RECRAFTING SECTIONS 15 & 16 OF THE SEXUAL OFFENCES ACT TO ENSURE THE BEST INTERESTS OF THE CHILD

FINDINGS FROM THE 'CONDOMS? YES! SEX? NO!' PROJECT

BACKGROUND TO THE PROJECT

This project was conceived following training workshops on the Criminal Law (Sexual Offences and Related Matters) Amendment Act, Act 32 of 2007 [referred to as the SOA/The Act] conducted in 2010 for health care workers employed by the Provincial Department of Health in the Western Cape. During discussions, workshop participants reported different experiences in implementing the provisions of the SOA which criminalised consensual sexual intercourse between teenagers aged 12 to 15, and required anyone with knowledge of such an offence to make a police report. Health workers 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 that the conflicting responsibilities in the legislative framework around sexual and reproductive health care for teenagers created a real concern for health care workers who considered patient confidentiality to be an essential condition for effective healthcare, but who are also mandatory reporters under the law.

There was clearly much to be understood about how these conflicting provisions were being implemented in practice, and the GHJRU therefore embarked on a study to explore how health care workers who provide reproductive health care to teenagers manage these seemingly conflicting legal rights and duties. The full report of the findings of the project - entitled *'Condoms? Yes! Sex? No!'* - is available on our website at: www.ghjru.uct.ac.za/pdf/Condoms_Yes_Sex_No.pdf.

THE 'TEDDY BEAR CLINIC' JUDGMENT AND REPORTING OBLIGATIONS

In October 2013, the Constitutional Court delivered judgment in the case of the *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35) - commonly known as the 'Teddy Bear Clinic' case. The applicants challenged the constitutionality of Sections 15 and 16 of Sexual Offences Act, which criminalised **consensual** sexual acts between adolescents, aged 12 to 15, including both penetrative and non-penetrative sexual acts such as kissing, hugging and touching.

These provisions directly impacted sexual and reproductive healthcare providers as Section 54(1)(a) of the Sexual Offences Act obligates providers who have knowledge of the commission of a sexual offence against a child to report it to the South African Police Services ('SAPS') immediately. Section 54(1)(b) further puts in place criminal sanctions for anyone (including health care providers) who fails to report these offences. In fact, under the law a person who fails to report knowledge of a sexual offence can be liable to a fine or to imprisonment for up to five years or both.

In practice, this means that when teenagers presented themselves for contraception or other reproductive health services after sexual activity, healthcare practitioners were faced with the dilemma of deciding whether to report the teen to SAPS or face criminal liability for failure to do so.

Whilst the legislature's intentions in drafting Sections 15 and 16 was to protect teenagers from unwanted or ill-advised sexual activity, the implementation of these provisions have proven to be highly problematic and have not always resulted in the 'best interest of the child' being upheld. A recent example is the much-publicised Jules High School case that saw three teenagers prosecuted for what was considered 'consensual' sexual activity.

IN BRIEF:

This brief is based on findings from the 'Condoms? Yes! Sex? No!' research project, undertaken between 2010 and 2014 by the Gender, Health and Justice Research Unit in collaboration with the Western Cape Provincial Department of Health. The project aimed to document and analyse the experiences, challenges and best practices in providing sexual and reproductive health services to teenagers aged 12 – 15 years.

This policy brief focuses on the ways that the conflicting laws that make up the legal framework on sexual and reproductive health for adolescents undermine the best interests of the child imperative. It aims to inform policy makers, health systems role-players and civil society actors of steps that can be taken toward law reform to ensure that this standard is upheld, and to ensure greater and more consistent access to services for adolescents.

This policy brief is one of two that emanate from the findings of the project. The other one provides recommendations for improving service provision to teens through, among other things, guidelines on service provision for teens, improved training, reinforcing of the framework for ethical and professional care, improving intersectoral collaboration and designing youth-friendly services and clinics.

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The crux of the Applicants' arguments in the Teddy Bear Clinic case was that the provisions in question harmed the very adolescents that they sought to protect given that consensual sexual activity of the kind addressed by the Act is developmentally appropriate for adolescents, and criminalising such behaviour not only exposes them to the harshness of the criminal justice system, but also bars access to information and damages the development of a proper understanding of, and healthy attitude to, sexual behaviour. The Applicants further argued that the provisions were particularly punitive for girls in that if consensual sex resulted in pregnancy the medical practitioner who provided the girl with pre-natal care would be required to report the girl to the SAPS, and charges may result.

From a constitutional law perspective, the Applicants argued that Section 15 and 16 infringed children's constitutional rights to dignity, privacy, bodily and psychological integrity and the right to have their best interest treated as being of paramount importance in all matters concerning them. The central issue that the court had to decide on was whether it was constitutionally permissible for children to be subjected to criminal sanctions in order to deter early sexual intimacy and combat the risks associated with it.

The Constitutional Court were persuaded by the Applicants' arguments, and found the provisions unconstitutional insofar as they imposed criminal liability on children under 16 years and violated the best interest of the child principle. The order of invalidity was suspended for 18 months for the legislature to amend the Sexual Offences Act.

A CHALLENGING LEGAL FRAMEWORK

The provisions in question are part of the regulatory framework that shapes a particularly tricky aspect of reproductive health care service provision: services for adolescents. Section 12(2) of the Bill of Rights of the Constitution vests all people, including adolescents, with the right to bodily and psychological integrity which includes the right to make decisions concerning reproduction.

Several laws, regulations and policies breathe life into this constitutional right and make it applicable to children. The current legal framework does however contain a range of inconsistencies that create conflicts between legal provisions specifically in relation to consent and confidentiality.

- Section 14 of the Constitution states that all people living in South Africa have the right to privacy.
- Section 5 of the Choice on Termination of Pregnancy Act 92 of 1996 allows girls of any age to obtain a termination of pregnancy up to thirteen weeks upon request *without* the consent of her parent or guardian.
- Section 134 of the Children's Act 38 of 2005 provides that children from the age of 12 cannot be refused condoms and contraceptives without the consent of a parent or guardian and that this service must be kept confidential. However, under this Act health care workers who reasonably believe that a child has been abused or neglected must report the case to the Provincial Department of Social Development.
- Section 7 of the National Health Act 61 of 2003 provides health care services can only be provided with the patient's consent, that that all patient information must be kept confidential.

The Sexual Offences Act however, sets the age of consent to a sexual act at 16. This means that any sexual acts with a child are criminalised - whether or not the child gave consent (although consensual sexual acts are considered lesser offences and carry lighter penalties). Most importantly, the SOA limits children's rights to confidentiality in that it mandates that **anyone** with knowledge that a sexual offence has taken place to report this to the police. Under this Act, this includes cases where children aged 12-15 engage in consensual sexual acts.

These obligations are complex, and at times contradictory, and mean that in practice nurses, doctors and counsellors are expected to provide health care, support and counsel teenagers about their choices, but also to report to sexual offences to the authorities. Even though the court in the *Teddy Bear Clinic* case did find sections 15 and 16 unconstitutional, and referred them back to the legislature for amendment, the judgment has not - and will not - substantially change the complexities of service provision in practice until the amendments are made to the legal framework, and these changes are trickled down to front line service providers.

METHODOLOGY

The project made use of numerous methods to gather empirical evidence from a range of stakeholders, including interviews with nurses and counsellors at primary care facilities across the Western Cape. The project also reviewed laws, directives and policy documents, including the National Health Act, the Children's Act, the Termination of Pregnancy Act and the Sexual Offenses Act to provide the legal and policy framework within which these health care workers provided their services.

This policy brief summarises data gathered primarily from open-ended interviews with nurses providing sexual and reproductive health services in the rural and urban Western Cape. Consistent with its qualitative nature, the study utilised a small and non-representative sample. A total of 28 health care workers, identified by the manager at each facility, were interviewed for the project. The Administrative Assistant to the Regional Court President further identified five magistrates from the four research sites who were interviewed for the project. Research sites included hospitals and clinics in the Cape Town metropole, Winelands, West Coast and Overberg.

These data are supplemented by transcriptions of workshop discussions held with health care workers, stakeholders with experience in children's law, public health, sexual and reproductive health rights, and representatives from the

Western Cape Provincial Department of Health. The purpose of these workshops was to gain in-depth insight into the experiences of these role-players in navigating the existing conflicting laws around teenage sexual and reproductive health.

FINDINGS

In general, the project found that health care workers (both in the research and workshop phases of the project) were unclear about their obligations under the different Acts outlined above. As a result, many could only explain "what we do here", which amounts to inconsistent implementation of the laws. A particularly confusing area of the law for health care workers was the age of consent for sexual relations, and the legal age at which teenagers are entitled to access contraceptives and termination of pregnancies. Most health care workers that we spoke to were not aware that they had an obligation to report consensual sex between teenagers to the police (under the now-overturned provision of the SOA that have been declare unconstitutional and will be amended by April 2015), and many preferred to refer teenagers to a social worker instead. Some six months after the Teddy Bear Clinic judgment was handed down, few health care workers were aware of the case, or how it impacted their service provision environment.

Our results also clearly show the complex and often contradictory roles that nurses play in providing sexual and reproductive health care to teenagers: on the one hand they are expected to be providers and offer support, counselling, care and education about healthy and safe sexual behaviour. On the other hand, they are expected to act as law enforcers and report knowledge of illegal sexual activity and sexual abuse. Within this space, nurses struggled with confidentiality for their patients, many of whom were brought in to the clinic by a parent or family member, many of whom in need of information on teenage sexuality themselves. This created a sticky triad for nurses, who must protect confidentiality, provide information and also act in the best interests of the child.

INCONSISTENT KNOWLEDGE OF THE LAW

Nurses reported very uneven knowledge of the legal rights that children and teenagers have under the legal framework on sexual and reproductive rights, and the obligations that health care workers have in providing this care which results in uneven implementation.

Health care workers' knowledge of the legal framework is critical, as their understanding of the rights and obligations it contains informs how they provide reproductive care to children and teenagers. Few respondents had received training on these laws, and while a few interviewees had received input on some of the Acts, none had been trained on how these laws work together, and the impact this has on the way that they should provide services to teens. Age of consent for receiving sexual reproductive health services was especially confusing for nurses, and nurses were unsure of when and in what circumstances they are legally obligated to report a sexual offence under the Sexual Offences Act. While knowledge of these rights is not a guarantee that they will be implemented, making sure that healthcare workers receive this knowledge is a critical first step to ensuring access to these rights.

CONFUSING TERMINOLOGY

Some of the health care workers' confusion stemmed from the fact that they found the terminology in the different Acts inconsistent and confusing. For example, nurses were unclear about the difference between having a 'suspicion on reasonable grounds' (in the Children's Act) and having 'knowledge' of children committing a sexual offence (the SOA). They were unclear about what the 'best interests of the child' standard means, and how it needs to be applied. They were also unsure of the distinction between 'medical treatment' and a 'surgical operation', and were also unsure of the difference between giving 'consent' and of 'informed consent'.

PERSONAL VALUES AND SERVICE PROVISION

As a result of a lack of clear understanding of what the law prescribes, and how services *should* be provided to teens, nurses' own values and attitudes (often as mothers themselves) shaped how they interact with their clients. While the nurses recognised there are very good reasons that parental consent for reproductive health care should not be required, especially in cases of domestic abuse, or where a child would otherwise avoid seeking health services, they were uneasy with the gap that is created where parents are not involved in teaching teenagers to make informed and deliberate decisions about when, where, how and with whom to have sex. The nurses we interviewed 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. Some felt conflicted between the course of action dictated by their professional training and what they felt was (morally) right as adults or as parents.

The study's findings clearly show 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 health care workers, when it comes to teenage sexuality they are expected to do far more than just provide medical care: they and are a critical source of reproductive health education and serve as trusted confidantes on matters pertaining to sex. The role of "law enforcer" - as assigned by the SOA - is therefore an uncomfortable fit.

Finally, the absence of appropriate, uniform training and guidance for health care workers on the content of law and their role as educators, counsellors and service providers leads to inconsistent approaches among the participants, and undermines the provision of quality, compassionate health care to teens.

RECOMMENDATIONS

The findings from the Conflicting Laws project suggest that health care workers are not adequately equipped to provide navigate the conflicting roles and obligations in providing sexual and reproductive health services to adolescents aged 12 – 15 years.

The current legal framework contains different, and inconsistent, ways of defining a child's best interests in terms of sexual activity. While the SOA suggests that any sexual exploration is harmful for teenagers under the age of 16, the Children's Act adopts a more neutral, pragmatic and public health oriented approach. The attempt to enforce both of these visions, however, renders each less effective, and leaves health care workers caught in the middle, with little guidance on either the content or context of the law.

LAW REFORM

Incorporating the 'Best Interests of the Child' Standard: Any legislative amendments involving children must meet the requirements of Sections 12, 14 and 28(2) of the Constitution which provides that a child's best interest is of paramount importance in every matter concerning the child. Determining the best interest of a child in any circumstances requires a complex and holistic analysis which must take into account a range of factors, including the child's well-being and ensuring that the child develops into a well-adjusted adult.

The Children's Act sets out a range of factors that must be considered when deciding whether a decision is in the best interests of the child, but it is only obligatory to apply these factors where the Children's Act requires such an application. These factors include, amongst others, considering the nature of the relationship between the child and a parent or caregiver; the attitude of the parent or caregiver towards the child; the capacity of the parent to fulfil the various needs of the child; the child's age; maturity; stage of development; emotional security; background and need for protection. Although not specifically applicable to the Sexual Offences Act, these factors can nevertheless go a long way in providing guidance for the Legislature in amending the Act. By using the 'best interests of the child' standard in amending the Sexual Offences Act the legislature can create clarity and consistency for service providers in regard to children's rights to privacy and confidentiality, and can improve the legal framework on sexual and reproductive health service provision for teens.

Strengthening Definitions under the Children's Act: To strengthen and better align the legal and policy framework that regulates the provision of sexual and reproductive health services to teens such that It both encourages healthy sexual behaviour, while also recognising the particular vulnerabilities to sexual violence that these teenagers face, the legislature should strengthen the definition of sexual abuse under the Children's Act, and bring it in line with those in the SOA.

IMPROVING SERVICE PROVISION

Collaboration: Adolescents, especially girls are vulnerable to sexual violence and abuse, and health care workers play an important role in identifying these cases and providing support to the survivor. This requires complex and sensitive health care provision at the intersection of the health and criminal justice system, with close collaboration with the Department of Social Services and strategies to initiate and maintain effective working relationships with the various sectors involved. To this end, we recommend that health facility should have direct contact with a designated representative of the local South African Police Service (SAPS), to assist with cases of suspected or confirmed sexual violence. Similarly, members of the local SAPS should be trained in the provisions of the Acts covering adolescent sexual and reproductive health care, as well as the new regulations that are to replace Section 15 and 16 of the Sexual Offenses Act.

Adolescent-friendly Services: In order to create adolescent-friendly, comprehensive sexual and reproductive health care services that are sensitive to adolescents' needs and attentive to their vulnerabilities, we recommend the following:

- ***Provide clear, practice-focused guidance for health care workers to use in the clinic setting*** that can assist nurses with assessing age of consent, guidance as to when to report, who to report to, and how best to act in the best interests of the child, as well as guidance on how to work and communicate with teenagers about health, sex, sexuality and violence.
- ***Improve training of health care workers providing sexual and reproductive health services to teenager,*** particularly on the SOA, the Children's Act, the National Health Act and the Termination of Pregnancy Act, the policies that guide their service provision and the differing roles that are assigned to them under these Acts. This training should be incorporated into health professions education at tertiary institutions, professional development courses and in-service training by the Department of Health. Nurses should be supported in seeking training through study leave and appropriate alternative staffing to cover their services.
- ***Reinforce the framework of ethical and professional care in sexual and reproductive health service provision*** to encourage nurses to provide services to adolescents in a professional and non-judgmental manner.
- ***Design youth-friendly sexual and reproductive health services and clinics*** for example through providing youth-specific services, including contraception services, HIV counselling and testing, and advice on termination of pregnancies once a week at a specified time; having designated youth-friendly staff, who want to work with youth, and have expertise in adolescent sexual and reproductive health care; and ensuring that every health facility provides safer sex resources for opposite sex and same sex couples (e.g. condoms, dental dams and lubricant).

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