Report on Aids Epidemic, Executive Summary* at 13; UNAIDS (n.d.) *HIV Prevention Fact Sheet*, accessed at: [http://data.unaids.org/Publications/Fact-Sheets04/FS\\_Prevention\\_en.pdf](http://data.unaids.org/Publications/Fact-Sheets04/FS_Prevention_en.pdf); and also Health Systems Trust South Africa, (n.d.) *Cultural obstacles to abstinence and being faithful present challenges for PEPFAR HIV programmes*, accessed at: <http://www.hst.org.za/news/cultural-obstacles-abstinence-and-being-faithful-present-challenges-pepfar-hiv-programmes>.

<sup>101</sup> Ibid. See also later research which found: "Only 34 per cent of youth (24 per cent of young women and 36 per cent of young men for low and middle income countries) can answer correctly the five basic questions about HIV and how to prevent it. UNAIDS (2011) *AIDS at 30: Nations at the Crossroads*, accessed at [http://www.unaids.org/unaid\\_resources/aidsat30/aids-at-30.pdf](http://www.unaids.org/unaid_resources/aidsat30/aids-at-30.pdf).

<sup>102</sup> Ehlers, V. (2003) Adolescent mothers' utilization of contraceptive services in South Africa. *International Nursing Review*, 50(4) at 236.

<sup>103</sup> Ibid at 235.

<sup>104</sup> Ibid at 236.

Low rates of contraceptive use in South Africa may also be rooted in the country's political and cultural contexts whereby family planning services were developed and implemented within a "demographic framework, rather than a health and human rights framework."<sup>105</sup> In setting out the historical background to the introduction of contraceptive provision, the Department of Health has suggested that the aims of the apartheid government from the 1930's onwards were to reduce the population of black South Africans while encouraging higher birth rates and settlement among white persons, such that by the late 1960's "the political rationale for family planning now became black birth control."<sup>106</sup> From the 1970's, national family planning clinics were used to implement these policies, providing free birth control services. These clinics operated independently from other health care provision and were only integrated with primary health care facilities as late as the 1990's.<sup>107</sup> As a result, the Department has argued that "opposition groups and the youth politicised government family planning services and labelled contraception as a tool of white oppression."<sup>108</sup> Nevertheless, a demand for contraceptive services remained throughout this period, but was often unmet or delivered in a manner which breached the human rights of patients and failed to prioritise their needs, such as not allowing them to choose their preferred method of birth control.<sup>109</sup> The legacy of this culture of poor service delivery for the majority of patients may continue to impact services today.

In the current context, existing research highlights numerous challenges that remain for young women attempting to access reproductive health services at clinics. Wood and Jewkes, for example, identified that the relationship between teenagers and nurses is particularly problematic.<sup>110</sup> Teenagers saw nurses as 'rude, short-tempered and arrogant' and complained that nurses asked 'funny questions' about whether they had boyfriends or why they wore mini-skirts'.<sup>111</sup> Furthermore, teenagers criticised that nurses would not allow them to choose their preferred method of contraception.<sup>112</sup> Conversely, nurses reported that they felt uncomfortable providing contraception for fear of encouraging teenagers to have sex,<sup>113</sup> and they also feared 'repercussions' from parents for giving contraceptives to teenagers.<sup>114</sup>

Another apparent problem is the stigmatisation of teenage sex. Asking for contraceptives is seen as a 'public admission of sexual activity', which is frowned upon by nurses.<sup>115</sup> Nurses would lecture teenage girls that they were far too young to be

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<sup>105</sup> Department of Health and Reproductive Health Research Unit, (2001). *National Contraception Policy Guidelines*, University of the Witwatersrand at 6.

<sup>106</sup> Ibid at 6.

<sup>107</sup> Ibid at 6.

<sup>108</sup> Ibid at 9.

<sup>109</sup> Ibid at 8.

<sup>110</sup> Wood, K. & Jewkes R. (2006) Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. *Reproductive Health Matters*, 14(7):109-118.

<sup>111</sup> Ibid at 113.

<sup>112</sup> Ibid at 112.

<sup>113</sup> Ibid at 113.

<sup>114</sup> Ibid at 114.

<sup>115</sup> Ibid at 113.

sexually active and must 'stop going around with men'.<sup>116</sup> Teenagers in Ehlers' study also battled with these attitudes among nurses, with some stating they had been turned away at the clinics without receiving contraception because nurses deemed them too young to be having sex.<sup>117</sup>

Scolding and abuse of teenage patients by nurses was also reported in other areas of reproductive services, such as labour wards.<sup>118</sup> In addition, teenagers feared remarks from other patients in the waiting rooms.<sup>119</sup> It should be noted, however, that the fieldwork for these studies was conducted in the mid-1990s, and the accessibility and provision of reproductive health services may since have changed. Since 2000, the non-governmental organisation loveLife together with the National and Provincial Departments of Health have promoted the National Adolescent Friendly Clinic Initiative (NAFCI) throughout South Africa. This initiative, which included technical assistance, training of health workers, and monitoring, was rolled-out to 345 clinics over the course of five years (2000-2005).<sup>120</sup> Assessments of clinics 12 months after the introduction of the programme reported improvement in terms of compliance with NAFCI standards; the value of these standards, however, and the way they were evaluated remains questionable.<sup>121</sup> Due to a lack of funding, NAFCI was discontinued in 2006.<sup>122</sup> It is therefore unclear whether NAFCI has had a long-term impact on the provision of teenage-friendly health services.

## Control of Teenage Sexuality

Teenagers' freedom to engage in sexual acts has long been restricted. The currently accepted status quo allows key players in teenagers' lives, including the State, their parents, teachers and certain professionals, to exercise not only a right, but also an obligation to prevent young teenagers from engaging in sexual acts and experimentation. This restriction is officially set by a recognised minimum age of consent, under which young people are legally prohibited from engaging in sexual intercourse. This legal restriction is seen as a matter of both public health and social morality aimed at protecting children.<sup>123</sup> Disadvantages to children who have an early

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<sup>116</sup> Mfono Z. (1998) Adolescent Contraceptive Needs in Urban South Africa: A Case Study. *International Family Planning Perspectives* 24(4) at 182; Wood & Jewkes (see note 110 above) at 112.

<sup>116</sup> Ehlers (see note 102 above) at 236.

<sup>117</sup> Ehlers (see note 102 above) at 236.

<sup>118</sup> Jewkes, R., Abrahams, N. & Mvo, Z. (1998) Why Do Nurses Abuse Patients? Reflections from South African Obstetrics Services, *Social Science Medicine*, 47(11) at 1786 - 1787; Kruger, L. M. & Schoombee, C. (2010) The Other Side of Caring: Abuse in a South African Maternity Ward. *Journal of Reproductive and Infant Psychology*, 28(1) at 94.

<sup>119</sup> Wood & Jewkes (see note 110 above) at 113.

<sup>120</sup> NAFCI was rolled-out to a total of 345 clinics nationally. Within each province between 9% and 14% of all clinics participated in the programme. For more information on the programme see loveLife, (2005) *Annual Report* at 61 - 64.

<sup>121</sup> Ibid at 66.

<sup>122</sup> Ibid at 61.

<sup>123</sup> See also the Committee on the Rights of the Child General Comment No. 4 (2003) Adolescent health and development in the context of the Convention on the Rights of the Child CRC/GC/2003/4 at paragraph 6 (d) which specifically recommends that: "States parties need to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent".

age of first sex include an increased risk of unplanned pregnancy and sexually transmitted infections, including HIV and human papillomavirus.<sup>124</sup> The State, therefore, has the responsibility to ensure policies are in place to educate young people about the risks of early sexual debut, and also to provide effective reproductive health care for those who do engage in sexual activity before the age of consent. The State also has the power to enforce compliance with the age of consent through the criminal law.<sup>125</sup> In South Africa, the age of consent is set at 16 and is enforced under the SOA.

In this context, the need to provide children and adolescents with comprehensive sexuality education has been emphasised as a matter of urgency.<sup>126</sup> UNESCO has called for governments to implement “age-appropriate, culturally relevant and scientifically accurate information” within school curriculum and health care provision and the organisation provides a guide for such content. The UNESCO study also evaluates the effectiveness of international sexuality education programmes and stresses the need for a multi-faceted approach.<sup>127</sup> It notes that while advising sexual abstinence and delay of first sex are legitimate educational messages, programmes that focused exclusively on abstinence had little effect on the sexual behaviour of the participants.<sup>128</sup> These findings support earlier studies in the United States,<sup>129</sup> which found that abstinence programmes cannot operate effectively in isolation from other sex education focuses, such as providing information on contraceptives and the prevention of sexually transmitted diseases.<sup>130</sup> In South Africa, abstinence has been promoted as part of a public health message associated with reducing levels of HIV infection in the context of ‘ABC’ programs: **A**bstain, **B**e safer (by being faithful or reducing the number of partners) and **C**orrect and consistent condom use’ which are internationally recognised and have been promoted by UNAIDS.<sup>131</sup> However, ABC messages have been criticised for failing to recognise the reality of many women and girls, especially in developing countries, who are unable to negotiate condom use or

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<sup>124</sup> McGrath N., Nyirenda M., Hosegood V., & Newell, M.L. (2009) Age at First Sex in Rural South Africa, *Sexually Transmitted Infections* 85(Suppl 1) at 49–55.

<sup>125</sup> Internationally, the age of consent varies considerably. Colombia, Panama and Mexico have the youngest ages at 12 for girls and 14 for boys (12 in Mexico). In Japan, Syria and Spain the age of consent is set at 13 for both sexes. At the other extreme, the age of consent in Tunisia is 20 and in Cameroon it is 21. In several Middle East countries, including Oman, Qatar and Saudi Arabia there is no age of consent as sexual intercourse prior to marriage is a criminal offence. Information from UNICEF webpage *Am I old enough?* Accessed at [http://www.unicef.org/rightsite/433\\_457.htm#to\\_have\\_sex](http://www.unicef.org/rightsite/433_457.htm#to_have_sex) and AVERT, *Worldwide Ages of Consent* available at <http://www.avert.org/age-of-consent.htm> [accessed 20 December 2012].

<sup>126</sup> UNESCO (2009) *International Technical Guidance on Sexuality Education* available at <http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>.

<sup>127</sup> Ibid at 22.

<sup>128</sup> The findings note that of the 11 abstinence programs evaluated “none of the seven studies that measured impact on condom use found either a negative or positive impact, and none of the six studies that measured impact on contraceptive use found an impact.” Ibid at 15.

<sup>129</sup> Bennett S.E. & Assefi, N.P. (2005) School-based teenage pregnancy prevention programs: a systematic review of randomized controlled trials. *Journal of Adolescent Health*, 36(1), 72–81.

<sup>130</sup> Bennett & Assefi (ibid) noted the paucity of other abstinence compared with abstinence-plus comparative studies, but concluded that in their research “the majority of abstinence-plus programmes increase rates of contraceptive use” as opposed to abstinence only programs which did not.

<sup>131</sup> UNAIDS (n.d.) *HIV Prevention Fact Sheet*, accessed at [http://data.unaids.org/Publications/Fact-Sheets04/FS\\_Prevention\\_en.pdf](http://data.unaids.org/Publications/Fact-Sheets04/FS_Prevention_en.pdf); and also Health Systems Trust South Africa (n.d.), *Cultural obstacles to abstinence and being faithful present challenges for PEPFAR HIV programmes* accessed at <http://www.hst.org.za/news/cultural-obstacles-abstinence-and-being-faithful-present-challenges-pepfar-hiv-programmes>.

fidelity from their partner.<sup>132</sup> The South African Department of Health includes abstinence as one of several information strategies it sets out in the 2001 *Policy Guidelines for Youth and Adolescent Health*,<sup>133</sup> where it pledges to provide information to “emphasise that the safest way of avoiding disease and pregnancy is abstention from penetrative sexual activity,”<sup>134</sup> as well as condoms and other contraceptive methods and the right to TOP services.<sup>135</sup> How the abstinence message is conveyed in practice, however, has significant influence over how effective it is likely to be. Multi-disciplinary policies which involve parents, schools, health professional and the wider community in an open and un-stigmatising manner are likely to be most effective, however, and Bennett and Assefi warn, that: “community attitudes may ultimately determine the acceptability of publicly funded school-based sex education programmes”<sup>136</sup> and likewise, “the prohibition of contraceptive education in school-based pregnancy prevention programmes prevents student exposure to information that has the greatest potential to decrease the pregnancy rate.”<sup>137</sup> Their findings emphasise the difficulty for those providing sexual education in a cultural and societal context which admonishes the reality that teenagers below the age of consent do engage in consensual sexual intercourse.

For many, the fact that young teenagers have sex is an indicator that moral norms and standards have slipped. Commenting on American policies, Ehrlich suggests that female teenage sexuality in particular, has long been used as a lens through which to judge the mores of the wider society and argues: “The sexually active young woman is at the heart of this storm as she crosses the boundary of morally acceptable behaviour based on a powerful combination of gender and age.”<sup>138</sup> Ehrlich traces the roots of this view to two periods of active campaigning to reduce adolescent sexual activity, the first by religious campaigners in the early nineteenth century, and the second by anti-poverty policies from the 1960’s onwards.<sup>139</sup> She suggests that nineteenth century religious campaigners were quick to categorise as delinquent those girls who were wilfully sexually active, imposing harsh ‘reformatory’ treatment, including incarceration, as a punishment and a deterrent that was not similarly meted out to their adolescent male counterparts. Campaigners thereby sought to control the issue of adolescent sexuality by focusing on female sexual delinquency in a context of Victorian morality, ‘rather than punishing men for having sex with underage women’.<sup>140</sup>

In the latter twentieth century, Ehrlich argues that the motivation to tackle high levels

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<sup>132</sup> The Global Commission on Women and AIDS (UNAIDS) (n.d.) *Background Comment*, accessed at [http://data.unaids.org/gcwa/gcwa\\_bg\\_prevention\\_en.pdf](http://data.unaids.org/gcwa/gcwa_bg_prevention_en.pdf).

<sup>133</sup> Department of Health South Africa, (2001) *Policy Guidelines for Youth and Adolescent Health*. Accessed at <http://www.doh.gov.za/list.php?type=Policy%20Documents&year=2001>.

<sup>134</sup> *Ibid* at 40, para. 6.1.3 (b).

<sup>135</sup> *Ibid* at 40.

<sup>136</sup> *Ibid*.

<sup>137</sup> *Ibid*.

<sup>138</sup> Ehrlich, J.S. (2006) From Age of Consent Laws to the “Silver Ring Thing:” The Regulation of Adolescent Female Sexuality, *Health Matrix* 16:151-181 at 151.

<sup>139</sup> When police officers and governments then considered legalising prostitution as a means of protecting women from exploitation, moral campaigners were outraged and lobbied instead for minimum ages of consent. Ehrlich, *ibid* at 154.

<sup>140</sup> *Ibid* at 152.



of adolescent sexual activity was influenced by anti-poverty research which identified that high birth rates among America's urban poor were inextricably linked to poverty. Subsequent public health measures, including free access to contraception for teenagers, were introduced to reduce populations levels within this demographic. Ehrlich argues that although contraception then became the "State's business," the public health motivations behind the programs were "morally neutral".<sup>141</sup> The right wing backlash to *Roe v Wade*<sup>142</sup>, however, signalled a change of position, and in Ehrlich's view, moved the policy focus from contraception to chastity. The subsequent campaigning for abstinence among teenagers and for parents' right to know if their child is sexually active is seen by Ehrlich as setting the stage for "a new era of effort to control the sexual and reproductive conduct of young women".<sup>143</sup>

Indeed, teenagers' own views and their individual rights to decide when to become sexually active have been largely left out of the debate. Psychologist Amy Schalet suggests that regulation of teenage sexuality in America has been governed by two paradigms: the 'abstinence-only-until-marriage paradigm' and the 'sex-as-risk' paradigm.<sup>144</sup> Schalet argues that teenagers need to be given skills to use to independently decide for themselves when they are ready to enter into sexual relationships and calls for a new paradigm, which supports teenagers to 'develop as healthy sexual and emotional beings'.<sup>145</sup> Comparing the sexual education approaches of America and the Netherlands, she argues that the restrictive approach of the former country has resulted in significantly higher levels of teenage pregnancy, rates of HIV and sexually transmitted infection and calls for youth educators and those working in the field of teenage reproductive health to be aware of the positive components of adolescent sexuality, such as pleasure, intimacy, and discovery, and to teach these alongside educating teenagers of the risks involved. She argues:

*Young people who have access to the basic necessities of life and who have developed the sexual self-knowledge and self-regulation necessary to exercise sexual autonomy are much better equipped to make intentional and respectful choices about when and how to engage in sex.*<sup>146</sup>

Schalet's findings highlight, however, that the ability of teenagers to form autonomous healthy decisions regarding when to become sexually active and how to control their sexual relationships are significantly affected by their socio-economic status. She argues that the paradigms of abstinence and risk control fail to recognise the "socio-economic deprivations that are at the root of many negative sexual health outcomes and must be addressed to foster healthy development."<sup>147</sup> Such socio-economic barriers to healthy sexual development include: growing up in poverty, a lack of formal

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<sup>141</sup>Ibid at 161-163.

<sup>142</sup>*Roe v Wade*. 410 U.S. 113 (1973), which legalised abortion for women in America. The court held that a woman had the right to decide, with the advice of her doctor, to terminate her pregnancy without restriction in the first trimester of pregnancy, and with limitations thereafter.

<sup>143</sup> Ibid at 161.

<sup>144</sup> Schalet A.T. (2011) Beyond Abstinence and Risk: A New Paradigm for Adolescent Sexual Health. *Women's Health Issues* 21.3S S5-S7.

<sup>145</sup> Ibid at S5.

<sup>146</sup> Ibid at S6.

<sup>147</sup> Ibid at S5.

education on contraception and financial or emotional barriers to obtaining contraceptive and abortion services. These barriers are all deeply prevalent in South Africa. Indeed, within South Africa, the fertility rate among teenagers varies greatly according to such factors, with those populations groups living in poor, rural and urban informal settlements experiencing far higher rates of fertility.<sup>148</sup> These specific challenges must be kept in mind when considering effective methods of providing sexual education for adolescents in South Africa.

## Nurses' Roles and Responsibilities

Public health studies conducted internationally and in South Africa have found that the role of primary health care nurses has shifted significantly from providing individually focused care in a clinical role towards including a more population centred or community oriented approach.<sup>149</sup> This shift in focus has been necessitated by the need for health care practitioners to have an understanding of the socio-economic circumstances and policy influences that impact their clients' health and to intervene accordingly.<sup>150</sup> In this context, the importance of the nurse as a link to the community has been underlined, as primary health care nurses have more contact with the community at a grassroots level than other civil society organisations.<sup>151</sup> In addition to their traditional clinical care duties, nurses are increasingly finding themselves with more community oriented duties such as health promotion, prevention and intervention – due to the dynamic nature of the environment in which they operate. In order to effectively perform their health promotion roles, nurses need to forge relationships that are based on mutual trust, understanding and respect with the communities in which they work.<sup>152</sup> There is an inevitable tension then, when nurses are seen to provide controversial reproductive health care services, including TOPS and sex education to sexually active children and teenagers. These services – and the reality of sexually active adolescents they represent – are in tension with traditionally conservative moral judgments of the community and society.<sup>153</sup> Nurses in this study

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<sup>148</sup> The 1998 South African Demographic and Health Survey reported almost double the fertility rate among teenagers in rural settings (99 per 1000) than among those in urban settings (56 per 1000). Commenting on the disparity of fertility rates among population groups in South Africa, Panday et al. (see note 89 above) at 105 suggest: "While (fertility) rates are significantly higher among Black and Coloured adolescents, fertility among White and Indian adolescents approximates that of developed countries. This difference can in all likelihood be accounted for by the wide variation in the social conditions under which young people grow up, related to disruptions of family structure, inequitable access to education and health services, as well as the concentration of poverty and unemployment in Black and Coloured communities. However, international research shows that even when the above factors are controlled for, differences between populations groups persist, indicative of cultural differences with regards to pregnancy."

<sup>149</sup> Borrow, S., Munns, A. & Henderson, S., (2011), Community-based child health nurses: An exploration of current practice. *Contemporary Nurse* 40(1), 71-86; Philibin, C.A.N, Griffiths, C., Byrne, G., Horan, P., Brady, A.M. & Begley, C. (2010) The role of the public health nurse in a changing society. *Journal of Advanced Nursing*, 66(4), 743-52; Reid, S.J., Mantanga, L., Nkabinde, C., Mhlongo, N. & Mankahla, N. (2006). The community involvement of nursing and medical practitioners in KwaZulu-Natal. *South African Family Practice*, 48(8); Sistrom, M.G. & Hale, P.J. (2006). Outbreak investigations: Community participation and role of community and public health nurses. *Public Health Nursing*, 23(3):256-63.

<sup>150</sup> Reid et al. (see note 149 above).

<sup>151</sup> Borrow et al.; Reid et al.; Sistrom & Hale (see note 149 above).

<sup>152</sup> Reid et al. (see note 149 above).

<sup>153</sup> See Bennett & Assefi (see note 129 above).

have reported criticism from community members who believe that providing contraception to teenagers encourages them to have sex, or that by providing TOP services – including information on the right to a TOP – nurses are complicit in encouraging TOPs. These views represent a counter interest to the rights of the individual patient to access those services and it is therefore important that nurses are able to broker such situations.

Research suggests, however, that the majority of South African nurses have had little, if any, training in the principles and pragmatics of a health promotion approach.<sup>154</sup> This suggests a knowledge translation gap from health policy to nursing practice. In order to be effective in their community-orientated roles, nurses require competency skills such as analytic assessment skills, therapeutic, communication, brokerage and facilitation skills. They need basic public health science knowledge and community dimensions of practice.<sup>155</sup> Nurses work in multidisciplinary teams and therefore also require networking and collaborative skills to effectively engage with other community institutions and other health care professionals.<sup>156</sup>

One might expect that the knowledge translation gap – from health promotion policy to nursing practice – would result in nurses' strict adherence to a clinical regimen, a hesitation to delve into education, advocacy and prevention efforts. The evidence suggests, however, that nurses *do* view these health promotion activities as their responsibility, but in the absence of formal training, their interactions with patients are often tempered by personal values and beliefs, and efforts to 'educate' swiftly devolve into moralising.<sup>157</sup> A 2002 study focusing on the experiences of HIV positive patients within the health system found nurses' personal attitudes negatively impacted on the level of care and services patients perceived, concluding:

*...[I]t is clear that poor attitudes may reflect health care providers' views of particular groups of patients – not only those who are HIV positive, but also young women attending pregnancy or maternity services, or foreigners.<sup>158</sup>*

In the context of reproductive and sexual health care for youth, the principles of health promotion align with a harm reduction approach – emphasising the importance of enabling and supporting youth to make healthy life choices via sexuality education and access to preventative health care. Several studies have evaluated South African nurses' perceptions of their scope of practice in reproductive and adolescent health services.<sup>159</sup> Findings show that while nurses often see themselves as necessarily involved in education and prevention efforts, their involvement is often dictated by personal values and beliefs. In a study on the attitudes of health providers to TOP,

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<sup>154</sup> Onya, H., (2007), Health Promotion in South Africa. *Global Health Promotion*, 14(4), 233-237; Wood & Jewkes (see note 110 above).

<sup>155</sup> Sistrom & Hale (see note 149 above).

<sup>156</sup> Ibid.

<sup>157</sup> Wood & Jewkes (note 110 above).

<sup>158</sup> Modiba, P., Gilson, L., & Schneider, H. (2002). Voices of User Authors. In A. Ntuli, F. Suleman, P. Barron, & D. McCoy (Eds.), *South African Health Review*. Durban: Health Systems Trust, at 198.

<sup>159</sup> Wood & Jewkes (see note 110 above); Harries J., Stinson K. & Orner, P. (2009) Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. *BMC Public Health* 9:296; Ehlers (see note 102 above).

Harries et al. suggest that there is greater need for values clarification workshops for nurses, given that many of their respondents' willingness to provide TOP care was "tempered by indirect or direct personal experiences."<sup>160</sup> In a similar study evaluating the perspectives of clinic nurses towards adolescent sex and contraception in the Northern Province, Wood et al. found that respondents stressed the abstinence method, articulated moral motivations for their advice, and spoke of counselling teenage patients as "giving them lectures."<sup>161</sup> These authors expressed concern that information disseminated in a judgemental and moralising manner could negatively impact teenagers' care-seeking behaviours.

In addition to the health promotion role, another important aspect of nurses' community nursing mandate is a requirement that they intervene if they become aware that a client may be at risk. This intervention may take the form of counselling or reporting the risk to the relevant authorities, which is now mandatory in cases of child abuse or neglect under the Children's Act and the SOA. Nurses, by the very nature of their profession, are often in situations whereby they may be the first person to encounter signs that abuse or violence against patient is taking place. This places nurses in a critical position of responsibility given the wide-spread nature of interpersonal violence and violence against children within South Africa.<sup>162</sup> The authors note that "interpersonal violence [is] the leading risk factor, after unsafe sex, for loss of death and disability-adjusted life years in the country [South Africa]" and further that "half the female victims of homicide are killed by their intimate male partners and the country [South Africa] has an especially high rate of rape of women and girls."<sup>163</sup> Commenting on the need for prevention of violence and injuries to form part of the public health strategy, Seedat et al. cite findings related to the prevalence of gender-based violence in South Africa:

*Research has shown that 39% of girls report having undergone some form of sexual violence (e.g. unwanted touching, forced sex, or being exploited by much older men) before they were 18 years old ... Most of this violence is not reported to the police; however, rape dockets from Gauteng province in 2003 show that 40% of victims who report rape to the police are children younger than 18 years, with 15% younger than age 12 years. Most (84%) rapes in the young age group are perpetrated by men who are known to the child, whether relatives, neighbours, friends, or acquaintances, by contrast with adult rapes, of which half (48%) are perpetrated by strangers.<sup>164</sup>*

In this context, where rape and sexual abuse of young girls and teenagers is highly prevalent, it is important that nurses understand the signs to look for and have training and guidelines that enable them to help patients and refer such cases to the

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<sup>160</sup> Harries et al. (see note 159 above).

<sup>161</sup> Wood & Jewkes (note 110 above) at 31.

<sup>162</sup> Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S. & Ratele, K. (2009)., Violence and Injuries in South Africa: Prioritising an Agenda for Prevention, *The Lancet* 374: 1011–22.

<sup>163</sup> Ibid at 1011.

<sup>164</sup> Ibid at 1013. The authors refer to Vetten, L., Jewkes, R., Fuller, R., Christofides, N., Loots, L., & Dunseith, O. (2008). Tracking Justice: The Attrition of Rape Cases through the Criminal Justice System in Gauteng. Johannesburg: Tshwaranang Legal Advocacy Centre; as well as Kaminer, D., Grimsrud, A., Myer, L., Stein, D.J., Williams, D.R.. (2008). Risk for Post-Traumatic Stress Disorder Associated with Different Forms of Interpersonal Violence in South Africa. *Social Science & Medicine* 67: 1589–95.

police or social services.<sup>165</sup> Unfortunately, in contrast to the preventative, educational and advocacy roles of health promotion which nurses appear to embrace (albeit sometimes without sufficient skills and resources), studies in South Africa have identified that nurses are reluctant to intervene when clients present with symptoms suggesting that they are at risk of abusive or criminal behaviour. Joyner's 2009 study of nurses' role in providing services for victims of domestic violence found that many health care providers were reluctant to become involved in domestic violence cases by screening for domestic violence amongst patients (asking all patients basic questions to identify abuse) or enquiring about suspected domestic violence.<sup>166</sup> Many believed that they were not responsible for responding to domestic violence, beyond treating immediate injuries and symptoms. Some felt that domestic violence was too personal to discuss with patients, and this was particularly problematic for health care providers involved in abusive relationships themselves.<sup>167</sup> Kramer notes that, as with other service providers dealing with victims of domestic violence, health care providers find their lack of control over patients' decisions frustrating, especially when patients decide to remain in abusive relationships.<sup>168</sup> Indeed, Joyner found that many health care providers felt that nothing could be done about domestic violence, and were thus reluctant to enquire about suspected domestic violence if there was no available 'treatment' regime. They felt uncomfortable with non-medical interventions, such as providing information and referrals for psycho-social services, and with medico-legal documentation (filling out the J88 form) in cases where charges had not been laid with the police.<sup>169</sup> This reluctance to get involved often stems from fear of having to testify in court, which is highly problematic as medical evidence can have a great impact on the outcome of a domestic violence case<sup>170</sup> and likewise, cases of child abuse.<sup>171</sup> Research has therefore emphasised the need for medical staff to be trained in the importance of taking accurate patient history<sup>172</sup> and giving effective witness statements.<sup>173</sup>

While the South African studies are specific to domestic violence, international research suggests medical professionals may similarly be reluctant to report cases of child abuse, despite mandatory reporting obligations. Vulliamy and Sullivan's study of Canadian paediatricians' experience in reporting child abuse noted the most frequent

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<sup>165</sup> The British Medical Council Guidelines at 58 (citing the Royal College of Paediatrics & Child Health (2006). *Safeguarding Children and Young People: Roles and Competences for Health Care Staff*. London, UK) advises that "If you work with children or young people, you should have the knowledge and skills to identify abuse and neglect".

<sup>166</sup> Joyner, K. (2009). *Health Care for Intimate Partner Violence: Current Standard of Care and Development of Protocol Management*, PhD Dissertation, University of Stellenbosch.

<sup>167</sup> Ibid.

<sup>168</sup> Kramer, E. (2008). Developing a Health Sector Response to Domestic Violence. Paper presented at the Tshwaranang Legal Advocacy Centre (TLAC), the Centre for Health Policy (WITS) & the School of Public Health (WITS) 'Developing a Health Sector Response to Domestic Violence – A Roundtable Discussion' workshop, held in Johannesburg 11-12 August 2008.

<sup>169</sup> Joyner (note 166 above).

<sup>170</sup> Martin, L.J. & Artz, L. (2006). The Health Care Practitioner's Role in the Management of Violence Against Women in South Africa. *Continuing Medical Education*, 24(2), 72-77.

<sup>171</sup> Brennan, L. (2012). Court Testimony, Child Welfare and Justice Systems, and the Emergency Physician *Clinical Paediatric Emergency Medicine*, 13(3), 249-256.

<sup>172</sup> Martin & Artz (see note 170 above) at 60.

<sup>173</sup> Brennan (see note 171 above) at 249.

reasons given for non-reporting included: poor experiences of the child protection system (especially a lack of feedback once reports had been made); negative views of the court system; concerns about confidentiality; a belief the reporting was detrimental to families; ignorance of reporting laws and procedures, and an unwillingness to get involved.<sup>174</sup> The authors call for better inter-disciplinary collaboration between health and social welfare departments, with increased training for medical and social workers as one way of improving protection mechanisms for vulnerable children.<sup>175</sup> These findings were supported in a larger and more recent study in the United States which found that primary health care practitioners were “unlikely to report cases unless they expect that reporting to state CPS [child protection services] will benefit the child.” The study recommended that the CPS should be required to provide feedback on cases to the reporting professional.<sup>176</sup>

Criticising mandatory reporting systems of child protection, Melton<sup>177</sup> cites the findings of the United States Advisory Board on Child Abuse and Neglect that argues that the US system focuses more on the punishment of abusers than welfare for victims:

*The most serious shortcoming of the nation’s system of intervention on behalf of children is that it depends upon a reporting and response process that has punitive connotations and requires massive resources dedicated to the investigation of allegations.*<sup>178</sup>

Melton argues that a further disadvantage of mandatory reporting systems is that training for health care professionals on child abuse includes an emphasis on reporting procedures, rather than “[their] roles in treating, referring, and preventing family violence.”<sup>179</sup> In countries where a mandatory system of reporting exists, a negative effect has been the overwhelming increase of cases, with the effect that social service departments are often unable to prioritise the most vulnerable cases.<sup>180</sup> While accepting that child protection systems in developing countries focus mainly on extreme cases of physical and sexual abuse, Melton warns that in time the mandatory reporting system may result in the same ‘explosion of cases and misdirection of resources’ that will prevent the system from investigating and protecting even the most vulnerable of victims.<sup>181</sup>

In light of these findings, a system of mandatory reporting of consensual sexual activity of underage teenagers will have serious implementation problems in South

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<sup>174</sup> Vulliamy, A. & Sullivan, R. (2000). Reporting Child Abuse: Paediatricians’ Experiences with the Child Protection System. *Child Abuse & Neglect*, 24(11) 1461–1470.

<sup>175</sup> Ibid at 1469.

<sup>176</sup> Sege, R., Flaherty, E., Jones R., Lyn Price, L., Harris, D., Slora, E., Abney, D., & Wasserman, R. (2011). To Report or Not to Report: Examination of the Initial Primary Care Management of Suspicious Childhood Injuries. *Academic Paediatrics*, 11(6), 460–466.

<sup>177</sup> Melton, G. (2005). Mandated Reporting: A Policy Without Reason. *Child Abuse & Neglect* 29(1), 9–18.

<sup>178</sup> US Advisory Board on Child Abuse and Neglect (1990). *Child Abuse and Neglect: Critical First Steps in Response to a National Emergency*. Washington, DC: US Government Printing at 80, quoted in Melton (see note 177 above) at 13.

<sup>179</sup> Melton quotes the US Committee on the Training Needs, 2002, p. 72, Ibid at 14.

<sup>180</sup> Bell, L. & Tooman, P. (1994). Mandatory Reporting Laws: A Critical Overview. *International Journal of Law and the Family* 8, 337-356, at 342-343; Australian Institute of Family Studies, (2012). *Mandatory reporting of child abuse and neglect*. Last accessed in December 2012 from <http://www.aifs.gov.au/cfca/pubs/factsheets/a141787/index.html>.

<sup>181</sup> Melton (see note 177 above) at 13.

Africa. Resource and capacity constraints already impact the ability of different services to work effectively (which was evident in the findings of this study and is discussed below). Given the significant barriers to service provision that already exist – including a lack of training for health professionals on the new requirements, a fear among medical professionals entering into the domain of the criminal justice system and a severe lack of resources required to foster inter-disciplinary understanding and working between social services, health and the police – it is questionable whether a system of mandatory reporting would be functional, especially given its focus on *consensual* sexual activity.

As discussed above, despite the fact that nurses may be motivated to engage in health promotion and community oriented roles, the process is not always smooth and there are intractable challenges for policy-making, including high workloads, a lack of skills training, a shortage of funding, uncommitted community members, role ambiguity and unclear legal mandates.<sup>182</sup> Such limitations on a nurse's ability to perform multiple roles has specific relevance to this study in the context of the expectation that they provide sexual education, reproductive health services and must fulfil the obligation of reporting under age sexual activity under the SOA. These challenges for nurses are discussed in Part II of the report.

## Methodology

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For purposes of this study, a total of 28 interviews were conducted with nurses providing reproductive health care at rural and urban health facilities in the Western Cape. Qualitative interviews were conducted using an open-ended, structured questionnaire to elicit data on how nurses make decisions and what challenges they experience when providing reproductive health care services to teenagers. Where appropriate, researchers asked follow-up questions to clarify or probe further.

## Sampling

Reproductive health care services are divided between clinics and hospitals, with clinics largely focusing on family planning and contraceptive services while designated hospitals offer TOPs. The sample therefore included both hospitals and clinics. The study used a convenience sampling method to select urban and rural hospitals and clinics. At the time the research was planned, a limited number of specialised youth health centres (n=4) and reproductive health centres (n=6) were said to exist in the Cape Town Metropole.<sup>183</sup> Our urban sample sought to include these specialised facilities because we hypothesised that young women likely prefer accessing

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<sup>182</sup> Borrow et al. and Reid et al. (see note 149 above).

<sup>183</sup> See <http://www.westerncape.gov.za/eng/directories/facilities/6443>. At the time of writing the website states that three youth clinics are active: Bellville Youth Centre, Crossroads 2 Youth Centre and Mitchell's Plain Youth Centre. However, we found that Mitchell's Plain and Bellville no longer operate as specialised Youth Clinics.

specialised and/or youth-focused service providers. However, two of the youth facilities, Bellville Youth Centre and Mitchell's Plain Youth Centre, do not exist as youth focused centres any longer, although they remain listed as such on the Department of Health website. Most of the specialised youth and/or reproductive health centres do not offer TOPs. We therefore selected additional facilities by asking service providers at the specialised facilities to which TOP facility they refer their clients. Data collection in the metro area focused mainly on clinic facilities, which provided more extensive reproductive health care, although two TOP facilities were also included in the urban sample to provide some comparison.

In total, 13 interviews took place in facilities in and around the Cape Town central (city) area. The urban facilities at which these interviews took place included six clinics that provide reproductive health care, two specialised youth clinics,<sup>184</sup> one community health centre (which is designated for TOPs) and one hospital. Within these facilities, most interviewees were nurses (n=11)<sup>185</sup> three of whom were senior nurses who were at a managerial level. Two interviewees in urban clinics identified themselves as educators or "health promoters."

For the rural sites, we selected three districts (West Coast; Cape Winelands; and Overberg) that are within driving distance from Cape Town and used the list of designated TOP facilities in these districts as a sampling frame.<sup>186</sup> We randomly selected ten hospitals designated for TOPs in these districts and then purposively chose a clinic in each of the selected towns for the interviews on family planning. In total, 15 interviews took place at rural health care facilities, including six health care clinics and nine hospitals. All but one of these hospitals were facilities that perform terminations of pregnancy.<sup>187</sup> Interviews at these hospitals were conducted with nurses, of whom nine were senior nurses at managerial level.<sup>188</sup>

## Logistics

In addition to ethical approval from the University Research Ethics Committee, we applied for ethical approval from the City of Cape Town and the Western Cape Department of Health, respectively. Once the research had been approved by the City of Cape Town/Department of Health, a researcher contacted each facility telephonically and explained the research to the person who is in charge of the nurses, either the Matron or the Operations Manager. Each facility also received

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<sup>184</sup> The intention was to conduct interviews in specialised urban youth centres; however, at the time the research application was submitted, very few were still operational. When the Mitchell's Plain Youth Centre interview was scheduled, we were told that the clinic was no longer a youth centre and now served a wider population. It is interesting that the clinic reported a drop in the number of teenagers using the facility since it began to serve the wider community.

<sup>185</sup> This number includes six professional nurses, two junior nurses, and three nurse managers.

<sup>186</sup> Two facilities from this list were not included in the sampling frame because they were too far away from Cape Town.

<sup>187</sup> An interview was scheduled at Robertson hospital, which was listed by the Department of Health as a TOP facility. During the interview it became clear that the facility does not perform TOPs anymore.

<sup>188</sup> One was an assistant manager, one was a Matron, four were Operations Managers and three were Heads of Nursing services.



written information on the study and a copy of the Provincial/City letter of approval via fax or email. During a follow-up phone call, the Matron was asked about which weekday and what time would be most appropriate for an interview with one of the nursing staff – in order to minimise impact on service delivery – and interviews were arranged accordingly.

Participants for the interviews were selected purposively depending on who was available on the day of the interview. For the interviews at TOP facilities, researchers were generally referred to the particular nurse who is involved in TOP services, which in seven cases was the Matron/Operations Manager herself/himself. This “pre-selection” of participants may affect the findings of this study. A further limitation is that all interviews were conducted in English which limited the number of nurses that were available for an interview at the facilities. One interview fell through because the only nurse who was able to do the interview in English was not available on the day we arrived for the interview. Another facility was short-staffed on the day of the interview due to illness and the interview was therefore abandoned. Two hospitals that are designated for TOPs and are included on the Western Cape Department of Health listing do not in fact offer TOPs. In one instance, the researchers only found out during the interview that the facility does not offer TOPs anymore. This interview is still included in the analysis because questions around nurses’ decision-making about reproductive health care and mandatory reporting of teenage sexuality still apply.

Interviews were conducted by two interviewers who were researchers at the GHJRU, one to lead the interview and the second to assist with taking detailed notes and provide additional follow up questioning when necessary. The interviews were also recorded for the purposes of accuracy, and then transcribed as soon as possible. The transcriptions were then subject to quality control by another researcher, to check the accuracy of the transcript against the recording. Where interviewees spoke in Afrikaans translations of the relevant words or phrases was completed by Afrikaans speakers at the GHJRU. For the purposes of analysis, the interview data was divided on the basis of service provision (TOPs and RHCs) and analysed on a thematic basis for commonalities and differences in responses.

## PART II: FINDINGS

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This project examines how health care workers actually provide reproductive health care to teenage patients. It looks at how they perform their seemingly conflicting duties under the Children's Act, the SOA, the CTPA and the NHA and tries to understand why they act and fulfil their assigned roles in certain ways. To accomplish this task it is important to first understand the mind-set of the healthcare workers and the particular contexts in which they work. The first part of this section thus presents findings that describe the particular group of healthcare workers who were interviewed for this project and the particular environments in which they work. The second part of this section evaluates the knowledge healthcare workers have regarding the legal framework on reproductive healthcare and the training they have received. The final part examines the ways in which the rights and responsibilities included in this framework are – or aren't – implemented by health care workers, while distinguishing between three types of responsibilities that are assigned to them: health education, provision of health services and law-enforcement.

### The Participants

The participants interviewed for this study came across as extremely hard-working and caring professionals. Many expressed concern not only about the general problem of teenage pregnancy but also about making sure that their patients had the information and assistance they needed to be healthy and safe. In spite of their very busy schedules, they were cooperative and interested in the study. Participants had a wide array of nursing experience, ranging from one to forty years, with the majority having more than two decades of nursing experience. One third of the participants worked in all areas of their clinics and hospitals, while the rest dealt exclusively with maternity and gynaecology, family planning, reproductive healthcare, and termination of pregnancies.<sup>189</sup>

For many of the participants, nursing was a desirable career option, though it had not been everyone's first choice. When asked why they became nurses or entered the healthcare profession, many participants (n=11) spoke in terms of a strong vocation to help people and expressed either that they had always wanted to become nurses or that they always had a passion for nursing.<sup>190</sup> For several (n=5) participants, nursing was the second best available choice; they had originally wanted to pursue careers in education (n=3), social work (n=1) and medicine (n=1). A significant proportion (n=8) of the participants, however, said they turned to nursing due to a lack of other options. In part, their career choices were greatly limited by the discriminatory policies in place under apartheid. As one nurse explained, while growing up she could remember feeling like there were only four options: "one was one [was] to become a teacher, one

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<sup>189</sup> Nine participants work in all areas. Most of the rest of the participants work in a combination of areas. Five mentioned working in obstetrics/gynaecology, six in family planning, five in reproductive healthcare, four in primary care, and one in emergency. Two worked solely with termination of pregnancies.

<sup>190</sup> This question was not asked at two of the earlier RHC interviews.

[was] to go for police and one [was] to go and become a nurse and I chose to be a nurse. Or there was a prison warden, that was all" (TOP 8).

Two thirds (n=10/15) of the reproductive health clinic participants chose the area of nursing in which they are currently work. The other five participants deal with teenagers and provide reproductive health services not necessarily because they sought out this position themselves, but because of certain rotational requirements or based on need in the facilities. All, of the participants (n=16) who were asked expressed satisfaction in their current positions, albeit that their reasons for saying so differed, from an appreciation for the practical nature of the work, that they liked the working hours, or that they have a love for the kind of work that they were doing. At TOP facilities, most of the participants were involved in TOP provision as part of their wider nursing duties, and the nurses at the rural hospitals especially emphasised the need for them to work across all practice areas. Only two participants' work involved TOP provision as the major aspect of their nursing duties. Nearly all (n=8/9)<sup>191</sup> participants agreed with providing TOPs, however, it was noted that these healthcare workers were often the only ones in their facility who were prepared to assist with TOPs. Also, despite agreeing with TOP provision in general, most (n=8/9) of these participants expressed some kind of qualification on the extent to which they thought the service should be provided. Thus, three participants did not agree with TOPs after 12 weeks of pregnancy and five participants were uncomfortable with patients accessing repeated TOPs.<sup>192</sup> One such participant felt TOPs should only be used in exceptional cases, such as rape and as a "worst case scenario" (TOP8) rather than as a service a woman can 'pick'. Only one of the participants who was in favour of TOPs also noted that providing the service ran contrary to her religious beliefs. This nurse was Catholic but justified her work providing TOPs as an important service and part of her professional duty (as a nurse) which seemed to outweigh her personal feelings. She explained:

*[M]y view is first and foremost, I'm a nurse. I'm a nurse and the day I become a nurse, I'm here to serve the people or somebody, no matter what his problem is or what is, whatever is wrong with him. So, I do this with mixed feelings, but it's okay. Because I see that as part of my ... service and it's really a service that the, that the people and the ... youth need (TOP1).*

Participants perceived their jobs as involving a number of different roles, including that of caregiver, teacher and social worker – a fact that is supported by their responses about the various aspects of their jobs that they enjoyed. In particular, many (n=15/28) of the participants mentioned that they like helping and interacting with patients. For example one participant stated:

*I like my job very much. It's varied it's a service orientated work, you can have input into people's lives, you can improve their health status but also their general wellbeing (RHCI6).*

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<sup>191</sup> This question was not asked in one interview due to time constraints.

<sup>192</sup> Two of these participants expressed frustration with adult patients having multiple TOPs while the other two gave examples of young patients.

Several others expressed their enthusiasm for giving advice, teaching and working with patients. As one nurse said:

*[Our clients] are unsure what is right and wrong. You have an opportunity to teach them. They don't even understand the meaning of 'family planning,' you teach them ... it's very challenging. You have to teach them. They want to do everything. You have to give them a good message so they spread it outside (RHC 8).*

As this quote suggests, the teaching role that this participant perceived was not limited to the individual relationship between health care worker and patient, but one which extended to the 'outside,' – in other words, the wider community. This sentiment is consistent with the health-promotion approach that has generally been adopted by the public health system. Another participant, a health promoter, expressed the idea that her work involves a substantial amount of counselling, similar to the work performed by a social worker: "I really wanted to become a social worker. And sometimes I feel like that I'm a social worker" (RHC9).

These statements, and the broad approach to reproductive healthcare that they embody, are reflected in the ways in which healthcare providers actually distribute their services, and raise important questions about the educational and advisory role that healthcare workers are intended to fulfil. While nurses are obviously well placed and suited to teach the youth about reproductive health in the narrow sense – what forms of contraception are available, how they work and how to use them – by default they seem to have acquired a broader educational role that includes providing guidance on morality, sexuality and relationships. This is problematic both in practice – because they are not adequately trained to provide this type of counselling – and in theory – because discussions of morals, sexuality and relationships necessarily involve the application of values and judgments which then contaminate what ought to remain a therapeutic "safe space" for teenagers. This point is further developed below, where we discuss healthcare workers' implementation of their educational role.

## Service Provision

As noted in the methodology, participants in this project were from a range of healthcare facilities. Only two of the respondents worked in youth-specific clinics, although all of the respondents had acquired experience working with teenagers.<sup>193</sup> Respondents highlighted a number of infrastructural and procedural aspects of their facilities that created challenges for teenagers, including: a lack of privacy in waiting rooms, administrative procedures that created waiting periods, and limited clinic hours for youth only. There was a strong feeling from interviewees that only a minority of teenagers in need of reproductive health care services actually came to the clinics and hospitals, as many teenagers are deterred by the factors listed above. As one

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<sup>193</sup>All except one of the interviewees stated they worked with teenagers. The exception was a nurse who now held a managerial role at a TOP facility. Although no longer working directly with patients, she did have experience of working with teenagers from her nursing past (TOP4).

participant noted: "Most of them refuse to come for family planning. They don't want it ... Education is all we can do. Some will come" (RHC8).

Each of the reproductive health clinics offered a range of services for teenage clients, including: contraceptive advice and provision, pregnancy testing, HIV testing and counselling, STI testing and treatment, pap smears, breast examinations and referral for TOPs.<sup>194</sup> Of the TOP facilities, three were rural hospitals, which provided a broad range of general health services and emergency care. The nurses interviewed from these hospitals worked across all of the wards. Their descriptions of their daily routines and duties included a diversity of nursing tasks, from emergency care to accompanying doctor's rounds, stock taking and x-rays, administering medication and attending to patients in the wards (for example, the labour wards). In TOP facilities where nurses worked permanently on specific wards such as ER, Maternity or TOP, their routines appeared to have more structure in terms of which days they would do specific tasks relating to reproductive health services, including sonars and TOPs. At most of the TOP facilities Contraceptive services were not generally available to the public on a 'walk-in' basis, but were always provided following a TOP procedure.<sup>195</sup>

All of the reproductive health clinics were open for a period of eight hours, Monday to Friday. Clinic opening times varied slightly, with the earliest being open at 7:00am and the latest at 8:30am. One interviewee working in a Cape Town township suburb explained that the clinic opened a half-hour later in the winter, as it was too dangerous for nurses to journey to the clinic in the dark.

Respondents repeatedly highlighted that it was difficult for teenage learners to come to clinics during school hours.<sup>196</sup> Thus, the most popular time for teenagers to access services was after school, from 2:00pm onwards, and some clinics had made a positive effort to accommodate teenage patients during these times. One clinic, for instance, stayed open until 7:00pm one night a week for general family planning services, whereas another gave teenagers priority after 2:00pm, in a "fast lane," to minimise communal waiting time (RHC4). Besides the two specifically designated youth facilities, however, only two clinics allocated specific, exclusive time, one afternoon per week, for a youth clinic. Notwithstanding the additional clinics which stayed open later on the specific days, closing times varied only slightly, between 3:30-4:30pm.<sup>197</sup>

Although respondents did not seem to consider clinic hours to be problematic for teenagers per se, they did repeatedly suggest that the dearth of teenage-specific clinic times was a serious obstacle to healthcare access because of privacy concerns. Participants felt teenagers were afraid they would be identified while waiting in the clinic and also feared their visit would be reported to parents or become a source of community gossip. As one nurse said: "[T]hey don't want to come to the clinic, because

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<sup>194</sup>Not all of these services were mentioned by each of the respondents, although it is likely that this is merely due to a lack of thoroughness in answering the question. All clinic respondents mentioned contraception, six mentioned STI's, five mentioned HIV/ARV services, and 10 mentioned offering referrals for TOPs.

<sup>195</sup> In larger TOP facilities contraception was available to the public through the Casualty (ER) Ward.

<sup>196</sup> This question of opening hours was not asked specifically in TOP facilities, but three nurses mentioned starting their working day at seven am. (TOP3, TOP7, TOP8. TOP5) opened at eight am.

<sup>197</sup> While conducting the interviews at the facilities researchers noticed the nurses arrived after the stated opening times and at another facility the clinic was closed earlier than the stated closing time.

then everyone will know - or they think everyone will know - that they are on birth control"(RHC3). Another nurse explained:

*[I]t's a big thing to get the teenagers to come to the clinic because ...the church women, the elderly women, they sit in this waiting room and they discuss everybody that's coming in and it's a small community, ok not that small, but people know each other ...and they will say: "oh I saw your child yesterday". And teenagers don't want to hear stuff like that (RHC1).*

Indeed, one respondent who worked at a facility that had recently been expanded from a youth clinic to one that services general patients attributed a subsequent drop in the number of teenage patients accessing services to fear that an adult acquaintance would see them and tell their mothers.

Teenagers were also at risk of being subjected to negative comments from clinic staff or other patients waiting in the general reception areas, which were also perceived as a deterrent. Thus, three participants mentioned that there may be some form of confrontation between teenage patients and older patients which may deter them from coming to the clinics. One nurse noted that other nurses too, may make comments that embarrassed them:

*I do experience other challenges with ... maybe like the older staff, you know the things they say to teenagers, and also the community ... how they handle it ... and if they see youngsters in the facility now they will comment. In the waiting room, they'll see a youngster go into the room and they'll comment and say "ooh, this one's you know ... ripe before their time" (RHC12).*

While gossip and lack of privacy were mentioned as an issue by participants working at both urban and rural facilities, the problem may be particularly acute in rural facilities where clinic patients tend to be from local, small communities (see the comment made by RHC 1, cited above).

The privacy problem is exacerbated by procedural rules, which require, for example, that all patients retrieve their medical files and undergo certain basic tests (e.g. blood pressure) before any treatment can be provided. Thus, at one TOP facility, the Nursing Manager noted that a person who comes to the hospital for a TOP must first wait in a general waiting room to have observations done in casualty before proceeding to the privacy of the TOP ward where they were likely to encounter 'flack' from other patients (TOP5).

In reproductive health clinics, even if teenage patients have an existing patient file, they need to wait to retrieve it and are also required to complete the standard observations at each appointment. While it is recognised that record taking is necessary for purposes of accountability, the inflexibility of these rules has removed nurses' discretion and made it difficult for them to always meet the needs of their patients in sensitive cases. One nurse explained how this policy came into conflict with practices aimed at increasing privacy:

*But now they want us to keep a file ... and [teenagers] are too shy to go to the front, to sit in the front, and that's very sad for me... One day there was four of them [teenage patients] ... and they said, one of them ... think[s she] is pregnant [and] they want me to test the urine ... [A]ll four of them go to the toilet and then all four of them come back, so I never know [whose urine sample had been provided]. It was negative eventually; if it was positive I would have known. But that's how I want to do it, but I can't ... they must have the file ... I must write everything down, I must do a blood pressure, must do a weight (RHC2).*

The problem is further exacerbated when the health practitioner herself is a member of the patient's community, especially when one considers the 'health promotion' approach to healthcare, which explicitly assigns to healthcare providers a communal role. In a number of cases respondents spoke about their teenage patients being aware that providers knew their families and were thus concerned about confidentiality:

*I think the biggest, biggest problem why teenagers don't go for contraception is because that is my mother of my aunt's friend who [is] the provider of the contraception. And everybody in the clinic knows everyone and knows everyone's mother and teacher and where you go to school and all your friends and that is a big problem (TOP6).*

And:

*Some of them ... won't go to the clinic because they know the sister at the clinic. And they know the people that go to the clinic and they have to sit there for a long time and wait. So waiting times is a problem ... And the Sister would tell their mom "your daughter was there, what was she doing there?" Yeah that's why. I think it's because of the confidentiality (TOP1).*

Belonging to the same community as their patients may also impact on the way healthcare workers provide services. For example, one respondent, who worked in a township clinic in the Metro area, noted that she was afraid to report rape to the police if the victim did not want to report it: "If there is a rape victim and you [nurses] report to the police, the perpetrator will kill you [nurses]. This is a very dangerous area" (RHC7). Another respondent, a nurse in a rural TOP facility, explained the practical difficulty she had experienced while organising TOP procedures for patients who were the children of clinic staff (for example, nurses and cleaners) and how she would have to schedule the child's TOP procedures around their parents' time off. She also spoke of the guilt she felt towards observing confidentiality about the TOP procedure she had carried out on her neighbour's young daughter. She illustrated how in this setting, privacy concerns work both ways:

*[M]y neighbour's daughter, she was in grade 11 ... and it was difficult for me not telling that mother that her daughter was here ... so ... then I just didn't go there anymore [to visit her neighbour] because I got a lot of guilt in myself, not for doing the procedure but just knowing that the child was here (TOP4).*

In general, participants were aware of teenagers' sensitivity to the lack of privacy at health care facilities and expressed frustration at their inability to overcome teenagers' concerns. Two nurses, for example, mentioned keeping patients' clinic cards at the clinic, so that their parents would not find it (RHC4 and RHC5). Another clinic worker, (RHC2) told how she allows teenagers to come straight to her clinic room to obtain contraceptive services, without a file and without having undergone observations, so as to avoid the waiting room. Given the need for accountability in the provision of medical services, this practice appears irregular, and stricter procedural rules have now made it impossible. It is evidence, though, of this healthcare worker's awareness of the problem, and of her attempt to resolve it out of concern for her patients and a belief that a priority of her job is to facilitate access for teenagers to reproductive healthcare.

These systemic difficulties are of serious concern and must be addressed if teenagers are to be assured of access to reproductive healthcare. A more discreet structure, however, will only be effective if healthcare workers are also knowledgeable about the legal framework and their patients' rights, and are prepared to implement and enforce them. The next two sections present the findings on these two issues.

## **Healthcare Workers' Knowledge of their Legal Duties**

This section explores the extent to which the healthcare workers who participated in this study were familiar with the legal rights that children and teenagers have in terms of their reproductive healthcare, and the obligations that healthcare workers have in providing this care. The section further examines how the study participants understood these rights and obligations and tries to discern from where these understandings derive. The ways in which healthcare practitioners implement these rights and obligations – i.e. the actual practices of reproductive healthcare – are addressed in Part III of this report. This distinction, however, between law and practice, is not always clearly maintained by the healthcare workers themselves. To some extent, therefore, this section also speaks about how healthcare workers actually provide reproductive care to children and teenagers. We address this under the headings: training on working with teenagers, training on relevant legislation; knowledge of the legal ages of consent for sex, terminations of pregnancy and contraceptives; knowledge of the confidentiality obligation and reporting duties.

### **Training on Working with Teenagers**

None of the clinic practitioners had access to any written guidelines or policies that applied specifically to healthcare for teenage patients. Although the participants knew of policies that were in place for particular healthcare services, such as HIV care or terminations of pregnancy, these reportedly address patients of all ages and are not specific to teenagers. One respondent from a youth clinic said that there are very specific written policies, but this participant seemed to be referring to particular rules



that applied to teenagers within policies on particular issues (e.g. an HIV test is mandatory for teenagers receiving treatment through the STI Programme). A couple of the respondents seemed to think that such policies exist, but they were very vague in describing them, were unfamiliar with the policies and/or thought they would be able to access such policies should they feel it was necessary. One of these respondents was a health promoter and seemed to be referring to policies that would address educational aspects of healthcare. The other, a nurse, stated: "Ahh, there is supposed to be but ... umm, when I don't know something I ask one of the other Sisters who is [here] longer than me" (RHC3). Others referred to legislation and general principles, such as the Children's Act, the Patients' Rights Charter, informed consent and confidentiality.

Only one respondent, who worked at one of the youth facilities, made clear<sup>198</sup> reference to, and had an accessible copy of, a specific policy applicable more generally to adolescent healthcare, namely the "Policy Guidelines for Youth & Adolescent Health." This is a detailed document from 2001<sup>199</sup> that covers the legal framework relevant to teenage health, as well as 'guiding concepts', 'general strategies', 'intervention settings' and 'health priorities' for this age group. This policy document has not been updated since the enactment of either the SOA or the Children's Act.<sup>200</sup>

Respondents were asked whether they had received specific training for working with teenage patients. Only one clinic nurse said she had attended a week long course on adolescent health that focused on the management of young adult patients, which she found very helpful. A few others (n=5) mentioned specific instances in which adolescent care was addressed in the context of particular training sessions or courses. These included: specific references made in a presentation by a visiting gynaecologist; a counselling course in which teenage patients were specifically addressed; and family planning courses which provide specific guidelines for working with teenage patients.

Information about these family planning courses – and those parts that relate specifically to teenagers – was varied, suggesting that this is not standardised, mandatory training. According to one nurse, the family planning course was a three-week course offered by the Human Resources Development section of the Regional Office of the Department of Health, which taught nurses how to handle teenage sexuality and family planning and pregnancies. This interviewee thought that all clinic sisters (at her clinic) would have attended this course, but this did not appear to be

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<sup>198</sup>It was unclear whether RHC 13 also made reference to a particular policy on adolescent health.

<sup>199</sup> The reference that the researchers noted during the interview indicates that this policy was published in 2006. The only policy with this title that could be found on the DOH website, however, refers to a policy published in 2001. Since the clinic had been unable to provide the researchers with an actual copy of the policy, the reference to "2006" may have been a scribal error.

<sup>200</sup> These policy guidelines, dated September 2001, are still listed as current on the Department of Health's website: <http://www.doh.gov.za/docs/policy/2001/part1.pdf> (accessed 22nd November 2012). We contacted the Department of Health to confirm, and were told this Policy Guideline was currently under review but with no dates in place for publication of an updated version. Adolescent reproductive and sexual health care is also covered within the general National Contraception Policy Guidelines (2001) which are expected to be re-published in a revised and updated version in early 2013. There is a further policy document, 'Policy Guidelines, Child and Adolescent Mental Health', dated 2008, but this only indirectly refers to adolescent reproductive health care (in the context of children at risk of sexual abuse) and does not reference the legislation under discussion in this study.

the case at other clinics. One other nurse mentioned a family planning course that addressed teenage patients, but said that “[M]ostly we teach ourselves” (RHC 8). According to this respondent, the City of Cape Town does offer a six-month course on family planning and reproductive health, but she had not yet received this training. Another respondent who mentioned a reproductive health course said that the course did not include a specific section dealing with teenagers. The two health promoters each mentioned specific training, although the information provided was vague and very different: one mentioned a youth educator course that she attended about twenty years ago, which was a few months long and run by the Department of Health. The other mentioned a five-day workshop.

Overall, the findings suggest that there is no standardised training course or workshop that focuses on the management of teenage patients that all healthcare workers who provide services to this population are required to attend. There is also no up-to-date policy that provides guidance to healthcare workers on the management of teenage patients.

## **Training on relevant legislation**

As set out in the policy review above, the new Children’s Act was enacted in 2005, although it was not fully in force until 2010. As of the period in which this research was conducted (interviews were conducted between November 2011, and June 2012), most (n=13)<sup>201</sup> clinic participants said that they had received no specific training on the Children’s Act or that they did not know whether they had received such training. In some cases participants mentioned that they received notices and/or copies of the new legislation but no specific training, while others indicated that they had had some training on the Children’s Act, but not in recent years, such as in their general nurse’s training or in a previous job (e.g., as a school nurse). One respondent said that she had attended a presentation given by a social worker, but noted that there had been many questions that the social worker had been unable to answer in terms of the new Act. Regarding this and other relevant pieces of legislation (e.g. the SOA), respondents reported that it is sometimes the case that one or more clinic workers will go to a particular training session and will either report back to the others, or will be looked upon as the person designated to deal with those issues.<sup>202</sup> The absence of specific, standardised training on the new access to contraception provisions contained in the Children’s Act is problematic, given their centrality to the work that reproductive healthcare clinic workers provide. Indeed, this lack of training is reflected in the level of knowledge nurses showed when asked about particular issues, such as the age of consent for access to contraception, as discussed further below.

Training on the Children’s Act was sometimes combined with training on the SOA. Although this is not necessarily problematic – and indeed is perhaps useful, given

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<sup>201</sup> One respondent was silent in answer to this question but the interviewers were given that her silence meant she had not received any such training (RHC16).

<sup>202</sup> Regarding the Children’s Act, a respondent made this comment as a general statement but said that she could not remember whether she had received training or whether her colleagues had been trained and given her feedback.

problems pointed out in the relationship between these pieces of legislation – researchers had the sense that the primary concern in these workshops was child abuse and not the more common issues, such as access to contraception and consensual sex between teenagers. Thus, only one of the participants who worked at a designated TOP facility said that she had received training on the Children’s Act, in the context of training on sexual assault. Two other nurses mentioned receiving limited information,<sup>203</sup> while three other nurses said that they had received documentation on the Children’s Act to read in their own time.<sup>204</sup>

It is perhaps not surprising that only two of the respondents – a head of nursing services at a designated TOP facility and a facility manager at a clinic – had received specific training on the NHA beyond his or her general nurse’s training, since the NHA is a more general piece of legislation that deals with a wide variety of issues related to healthcare management. As with the Children’s Act, a couple of participants noted that they were given copies of relevant legislation, and that the supervisor “lets us read the policies when they arrive” (RHC 8), but that they did not receive any training as such. It is significant, however, that healthcare workers do not have periodic workshops that deal with fundamental principles like confidentiality, which are likely to raise on-going challenges, particularly when working with children and teenagers.

Most participants (n=18) had also not received any training on the new SOA, although one clinic nurse said that she would be attending a training course within the next few months. As noted above, two of these nurses explained that there were designated sisters at their facilities who had attended such training, such that any questions on this subject would be referred to these sisters.<sup>205</sup>

Five nurses seemed to have received more substantial training on the SOA. The content of these workshops varied. One workshop focused on completing the J88 form, whereas another was a three day seminar given by Rape Crisis five years previously (which would have been around the time that the new SOA was enacted). Four<sup>206</sup> participants referred to two or three day training workshops conducted by the Department of Health whereas another described the workshop she had attended as “quick-quick,” noting that they went through the “referral system for children” together with workshop participants from social welfare (RHC 2). As a clinic nurse, this final healthcare worker did not seem to consider this training to be particularly relevant for her job, since she thought most sexual offence victims went to the hospital (for forensic examination) rather than the clinic. This attitude seems to reflect a stereotypical understanding of sexual offences, as a once-off stranger-rape incident that is reported more or less immediately to the authorities.<sup>207</sup> It does not consider

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<sup>203</sup>One nurse spoke of a three day informal training workshop given by the Department of Health, while another vaguely remembered a talk of some kind given by a doctor at the facility.

<sup>204</sup> These respondents mentioned: receiving an email (TOP6), a paper to read (TOP7) and one said merely she had been ‘sent something’, (TOP9).

<sup>205</sup> One of these respondents was from a designated TOP facility and one was a clinic nurse. The former respondent thought this was a two week training course, last held in 2009 and conducted by the Department of Health.

<sup>206</sup>In one case, the training was ten years previously.

<sup>207</sup> This understanding may be perpetuated by the lack of guidance materials available on sexual offences, at the time of writing the only guidelines published by the Department of Health are detailed medico-legal protocols for the examination and treatment of survivors of sexual offenses, which are applicable in cases where a person has

long-term sexual abuse, for example, which seems far more likely to be first reported at a clinic than a hospital. This limited understanding of sexual offences was echoed by others and at other points in the interviews, as many participants (n=11) tended to see sexual offences as outside of their area of expertise or responsibility. Furthermore, they generally referred patients who disclosed an experience of sexual abuse to a social worker and felt it was the social worker's job to make whatever reports were required. One participant thus said when asked about training on the SOA: "Let me see, am I a police woman now?" (RHC9).

Three nurses also mentioned covering sexual offences in their general nurse's training, while another participant, who had previously been a school nurse, recalled that "[t]here were workshops around while I was a school nurse" (RHC 12), however she could not remember details about a specific workshop on sexual offences or abuse that she had attended, except that it would certainly have been more than three or four years previously.

By contrast, more than half of the participants (n=17) had received some kind of training on the CTPA.<sup>208</sup> This included practical training on terminations of pregnancy (n=2), theoretical training (n=2), counselling for TOPs (n=3) and/or values clarification (n=5).<sup>209</sup> Surprisingly, only four of fifteen nurses working specifically in designated TOP facilities had received any such training. Training was inconsistent with some nurses attending formal workshops organised by the Department of Health or NGOs, while others referred to more informal processes such as discussions in hospitals.

In summary, none of the nurses mentioned participating in training offering skills to better communicate with and address the needs of teenage patients. The findings further reveal that many healthcare providers who were interviewed have not received specialised training on the rights of children and teenagers and on the obligations they have as healthcare workers under the new reproductive healthcare framework established by the Children's Act, the CTPA and the SOA. Where training has been provided, it appears that it has not been comprehensive, integrated or standardised. As the next section demonstrates, this lack of standardised and integrated training is reflected in the different levels and pieces of knowledge that healthcare workers had on certain aspects of these laws, and in the sense of confusion explicitly expressed by some respondents as to how to make sense of their multiple duties and responsibilities under these laws.

## **Knowledge of the legal ages of consent for sex, TOPs and contraceptives**

As noted above, the Children's Act and the CTPA give girls the right to access a TOP

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reported a rape, immediately after the fact, rather than report of a longstanding situation of abuse (Criminal Law [Sexual Offences and Related Matters] Amendment Act Regulations [DoJCD, 2008]) .

<sup>208</sup> The answer of one of the respondents was unclear, although she said she had received training "very long ago" (RHC2) and is thus included in this number. This question was not asked in one interview, (TOP2)

<sup>209</sup> Some participants did not indicate the focus, or recall details of the training they had received (RHC1, RHC2, TOP9, TOP1 and TOP2). In two cases, both the counselling and value clarification training was apparently a part of the reproductive health course given by the Department of Health.

confidentially and without parental consent at any age, and the right to access contraception in a similar manner from age 12. While knowledge of these rights is not a guarantee that they will be implemented – as we shall see in below – making sure that healthcare workers receive this knowledge is a critical first step to ensuring access to these rights. This section thus sets out the findings on healthcare workers' knowledge of the legal ages of consent for sex, terminations of pregnancy and access to contraceptives.

### ***The age of consent for sex***

Only six of the 28 participants (three of the 13 RHC respondents and three of the 15 TOP respondents) knew that a teenager can give legal consent to sexual relations at 16 years old.<sup>210</sup> Among the incorrect answers given, three respondents thought the age of consent was age 12; two that it was age 15; three that it was age 18; one that it was age 21. Three nurses answered that they did not know what the age of consent was; and one that expressed it was a “personal choice” (since they do not need parental consent for family planning or a TOP [RHC15]). This lack of knowledge is perhaps not surprising, given that the law provides teens the right to contraception at a younger age and the level of confusion some nurses expressed in this regard. All of these RHC respondents also later said that it is against the law for teenagers under this age to have consensual sex,<sup>211</sup> although in some cases the line between what respondents thought *was* against the law and what they thought *should be* against the law was very blurred. These issues are discussed further in this section below.

Although most of these respondents were consistent when we compared what they said about the age of consent and their responses on the lawfulness of consensual sex between teenagers, the RHC respondent who said that the legal age of consent for sex is 12 also said that it is against the law for teenagers to have consensual sex.<sup>212</sup> Similarly, one of the TOP respondents thought that a girl could consent to sex at any age (from the time that she could become pregnant), but also noted that she had a legal obligation to report such consensual sexual relations between teenagers. The apparent inconsistency between these responses can perhaps be partly explained by the different ways in which the term “consent” is used. If we talk about “consensual sex” between teenagers under the age of 16, then clearly there is a sense in which children of this age can give “consent.” This is the difference between offences like rape and the offence prescribed by section 15 of the SOA<sup>213</sup>. These different uses of the term “consent” were also evident in other responses. Thus, in one case, when asked about the age of consent, the participant responded, “I can’t tell you that one

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<sup>210</sup> One respondent was unsure whether it was 16 or 14 now.

<sup>211</sup> Clinic participants were asked about the legal age of consent for sex in two different ways. They were first asked about this near the beginning of the interview, after a number of background questions and a series of questions on the training they had received around the reproductive healthcare rights of teenagers. Later in the interview, as a prelude to the questions on mandatory reporting, they were asked specifically whether they thought it was legal for teenagers below the age of 16 to have consensual sex.

<sup>212</sup> On the other hand, the TOP respondent who said that 12 was the age of consent was not aware of any legal obligation to report consensual sexual relations between teenagers (she was not explicitly asked whether this was against the law).

<sup>213</sup>Section 15 of the SOA relates to ‘Acts of consensual sexual penetration with certain children (statutory rape).’

because they give consent but I don't think they know what they are doing." (RHC2). When asked more specifically about "what the law requires," however, she responded that pregnant children under the age of 16 are reported to the police and to social services, adding "it's rape, even if they gave consent" (RHC 2).

The confusion surrounding this term reflects the law's ambivalent attitude to teenage sexuality: on the one hand the SOA recognises that a young teenager's consent to have sex with another teenager cannot be entirely disregarded and that this is not the same as an act of coercion; at the same time, it seems to insist – by criminalising this behaviour – that children of this age do not have the emotional and psychological maturity to make healthy and safe autonomous decisions about sex.<sup>214</sup>

Another factor that created confusion for healthcare workers around the age of consent for sex is what they understood from the inconsistent messages conveyed by those laws that regulate access to contraception and TOPs on the one hand, and the age of consent established by the SOA on the other. Thus, one respondent said: "The media says 16, then 18, then 21 another day. They have sex from 12, they have TOPs" (RHC7). Another nurse, who did not know what the age of consent for sex is, explained why she was perplexed:

*... That is my concern. That is what is confusing us ... Because for the TOP, they said we can ... refer someone from the age of twelve years ... because that twelve year [old], according to the government, is allowed to have sex ... (RHC14).*

Three other RHC respondents made similar statements, which refer to the age of consent for accessing family planning as an indication of the age of consent for having sex. One of these nurses said:

*I think the law says it's ok [for teenagers to have consensual sex] because the law is saying that you can have an abortion at the age of 12, then they can have family planning at the age of 12, so I think the law says yes" (RHC17).*

This confusion was also evident in the failure of many participants (n=13) to distinguish in their answers between questions of law and practice – in other words, what teenagers are legally permitted to do and what they do in practice. In response to the age of consent question (for having sex), for instance, one respondent, said: "12... it's legal to give family planning from 12. We can't decide on the law. We can't tell them when [sex] is legal. (RHC7).

Further, a number of respondents failed to distinguish between normative/descriptive and prescriptive questions that were asked regarding the age at which teenagers are allowed (prescriptive), or should be allowed (normative), to have sex. After asking about the age of consent for sex, participants were asked whether they thought it "was against the law" for teenagers to have consensual sex,<sup>215</sup> and then whether they

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<sup>214</sup>This ambivalence is discussed further below.

<sup>215</sup> In four interviews this was followed up by a question of clarification, such as "It is against the law?" (RHC3) or "Is there any law which makes this illegal?" (RHC2). The follow up questions was also phrased as: "Right, so you, think that it should be illegal," (RHC10) and "But do you think umm that the law says that they're not allowed?" (RHC17)

thought consensual sexual relations between teenagers *should be* against the law. A number of respondents, however, responded to the prescriptive question (*is* it lawful for teenagers to have consensual sex?) with a normative response (*ought* it to be lawful). In some cases, responses also blurred the lines between these different types of answers. Thus, in response to the prescriptive question, one nurse said: “No, shouldn’t be legal. It isn’t legal. Ok. It’s rape according to me” (RHC 1). Similarly, another participant initially responded to the foregoing question as follows: “No. No they are still children in my eyes, I don’t think their bodies are developed for that, I don’t know how to put it, but they are still babies” (RHC2). Only after the interviewer prompted the participant to focus on what the law actually says (“Is there any law which makes this illegal?”) did the participant respond more accurately to this question. In both cases, when prompted about the law, the respondent relied on her knowledge of her reporting obligation to deduce that there must be a law that makes it illegal for teenagers to have sex, though she did not mention any law by name.

These disjunctures between prescriptive questions and normative answers, and the tendency to focus on practice, or to respond in terms of what one thinks ought to be the law, (rather than what the law is), suggest that the law is actually of little help to those working at service delivery level. What the law says does not feature as an important factor in the way healthcare workers think about and deal with these issues. These normative answers may also be a way for respondents to “cover up” their lack of knowledge, (in other words, since I don't know what the age of consent for sex is, I will tell them what I think the age of consent for sex *should* be) but these responses nevertheless highlight the strong opinions that some healthcare workers have on these matters, which in some cases are reflected in the ways in which they implement their duties.

### ***Age of consent for TOP***

As noted above, the CTPA established the right of any female person, of *any* age, to have a TOP, without parental consent, during the first 12 weeks of gestation. Only one of the participants from each type of facility knew this to be the case. Quite a few of the respondents (n= 4 for TOP respondents and n=7 for RHC respondents) thought that the age of consent for a TOP is 12 years old,<sup>216</sup> while others thought girls had to be 13, 14, 15 or 16 years old to give consent for a TOP. Two RHC participants and one TOP participant said that they did not know.

As with responses on the age of consent for sex, a couple of participants reported on practice, when asked about the law. One said that they refer children of all ages for a TOP and that it is the doctor who performs the TOP who would determine whether the “age factor is right” (TOP 11). Likewise, in another case, having told us that she thinks the age of consent for sex is 18, we asked one of the nurses who actually worked in a designated TOP facility whether this is the same as the age of consent for a TOP. She replied:

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<sup>216</sup> Two RHC participants were not asked about the age of consent for a TOP. This question was added to the questionnaire after the initial round of interviews.

*No, it's a different age. Our age groups here becomes ... or the clients that we saw, the youngest ones is from 14 years old. I mean paediatrics is must under, under, um, 13, so anything above 13 is not paediatric anymore ... According to our statistics (TOP7).*

These findings show that most of the nurses interviewed, including those who provide TOP services in designated TOP facilities, do not know that a pregnant girl has the right to access a TOP at any age. In part, this may be explained by the fact that few nurses may actually be confronted with really young patients requesting TOPs. Thus, those nurses who said that the age of consent for a TOP is 12, or even 13 or 14, may not have had experience with or considered the possibility of younger patients. The findings also suggest, however, that some nurses are not overly concerned with legal prescriptions, perhaps being more focused on the practicality of providing care.

### ***Age of access to contraception***

The Children's Act protects the right of girls to access contraception without parental consent from the age of 12.<sup>217</sup> Only six RHC practitioners stated that 12 is the legal age for providing contraception.<sup>218</sup> Responses from other participants were again based on practice: two nurses said that they would provide contraception to twelve year olds, but this was not necessarily based on their understanding of the law. Two other RHC nurses said they would provide contraception without a parent from the age of 15,<sup>219</sup> whereas another two said that the legal age of consent for contraception is 14. In practice, however, one of the latter respondents said that nurses used discretion in deciding whether to provide contraception to younger children. The factors on which she based her exercise of discretion included whether the girl was sexually active and the age of the girl's partner: if the girl's boyfriend was only a year or two older, she would "maybe still consider giving her family planning" (RHC 6), but if her partner was a much older man she would probably refer the girl to the social worker, which would likely result in the girl being told to fetch her parents. In the end, she asserted that it is:

*... An individual choice and responsibility that you have to take after a judgment call. Sometimes you will start them on family planning, even if they are a very*

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<sup>217</sup>Two RHC participants were not asked about the age of consent for contraception. This question was added to the questionnaire after the initial round of interviews.

<sup>218</sup> In the first round of interviews, however, this question was asked in terms of practice; "at what age do you provide birth control?" (RHC1, RHC2 and RHC3). The question was revised before the second set of interviews so that the question was more clearly aimed at knowledge of the legal age of consent. It was then asked in a series of questions around the legal age of consent for sex, a HIV test, a TOP and lastly, birth control, in a variation of question form "what is the legal age of consent for...?" In ten of these interviews the word 'legal' was included in the question and of these, four respondents answered "12" (RHC5, RHC7, RHC8 and RHC12). In four other interviews, however, the question did not expressly include the word legal and was asked as "what is the age of consent?" these four responses only one answered age 12. Where interviewees were uncertain in their responses to the age of consent question, a follow up question asked at "what age would you provide contraception if a child comes without her parents?"

<sup>219</sup> This respondent clarified her initial answer of 15 after further questions and noted that if the child was menstruating and was sexually active and had come to the clinic without her parents she would provide contraception if the child was over 12.



*young age, and they are sexually active in any case (RHC 6).*

Other respondents were unsure whether the legal age was 12 or 14. For one of them, her uncertainty was exacerbated by what she saw as her contradictory obligation to report a child who has sex under the age of 16:

*[T]here's contradicting things because there's some that say 12 [years] and some say 14 [years] you see ... and there's also contradicting where there must be ... notified ... [to] the police ... if they have sex before 16, so that is very confusing. I mean you must have ... the patient is relying on you for ... confidentiality. That's what [it] is, and then the law says I must be reporting her, so where is confidentiality? ... That's one of the most contradicting things that we got (RHC 4).*

Similarly, another of the participants also expressed confusion on this question. When asked specifically what she would do if a 12 year old requested birth control without her parents' consent, she replied: "That is very difficult ... If that twelve year old can come and request for a TOP ... why can't I give her family planning?" (RHC14). When pushed further on this question, the nurse eventually replied that "for me personally, I give [contraception], because that person, if that twelve year old ... can go for a TOP, why can't I give her an injection?" (RHC14). Thus, while this practitioner was, in fact, observing the law correctly, from her own perspective she was exercising her own judgment, which attempted to reconcile her own understanding of a number of potentially conflicting and confusing legal duties that she had.

Three participants said that they would provide contraception from the time a child has begun to menstruate, although one of them thought the child would have to have a guardian with her if she was nine years old. Another two participants said they would provide from whenever the child became sexually active. At least two of these responses seemed to be based on practice, rather than an appreciation of the law. Thus, one of these respondents stated:

*Birth control is as long as the child is sexually active and has had the periods for more than a year. If she had her menstrual periods for more than a year, she can start the contraception.*

***Interviewer: So does it matter what age she is, or it's just whether she's uh started her periods?***

*And she's sexually active*

***Interviewer: And sexually active. At any age?***

*Yes...Usually it is twelfth, from twelve years onwards they start. Because you find out they get babies at thirteen (RHC 10).*

Another respondent similarly was most concerned with whether the child was sexually active in practice, noting that teenagers usually came for contraception from age 13. Interestingly, a number of participants (n=4) at the reproductive health clinics noted

that, in practice, young girls (of 12 or 13) requesting contraception were usually accompanied by a parent. Indeed, in some cases, it was the parent who was requesting that the child be provided with contraception – sometimes against the will of the child, who did not want to receive an injection, one of the common methods of family planning.

Nurses who worked in a designated TOP facility, were less knowledgeable about the age at which a girl may legally be given contraception<sup>220</sup>, even though they were often responsible for discussing contraception in pre-TOP counselling, and for providing the first post-TOP contraceptives.<sup>221</sup> Only one of these nurses said that the age of consent for contraceptive treatment is 12. One nurse said that she doesn't know.

Like the RHC nurses, responses of some TOP nurses also reflect a focus on practice and care-giving, and confusion deriving from other legal and professional duties. Thus, one nurse was uncertain about the legal age for contraception and spoke about when girls actually come to request this. On consideration, she thought the answer would be as soon as the girl is sexually active and gets normal periods. Similarly, one of the respondents said she thought the age of consent was 11, but immediately added that:

*I mean as long as she is sexually active and requires family planning, we cannot deny her family planning. If she is eleven years old, menstruating already, and has decided to go to family planning, we are not going to say, 'we're not going to give' [family planning] (TOP13).*

In another instance, referring specifically to the example of a 14 year old girl who requests the “morning after pill,” a TOP nurse first said; “that it is the girl's choice, just like a request for a TOP”. When asked, however, whether there was any age at which she would not respect the child's choice, she referred to her obligation to report underage sexual relations to the police, suggesting that she was not sure how this new obligation might impact on her responsibility to provide reproductive healthcare. She was very uncertain as to the nature of this obligation (and was mistaken, in fact, in terms of the age at which reports were required):

***Interviewer: But would you do the same if the girl is 12 years old or 10 years old? Is it always the same? Would you always say 'it's her choice' or is there some age where you'd say, 'no I wouldn't give [contraception] to her'?***

*Um, the latest thing came up with us now. Um, and I'm not so sure where I read it or heard it but it was quite recently where they said, 'actually before the age of 15, you're actually supposed to contact the police'. ... If it was now a sexual assault, you know. (TOP7).*

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<sup>220</sup> In five interviews the respondents were asked a series of questions relating to the legal age of consent for sex, a HIV test, a TOP and lastly, birth control/contraception. In two interviews, however, the question was asked as 'the age of consent' without specific mention to the law.

<sup>221</sup> Three TOP participants were not asked about the age of consent for contraception. This question was added to the questionnaire after the initial round of interviews.

Once again, these responses suggest that what is permitted by law is simply not a consideration that is weighed heavily by these practitioners. The focus here is on providing care and protection, which is completely at odds with an arbitrary age established by law. While some are aware of their legal obligations, many have inadequate knowledge and some are confused by the knowledge they do have and the seeming conflict between their various legal duties.

## **Nurses' awareness of confidentiality and reporting obligations**

Nurses were asked about confidentiality and exceptions to the rule of keeping all health-related information of a patient confidential. As set out in the policy review section, confidentiality granted under the NHA can be overridden by a law that requires the disclosure of particular patient information. Nurses' reporting obligations under the Children's Act – the duty to report child abuse, including child sexual abuse – and the SOA – the obligation to report sexual offences between and against children – can therefore be interpreted as lawful limitations of confidentiality.

All of the participants were very familiar with their obligation to keep all matters between them and their patients confidential. A few of them (n=3) spoke explicitly about this obligation being necessary for maintaining their patients' trust. As one nurse warned expressly, if confidentiality was broken there was a danger "that child won't trust you anymore" (RHC11). A similar connection was inferred by another participant when asked about her reporting obligations:

*To me it's such a delicate situation that you, I don't feel I must be the one reporting it, because I must ... have that rapport with my patients so if that happens then it's broken, I mean then that patient doesn't come back to you with other stuff and I mean we usually the people that come to with anything (RHC4).*

Likewise, another healthcare worker feared that if she reported sexual activity to the police, the children may not "come back here afterwards"(TOP1). Two other respondents also spoke implicitly about confidentiality and trust in the context of reporting obligations. Thus, one nurse stressed the importance of her patients having "confidence" in her (RHC2) while another was insistent that she would "put her client first" (above her duty to report) (RHC5). Other respondents were equally aware of their confidentiality obligation – and seemingly held it to be equally important – but did not speak about the link between confidentiality and trust. Thus, for example, one of the health promoters felt the idea of breaking patient confidentiality would "not be professional" (RHC15).

Responses were uncertain and varied, however, when asked directly whether there were any exceptions to the confidentiality rule: only three of the respondents said

they must report pregnant teenagers (under age 16<sup>222</sup>) to the police (n=2) or to a social worker (n=1); and three mentioned their obligation to report in cases of rape, incest or molestation, or to break confidentiality in a life-threatening situation. Other exceptions mentioned included: disclosure to other healthcare professionals; if necessary for the patient's health; in accordance with a court order; or if the child was younger than 12 years old.

A few of the respondents were more ambiguous, as they were clearly struggling with the gap between what they knew to be the legal rule and the practical application of their confidentiality obligation. As one nurse expressed:

*No exceptions [to confidentiality], but it depends on the situation. For example, a 13-year-old came for family planning. She wasn't sexually active, she was HIV positive, and she was pregnant. You can't talk to her alone, you need the parents. You have to get her consent, you have to convince her, but she's not happy. You can't really talk to a 13-year-old about HIV and pregnancy on their own. We can't start a child on ARVs. The mother was very angry. We had to break confidentiality. They need parents for support (RHC8).*

The fact that so few respondents mentioned their reporting obligations when asked about exceptions to the confidentiality rule is explained, in part, by the fact that so few respondents were aware of their obligation to report underage sexual activity, as indicated below. Another factor may be that some of the nurses do not see reporting to a social worker as a violation of confidentiality, particularly when that social worker is based at the same healthcare facility. A further possibility is that reporting did not spring to mind as an exception simply because this obligation is not one that healthcare workers generally implement.

As discussed above, the Children's Act places an obligation on health-care professionals to report cases of child abuse, including sexual abuse, to a social worker or police officer, and the SOA also creates an obligation to report sexual offences against children including 'consensual' sexual acts between teenagers that constitute statutory rape or statutory sexual assault. The Act also stipulates that they must inform the police immediately.<sup>223</sup>

Because sexual abuse was not a focus of this study, participants were not asked specifically whether they knew they had an obligation to report sexual abuse of a child to the authorities. They were asked, however, whether there was a particular protocol they followed in practice when a patient disclosed that she had been sexually abused, and whether, in practice, they reported such cases to a specific authority.<sup>224</sup> In fact, only one of the healthcare workers interviewed for this study referred to specific, written policies that provided guidance in dealing with situations of child sexual

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<sup>222</sup> One referred to a 13 year old patient, but was not implying that this exception would not apply for an older child.

<sup>223</sup> Section 54(1)(a) of the Sexual Offences Act.

<sup>224</sup> This question was not asked in one RHC interview, nor in three TOP interviews,

abuse. This had been written by the social worker at the hospital.<sup>225</sup> While a number of other participants (n=4) referred to the existence of a written protocol, none of these seemed to have access to it, to have consulted it or to be aware of its content.<sup>226</sup> Ten participants referred to an informal protocol of referring the patient to either a social worker or more experienced medical colleague and three others relied on their own knowledge of what to do from their nursing training. As one of these nurses said: “we just know it from [the] law, but we don’t have something tells us step by step” (TOP10).

These responses highlight the lack of clear policy and guidelines for dealing with the disclosure of child abuse in a healthcare setting. At the national level the detailed medico-legal protocols for the examination and treatment of survivors of sexual offenses<sup>227</sup> are not particularly relevant, as they relate to the medical examination of a person who has reported a rape, immediately after the fact, rather than report of a longstanding situation of abuse. From this study it would appear that even at the local clinic level there are no policies in place to deal with reports of such abuse. This is very problematic as it is clear from this study that the majority of the participants (n=19)<sup>228</sup> have had patients who have disclosed situations of abuse. This is discussed further below, where we review the findings regarding healthcare workers practices in reporting abuse.

A more central question in this study was whether healthcare workers were aware of their more recently imposed obligation – whether in terms of the Children’s Act or the SOA – to report consensual sexual acts between teenagers to the authorities. A minority of respondents (n=11) were aware that they have such an obligation.<sup>229</sup> Indeed, when asked whether they were aware of laws that require them to report consensual sex between teenagers, some healthcare workers were bemused by the very idea. As the next section of this report shows, the fact that many healthcare workers are not aware of their obligation to report consensual sex between young teenagers does not necessarily mean that they do not do so – at least to social workers – in cases of pregnant teenagers, and in spite of their obligation of confidentiality. Reporting of pregnant teenagers without being aware of an obligation or justification to do so suggests that healthcare workers may not feel equipped to provide the range of support that young pregnant teenagers need, even before they have made a decision about terminating the pregnancy, and have a need to share this burden.

Overall, the findings reviewed in this section of the report suggest that most

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<sup>225</sup> When asked for more information about its content, the participant was uncertain. She went on to explain that usually the parents and the police are called, but that in some cases, for example, if the patient changes her story about having been sexually abused or raped, then she will decide who to call according to the individual circumstances (TOP5).

<sup>226</sup> In one interview the recording stopped (due to technical problems) after the question about existing policies. The respondent is only recorded as answering ‘yes’, so it is unclear whether these policies were written or practical (RHC7).

<sup>227</sup> See footnote 191 above.

<sup>228</sup> Six of these participants have had numerous or ‘many’ patients disclose sexual abuse to them.

<sup>229</sup> One of these respondents answered that she was aware of a law that required her to report consensual sex between teenagers but when asked what she thought about this law she spoke about the need to support rape victims and seemed unclear of the distinction of consensual sex between teenagers and sexual abuse (TOP8).

healthcare workers do not receive specialised, standardised training that would support the reproductive healthcare work that they do with teenagers. The findings further suggest that healthcare workers are not well informed about the new legal rights and duties that have been granted and imposed by the CTPA, the new Children's Act or the Sexual Offence Act. Moreover, some of the findings reflect a disjuncture between questions on legal age restrictions (for sex, contraception, TOPs and so forth) and responses that relate to practice or opinion, suggesting that the practice of healthcare workers is perhaps driven more by patient need, considerations about feasibility or nurses' values and beliefs than by seemingly arbitrary legal rules. The next section looks more closely at the actual practices described by healthcare workers in providing reproductive healthcare education and reproductive healthcare and in fulfilling reporting obligations.

## Implementation of legal duties

While the previous section provides information as to the knowledge healthcare workers have of their various legal obligations, this section looks at the way these obligations are carried out in practice and explores the gap that exists between law, to the extent that it is known, and practice. In order to help shift our attention to practice, this section distinguishes between the different roles and responsibilities that are supposed to be implemented by reproductive healthcare professionals, rather than focusing only on specific legal rules. At a minimum, these roles include those of educator, caregiver and law enforcer. While examining the ways in which these roles and responsibilities are actually carried out by health-care providers, particular attention is paid to the challenges they face in fulfilling certain roles, and the choices they make when faced with conflicting duties. By focusing on these issues, this study illuminates some of the unresolved or controversial questions we confront as a society around teenage sexuality.

### Nurses as Educators

As noted above, consistent with global trends, South African health care policy has expanded the role of health care providers to include "the promotion of health and family planning by teaching to and counselling with individuals and groups of persons."<sup>230</sup> Within such a healthcare paradigm, nurses are perceived as an important link to the community and increasingly find themselves with more community-oriented duties. The findings reviewed above suggest that the health care providers who participated in this study have internalised and embraced this role. The data, however, suggests that these workers face a number of challenges in providing reproductive healthcare education, which has no standard format or content, and for which healthcare workers have not been adequately trained. The findings described in this section show how some healthcare workers think about these challenges; how they

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<sup>230</sup> The South African Nursing Council Regulations Relating to the Scope of Practice of Persons Who are Registered or Enrolled under the Nursing Act, 1978, Government Notice No. R. 2598, 30 November 1984 as amended by: No. R. 146 10 July 1987; No. R. 2676 16 November 1990; No. R. 26015 February 1991.

manage this aspect of their jobs and how they exercise their discretion in determining the message and information they try to convey to their patients. In particular, the findings suggest that the lack of standardisation makes space for an infusion of values and morality into healthcare and for the types of judgment and lecturing that teenage patients find so problematic when accessing reproductive health services. The findings further suggest that the new Children's Act provisions, which seek to invest young teenagers with greater autonomy, may exacerbate this situation.

Before turning to these findings, it is important to note a key distinction between two different aspects of healthcare education. The first involves teaching the physiology and mechanics of sex and contraception. The second deals with more holistic education around sexuality, relationships, lifestyle and healthy choices. The need for better reproductive healthcare education and the challenges healthcare workers face in providing both types of education were spoken about at a number of points during the interviews and included logistical challenges as well as communication and attitudinal challenges.

### *a. Structural Challenges*

The logistical challenges mentioned by participants related mainly to the provision of technical, physiological information about sex and contraception – the type of information that both Wood et al. and Ehlers' research found was lacking among the teenagers in their respective studies.<sup>231</sup> The majority of the participants (n=17/28) mentioned the need for better sex education in schools. Half of the participants (n=14), for example, spoke about difficulties in gaining access to schools to provide information on reproductive health services. Barriers discussed included time and manpower constraints, such as the closure of school clinics or removal of school nurses; restricted access by education officials; and the reluctance of parents to have sex education taught in schools. Four health workers, who were able to access schools, voiced frustrations about restrictions on the kind of information and services they were permitted to provide (e.g., condom use demonstrations and the provision of methods of contraception). For example, nurses described:

***Interviewer: What do you think could be done to reduce the number of teenage pregnancies?***

*Oh I think education. In schools. You know that we're not allowed to go to the schools to talk about condom use.*

***Are you not allowed?***

*No. You can put [condoms] down but you're not allowed to talk about it. Or do demonstrations. Especially not [at] the Afrikaans schools.*

***Oh really, not at the Afrikaans?***

*No. I think they [are] so shortsighted. No we're really not allowed, I think if you*

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<sup>231</sup>Wood et al. (2006) see footnote Error! Bookmark not defined. above and Ehlers (2003) see footnote Error! Bookmark not defined. above.

*...speak to any of the Sisters at the clinic they say we're allowed to go and put the condoms in the, in the toilets whatever, but we're not allowed to give a demonstration how to use a condom and why they should have condoms (TOP1).*

Most were confident that teenagers who actually came to the clinic would receive the necessary information. Indeed, a few of the respondents indicated that any time a teenager enters the clinic, even if accompanying a friend, healthcare workers seize the opportunity to provide this type of education. As one healthcare worker noted:

*For every teenage patient that comes we go through that as part of a basic integrated information that you've got to do with every patient. If they come for a coffee even, we will ask them if they are sexually active; when was their last menstruation; what are they using as family planning? (RHC6)*

At some clinics, however, time constraints also impacted on healthcare workers' ability to fulfil the role of educator. So, while all of the respondents at reproductive health clinics stated that they provided some verbal information about contraception to teenage patients, some clinics also relied on HIV counsellors or Health Promoters to supplement this function. Seven facilities had these health professionals available for teenagers and they provided information on HIV prevention and testing and also contraceptive matters.<sup>232</sup> At another clinic, volunteer counsellors from an NGO were available for this purpose. These counsellors were clearly performing an important support role for nurses who were unable to allocate sufficient time to reproductive health education for their patients. One nurse summed up the relationship: "...you know with a busy clinic that's the other thing, you'd like to give them more time but that's why we have the counsellor there"(RHC4).

These findings emphasise that healthcare education takes time and resources, which are not always available at healthcare facilities, whose primary function is to provide care. If we expect nurses to fulfil this educational function, additional resources, specifically aimed at achieving this goal should be considered, with training programs offered to all those who are actively involved in performing this task. Further, in order to reach those teenagers who do not attend the clinic, better cooperation is needed between health and education authorities to ensure that reproductive health education is widely available in schools.

### ***b. Communicating with Teenagers***

Research has shown that the way in which healthcare workers communicate with teenage patients plays a critical role in ensuring that these patients access reproductive healthcare, and that judgmental attitudes displayed by healthcare workers act as a barrier to such access.<sup>233</sup> Overall, respondents understood that

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<sup>232</sup> Interviewees were not all specifically asked about the availability of counsellors, thus it could be that this was a more common feature of the clinics than is indicated here.

<sup>233</sup> See especially the findings of Wood et al. at 113 and 116, (see footnote **Error! Bookmark not defined.** above). See also Jewkes, R., Gumedde, T., Westaway, M., Dickson, K., Brown, H. & Rees, H. (2005) Why are women still aborting outside designated facilities in metropolitan South Africa? *International Journal of Obstetrics and*



educating adolescents required a different approach than teaching adults and some were explicitly sensitive to the concerns raised by the foregoing research. Thus, for example, having been asked about the differences between working with adults and teenagers, a number of participants spoke about the challenges of teaching and communicating with young adults about sex and sexuality. In particular, respondents spoke about: the “generation gap;” how emotional and sensitive teenagers can be; being gentle; and the importance of empathy. As one participant pointed out: “You must handle them [teenagers] in a certain way, because they got their own views and you must try and understand where they coming from before you can work with them” (RHC4). Another similarly noted the importance of empathy and connection in working with teens: “You know, we need to get to their level. You need to go down to a teenager’s level and ... make them understand that you were also there” (RHC11).

While some cited teenagers’ lack of prior knowledge of sexual matters as a challenge, several participants rather thought that this made it easier to instruct them. They found teenagers were sometimes more open to suggestion, ‘full of questions’ or eager to learn and take advice than adults, and spoke of providing more detailed explanations and grasping the opportunity to teach teenagers who had little knowledge of reproductive health matters. One interviewee highlighted that this aspect of working with teenage patients added an interesting dimension to her role:

*[T]hey are also ... very very open to ... teachings so they will also ask quite a lot, they want to know about their condition; and of course they want to know about sexuality and all those types of things which you can answer again - so it’s quite interesting (TOP5).*

A number of respondents (n=7) were aware that their approach and attitude towards teenage patients had a critical impact on whether they felt comfortable using the clinic and would return for future appointments and treatment. One commented: “It’s only about your attitude and if you are speaking with the youth and they will understand us and they will come more to us” (RHC16). And further: “[B]y word of mouth if they had a good experience in the clinic they go and tell their friends and then come back” (TOP1).

Others, however, expressed frustration vis-à-vis teenagers’ attitudes and behaviour, including what one nurse described as the “never-mindedness” of teenagers (TOP2). As one nurse emphasised: “I get the idea they still think it can’t happen to them”(RHC1). Other participants felt that teenagers did not listen to the advice they were given, lied to them or were not open with the truth. In the words of one participant: “[Y]ou find that ah, they are not listening, whenever something that you say they mustn’t do, they do it” (TOP10). It is difficult to assess to what extent this frustration impacts on the way in which healthcare workers actually communicate with their patients. In some cases, however, the tone and the words that some of the participants in this study reported using sounded precisely like the type of “lecture” or scolding tone that teenagers found problematic according to Wood et al.’s study. For example, one nurse

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*Gynaecology* Vol. 112, 1236–1242, as cited by Wood et al. which found the “fear of hospital staff rudeness was a major barrier” to TOP service access and resulted in some women using illegal abortion services, at 1241.

articulated her advice to young pregnant teenagers as follows: “[Y]ou must play with your dolls – not with men. I will ask them ... ‘Don’t you know about contraception? Don’t you know about HIV?’”(RHC2).

Specific training on dealing with teenage patients could perhaps make healthcare workers more aware of the impact of their words – as well as their tone of voice – on the willingness of teenage patients to access the clinic.

### *c. Content and Format of Health Education*

A primary concern for the clinic healthcare workers interviewed for this study was to ensure that teenagers received basic information about family planning methods. Notwithstanding the occasional use of visual aids, including pamphlets, posters and pictures, all of the participants seemed to prefer giving such information verbally. Written information, in contrast, was mainly seen as supplementary or incidental. When written information was available it usually (n=13) took the form of pamphlets. One nurse noted that teenagers were not interested when they were given the pamphlets and would “chuck them” outside the clinic (RHC4). One of the clinics exhibited the same disinterest by stacking pamphlets on a shelf in the waiting room, barely visible or accessible to patients. In most clinics, however, the pamphlets were available in the waiting room for teenagers to pick up if they wanted to. One participant expressed a wish for better pamphlets that focused specifically on the needs of teenage patients. Only two interviewees mentioned they did not have access to pamphlets at all. Surprisingly, TOP facilities were not as reliable in providing basic sex education. Two of the TOP nurses answered that they did not provide any information regarding reproductive health care to teenage patients, and pamphlets or written information was reported to be available at only three of the TOP facilities.

Although most sex education discussions took place on an individual basis, three interviewees noted that teenagers often came to see them in a group, as they generally felt more comfortable when they were surrounded by their peers. In such cases, these respondents indicated they would try to speak to the girls in a group.

As noted above, however, it is accepted that healthcare workers should have a broad goals in terms of their educational role. They are not supposed to limit themselves to teaching their patients about contraception and how to use a condom (which we refer to as “sex education”) but are, in fact, expected to promote a healthy lifestyle, including healthy choices around sex and sexuality (referred to here as “sexuality education”). The findings suggest that nurses have embraced this broader educational mandate but have no clear guidelines to follow in their implementation of this role. What guidance is provided by the legislative framework seems to require an educational message that promotes abstinence, while at the same time respecting and promoting a teenager’s right to access contraception. In practice, the findings suggest that the healthcare workers in this study communicate a range of educational messages on issues related to sex and sexuality, including the messages on abstinence and access to contraception cited above. The ways in which these messages are conveyed, however, seem to be influenced, among other things, by the values held by the health worker and/or by the training that he or she has received. The findings

challenge the notion that healthcare workers can convey these conflicting messages while effectively fulfilling their primary role of providing basic sex education and healthcare.

Besides family planning methods and basic sex education, healthcare workers thus reported giving guidance or advice to their patients in connection with one or more of the following reproductive health-related issues and decisions: abstinence, safe sex, boyfriend and relationship issues (including parental relationships and abusive relationships) and counselling related to pregnancy and termination of pregnancy. Abstinence was part of the message conveyed by several of the participants in this study. In some cases, this was conceived as the primary educational message that nurses sought to convey. Thus, for example, asked about her approach when a 13 year old comes to the clinic for contraception, one participant suggested that while contraception must be provided, her main objective would be to promote abstinence:

*Because the policy says we must start at 12 years, so we do as usual; we give them the pre counselling and post counselling. They don't need their parent or guardians to come with them, so we do ... health education is the most important ... so we educate them about abstinence (RHC17).*

This approach was consistent with her view that sex between teenagers should be against the law because "they're still young" (RHC17). She was unaware, however, that such activity *is* against the law, as she mistakenly believed that since teenagers have the right to access contraception and TOPs then the law permits them to have sex. In promoting abstinence, therefore, this nurse was imposing her own judgment – whether based on her training as a healthcare professional or on her own personal beliefs – which was incidental to what she believed to be the situation in law.

Abstinence seemed to be the main message of another participant too, who reported that she told 16 year old teenagers they were too young to be having sex (RHC2) which was consistent with her strong view that sex between teenagers should be against the law (she was also one of the participants who knew that it was in fact against the law). This nurse enforced the law by reporting pregnant teenagers (but not teenagers who were merely sexually active) to the police and to a social worker. This same participant, however, also seemed to consider the abstinence message as futile. In response to a later question about providing a 13-year old with contraception, she said:

*I counsel them not to have sex but that's not going to help so I will take out my little book and sit with them tell them the pros and the cons and the condoms and safe sex and HIV" (RHC2).*

While abstinence education is a popular public health approach both in South Africa and abroad, neither of these responses appears to respect the notion that teenagers can (or should) make their own decisions about sex, and that they have the right to access protection should they decide to have sex, as permitted by the Children's Act. Although they follow the public health message of promoting abstinence, they also take a pragmatic, protectionist approach, which seeks to ensure that sexually active

patients are provided with contraception, counselled about HIV and so forth. Another participant took a more polarised approach. Although she clearly saw abstinence as one of her objectives, and believed personally that teenagers should not have sex, she rejected the notion of preaching abstinence entirely, as she saw this as an imposition of values, which might “scare off” her patients. Instead, she described an educational approach based on autonomy and choice:

*Give them all the information; find out if child is sexually active, give them info on STIs, at the end of the day, the child will learn that they are not ready to be sexually active because that information will convince them. Sometimes peer pressure forces them to become sexually active because friends are. [We] need to give them all the information, and let them make the decision when they come to the clinic. We will show the info pamphlets on STIs to the patients ... don't scare them off, don't force your values on them (RHC15).*

This participant's view is consistent with the sexual autonomy recognised by the Children's Act but is contrary to what is required under the SOA. This participant appears also to have held a mistaken view that the law permits teenagers to have sex. She was not aware of the prohibition found in the SOA or of her own reporting obligation.

These examples highlight the fact that healthcare workers do not have a uniform understanding of their legal obligations, but they also suggest that an understanding of legal rules and values does not necessarily translate into educational practice. This is important in light of the need to ensure patients' rights to reproductive health care are respected. Even when implementing public health messages, such as abstinence, there is a danger that without the knowledge of the law and patients' right to services, effective sexuality education will not be delivered. Better training is necessary to ensure that healthcare workers have both a clear understanding of legal rights and obligations and a clear sense of how to translate these rules into educational messages.

These examples also, however, raise the question of whether healthcare workers should be involved at all in teaching abstinence. Although the two approaches above that include this message are more consistent with the current legal framework, the last approach posits that telling a teenager to abstain is an imposition of values that may “scare them off” (RHC15). This claim requires further empirical research to determine whether a message of abstinence per se (in other words, even when communicated in a non-judgmental way) discourages teenagers from accessing reproductive healthcare. If, however, this turns out to be the case, the role of healthcare workers in providing this type of sexuality education and in enforcing the SOA provisions must be reconsidered. Should healthcare workers continue to be responsible for communicating the message that underpins the SOA provisions, training should ensure that nurses do not perceive the legal framework as a license to scold and that the relevant messages are conveyed in a non-judgmental manner.

This concern about imposing values also applies to other advice given by healthcare workers. Healthcare workers frequently (n=10) provided guidance, for example, on the

problem of exploitation by an older sexual partner.<sup>234</sup> These concerns appear well placed in light of a 2001 study, also based in Cape Town, which found an average age difference of 5.1 years between pregnant young women and their male partners, and a difference of four years between non-pregnant young women. Preventing sexual exploitation is one of the explicit rationales behind the statutory rape offences established by the SOA, and a healthcare worker who knows that her teenage patient is sexually involved with an older partner is required to report the case. Although the relevant SOA offences are defined in terms of age rather than the nature of the relationship, this seems to bring the whole question of healthy relationships within the educational purview of healthcare workers. When faced with these issues, one nurse focused on the need to ensure that her patient was protected from the possible health consequences of a potentially exploitative relationship, without expressing a value judgment:

*[A] lot of their parents don't know that they [the teenage patient] are in relationships, and sometimes it's with elderly men, you know, or with boys who are not their age group. And you know that this person is going to manipulate this girl in some way. and so that's why you can't really let the client go from here without the method. You can't. You can't. You listen and you know (RHC11).*

Another respondent, however, a health promoter, responded to information about her teenage patient's relationship with her 20 year old boyfriend by censuring the relationship, saying: "Oh my word, he's going to prison, do you know that?"(RHC9). Although this approach is consistent with the spirit of the SOA, it expresses a value judgment that may discourage the patient from seeking reproductive healthcare in the future. This example reinforces the assertion that if we expect healthcare workers to provide this kind of counselling (which the SOA seems to require), which goes beyond basic sex education, they need specialised training and clear guidelines. Applying the best interests framework under the Children's Act as a means of directing healthcare workers' discretion on when to report (as discussed in the literature review above<sup>235</sup>), it is arguable that in cases where one party of the sexual relationship is significantly older or is in a position where they are able to exploit or manipulate the other, as it appears is the case in the above quotes, then the health care worker should report those relationship to a social worker.

These examples show that because healthcare workers are in a position of providing essential information and education to their clients, it is clearly not desirable for them to impose their own values on their patients. However, given the very value-laden nature of the topics they are discussing, it is unrealistic to think that they may not do so. Thus, in one problematic case, a nurse reported her refusal to mention the option of a TOP to pregnant teenagers because, in her words: "I'm morally opposed to, I don't agree with termination of pregnancy" (RHC6).<sup>236</sup> Other respondents gave more subtle

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<sup>234</sup>Jewkes, R., Vundule, C., Maforah, F. & Jordaan, E. (2001). Relationship dynamics and teenage pregnancy in South Africa. *Social Science & Medicine*, 52(5), 733-744, as quoted in Macleod, C.I., & Tracey, T. (2010). A decade later: follow-up review of South African research on the consequences of and contributory factors in teen-aged pregnancy. *South African Journal of Psychology*, 40(1), 18-31.

<sup>235</sup>See also the GMC Guidelines (note 71 above).

<sup>236</sup> If asked for information on the service she would refer the patient to another colleague or alternative facility.

examples of how their own values impact their service delivery, such as showing pictures of a developing foetus to a pregnant teenager who asks for a TOP (TOP5). While nurses should not be required to act contrary to their own conscience by participating in providing the TOPs in question, this must be distinguished from the teenage patient's right to information on the existence and availability of TOP services.

Other participants, however, who did not express a personal objection to TOPs, were unsure how to discuss this option with their patients as they were afraid to be seen to be promoting this procedure. Three healthcare workers would only bring up the subject fully if it was first broached by the teenager, because they all feared being seen to promote abortion. One nurse explained:

*[A]h it's a difficult thing, because you, we ask them if, "how do they feel" ... but we must make sure that we don't lead her to say "I want the abortion", but you try ... to show that there are other things if she is interested, you know? ... [People] said we are introducing or we are promoting TOP if we tell them straight that "if you want to do TOP you can do TOP" but you must try not to tell straight, if it's not from her, that she says "I'm not ready for the child" If she says she's not ready for the child, then you can (RHC17).*

While it is certainly important to ensure that the decision to have a TOP is made freely by the patient, the approach taken by these three healthcare workers clearly runs the risk of failing to inform the patient of her options. This is a further example of essential health information being denied to patients because of the nurses' personal judgment, which in this case is a fear of being seen to promote TOPs, despite the fact that providing such information is a legitimate and essential part of a reproductive healthcare worker's role. It is hard to see how one can provide TOP counselling without a discussion of values, however, and therefore the need for training and guidelines regarding the minimum information that should be provided to patients is even more critical. If this counselling is to be provided by healthcare workers, they should be trained to facilitate this type of discussion without imposing their own values. An alternative solution might be to assign this counselling responsibility to trained, clinic or facility-based health promoters, counsellors or social workers, instead of nurses. This would maintain a separation between those responsible for value-based discussions and those responsible for providing treatment, thereby reducing the risk that the fear of value-based judgments will discourage teenagers from accessing treatment.

These findings point to the challenges healthcare workers face within the current legal framework, which expects them to go beyond sex education and public health interests to counsel and advise patients on broader questions related to teenage sexuality, without having received specialised training for dealing with these issues. Within this context, healthcare workers face the additional challenge of navigating these value-laden issues without expressing judgment in a way that might be perceived by their patients as a rebuke, or might otherwise discourage their patients from seeking healthcare services in the future. Serious consideration should be given to the kind of training healthcare workers need to receive in order to provide the kind of broadly construed sexuality education that we seem to expect. At the same time,

thought should be given to limiting the circumstances that would require nurses to provide this type of value-based education such that teenagers will feel comfortable seeking and accessing basic sex education and reproductive healthcare services at the available clinics.

#### *d. Who is Responsible?*

As set out above, the Children's Act and the CTPA grant young people the right to access certain reproductive healthcare services, such as contraception and TOPs, confidentially and without parental consent. This recognised the reality that parents are frequently uninformed about their children's sex lives. For many social, cultural, and practical reasons, parents often are not their children's primary source of sexuality education – at least in relation to specific relationships or events about which they are unaware. While there are very good reasons for eliminating the need for parental consent for reproductive health care, especially in cases of domestic abuse, or where a child would otherwise avoid seeking health services, this limitation of a parent's role creates a critical gap in the responsibility for teaching teenagers to make the 'right' choices around sexuality.

It is important that healthy sex education messages are delivered to young people so that they are able to make informed and deliberate decisions about when, where, how and with whom to have sex. It is clear, however, that this is not the reality for many teenagers and when teenagers do seek advice, the people they turn to (including nurses) should try to help them make healthy decisions. Whether nurses are the right role players to provide this service, however, should be questioned in light of the finding that the content of such information is influenced by personal views on the morality of teenage sexuality and/or TOPs. As discussed above, the taboo of teenage sexuality continues to influence the provision of reproductive health services in South Africa, and this was evident in our study in that, although all of the participants agreed that providing contraception does not encourage sexual activity, some nevertheless expressed a reluctance to be seen to condone under-age sex by providing services.

The findings suggest that the absence of parents weighs heavily on healthcare workers in this regard. A number of participants (n=6) thus spoke about wanting parental participation when dispensing contraceptives or discussing a TOP. They expressed a strong sense of the burden they carried by being the only adult responsible for the reproductive healthcare decisions that their young patients make. For example, one nurse spoke about feeling "guilty" providing family planning to "very young" patients (aged 12-13) without their parent's knowledge (RHC8). Another nurse spoke of how she worried for the welfare of young patients who accessed TOPs without the support of their parents:

*I'm mostly concerned about the ... TOP's to 12-year-old ... I wish it can change. From the fact that we must keep it confidential from 12 years to ... maybe not to keep it confidential at 12 years, maybe to tell a parent at 12 years. Because I feel like a 12-year-old is too young to take decisions ... Because if it's a 12-year-old comes to me to ask for a TOP I, most of the time feel like it's unfair towards*

*the child because there's no one for this child and maybe the child doesn't want me to go to anyone. So I usually feel like, if I'm, I'm not doing good for the child because at that age she's too young (RHC13).*

The sense of responsibility that is provoked by the absence of parents may be further exacerbated by healthcare workers' own feelings as parents. When speaking about the healthcare education and advice they provided to their teenage patients, a couple of participants revealed the conflict they felt between the course of action dictated by their professional training and what they felt was right as parents. For example, in response to a question regarding the provision of contraceptives to a 13 year old, one health care worker said:

*[F]or us as health professionals, it's confusing, that law is really confusing. It's very confusing ... and sometimes you really want to act as a parent, but as a nurse ... as a parent sometimes you feel, Ah! Uh! Uh! And the patient comes and requests these [contraceptives] and you don't know what is the situation is outside there, unless you sit down with this one, and the reason for that child to come and request for a TOP ... I mean for... birth control (RHC14).*

Within this context, it is perhaps not surprising that some healthcare workers adopt a parental attitude towards their patients. As one participant noted:

*I think about my own children ... I'm in this fortunate position where my children become teenagers, I could talk to them, and there's teenagers that don't have that ... they want to have know the knowledge but they don't know how to go, then ... I'll treat them as my own child (RHC9).*

While the concern expressed by this healthcare worker is welcome, her attitude may make it difficult to maintain a professional distance when discussing value-laden issues such as the choice to become sexually active or the decision to have a TOP. This statement highlights, however, that teenagers need guidance for healthy decision-making, which they do not necessarily receive from their parents, and which healthcare workers may not be in the best position to provide. It is crucial that we consider who is responsible for providing this guidance, particularly when parents cannot, and that we allocate sufficient resources to ensure that those responsible are adequately trained and have sufficient time and manpower to fulfil this role.

## **Nurses as Caregivers**

Previous research has highlighted a number of problematic aspects of the reproductive healthcare treatment that teenagers receive, including: insufficient sex education at too late an age; insufficient information about and barriers in accessing contraception, especially emergency contraception; unfriendly or scolding attitudes of nurses at clinics; and barriers to accessing TOP services.<sup>237</sup> Although this study was based on a small sample and was not intended to provide quantitative, generalisable

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<sup>237</sup>Wood et al. (2006) see footnote 110 above; and Ehlers (2003) at 237, see footnote 102 above.



findings, it aimed to highlight and try to understand reproductive healthcare management practices from the perspective of healthcare providers. The following section examines the practices and decisions of healthcare workers in providing reproductive health care services that were affected by recent changes to the legislative framework.

#### *a. Free and Confidential Access to Contraception*

The Children's Act provisions, which reduced the age at which females could access contraceptives without their parents' knowledge or consent,<sup>238</sup> made this aspect of healthcare management a focal point of this study. Questions about the way this provision was being implemented were further prompted by the apparent conflict between the message conveyed by this provision – that 12 year old girls have the right to freely access contraception – and the message underpinning sections 15<sup>239</sup> and 16<sup>240</sup> of the SOA, which clearly condemn teenage sexuality.

None of the participants in this study believed that giving teenagers contraceptives encourages them to have sex.<sup>241</sup> On the contrary, while a number of healthcare workers were troubled by the rate of teenage pregnancy and expressed disapproval of teenagers having sex, there was a strong consensus among participants as to the importance of access to contraceptives as protection against unwanted pregnancy and STIs. The majority of respondents (n=15) emphasised that teenagers would engage in sex regardless of whether they had access to contraception. Explaining her reasoning, one nurse, who at the outset of her career had initially focused on advocating abstinence among young patients, told us why she had reconsidered this practice:

*I really do not think it encourages, I feel that they are gonna do it anyway ... you eventually come to the stage when you think well 'preventing [sex] is getting you nowhere' so let's just give, give, give, give, you understand? I think that is probably why I eventually decided I'd rather give family planning, I'd rather give prevention than have unwanted babies (RHC5).*

Similarly, four other participants stressed the importance of protecting their patients against unwanted pregnancies or sexually transmitted diseases. One participant in particular stressed the importance of emergency contraception in this context. She further highlighted that the opportunity of providing sex education to teenage patients when they came to request contraceptive services may, in fact, discourage them from having sexual intercourse.

Notwithstanding the widespread belief in the importance of having access to contraceptives, the results of this study show that while most participants (n=15 of

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<sup>238</sup> Section 134 of the Children's Act.

<sup>239</sup> Section 15 of the SOA relates to 'Acts of consensual sexual penetration with certain children (statutory rape).'

<sup>240</sup> Section 16 of the SOA relates to 'Acts of consensual sexual violation with certain children (statutory sexual assault).'

<sup>241</sup> The question "Do you think giving out contraception encourages teenagers to have sexual intercourse" was only asked at reproductive healthcare facilities. One participant was unsure, answering "50:50" (RHC3).

18)<sup>242</sup> said that they would supply a 13 year old girl with contraceptives without the presence (or consent) of a parent or guardian, and that they would treat 13,16, and 18 year olds in the same way for this purpose, three out of eighteen respondents exercised discretion in this matter. Of these, one nurse would always first refer the 13 year old to a social worker;<sup>243</sup> one would refer to a social worker on a case-by-case basis; and one would require a parent or guardian to accompany the 13 year old to obtain contraceptives.

In this sample, there was no necessary correlation between knowledge of the legal right and implementation of that right. Thus, some nurses who did not know that they have a legal obligation to provide a 12-year old girl with contraception said that they provide this service based on their understanding of their professional obligations and concerns as caregivers. For example, one nurse was unsure what the legal age of consent to receive contraception was and thought it was either 12 or 14. Nevertheless, when asked whether she would provide contraception to a 13 year old patient who requested it without her parent's knowledge, the nurse confirmed that she would: "You counsel them [yes], and then you give them, because they usually sexually active when they come" (RHC4). She went on to clarify that her approach was based on the maturity rather than the age of the patient:

*Some of those 13 year olds are like 20 year olds, some you know it depends on the one, some are fully informed by the time even if they 13 you wouldn't say. But there will be a difference ... I mean with a counselling that will come out (RHC4).*

Another nurse, who thought the age of consent for contraception was 14, was prepared to start a 13 year old on family planning in individual cases, based on a 'judgment call', explaining: "Sometimes you will start them on family planning, even if they are a very young age, and they are sexually active in any case" (RHC6).

These findings point to the possibility that healthcare workers' perceptions of what it means to be a caregiver may be a more important factor in determining their behaviour than legal rules. The majority of healthcare workers in our sample were guided by what they perceived is best for their patient. This is consistent with the literature<sup>244</sup> that has shown that in the absence of consultation as to legislation that affects their practice, nurses are more likely to rely on their own values which might include their own perceptions of their own roles.

Even when nurses were aware of and/or enforced a teenager's right to access contraception, their implementation was shaped by perceptions of their professional

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<sup>242</sup> This question was only asked at the Reproductive Health Clinics.

<sup>243</sup> It was not specified whether the social worker was also employed by the health care facility, but, as the participant made reference to her professional relationship with 'the social worker' throughout the interview, this would appear to be the case. In any event, the participant believed the social worker to be also bound to maintain the patient's confidentiality. Later in the interview, in the context of reporting sexual abuse without the consent of the patient, she stated: "I always share with her [the social worker] – I would go cuckoo if I had to keep it all – I would tell my patients it's my duty to tell the social worker but that she will also maintain the confidentiality." (RHC18).

<sup>244</sup> See Walker et al. (2004) at footnote 88 above.

duties and/or conflicting beliefs or values that they held about teenage sex. Although one nurse was aware that the law allows even young girls to consent on their own to contraception, she sounded reluctant to enforce this right, noting that she would normally tell them they were too young, at age 16, to be involved with men (RHC 2). Likewise, the practice of another healthcare worker who was unfamiliar with the age of consent rules around sex, was shaped by her understanding that it was her job to promote abstinence:

*We start the family planning at 12 years [laughter] so I'm not sure if at 12 they can have sex, but we only promoting that they must be having, I mean must, what you call that?*

**Interviewer: Abstain?**

*Yes, they must abstain.*

**Do you know what the law says about the age a child can give consent is?**

*No (RHC17).*

Another participant, who was not familiar with the age of consent rules concerning sex, simply inserted her own belief of what was appropriate: "I can't really say. Normally I'd say 18. Rape Crisis came and said 17. Teenagers think it's 15. I say 18 when they ask" (RHC 8).

Besides reflecting a need for increased training regarding age of consent rules, these statements illustrate an underlying paradox of our reproductive healthcare framework and the need for training that will assist healthcare workers in adopting a more nuanced and sophisticated approach to dealing with its mixed messages. The paradox lies in the belief that 12 year olds are not mature enough to make decisions about having sex, but are mature enough to handle decisions about birth control. In most cases, they confront making these choices because they have made the decision to have sex on their own, or at least without involving their parents.

Thus, on the one hand, the position taken by the SOA entrenches the belief that sex is harmful to children under the age of 16; that it is exploitative *prima facie*; or that children of this age are simply not mature enough to make a healthy and autonomous decision to have sex. At the same time, the legal system recognises that children of this age will, in fact, continue to have sex, which makes it crucial that they be able to access contraception. Ensuring the right to contraception also stems from recognition of the fact that parents sometimes act as an obstacle to such access. Eliminating the need for their consent removes that obstacle, and also helps to ensure patient confidentiality. The need for parental supervision and consent, however, has not been replaced by any other form of supervision – other than that of healthcare workers – thereby implying that young teenagers are considered capable, under the Children's Act, of making autonomous and mature decisions about the use of contraception.

Healthcare workers, therefore, find themselves caught in the middle of this paradox, and it is perhaps no surprise to find that their practices seek ways to reconcile this situation in a way that they can feel comfortable with. Overall, more than half (n=16 of

28) of participants in this study expressed the view, at one point or another, that young teenagers were not mature enough to make decisions about sex or reproductive healthcare on their own. Because they were *nonetheless* obligated to provide contraception, many felt compelled to try to get parents involved. Thus, for instance, of those who said they would provide contraceptives to young teenagers without parental involvement, several *nonetheless* also said that they would encourage – and in at least four cases seemed willing to pressure – teenage patients to involve their parents in their decision. As one participant noted:

*When they are very young (12-13) they have the right to family planning, but we usually encourage parents to come ... We do tell them we need their parent/guardian to be informed. If they refuse, we still give treatment, but encourage them to tell their parents. We ask, "Can I ask your mother?" (RHC8).*

The desire for parental involvement was felt both with regard to aspects of this decision that could be termed "moral" or that relate to healthy life choices in general (such as whether the child should be sexually active), and in connection with particular treatment issues, such as the need to remember injection appointments. For example, one participant, when asked about the challenges of providing contraception to children without the consent of their parents, stated:

*I think the biggest challenge is the understanding and the fact that you don't know the history of this patient at all, and understanding also pertains to whether they actually know about safe sex, do they know how to use their medicines do they know about all these things as well, you know?(RHC5).*

Likewise, another participant felt it was better, from a practical perspective, to have parental consent:

*Sometimes you feel that they, they take more responsibility and there's more family support in the whole issue, if her mother knows what's going on"(RHC6).*

A problematic picture emerges from this data. Few healthcare practitioners from this sample understand or accept the underlying premise of the Children's Act, namely that even very young teenagers are capable of making decisions about sex on their own, or that it is better to allow them to make this decision on their own than to risk a parent-induced obstacle. This is how one participant explained her belief that young teenagers are not able to make responsible decisions about sex:

*[I]t leads to being pregnant and it's robbing a child of its youth. I, I dunno. No ... (pause) ... children at that age should still be children, they aren't grownups and being a grownup leads to certain responsibilities and having sex also leads to certain responsibilities and they are not ready for that responsibilities at that age (RHC 1).*

Some try to insist, therefore, upon parental involvement in their children's health care. Irrespective of whether nurses actually violate their patient's confidentiality, however, the patient's knowledge that, if she comes to the clinic for help, she will be pressured

to disclose her sexual activity, pregnancy, or other sensitive information to her parents, is likely itself to be a significant obstacle that would discourage teenagers from seeking help in the first place.<sup>245</sup> Increased training would perhaps help healthcare workers understand and accept the premises of the Children's Act and navigate this territory in a way that respects a teenager's right and need to make choices about sex, while making her aware that certain choices are not only against the law but risky and unwise.

### ***b. Free and Confidential Access to TOPs***

The burden on health care workers and the need to share this responsibility with parents and others becomes even greater when dealing with pregnant teenagers and the decision to terminate a pregnancy. Having a baby is a huge responsibility, and the physical, emotional and financial demands of motherhood are enormous. Having an abortion also has physical and emotional consequences and may have long-term psychological effects for the teen concerned. It is critical for teenagers to understand and discuss the consequences of either course of action so as to make a decision that is as well informed and thought-through as possible. At the same time, the teenage mother may feel very emotional during this critical decision-making period and may be vulnerable to feelings of guilt or regret.

These discussions and thought processes are not medical, nor are they primarily about the mother's or baby's health. They are really about the social, emotional and financial impacts of motherhood: the kinds of discussions that one normally associates with the work of social workers. Yet, it is for the most part nurses who have these discussions with their patients, since there is no mandatory requirement under the CTPA for patients to be referred to see a social worker. Thus, besides their roles as educators and caregivers, reproductive healthcare nurses must also assume the role of social worker in this context.

This counselling role was the focus of questions in this area of the interviews because it was during these discussions that teenagers would effectively be provided (or discouraged from, or refused access to) a TOP referral. As noted above, one problematic finding of this study was that one of the participants interviewed does not discuss the possibility of terminating the pregnancy with her teenage patients, referring them instead to another staff member at the clinic or to a crisis pregnancy centre in a nearby city:

#### ***You don't [tell them about the option of a termination of pregnancy]?***

*Because I'm ... morally I don't agree with termination of pregnancy, so if she had any [questions], there is a crisis pregnancy centre in [town name] which I would give her the advice to go there and discuss it with someone, but if she comes in and requests a TOP I would refer her to one of the other staff. I would refer her to someone else (RHC 6).*

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<sup>245</sup> And was one of the barriers to accessing contraception services identified in Wood et al.'s study (2006) see footnote 110 above.

This kind of service provision, along with many of the other 'implicit' practices of discouraging teenagers from going through with the pregnancy, clearly provide a barrier to a teenager who is trying to access (or make a decision about) TOP services. While the sample in this study was small and not necessarily representative, this interview, and the other examples referred to above, suggests that there is a need for additional value clarification workshops for healthcare workers.<sup>246</sup> Alternatively, healthcare providers who are unwilling for reasons of conscience to inform patients about the possibility of a TOP, should perhaps not be providing reproductive healthcare services to teenage patients.<sup>247</sup>

Beyond the question of referral itself, and in light of previous research<sup>248</sup> which found that teenagers experienced nurses as judgmental and intimidating, this study attempted to understand what issues and information healthcare workers thought were relevant to their counselling of pregnant teenage patients who come to access reproductive health care services, and how they handled these discussions. Teenagers who want to access TOP services should not only be provided information about the availability of TOP services, but should – even though it is not mandatory – be provided access to counselling about their decision. The findings show that the healthcare workers understand a range of topics to be relevant to these counselling sessions. When asked about the questions they ask pregnant teenagers, including whether they ask about the circumstances under which they became pregnant, only a handful (n=5) of the nurses mentioned that they ask the patients typical health-related questions, such as how far along they are in their pregnancies, when they had their last periods, and so forth. The most popular questions nurses reported asking their pregnant teenage patients related to the patients' relationship status or about their boyfriends. Over half of the nurses (n=13) mentioned asking pregnant teenage patients about the identity of their unborn child's father, his age and/or his occupation. Some nurses also reported asking questions about the past and the future, including previous partners and future plans, as is apparent in the following quote:

*I would ask her about her partner, I would ask her how it happened ... about how her partner, who's her partner? How old is the partner? Have they had sexual relationship for a long time? Does she ... (pause) ... how many partners she's had? What are her plans for the future after the baby? What's her plans for herself for her life and herself after the baby? (RHC 6)*

Other questions nurses ask their pregnant teenage patients include: whether her parents or family members know about the pregnancy (n=4 of 18), her social circumstances (n=4 of 18), and how they feel about the pregnancy (n=3 of 18). Five of the nurses said that they ask certain questions to find out if the patient had consensual sex or if it is a case of rape. Nurses that work in TOP clinics were also

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<sup>246</sup> This participant had attended a one-day training seminar on the CTPA five years ago.

<sup>247</sup> It should be sufficient, however, for a healthcare worker to initiate an offer, without judgment, to refer the patient should she wish to discuss a TOP as a possibility.

<sup>248</sup> Wood et al., (2006) see footnote **Error! Bookmark not defined.** above; and Ehlers (2003) at 237, see footnote **Error! Bookmark not defined.** above.

interviewed about whether they enquire about the circumstances under which the patient became pregnant when the patient requests a TOP at the clinic. Six of these nurses ask about the patient's relationship status, whether they have a boyfriend, and other details about the boyfriend. As one nurse explained:

*And you know if you listen to some of their stories they don't even know the man's name. I think that's why it's nice with that one we always ask the name. They don't know the man's name that they slept with, they don't know his age, what he ... where he comes from (TOP1).*

While some of these questions are certainly relevant to a decision to terminate a pregnancy – for example, questions about the baby's father may be relevant to maintenance and support – it is clear that other questions go beyond what is necessary. The identity of the child's father, for example, is certainly not relevant, and the number of partners the patient has had previously is of questionable relevance. As suggested by the findings from the Wood et al.'s study, in which teenagers complained of nurses asking "funny questions,"<sup>249</sup> this type of interrogation may lead some teenagers to feel uncomfortable. We should be careful, however, in automatically faulting healthcare workers when teenagers report that nurses are judgmental, as it is inevitable for some teenagers to find such counselling sessions difficult and uncomfortable and perhaps even to project their own feelings of embarrassment or unease onto healthcare workers. This is not to say that some healthcare workers are not inappropriately judgemental and should not be admonished for the type of "lecturing" that has been reported by teenagers. Indeed, lecturing of this sort was evident in some of the practices reported by a couple of the participants in this study. Thus, for example, when asked about the way she deals with pregnant teenagers, one participant said:

*That's why I say teenagers are very blatant ... They will tell you and they uh had sex and this happened and now what. Then I say 'now what?' Then she ask me, 'now what?' Then I say, 'now what? Tell me, now what?' Oooh, they're teenagers!"*  
(RHC9)

These findings indicate that if we do want healthcare workers to continue to fulfil this counselling role for TOP services, they should receive specialised training for this purpose. Alternatively, we should consider the possibility of requiring all clinics to have a resident social worker who would have responsibility for counselling in these situations. While this would mean a revision of the confidentiality rule to allow for referral to the social worker, this should not be a problem if we ensure that all conversations between social workers and their patients are subject to the same privilege of confidentiality. As noted below, referrals to social workers are happening to some degree in any case and this would allow nurses to focus entirely on physical health aspects of care giving and make teenagers more comfortable in approaching them.

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<sup>249</sup> Wood et al. (2006) see footnote 110 above.

## Nurses as Law Enforcers

As set out above, the new legal framework on reproductive health care includes a number of obligations to notify the authorities when healthcare workers become suspicious or aware of situations of sexual abuse or other types of offences.<sup>250</sup> One of the primary aims of this project was to investigate whether healthcare workers who provide reproductive healthcare to teenagers are fulfilling either or both of these reporting obligations; why they do or do not fulfil these obligations; and how they feel about these obligations, particularly in terms of their conflict with promises of confidentiality and their role as caregivers in reproductive health care. This section looks at the findings that emerged on these issues.

### 1. Cases of Abuse

As noted above, the findings suggest that the healthcare facilities included in this study do not have standard protocols that guide nurses in dealing with cases of child abuse. Instead, the data shows that 'what to do' was, to some extent, a matter for individual discretion. The disparity in participants' actions on encountering abuse appeared to be influenced by whether respondents felt reporting the abuse was in the patient's interests or if the patient was better served by maintaining their confidentiality.

As indicated earlier, 19 out of 27 (70%)<sup>251</sup> of the respondents had experience of a teenage patient or a child disclosing sexual abuse. When asked what they do in such situations, all of the respondents told us they had reported the abuse to someone and nearly all spoke of wanting to help the abused patient. We identified a divergence in their approach, however, in terms of whether they would involve the criminal justice system or seek welfare counselling services for the victim. The majority of the respondents had favoured social services and reported or referred to social workers (n=11) or to NGOs providing services for victims of sexual violence (n=4). Nine of the respondents involved the police; however, only two of this group did so exclusively,<sup>252</sup> while five reported to the police in conjunction with another body such as a social worker or psychiatrist, and two in conjunction with the patients' parents. In other words, most participants in this study fulfilled their obligation under the Children's Act but the majority did not fulfil their duty in accordance with the SOA.

Respondents who had not experienced a child or teenage patient disclosing that they had suffered sexual abuse (n=8) were asked what they *would do* in such a situation. Seven answered that they would involve welfare services and report to a social worker

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<sup>250</sup> Under the Children's Act, the healthcare worker's obligation is to report – either to the provincial department of social development, a designated child protection organization, or a police officer – when they conclude or reasonably believe a child is a victim of abuse. Under the SOA, every person has an obligation to notify the police immediately if they have knowledge of a sexual offence having been committed against a child.

<sup>251</sup> This question was not asked in the second TOP interview.

<sup>252</sup> One other respondent (TOP7) did note that her usual practice had been to just call the police, but she did sometimes also involve the social worker, depending on the needs of the patient.



(n=4) and/or an NGO (n=5). Two respondents stated they would (also) report to the police. Both of these nurses and three of the participants who answered that they would refer to counselling services, stated that they would only report with the consent of the patient, emphasising that they would prioritise their confidentiality obligation over the obligation to report. One respondent thought that the police would have been informed before the patient came to the hospital. This response again highlights the fact that healthcare workers think about abuse in terms of a stereotypical incident of rape, rather than domestic abuse that takes place over a long period.

In order to determine how healthcare workers would act when confronted with an outright clash between their reporting and confidentiality obligations, respondents were also asked what they would do if a patient disclosed that they had been abused but explicitly asked the care-giver not to report this to the authorities. A number of respondents expressed uncertainty, particularly if they had not actually had this experience. In fact, most participants (n=18) answered this question from a hypothetical perspective. Some expressed their discomfort with this hypothetical situation by describing how they would try very hard to persuade the patient to consent to them reporting the abuse (n=2) or would defer the decision to report to a colleague or a social worker (n=4). Five of the participants were emphatic that they had a legal or professional duty to report, as one said:

*I would still report it, yes. I would explain to them that this was out of their hands and my hands, that I've got a legal responsibility that ... the country has a legal responsibility to ... look after them. It's not in my legal rights or their legal rights (RHC6).*

In contrast, seven participants stated they would respect the patient's wishes. One such participant saw this as an issue of respect:

*[I]t's also sometimes you need to respect her. If she open up to you but she don't want any other people involved, then you must sit with that girl, and you must sort that thing out. If she refuse, [to allow reporting], you can't do anything if she's not ... if she don't want to go make a case or lay a charge (RHC11).*

One respondent, a nurse working in a particularly deprived area of the city, added a concern for her own personal safety as a reason why she would not report sexual abuse to the police without the victim's consent. She argued that nurses' lives would be in danger from the perpetrators if they took such action.

Nine respondents who had actual experience of this situation and still also expressed confusion over what they *should* do. They had all responded by trying to persuade the patient to allow them to notify a parent or social worker and only two participants had experienced success in perusing this course of action. Practices varied, however, if the patient could not be persuaded to tell anyone. Four respondents said they would respect the patient's confidentiality above all else, but nevertheless expressed uncertainty in whether this was the correct approach. In one case, for example, the

respondent was confused by what she would do, answering: "I don't really know to be very honest with you, I mean there is patient - client confidentiality..." (RHC5). This nurse resolved the confidentiality versus reporting conflict based on age: she would only report if the patient were younger than 15 years old. Another nurse, expressed her decision to prioritise confidentiality as follows:

*You know, you're always sitting there and wondering 'are you, shouldn't I [report],' but of course you have this confidentiality thing, and that must lead me, so I didn't [report], but I felt sad (TOP5).*

Later, however, when discussing the factors that would influence her decision to report, this nurse qualified her earlier response when applied to cases of physical abuse: "when of course, I seen people with marks and bruises and things and in that case I will report ... I didn't even give her a choice I just tell her 'I'm going to report' and I report it" (TOP5). Of course, whether this means that the nurse in question places higher priority on cases where there is physical evidence (and therefore sees it as a case that warrants reporting in violation of patient confidentiality), or whether she doubts the voracity of cases where physical evidence is absent (and therefore avoids reporting) is not clear. Either way, these kinds of problematic attitudes, result in secondary victimisation for teens, and disparate implementation of the law.

Three of the respondents felt their paramount obligation was to report the abuse regardless of the teenager's wishes. One nurse reported directly to the police, while the other two respondents complied with their obligation to report the abuse by referring the patient to a social worker. Thus, one nurse said:

*I DO report it, I always share with her - I would go cuckoo if I had to keep it all - I would tell my patients it's my duty to tell the social worker but that she will also maintain the confidentiality. I will try and convince them that it needs to be reported (RHC18).*

### ***b. Consensual Sex***

Unlike situations of abuse, healthcare providers in this study were far less likely to report cases of teenage patients who had engaged in consensual sexual relations with teenage partners. Indeed, many of the participants seemed perplexed or even amused at this suggestion.

Almost all of the nurses interviewed said that they have pregnant teenage patients who are in consensual sexual relationships with other teenagers.<sup>253</sup> A nurse in a youth clinic made the point that most of their cases fall into this category. Only two of the clinic nurses denied having such patients, as they said that the pregnant teenage girls that they see are generally involved in sexual relationships with older, more mature

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<sup>253</sup> One of the TOP respondents was not asked this question, due to time constraints. Two other TOP respondents did not respond to this question directly, but implied in later responses that they did have such patients.

men.<sup>254</sup> One other respondent noted that most of their pregnant patients are between 16 and 18 years old and they generally come to the clinic with female friends, rather than with their boyfriends (which means that she does not necessarily know how old the boyfriends are).<sup>255</sup>

Although the obligation to report consensual sex and sexual acts (as per the offences defined in sections 15 and 16 of the SOA<sup>256</sup>) is based on the understanding that the relationship is indeed consensual, statements made by several (n=6) healthcare workers indicated that even when speaking of consensual sex with or between teenagers the male partner was generally perceived as a perpetrator, and the obligation to report (as well as the question about this obligation) was thus understood as being directed at the male partner. As one nurse explained, although she no longer reported consensual sex between teenagers: "I always do advise them [the girl patients] "you are having underage sex it is illegal. This chap, whatever age he is, he is not legally having sex with you. You should be going to report it"(RHC5). Similarly, examples given by participants when speaking about consensual sexual relationships between teenagers were often focused mainly on the (young) age of the female partner, as if the age of the male partner was irrelevant.

Reporting practices in cases of consensual sex between teenagers varied. As noted above, only 11 participants knew that they are legally required to report consensual sex with teenagers.<sup>257</sup> As will be shown below, however, reporting practices were not correlated with participants' knowledge of the reporting obligation. Only 12 of 25<sup>258</sup> respondents said that they report some cases of consensual sexual relationships between teenagers. Only one of these, however, reports consensual sexual relationships of *all* teenagers under the age of 16 only to the police,<sup>259</sup> and one reports to both the police and to a social worker. Asked how they felt about the obligation to report, one of these respondents expressed approval, suggesting that this would help bring an end to the problem of teenage pregnancy.<sup>260</sup>

Two of the foregoing 12 respondents exercise discretion based on age, either in terms of whether to report at all or as to whom to report. Thus, one nurse reports only when the teenager is under the age of 15 (instead of 16, as the law requires) and reports

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<sup>254</sup> One of these nurses, however, later mentioned a case of a pregnant 14-year-old girl whose partner had been 16. Oddly, nurses from two youth clinics located not far from each other gave opposite answers: one said that most of their cases were of teenage girls who were in relationships with other teenagers, whereas the other said that their clients were "dating very old people" (RHC 7).

<sup>255</sup> In her next response, however, this participant, a health promoter, implied that she does ask about the boyfriend's age. She further did not seem to distinguish between the lawfulness of sexual relationships between young teenagers (under 16) and older teenagers: "But, even if they sixteen and up, 'now how old is the boyfriend?' 'twenty,' they say, 'Oh my word, he's going to prison, do you know that?' ..." (RHC 9). This quote highlights how misinformed healthcare workers may provide incorrect information to their patients, with severe consequences.

<sup>256</sup> See above for discussion of these sections.

<sup>257</sup> See above for discussion of this issue.

<sup>258</sup> This question was not asked in one TOP interview and not answered in two RHC interviews, in the RHC interviews the participants stated they had not had the experience of a patient aged under 16 disclosing that she had had consensual sex with an underage partner

<sup>259</sup> In one of these cases (TOP7), the example given by the researcher to clarify the question was of a teenager under the age of 15. The respondent was aware of the reporting obligation under the Children's Act (though she did not know the correct name of the legislation).

<sup>260</sup> This participant did not seem to understand that both the boy *and* the girl would be investigated under the SOA.

only to a social worker. One other nurse reports cases of younger children (for example, 13 years old) to the police, whereas in cases of 15 year-olds she would first ask them to come to the clinic with their parents and speak to the social worker, who would then be expected to report to the police. Seven of the respondents report only to a social worker,<sup>261</sup> although in two of these cases the nurse expected the social worker to report to the police in at least some cases.<sup>262</sup> In one of these seven cases, it was not clear whether the respondent reports to a social worker, or simply refers to a social worker. Such a report/referral was made only if the patient was pregnant and her mother did not know about the pregnancy<sup>263</sup> and when the respondent felt that the patient did not have support. One other respondent said that she has not had any cases of consensual sexual relationships between teenagers<sup>264</sup> and has never made such a report. She said that she *would* make such a report, however, in cases of consensual sex between two young teenagers (two 14 year olds), although, oddly, she would not report a case of a young teenager who has consensual sex with an older man.<sup>265</sup> This kind of variance in practice is clearly problematic.

Although these 12 healthcare workers in some instances prioritised reporting over confidentiality, they did not all do so lightly. One clinic nurse very clearly articulated the concern that reporting consensual sex between teenagers violates confidentiality in a way that may damage the relationship that healthcare workers have with their patients and may discourage teenagers from seeking their help:

*I don't feel I must be the one reporting it because I must I must have that rapport with my patients so if that happens then it's broken, I mean then that patient doesn't come back to you with other stuff and I mean we usually the people that come to with anything (RHC 4).*

Despite this, the nurse in question nonetheless said that she does report consensual sexual relationships between teenagers (albeit only to a social worker) because that is what the law requires.

The belief that teenage pregnancy is a social problem motivated three participants to report underage consensual sexual relationships between teenagers to social workers. One participant said that she reported a case of a pregnant 16 year-old girl who had consensual sex with an older partner to a social worker "because her social

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<sup>261</sup>In one instance, the respondent implied that she would also discuss it with the parents, though perhaps this was with the patient's consent.

<sup>262</sup> In one case the respondent expected the social worker to report to the police mainly in cases of young teenagers (e.g., 13 years old) who had sexual relationships with older partners. Where the teenagers were in the same age group, it was thought that the social worker may only provide counselling and ask to speak to the parents.

<sup>263</sup> This response referred to circumstances of pregnancy. It appears that no report would be made where the teenager was engaged in a sexual relationship but was not pregnant.

<sup>264</sup> To clarify the question, the respondent was asked, for example, whether she had had a case of a pregnant 14 or 15 year old who had been impregnated by a 14 or 15 year old boy. The respondent replied "no" to this question.

<sup>265</sup> Her explanation of why she would report consensual sex between two teenagers but would not report cases in which the male partner was over 18 was surprising; she stated that she would report consensual sex between two 14 year olds as they would "be in the same boat" in that neither of them would be mature enough to truly consent, whereas she would not report consensual sex between a 14 year old girl and an older man as in that instance she felt at least one of them would have the maturity to consent "for real" (RHC13).

circumstances [were] not that good and the boyfriend was much older than she" (RHC 3). This participant thought, generally, that the obligation to report consensual sex between teenagers was a good one, because she thought that teenagers' awareness of being "watched" might impact on their behaviour. She did not see this as an obligation she had as a nurse, but as an adult: "we as adults must do something about it, cause if we don't it will get, get just worse" (RHC 3). Surprisingly, the two other participants who reported to social workers for similar reasons said they were not aware of any law that required them to report such cases. Rather, one of these respondents explained that she also reports to a social worker because she is afraid to be blamed, later, for any repercussions:

*I choose to report to the social worker because most of the time if you have problems ... with that situation, they refer back to the hospital. They say "No, you was at the hospital, nobody do something about that" and they pass the buck. And that's why we report it to the social worker. (Pause) And because it's a social problem. Say for instance all the girls [are] under 15 or 14 and it become[s] a norm of ... in the society that that is a norm that you can get pregnant under 15 and 14 and have sex ... that's a social problem (TOP 6).*

These reports highlight the divergent factors that influence nurses' individual decision of whether to report: some fear reprisals from parents or the censure from community, others report because they believe it may prevent future pregnancies. Clearly, for these nurses the legal duty to report is not a primary consideration. These divergent approaches highlight the need for standardised protocols and training for nurses to assist them in deciding what to do when patients request that they do not report.

Thirteen participants said that they would not report cases of consensual sexual relationships between teenagers, and of these, most (n=11 out of 13) were also not aware of any obligation to report. Only two nurses were aware of the obligation to report (although one did not demonstrate very definitive knowledge of this obligation)<sup>266</sup> but chose not to fulfil their obligation for reasons of patient confidentiality.<sup>267</sup> In one case, the respondent had initially been very zealous in reporting such cases with the patient's consent<sup>268</sup> but had stopped this practice for two reasons: she felt that such reports were "a waste of time," since "the family always stops it [the police investigation], one way or another" (RHC 5) and she was concerned about patient confidentiality. Notably, as cited above, this nurse also understood the obligation to report as one directed at the male partner, regardless of his age. The other respondent who was aware of her obligation but chose not to report worked with TOP patients. She was aware of the obligation to report but explicitly prioritised the obligation of confidentiality that she had under the CTPA. Another respondent

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<sup>266</sup> This includes a range of knowledge about the obligation to report. Thus, for example, asked whether there is a law that requires her to report consensual sexual relationships between teenagers, one of these respondents replied: "I don't know but I would say 'yes', being the fact that sex underage, under 16 is (pause) there, there shouldn't be sex under 16, whether it was consensual or not it was still under 16, so I would still say 'yes.'" (RHC 5).

<sup>267</sup> See page 69-70

<sup>268</sup> It seems that even her initial zealousness in reporting was only with the pregnant teenager's consent, though this is not entirely clear.

expressed concern about confidentiality, expressly linking this concern to the fear that reporting would create a barrier to accessing reproductive healthcare. It was unclear, however, to what extent she understood herself to have a legal obligation to report in cases of consensual sex.<sup>269</sup>

Two nurses described how they exercised discretion in fulfilling the reporting obligation based on concerns about their patients' best interests and/or a lack of confidence in their police report having any impact. Thus, one clinic nurse said that she knows that she is supposed to report, but in practice only reports these cases when her patient is younger than 15 years old (as opposed to 16 years old, as required by law). She was ambivalent about this obligation: she had many cases of pregnant 15 year olds and considered the duty to report "a good thing" but, at the same time, expressed concern that the consequences of reporting (for example, the boyfriend being punished) would be counterproductive to her patient's need for support. She explained: "at the age of 15 that poor girl needs all the help she can get to get through this pregnancy and raise this child" (RHC1)<sup>270</sup>

Such concern over the consequences of reports, however, was not always a deciding factor, as in the case with one of the participants mentioned above who remained emphatic about fulfilling this obligation – a response that may have been influenced by her strong feelings about teenagers having sex. While it is not clear how, in fact, the police handle reports of teenage consensual sex, these examples highlight the need for greater communication between law enforcement officials and healthcare workers, so that the latter role players are aware of the actual consequences of reporting.

The findings in this section suggest that healthcare workers are unsure how to reconcile their competing obligations of confidentiality and reporting, both in connection with cases of abuse and of consensual sex between teenagers. While most healthcare workers did report cases of abuse in practice, only half said they would report abuse even if explicitly asked by the patient not to do so. Most of those who reported cases of abuse seemed to do so by virtue of their obligations under the Children's Act and not in terms of the SOA. Those who did report often did so selectively, based on discretionary criteria, and preferred reporting to social workers. Very few healthcare workers interviewed for this study fulfilled their obligation under the SOA to report all patients under 16 who engage in consensual sex, to the police.<sup>271</sup>

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<sup>269</sup>She seemed in one place to understand this as a case of abuse which one would then be required to report, but when asked explicitly whether she thought there was a legal obligation to report consensual sex, she said that she did not think so.

<sup>270</sup> In her example, the boyfriend was an 18 year-old boy/man, having sex with and impregnating his 15-year-old girlfriend, which does not, in fact, fall into the category of two young teenagers.

<sup>271</sup> It is important to note that the reporting question was generally asked in connection with pregnant teenagers, since it is under these circumstances that it is clear the teenager has actually engaged in sex (unlike when contraception is requested). It seems likely that even fewer health care workers would make any report merely based on the knowledge that their patients are engaging in sex.

## **PART III: DISCUSSION**

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This project set out to examine how healthcare workers actually provide reproductive healthcare to teenage patients and how they perform and reconcile their legal and professional duties under the Children’s Act, the SOA, the CTPA and the NHA. This section of the report considers what these findings say about the new reproductive healthcare framework, the impact it has so far had and the challenges it creates for healthcare workers and for the provision of effective, acceptable and accessible healthcare.

### **Ambivalent access**

This study’s examination of the reproductive healthcare framework focused primarily on the following specific rights and obligations: the right to access a TOP confidentially and without parental consent at any age; the ability to access contraceptives from age 12, confidentially and without parental consent; and the obligation to report children under the age of 16 who engage in prohibited sexual activity. The inherent conflict between these first two access provisions and the reporting obligations creates a health system which provides teenagers with ambivalent access to reproductive healthcare. Thus, while there are legal rules in place to promote access to contraception and to TOPs, which are largely being implemented by healthcare workers, there are a number of factors – including the provisions of the SOA – that act to undermine access in practice.

### **The Best Interests Of The Child**

As pointed out in the first part of this report, the Children’s Act strives to protect children by striking a balance between confidentiality, which is intended to promote access to reproductive healthcare and reporting in cases of suspected abuse. The Sexual Offences Act, which was enacted after the Children’s Act, upsets this balance by asserting that consensual sex also causes harm to young teenagers and tipping the scale in favour of reporting.

What McQuoid-Mason<sup>272</sup> highlights, as mentioned in the policy review above, is that these provisions are both subject to the Constitutional principle of the best interests of the child. A central question, therefore, is how we define the best interests of children when it comes to issues of sex and sexuality. While the Children’s Act (taken alone) recognises that some young teenagers have a greater interest in accessing contraception than in avoiding the harm that may result from consensual sex with other young teenagers, the SOA takes a different view – implying that children are best protected when the state exerts control over their sexuality through the threat of punishment. Although the formal obligations that flow from these two positions can be

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<sup>272</sup> See footnote 66 above.

reconciled through interpretation, they rest on very different moral and empirical claims and have radically different consequences. In the first place, the Children's Act does not express a moral view of consensual sex between teenagers. The SOA does, but prompts the question: what is the precise nature of the wrong that is committed when, for example, 15 year-olds engage in consensual sex? The answer to this question is critical if we are to consider whether the SOA approach is consistent with a child's best interests: the potential harm caused by this wrong must be weighed against the potential harm caused by criminalisation and reporting. Although this study did not collect data on the consequences of reporting, the safeguards adopted by the SOA, as well as anecdotal evidence relating to police responses to health care workers' reports suggest that the circumstances under which specific harm (from consensual sex with another teenager) is anticipated are vague and limited and could be dealt with under a more narrowly construed offence or else by measures outside the criminal law. On the other hand, the harm that will be caused if teenagers do not feel that they can safely and confidentially access family planning methods is likely to be substantial.

This analysis assumes that criminalisation was intended to protect against some form of harm that goes beyond public health concerns, such as pregnancy or sexually transmitted diseases. If however, the intention of the SOA *was* to target these public health concerns, and that reporting and criminalisation were, therefore, necessary for that purpose, this poses an empirical question regarding the likely impact of criminalisation and reporting: is criminalising consensual sexual activity between teenagers under the age of 16 and creating an obligation to report it, likely to reduce the rate of teenage sex and, therefore, teenage pregnancy and HIV/STI infection? There is no evidence to support this assumption. It would also be difficult to prove this conclusively and there would remain a substantial risk that reporting practices will discourage some teenagers from seeking healthcare. In cases of backstreet abortions, or HIV infection, this risk is one which involves life and death – a harm that is clearly greater than the harm of having a baby, or terminating a pregnancy, at age 15. The severity of this risk leads to a final question: even if we assume that criminalisation and reporting may discourage some people from having sex, is this the only or the best way to deal with this problem?

We argue here that it is not. Although healthcare workers in this study made both of the arguments mentioned above – that criminalisation and reporting might discourage teenagers from having sex, or discourage access to healthcare – overall they favoured improved education and greater parental involvement over legal prescriptions to deal with the problem of teenage pregnancy. Thus, even those who supported the obligation to report did not think this was the most effective way to deal with the problem of unprotected teenage sex and/or pregnancy.

This analysis raises questions about the extent to which the offences set out in sections 15 and 16 of the SOA can be justified in terms of the Constitutional principle which requires that the best interests of children be taken into account in all matters



relating to their welfare.<sup>273</sup> It further points to an urgent need to discuss how to define a child's best interests in terms of his or her sexuality, and to debate the best way to protect those best interests. As the focal point of service delivery in matters related to reproductive healthcare, health workers must be included in these discussions and must have the opportunity to express the challenges they face in fulfilling this role. The next section highlights a number of these challenges, with which any reproductive health care framework will have to wrestle.

## Access to TOPs

The focus of this study<sup>274</sup> was on the performance and attitudes of healthcare workers who provide reproductive health services, and while the participants are, likewise, not representative of all healthcare workers, the findings nevertheless raise important considerations regarding the extent to which they implemented the legal provisions mentioned above. The findings show that, although the healthcare workers interviewed for this study were often the only ones in their facility who were prepared to assist with TOPs, they do provide this service to young teenagers, without parental consent, in the TOP facilities in which this research was conducted, provided that their pregnancies had not progressed beyond 12 weeks, as stipulated by the CTPA.<sup>275</sup>

A number of factors, however, may undermine the access that is theoretically available. We found that information on TOP services, including the right of all women to access a TOP in the first 12 weeks of pregnancy, is sometimes not provided to teenage patients unless specifically requested. Nurses may refuse or be reluctant to offer information on TOPs, either due to their personal disapproval of abortion, or because of the nurses' fear of being seen to promote TOP services amid a wider community disapproval of the service. This manifestation of ambivalent service provision – wanting teenagers to have this option so that they don't turn to dangerous backstreet abortions, but not ensuring that they know they can exercise it – is highly problematic. Many teenagers may, as a result, not be made aware that they have the right to terminate their pregnancies, or may turn to unreliable sources to obtain this information (and, perhaps, to have the procedure).

Another problem for teenagers wanting to access TOPs may be the systemic disregard and ambivalence toward the promise of confidentiality that is crucial to a teenager's willingness to exercise her rights. This is reflected both in administrative or operational procedures, which require patients to wait for services or undergo observations in non-private parts of the facility, and in the SOA provisions, which both

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<sup>273</sup> Indeed, the constitutionality of these provisions are the subject of the Constitutional Court case *The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35.

<sup>274</sup> This study did not investigate logistical access barriers or the general availability of TOPs for teenage patients, such as the number of healthcare facilities at which TOPs are available, for example, or how far a teenager must travel in order to have this procedure. The study can say nothing, therefore, about the general availability of TOPs for teenage patients or about access barriers related to logistics.

<sup>275</sup> As noted elsewhere, this study was based on a small sample and is not necessarily generalisable. It is also important to note that the researchers specifically chose facilities for this study where TOPs were available. The study says nothing, therefore, about the wider availability of this procedure.

criminalise consensual sex between teenagers and require healthcare workers (and others) to violate their patient's confidentiality by reporting pregnant teenagers to the police.

For many participants in this study, the notion of reconciling their obligations under the CTPA with their duty to report under the SOA was irrelevant, since more than a third of the participants were simply not aware of the latter duty. Those who were aware of their reporting obligation, however, had received no guidance in terms of its relationship to confidentiality, which resulted in varied practices. While some nurses were comfortable reporting sexually active under-age teenagers to the police, a larger number reported or referred under-age patients to social workers. It is arguable that reporting to social workers better reflects the intention of the Children's Act to protect a child's best interests and represents a welfare-orientated approach for the patient, rather than the punitive and stigmatising outcome of involving the criminal justice system. While the consequences of such reports vary, it is clear that, at the very least, teenagers cannot count on accessing an abortion in complete confidence. The impact of such reporting on teenage patients is not yet known, in part because of the minimal extent to which it is actually being implemented. There is no doubt, though, that the potential violation of confidentiality presents a serious risk that teenagers will stop accessing legal TOPs and return to backstreet abortions in order to maintain their privacy. It is crucial that steps be taken to monitor the impact that reporting has on access to TOPs, particularly if and when the obligation to report becomes more widely known and enforced.

## Access to Contraception

According to the findings of the study, in most of the clinics we accessed, nurses were willing to hand out contraception to teenagers without parental consent. It is not clear, however, to what extent this was because healthcare workers were implementing the law (since many were unsure exactly what the legal age of consent was), or whether it resulted from the exercise of their discretion, or the accepted practice in their facilities<sup>276</sup> which saw contraceptives being provided to teens especially once they had begun to menstruate and were sexually active. Thus, while the Children's Act has certainly had an impact in some cases, professional considerations and concerns may have, in many cases, guided healthcare workers to the same result.<sup>277</sup> At the same time, some nurses in our sample were unwilling to provide contraception to 12 and 13 year olds without parental consent. This is in part because health care workers are not sufficiently familiar with the legal provisions. It is critical, therefore, that all healthcare workers who are involved in providing reproductive healthcare services to teenagers be made aware of the legal provisions that set out that children may be given contraception confidentially from the age of 12.

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<sup>276</sup> Which may itself have been a result of implementation of the law without the healthcare worker being aware of this.

<sup>277</sup> Researchers did not ask whether healthcare workers' practices changed since the Children's Act came into effect, such that it is impossible to know whether these health-workers were providing contraceptives to young teenagers previously, even without parental consent.

Notwithstanding the tendency to provide young teenagers with contraception, the message conveyed about birth control is also an ambivalent one. Some healthcare professionals thus preach abstinence from a moral rather than a public health perspective, scold their patients for being sexually active at a young age, or censure their relationships. Research has shown this type of lecturing and scolding behaviour by nurses discourages teenagers from seeking healthcare at the clinic.<sup>278</sup> Similarly, as is the case with TOPs, systemic disregard and ambivalence toward patient confidentiality may affect willingness to access contraception services at the clinic. Thus, the findings show that in some cases teenagers may be subject to substantial pressure to involve their parents; confidentiality is compromised by clinic structures, procedures, and waiting times; and reporting practices violate, or threaten to violate, patient trust and privacy.

## **Consensual Sex between Teenagers and Reporting**

The SOA makes it a crime for two young teenagers to engage in consensual sex. In order to enforce this prohibition, health workers (and others) are required to report such cases to the police. As such, a teenager who asks a healthcare worker for birth control so that she can have sex with her boyfriend is incriminating herself and subjecting herself and her boyfriend to possible police investigation. To say that these provisions undermine the access to contraception provisions is clearly an understatement. Fortunately, this legislation seems to have had the least impact on healthcare practices. This is probably in part because few healthcare workers have received training on this Act, and the training that has been provided seems to have focused on those provisions that deal with sexual offences committed by adults, rather than consensual sex between teenagers. Many of the healthcare workers in our sample did not know, therefore, at what age teenagers may legally consent to sex, and a number of participants incorrectly assumed that if young teenagers are permitted to access contraception, or TOPs, they must be permitted to have sex. Some health care workers who did not know the age at which teenagers may access contraception also made the assumption that if they are permitted to have a TOP than they must be permitted to access contraception. This is not the case, since girls of any age may access a TOP, while only those age 12 and up may receive contraception.

Likewise, even if they knew at what age teenagers may consent to sex, many healthcare practitioners in our sample did not know that they had an obligation to report underage sex to the police and did not, therefore, fulfil this obligation. For some healthcare workers in our sample, however, the failure to implement their reporting obligation was related to their difficulty in resolving the conflict they felt between the obligation to report and their obligation to maintain patient confidentiality. Since so few healthcare workers in our sample are actually reporting teenage sexual activity to the police, however, it is impossible to determine the extent to which such reporting would in fact damage the trusting relationship that healthcare workers work hard to create and discourage teenagers from seeking care. (Although a higher level of reporting takes place vis-à-vis social workers, this may not have the

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<sup>278</sup> Wood et al. (2006), see footnote 110 above.

same effect as reporting to the police. Certainly many healthcare workers did not seem to perceive such reporting as a violation of confidentiality.) As noted above, the impact of reporting should be closely monitored. Moreover, the confidentiality and reporting bind within which healthcare workers find themselves should be further examined, as set forth in the next section.

## The Multiple Roles of Reproductive Healthcare Providers

Existing studies<sup>279</sup> on teenage pregnancy and reproductive health care in South Africa suggest that nurses' judgmental attitudes towards the sexual behaviour of teenagers present an obstacle to teenagers accessing appropriate contraception services and other critical elements of reproductive healthcare. The findings of this study are consistent with other studies that have found concerns about privacy to be a contributing barrier to teenagers' access to reproductive health care, which are set out in the discussion section.<sup>280</sup> In contrast to the findings of both Ehlers and the Wood et al. study referenced above, however, which were based primarily on information provided by patients,<sup>281</sup> this study, which focuses on health care providers, found most participants to be sensitive to such problems and frustrated by their inability to overcome teenagers' concerns.

One of the implied assumptions of these studies is that nurses can, and should, be morally neutral when they advise teenage patients on reproductive healthcare services.<sup>282</sup> The current study problematises this assumption. By focusing on the varied duties assigned to nurses, and on the ways in which they perceive and perform these duties in practice, this study highlights how nurses are caught in the middle of the contradictory and conflicting positions vis-à-vis teenage sexuality and reproductive rights that have become embedded in the legal framework.

While they are trained as medical practitioners, when it comes to teenage sexuality reproductive healthcare workers are expected to do far more than just provide medical treatment. These nurses are also a critical source of reproductive health education and serve as trusted confidantes on matters pertaining to sex. By virtue of

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<sup>279</sup> Ehlers (2003), Jewkes (2005), Wood and Jewkes et al (2006) - see notes 102, 110 above.

<sup>280</sup> Ehlers (2003) see footnote 102 above and Wood and Jewkes (2006) see footnote 110 above.

<sup>281</sup> Ehlers interviewed 250 adolescent mothers who were under 19 years of age when they gave birth to their child. Wood et al.' interviewed approximately 60 adolescent girls aged between 14 and 20 years; 35 in interviews and the rest in focus group sessions of 5-6 participants. They also interviewed 14 nurses for their study within individual and group interviews. The nurses all worked in clinics providing contraceptive services to adolescents and were all from the same or similar ethnic and cultural background as the adolescents. (Ibid at 110) Nurses' attitudes were identified in the study as a contributing barrier to adolescent patients' use of contraception. The nurses admitted to feeling "very uncomfortable giving contraception to adolescent girls", feeling obliged to give young girls "a lecture" and reinforcing the perception that young sexuality was (or should be) stigmatised ( at 113).

<sup>282</sup> Ehlers (2003) proposes nurses *should* play a role in providing adolescents with sexual education but qualifies that only nurses who have no moral objections to providing reproductive health services, should work in this practice area. Jewkes et al (2005) also suggests in relation to TOP services that nurses should opt be placed to work in this area - thereby removing those who have moral objections from interacting with patients - the implication being that those nurses who do have strong moral objections are unable to be objective in giving education and advice.

its reporting requirement, the SOA assigns nurses an additional role: namely that of “law enforcer.” As outlined below, the findings suggest that nurses are not all comfortable with each of these roles and that it is problematic to expect the same person to perform them all effectively.

The healthcare workers interviewed for this project spent a significant amount of time educating children and teenagers about sex. Some of the healthcare facilities included in the study even have resident “health promoters” who primarily fulfil an educational role. For many of those interviewed, this educational role was an attractive aspect of their job. It is important that healthy sex education messages are delivered to young people, to empower them to make informed decisions. Whether nurses are the appropriate role players to provide this service, however, should be questioned in light of the findings of this study. The content of the sex education should not and cannot be dictated by healthcare workers’ personal views on the morality of teenage sexuality, as this compromises their ability to provide effective health care. The educational content mentioned by participants varied, ranging from discussions about relationships and when a person should begin to have sex to the more technical matters of demonstrating use of a condom. This goes beyond the physiological and medical information that we might expect a healthcare professional to provide. This educational role is not, however, one which is formally defined within guidelines or protocols that were available to, or accessed by the participants in this study and the findings indicate that reproductive health care nurses do not receive adequate training that would provide guidance in fulfilling this role.

The absence of uniform training and objective guidelines for the content of sex education and reproductive healthcare counselling leads to inconsistent approaches among the participants. The approach of the nurses in our study confirms earlier research which suggests that in the absence of consultation and training, healthcare workers act as street-level bureaucrats<sup>283</sup> and therefore provide services and information according to what *they* believe is appropriate. In providing contraceptive services, the participants believed that it was better to give family planning than leave the child without protection and risk teenage pregnancy. But their approaches varied based on personal criteria, such as the age at which they believed young teenagers should be sexually active, which does not comply with the rights of children to access services without their parent’s consent from 12 years old. In absence of clear guidelines and training, some nurses try to consolidate the inconsistent messages of the various laws or else are guided by what they believe is in the interest of their patients.

The findings further suggest that this educational role is experienced by nurses as a heavy responsibility, and one which is not being adequately shared by other appropriate role players, such as parents and schools. When asked about possible strategies for reducing teenage pregnancies, the majority of respondents spoke about the need for more education and/or greater parental involvement. Yet there are obstacles associated with each of these resources. How and what schools ought to be teaching about sex is a question that society and government has yet to address

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<sup>283</sup> Walker and Gilson (2004) see footnote 88 above.

adequately, and the teaching that happens on these subjects in the Life Orientation Curriculum remains limited, unevenly implemented and plagued by practical challenges<sup>284</sup>. In the meantime, as a number of participants reported, some health-care workers have difficulty accessing schools and/or obtaining permission to demonstrate how to use contraceptives. The value of comprehensive sex, gender and sexuality education has been well established from both a public health and human rights perspective. Such education is vital in creating less rigid gender roles and fighting discrimination on the basis of gender and sexual orientation, and are a critical strategy for addressing HIV and AIDS, other STIs and unplanned pregnancy, and improving public health outcomes<sup>285</sup>. There is a need for a joint taskforce between the Department of Health and the Department of Education to establish a better curriculum for teaching sex education in schools, and allows access to schools by healthcare professionals.

The problem with parents is more complex. Many parents and children have trouble communicating about sex. Parents do not always know how to speak about this subject and may have moral beliefs about when and with whom sex is appropriate, while teenagers frequently do not want to speak to their parents about sex and reject their parents' morality. Both the Children's Act and the CTPA try to deal with this problem by enabling young girls to access reproductive health care without their parents' consent. But while this may ensure that more teenagers have safer and healthier sex (which is of course a crucial objective in itself), this approach does not address the educational gap. In other words, it allows children to avoid their parents' moral views and to obtain necessary protection without their parents' consent, but it does not assign to anyone else the role of filling the knowledge (and moral) gap.

Most of the nurses interviewed for this project seemed to find this vacuum of parental involvement problematic. They felt that young teenagers were not equipped to make a variety of reproductive health care decisions on their own, both because they felt that they were not sufficiently mature to understand the consequences and/or because they could not be relied upon to follow up on various aspects of their medical care. The result is that, contrary to what the law aspires to achieve, many nurses pressure patients to involve parents – or at least other family members or close friends – in their medical treatment. Further, carrying this burden on their own, and knowing that parents are not being made aware of their children's activities, may encourage reproductive health care providers to moralise or lecture patients in the way that a parent or another familiar adult might (but that may undermine public health goals).

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<sup>284</sup> See for example, Prinsloo, E. (2007) 'Implementation of life orientation programmes in the new curriculum in South African schools: perceptions of principals and life orientation teachers', *South African Journal of Education* 27(1), 155-170; Rooth, E. (2005) *An investigation of the status and practice of Life Orientation in South African Schools in two practices*. PhD Thesis, Faculty of Education, University of the Western Cape; Smith, K.A. & Harrison, A. (2013) 'Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa', *Sex Education* 13(1) 68-81; Jacobs, A. (2011) 'Life Orientation as experienced by learners: A qualitative study in the North-West province' *South African Journal of Education*, 31(2), 212-223.

<sup>285</sup> See for example, UNESCO (2007). *Review of Sex, Relationships and HIV Education in Schools*, Paris: UNESCO; UNFPA (2010) *Comprehensive Sexuality Education: Advancing Human Rights, Gender Equality and Improved Sexual and Reproductive Health*. Bogota, Colombia: UNFPA; and Buckley-Willemsse, B. (2005) *Sexuality education and life skills acquisition in secondary schools: Guidelines for the establishment of health promoting schools*. Dissertation, Potchefstroom: North-West University.

This behaviour, in which health care providers take on a role which moves beyond the neutral professional arena and into one which is more parental, may be reinforced by the terms of confidentiality by which nurses are bound. Thus, reproductive health care providers work to establish a relationship of trust, in which a child feels safe to talk and ask about sex in the way we would like children to be able to speak to their parents. Nurses become privy to important details of teenagers' lives but cannot share these with their patients' parents. This imposes a profound sense of responsibility on health care workers, particularly as in many cases they are part of the same community and personally know family members of their patients.

The SOA, of course, assigns to nurses an additional role: that of law enforcer. While it is not just nurses who have the obligation to report knowledge of an offence, nurses are in a particularly useful position from which to fulfil this obligation. Besides friends and family, it is they who are most likely to know if a teenage girl is having sex with her boyfriend and they will be the first to know if she is pregnant. When a teenage girl requests an abortion, it may be that her healthcare providers are indeed the only ones who would be in a position to report. Most of the nurses who participated in the study were not aware of their obligation to make such reports and training on the new provisions is urgently needed if government intends for these to be implemented effectively. Arguably, however, if training on the SOA for health-care workers is prioritised by government, resources would be better employed to rather focus on the duty to report cases of sexual abuse, which some nurses in this study stated they did not report. This is an area that would benefit from further research. This study corroborates existing research that suggests that medical professionals do not comply with mandatory reporting requirements for reasons including a lack of faith in child welfare systems.<sup>286</sup>

Among those practitioners who were familiar with the obligation to report the consensual sexual activity of their patients, only a few made such reports to the police. In some of these cases, the law enforcement role forced on these healthcare workers seemed to validate their moral positions on teenage sexuality and to legitimise their expression vis-à-vis their patients. Most, though, did not report to the police and were not comfortable with the role of law enforcer. A few suggested explicitly that reporting was unprofessional or that it violates their patients' trust, making it counterproductive to providing effective health care. Contrary to what the researchers expected, however, a surprising number did not feel particularly troubled about their confidentiality obligation when they reported their patients to social workers. One way to explain this lack of concern is that health care workers are eager to share the responsibility they feel for teenagers' sexual activity and welfare, both in terms of the circumstances of particular patients and in more general terms for dealing with the problems associated with teenage sexuality.

The picture that emerges from these findings is one in which the new access provisions, which purport to recognise a 12 year-old child's ability to make autonomous decisions about reproductive healthcare, in fact put increased pressure

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<sup>286</sup> Vulliamy & Sullivan (2000) see footnote 174 above; Melton (2005) See footnote 177 above; Bell and Toolman (1994) see footnote 180 above.

on healthcare workers. This is because it is hard to accept that children as young as 12 or 13 can make these decisions responsibly on their own; yet it is known that they cannot always make them successfully with their parents. The fact that the SOA criminalises the very decisions the Children's Act allows children to make supports this ambivalent understanding. The responsibility that healthcare workers feel, and their inability to share this burden with (or transfer it to) a patient's parents, may make it difficult to restrict their educational role to one which is technical and neutral, and may encourage them to lecture or moralise in ways which are counter productive. The expectation that nurses report cases of consensual sex to the police may both validate such moralising positions and undermine the trust that nurses need to earn in order to provide a safe space from which to offer effective health care.

## Directions for future discussions

This study highlights two fundamental questions that any reproductive healthcare framework must wrestle with: firstly, what are a teenager's best interests in terms of their sexual and reproductive wellbeing? And secondly, how can the state best protect these best interests?

As indicated above, the current framework includes different and inconsistent ways of defining a child's sexual best interests. While the SOA suggests that any sexual exploration is harmful for teenagers under the age of 16, the Children's Act remains neutral on this issue and adopts a more pragmatic and public health oriented approach. The attempt to enforce both of these visions, however, renders each less effective, while healthcare workers are caught in the middle. Tackling the issue of teenage sexuality thus requires that stakeholders join together to redefine the goals of the reproductive healthcare framework. It is important to reconsider, for example, whether it is in the best interests of children to condemn all sexual exploration, under all circumstances and with all partners, as *prima facie* harmful and subject to criminal sanction, even if the only way to enforce this is by violating patient confidentiality. The answer to these questions must take into account different notions of morality and public health concerns, as well as what is possible and practical to enforce. Defining a child's best interests should also include identifying models of sexual wellbeing as well as the values and knowledge that must be inculcated and taught in order to make healthy decisions. These questions must be settled, and best interests identified, before it is possible to determine how best to protect them. Such a discussion should involve educators, healthcare workers, social workers, psychologists, sociologists and various other professionals and experts on teenage sexuality that may have insight into these matters.

Once we have a better conception around what best interests we are striving to achieve, we will be in a better position to consider how best to achieve them: whether it is sufficient and possible to achieve these interests through education and empowering teenagers to make their own decisions, or whether it is necessary to regulate certain acts. It is critical, however, that a strategy be devised that integrates all relevant role players, including parents, educators and healthcare workers, such that each is able to fulfil their primary roles effectively, while providing support to



other role-players. It is crucial, furthermore, that individual role-players receive training that will not only guide them in the performance of their duties, but will teach the values that underlie the system such that they understand and accept their own positions within this system.

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