ADOLESCENT ACCESS TO HIV PROTECTION MEASURES IN SOUTH AFRICA: A NUANCED UNDERSTANDING OF THE INTERSECTION BETWEEN LAW, PUBLIC HEALTH, AND ETHICS

BY

JACINTHA D. TOOHEY

A thesis submitted in partial fulfillment for the requirements for the degree of Doctor of Philosophy by Published Works at the University of Central Lancashire.

February 2024

RESEARCH STUDENT DECLARATION

Type of Award: Doctor of Philosophy by Published Works
School: School of Sport and Health Sciences

1. Concurrent registration for two or more academic awards

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution.

2. Material submitted for another award

I declare that no material contained in the thesis has been used in any other submission for an academic award and is solely my own work.

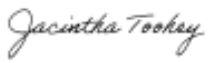
3. Collaboration

Joint-authored publications have been acknowledged in the thesis, and my contributions were confirmed by co-authors prior to registration for the award.

4. Use of a Proof-reader

A proof-reading service was used for the bibliography and footnotes - Dr Rose Kuhn.

Signature of Candidate



Print name: Jacintha Toohey

ABSTRACT

In South Africa, adolescents are at high risk of HIV infection. Legal barriers block access to critical public health services for adolescents; consent requirements for adolescents are complex, and healthcare professionals have a mandatory obligation to report suspected unlawful sexual activity involving adolescents. In this synoptic commentary, the role of South African law in supporting public health priorities is examined to find a balance between reducing the burden of HIV in the country, especially amongst adolescents, and providing protection for adolescents through consent/reporting requirements for unlawful sexual activity. Underpinned by a contextual and human rights approach, it is shown that South African law intersects with public health imperatives and ethics in HIV prevention for adolescents.

Eight selected peer-reviewed publications and two South African AIDS Conference poster presentations are included in this review. Commencing in 2007, the body of work has been developed through legal research using human rights approaches. For the purpose of this thesis, an in-depth reflective appraisal of the published works was undertaken to reveal themes and the primary contributions to knowledge. Reflective analysis was facilitated via the application of a bespoke appraisal framework.

Critical appraisal has highlighted the complexity associated with the interpretation and enactment of existing laws (for instance, overly restrictive or contradictory provisions) related to the public health strategy for addressing HIV infection in adolescents. Central to these challenges is the dual role of the law: adolescent consent laws must both support responsible sexual behaviour and reproductive health whilst also enabling protective measures.

This body of work contributes to a better understanding of the legal norms relating to HIV interventions for adolescents and how access to essential public health services for adolescents might be improved. Within the context of South Africa's burden of HIV amongst adolescents, a balanced but coherent rights-based approach is required for effective interaction between public health, law, and ethics.

Funding

The published works were supported by the SA AIDS Vaccines Initiative (SAAVI) and the National Institutes of Health award (1RO1 A1094586) CHAMPS (Choices for Adolescent Methods of Prevention in SA).

TABLE OF CONTENTS

GLOSSARY OF ABBREVIATIONS AND TERMINOLOGY

CJS	Criminal Justice System
CRC	Convention on the Rights of the Child
CHAMPS	Choices of Methods of Adolescent Prevention Study
CIOMS	Council for International Organizations of Medical Sciences
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
NIH	National Institutes of Health
EDCTP	European & Developing Countries Clinical Trials Partnership.
DTHF	Desmond Tutu Health Foundation
HAVEG	HIV AIDS Vaccine Ethics Group
NIH	National Institute of Health (NIH)
NDoH	National Department of Health
NSP	National Strategic Plan
NPA	National Prosecuting Authority
NDPP	National Director of Public Prosecutions
PrEP	Pre-Exposure Prophylaxis
PICO	Population, Intervention, Comparison, and Outcomes
RECs	Research Ethics Committees
SAAVI	South African AIDS Vaccine Initiative
SAHCS	Southern African HIV Clinicians Society
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation

"Child" means a person under the age of 18 years. Child/children in this context should be taken to refer to minors, and more specifically, adolescents between the ages of 12 to 15 and 16 or 17 years old.

"Best interests of the child "is entrenched in the South African Constitution, 1996, as a right. The Children's Act, 38 of 2005 provides general legal provisions which cover all matters concerning the care, protection, and well-being of a child. The standard that the child's best interest is of paramount importance must be applied with consideration of a range of factors described in the law.

"Evolving capacity" concerns a child's development linked to the principle of increasing autonomy.

"Harm and exploitation" refers to any of the following - **"Exploitation,"** defined in the Children's Act, 38 of 2005, as (but limited to) all forms of slavery or practices similar to slavery, forced marriage, and sexual exploitation. **"Commercial sexual exploitation"** is a form of illegal sexual activity or **"abuse"** refers to any form of harm or ill-treatment, including, but not limited to, **"sexual abuse,"** which includes sexual molestation, assault, procuring, inducing, forcing a child into such activities.

"Health research," defined in the National Health Act 61 of 2003, refers to any research that contributes to knowledge of biological, clinical, psychological, or social processes in human beings, improving methods for the provision of health services, the effects of the environment on the human body, and the development of new applications of pharmaceuticals, medicines, and health technology.

"Protective measures" refers to protective mechanisms that need to be in place (from a child-oriented human-rights approach in the dual role of law and ethics), recognising evolving capacity but that adolescents have not yet achieved the full capacity of an adult.

ACKNOWLEDGEMENTS

Thank you, Ngiyabonga, en Baie dankie,

To my exceptional Supervisors, Professor Doris Schroeder and Dr Kate Chatfield, I would like to express my deepest appreciation for your commitment to undertaking this journey with me.

Both of you represent qualities that Sir Andrew Likierman, best articulates in his article, 'The elements of good judgment', as being able to *'cultivate learning, trust, experience, detachment, options, and delivery.* '[1] You taught me *to d*elve deeper into critical thinking and reflect on higher-order thinking while remaining relevant to the real world—all within the art of *good judgment*. With your knowledge, unwavering patience, and motivation, I have had the opportunity to reach a goal I did not see within my reach. Your impact on my development academically and personally is for a lifetime.

I would like to thank Dr. Kenneth Young, my Research Degrees Tutor, for your tremendous support in facilitating my progression during the writing period. Thank you to the UCLan Research Admissions team for assisting me with my Ph.D. by Published Works off-campus and remotely. I sincerely thank C4Globe (a University of Central Lancashire Centre) and the University of Kwa-Zulu Natal, University Capacity Development Programme Plan (UCDP), funded by the Department of Higher Education and Training, for financially supporting my tuition.

The Ph.D. by published works is a culmination of works spanning over ten years of research that began in my early days in academia. In particular, I worked with the HIV/AIDS Vaccines Ethics Group, led by Dr. Catherine Slack, who facilitated opportunities for an interdisciplinary approach to legal scholarly contribution. My colleague and friend, Dr. Zaynab Essack, an excellent research collaborator. To Professors Michael Kidd and Darren Subramanien for facilitating processes in the School of Law so that I could focus on this thesis.

To Professor Ann Strode, an extraordinary human being. You are my dear friend and strong mentor who believes in my abilities. Thank you for being my intellectual soundboard and, at times, lifting my heavy head and heart to stay focussed on the path amidst all the curveballs life throws our way.

To my biggest supporter, my husband, and my best friend, Anthony, for creating distractions and maintaining routines for Jenna and Kellan so that 'mum could work in peace and quiet.' You are my rock! My two precious children, I hope I have inspired you and not put you off the lifelong learning process. My mum, thank you for your constant text messages from Australia, my source of strength and encouragement no matter how wide the ocean between us is. I love you!

[1] A. Likierman. (2020). 'The elements of good judgment.' *Harvard Business Review,* 98(1), 102-111. Available at https://ir.westcliff.edu/wp-content/uploads/2020/01/The-Elements-of-Good-Judgment.pdf . Accessed on 25 June 2023.

LIST OF INCLUDED PUBLICATIONS

Peer Reviewed Articles (8)

1. *Strode, A., and **Toohey, J.**, et al. (2013). Reporting underage consensual sex after the Teddy Bear Clinic case: A different perspective. South African Journal of Bioethics and Law, 6(2): 40-42.*
2. *Strode, A., Richter, M., Wallace, M., **Toohey, J.**, and Technau, K. (2014). Failing the vulnerable: Three new consent norms that will undermine health research with children. Southern African Journal of HIV Medicine, 15(2): 46-49.*
3. *Strode, A. E., **Toohey, J.**, Singh, P., and Slack, C. M. (2015). Boni mores and consent for child research in South Africa. South African Journal of Bioethics and Law, 8(1): 22-25.*
4. *Essack, Z., **Toohey, J.**, and Strode, A. (2016). Reflecting on adolescents' evolving sexual and reproductive health rights: canvassing the opinion of social workers in KwaZulu-Natal, South Africa. Reproductive Health Matters, 24(47): 195-204.*
5. *Strode, A., **Toohey, J.**, and Slack, C. (2016). Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa. South African Medical Journal, 106(12): 1173-1176.*
6. *Essack, Z., & **Toohey, J.** (2018). Unpacking the 2-year age-gap provision in relation to the decriminalisation of underage consensual sex in South Africa. South African Journal of Bioethics and Law, 11(2): 85-88.*
7. *Strode, A., Slack, C. M., Essack, Z., **Toohey, J. D.**, & Bekker, L. G. (2020). Be legally wise: When is parental consent required for adolescents' access to pre-exposure prophylaxis (PrEP)? Southern African Journal of HIV Medicine, 21(1): 1-5.*
8. ***Toohey, J. D.**, & Strode, A. (2021). "A critical review of the South African legal framework on adolescent access to HIV prevention interventions." South African Journal of Bioethics and Law, 14(1): 16-19.*

Please see Appendix 5 for the full-text articles.

Conference Poster Presentations (2)

1. ***Toohey, J.**, Strode, A. & Slack, C. (2007). Poster presentation. Legal obligations on researchers to report maltreatment, abuse, and neglect of children: implications and complexities. 3rd SA AIDS Conference. June 2007. Durban, South Africa.*
2. ***Toohey, J.**, Strode, A., & Slack, C. (2015). Poster presentation. Does South Africa's law facilitate the mass roll out of medical circumcision for adolescent boys? June 2015. 7th SA AIDS Conference, Durban, South Africa.*

Relevant Research Projects (3)

1. *South African AIDS Vaccine Initiative/South African Medical Research Council (SAAVI/SAMRC): Strengthening the Ethical-Legal Framework for South African HIV Vaccine Trials (HVTs).* Jan 2012-Sept 2013. Appointed as Research Assistant to conduct conceptual research and edit overall drafts in developing an online, 'certificate-generating' module on ethical-legal issues in adolescent HIV prevention trials in a co-sponsored collaboration with the TRREE programme.

2. *KwaZulu-Natal (KZN) Legislature Social Development Portfolio Committee and School of Law, University of KwaZulu-Natal (UKZN).* Oct 2013-Mar 2014. Appointed as Researcher in a collaborative effort with senior researchers at the Social Development Portfolio Committee, Kwa-Zulu-Natal Legislature, and the School of Law, UKZN. Undertook research, interviewing participants, transcribing data, contributing to the manuscript, developing the research findings, co-authoring the report, and subsequent peer-reviewed publication from the study.

3. *NIH-EDCTP-DTHF: Choices of Methods of Adolescent Prevention Study in South Africa (CHAMPS)* - 1RO1 A1094586. Apr 2012-Jun 2017. Appointed as Research Consultant to conduct legal research, review, and analyze relevant South African legal framework concerning adolescent access to specific HIV prevention interventions. Prepared legal memo drafts and contributed to manuscript development for journal publication in close collaboration with team members.

1 INTRODUCTION

In South Africa, the risk of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) infection among adolescents remains high and thus a serious public health issue.[2] There are a number of interconnected risk factors driving this national challenge, which include, but are not limited to, poor socio-economic conditions (linked to dependency-driven intergenerational, age-disparate relationships), early sexual debut(related to insufficient sexual and reproductive health education), a lack of social or family support structures, and poor health choices.[3]

As such, it is important that the South African government not only ensure the provision of targeted public health interventions but also monitor and identify barriers, such as punitive laws, which block access to critical public health services for adolescents. This untenable situation catalysed extensive work on *Adolescent access to HIV protection measures in South Africa: A nuanced understanding of the intersection between law, public health, and ethics*.

The work in this area began with research contributions to three South African, internationally funded research projects and conference poster presentations focusing on ethical-legal issues in adolescent HIV prevention trials and adolescent access to HIV prevention services (2007-2017). The body of research focuses on the intersection between South African law, ethics, and public health objectives concerning HIV prevention. It was undertaken from a human rights perspective.

This synoptic commentary draws upon the collection of published works that aimed to clarify whether legislation enables better achievement of public health objectives, specifically adolescent HIV prevention, in two branches of law. First, the civil law approach, for example, the Children's Act 38 of 2005 (hereafter referred to as Children's Act, 2005), which appears to be progressive based on legal provisions that promote adolescent evolving capacity (e.g., self-consent to access certain sexual and reproductive health services like HIV testing and condoms). However, the law also plays a *protective* role in children's evolving capacity (e.g., by including age-appropriate decision-making measures). Second, the criminal law approach, for example, the Criminal Law (Sexual Offences and Related Matters) Act 32 of 2007 (hereafter referred to as Sexual Offences Act, 2007), which appears to promote evolving capacity concerning decriminalising adolescent consensual sexual activity but maintains certain protective measures to prevent harm or exploitation.

[2] National Strategic Plan (NSP) 2017 – 2022.p25. Available at *https://www.gov.za/sites/ default/files/gcis_document/201705/nsp-hiv-tb-stia.pdf* Accessed on 13 January 2024.

[3] Mabaso, M., Maseko, G., Sewpaul, R., Naidoo, I., Jooste, S., Takatshana, S., ... & Zungu, N. (2021). Trends and correlates of HIV prevalence among adolescents in South Africa: evidence from the 2008, 2012 and 2017 South African National HIV Prevalence, Incidence and Behaviour surveys. *AIDS Research and Therapy,* 18(1), 97.

This commentary assesses how the published works, developed over the past ten years, helped form a theoretical construct to understand better how the law (and ethics) intersect with South Africa's public health approach to HIV prevention amongst adolescents. Synthesis and reflective appraisal of the works demonstrate key interactions, linkages, parallels, and overlap between elements in the research regarding adolescent sexuality and reproduction. The core thread and focus is that at the intersection between the law, the public health response, and ethics concerning adolescent sexuality and reproduction, decision-making and actions must be guided by a protective human rights approach.

The objectives of this synoptic commentary are twofold:

a. To undertake a critical appraisal of published work at the intersection of public health, law, and ethics concerning adolescent sexual reproductive health in South Africa and
b. To demonstrate how this body of work makes a significant and original contribution to knowledge in this field.

1.1 Chapter summaries

The chapter summaries are set out as follows:

- Chapter 2 provides background for the South African contextual realities relating to the prevalence of adolescent HIV infection, the South African government's public health response, and legal developments concerning adolescent sexuality and reproductive health. The chapter also highlights that revisions in the law must take into account the contextual realities of South African society.

- Chapter 3 describes the case of *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35 (referred to as the Teddy Bear Clinic case) as significant for law reform in adolescents' consensual sexual activity (age range 12 – 15 years), highlighting key human rights violations against adolescents.

- Chapter 4 provides an overview of the methods taken in the published works and this critical appraisal.

- Chapter 5 discusses the dual role of law in advancing adolescents' right to health based on child-oriented human rights approaches (a common strand articulated throughout the published work).

- Chapter 6 sets out how this body of work contributes significantly to knowledge in this field and concludes the commentary.

2 BACKGROUND

2.1 HIV Prevention in South Africa

South Africa has a population of 59.39 million people. According to statistics from 2022, the largest share of the South African population are children aged between 10 and 14 years (over 5.7 million people).[4]

While the Joint United Nations Programme on HIV/AIDS (UNAIDS) praised South Africa for progressive HIV policies, and while there has been a significant national (and international) effort over the last decade to reduce the spread of HIV/AIDs, the burden of disease remains high, with adolescents a key, at-risk population group.[5]

Globally, it was reported in 2020 that approximately 37.7 million people were living with HIV and 1.5 million new infections.[6] Of this total, an estimated 410,000 new HIV infections were in individuals from 10 to 24 years of age.[7] According to Statistics South Africa, in 2021, South Africa was bearing one-fifth of the global HIV burden with an estimated HIV prevalence rate of 19% and an estimated 8.2 million people living with HIV.[8]

In 2021, a Department of Basic Education report was presented at a South African Parliamentary Portfolio Committee meeting.[9] According to this report, there were approximately 1,300 new HIV infections among adolescent girls and young women weekly.[10] These indicators are concerning since they provide strong evidence that children are engaged in underage, unprotected sexual activity, which is the leading cause of HIV transmission amongst this at-risk population.

South Africa has a National Strategic Plan 2017-2022 to address HIV/AIDS, TB, and sexually transmitted infections (STIs). The fourth *South African National Strategic Plan 2017-2022* (hereafter, the NSP) sets out a comprehensive prevention plan for reducing new cases of HIV, TB,

[4]Statista. 'Population of South Africa in 2022, by age group and gender.' Available at *https://www.statista.com/statistics/1330839/population-of-south-africa-by-age-group-and-gender/* Accessed on 09 May 2023.
[5]UNAIDS. 'South Africa takes bold step to provide HIV treatment for all.' Available at *https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/may/20160513_UTT#:~:text=On%2010%20May%202016%2C%20the,with%20HIV%20by%20September%202016. Accessed on 09 May 2023.*
[6] UNAIDS. Global HIV & AIDS statistics. Fact sheet. Available at *https://www.unaids.org/en/resources/fact-sheet.* Accessed on 22 April 2022.
[7] HIV and AIDS in adolescents. July 2021. Available at *https://data.unicef.org/topic/hiv-aids/* Accessed on 22 April 2022.
8 World Population Review. HIV Rates by Country 2022. *https://worldpopulationreview.com/country-rankings/hiv-rates-by-country*. Accessed online 04 May 2022. See also Statistics South Africa. Statistical Release-P0302. Mid-year population estimates 2021. *http://www.statssa.gov.za/publications/P0302/P03022021.pdf* Accessed on 04 May 2022.
[9] City Press. Macupe, B. (2021). Every week, 1 300 adolescent girls and young women are infected with HIV. Available at *https://www.news24.com/citypress/news/every-week-1-300-adolescent-girls-and-young-women-are-infected-with-hiv-20210907* Accessed on 04 May 2022.
[10] ibid

and STIs. The NSP has eight goals with clear objectives, sub-objectives, and activities supporting the framework.

Goals 3 and 5 of the NSP include customised efforts to focus on key vulnerable populations, promoting human rights and access to justice. The emphasis is upon developing laws and policies, monitoring, and identifying gaps impacting key vulnerable populations' access to HIV prevention services. Goal 5 includes an urgent appeal to resolve the challenges raised in implementing a plan to address the tensions that exist between the Criminal Law (Sexual Offences and Related Matters) Act 32 of 2007, the Children's Act 38 of 2005, and the National Health Act 61 of 2003 (hereafter referred to as the National Health Act, 2003).[11]

In addition, Goal 8 sets a strategic approach to strengthen evidence-based information and critical prevention programmes through a coordinated research agenda to drive progress toward achieving NSP Goals. This includes access to and development of HIV treatment and prevention interventions or diagnostics.[12]

2.2 Consent norms in South Africa

In South Africa, the ages of consent have been extensively legislated. The age of full legal capacity, when a child becomes an adult (or legal major), is set at 18 years. The selected articles reflect on the implications of the changes in criminal law, which maintains that legal consent to have sex can be given from the age of 16 while also maintaining that adolescents between the ages of 12 and 15 can consent to sex without criminal sanction.

The published works interpret the impact of changes in criminal law on adolescent self-consent for specified health-related services provided in civil law. For instance, civil law has created a consent norm for adolescents self-consent from 12 years old to access certain health services like HIV testing, HIV status counselling, and contraceptives (including condoms). In other instances, the age of self-consent depends upon the nature and implications of the specific health-related intervention (see Appendix 1, Table 4). Nevertheless, each health intervention, even those corresponding with the minimum allowable age of 12 years for self-consent, specifies a slightly different set of corresponding requirements to aid the adolescent decision-making processes. The

[11] National Strategic Plan (NSP) 2017 – 2022. Available at *https://www.gov.za/sites/default/files/gcis_document/201705/nsp-hiv-tb-stia.pdf*. Accessed on 04 May 2022.

[12] NSP, p 47 provides:

> *"Research helps develop new prevention and treatment technologies and drugs, optimise the delivery of interventions and strategies, and answer key implementation questions not fully addressed through surveillance and surveys. South African researchers have been involved in many multi-country and local studies including those being used to inform this NSP. These include the investment cases for HIV and TB, the use of PrEP, sexual transmission pathways, short course preventive therapy for TB, treatment choices for MDR TB ,programmes that reach adolescent girls and young women, and models to improve differentiated care. Think Tanks for HIV, TB and STIs established by the National Department of Health are further vital assets in driving innovation and interpreting new knowledge to address the three epidemics."*

law appears to take a nuanced approach in matters concerning adolescent sexual reproductive health.

Additionally, certain age-related consent provisions, including those with corresponding decisional-support requirements, do not consider contextual factors like the developmental stages of adolescence (for instance, that the younger the child, the greater the need for decisional support) in implementing adolescent access to specified HIV prevention services. For example, where consent to specific health services is generally from the age of 12, early pubescent adolescents (between 9 and 11 years) who might be engaged in sex cannot self-consent and would thus require parental consent to access the same health interventions. This could be problematic because adolescents fear parental involvement, and the requirement may hinder access to key HIV prevention services. There is a substantial body of literature addressing the pros and cons of adolescent ages of consent, which suggests that the more severe, lasting, and high-risk the implication of a particular health-related matter is, the less independence and autonomy the child can express.[13]

Despite the extensive legislation in South African health law relating to children, challenges remain to the age of consent provisions in the legal framework. One such challenge, for example, was the criminal law provision concerning adolescent consensual peer-related sexual activity.[14] As indicated earlier, legal consent to sex is from 16. Thus, a child below the age of 16 could not consent to sex. In this instance, the legal position was that criminal law could override civil law as statutory rape has been committed. Legislators have attempted to address this tension by amending to distinguish between the legal capacity to consent to sex at 16 and the legal provision for decriminalising sexual activity amongst adolescents.[15] This has now been clarified in the law concerning the amendments to section 15 (hereafter referred to as s15) and section 16 (hereafter referred to as s16) of the Sexual Offences Act, 2007).[16]

As a law scholar researching health law and ethics, the changes to s15 and s16 of the South African Criminal Law (Sexual Offences and Related Matters) Amendment Act 5 of 2015 (hereafter referred

[13] G Lansdown. (2005).' The evolving capacities of the child.' (No. innins05/18). UN*ICEF Intentional Research Centre*. Available at *https://ideas.repec.org/p/ucf/innins/innins05-18.html. Accessed on 09 May 2023;* Barr-DiChiara, M., Tembo, M., Harrison, L., Quinn, C., Ameyan, W., Sabin, K., ... & Johnson, C. (2021). Adolescents and age of consent to HIV testing: an updated review of national policies in sub-Saharan Africa. BMJ open, 11(9), e049673; Shah, S. K., Essack, Z., Byron, K., Slack, C., Reirden, D., van Rooyen, H., ... & Wendler, D. S. (2020). Adolescent barriers to HIV prevention research: are parental consent requirements the biggest obstacle? Journal of Adolescent Health, 67(4), 495-501 and Mollel, Loveday, M., Goga, A., Dhai, A., Labuschaigne, M., Roussouw, T., Burgess, T., ... & Bekker, L. G. (2022). Ethically acceptable consent approaches to adolescent research in South Africa. Southern African Journal of HIV Medicine, 23(1).
See: https://www.unaids.org/en/resources/presscentre/featurestories/2022/february/20220214_parental-consent
See also *Christian Lawyers' Association of South Africa v Minister of Health (Reproductive Health Alliance as Amicus Curiae)* 1998 (4) SA 1113 (T) where the court held that:
> *"capacity is an intrinsic element of consent to a health intervention even if the legislature has set an age at which they are presumed to have capacity to consent to sex is based on age rather than decision-making capacity."*

[14] s15 and s 16 of the Sexual Offences Act, 2007.
[15] Discussed in Chapter 3 concerning the *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35 (referred to as the Teddy Bear Clinic case).
[16] s15 and s16 of the Sexual Offences Act, 2007.

to as the Sexual Offences Amendment Act, 2015) have been articulated in the body of published works. This has been achieved through legal interpretative methods (described in Chapter 4) to contribute to the field concerning adolescents' access to HIV protection measures where there is an intersection between public health, law, and ethics.

The scope of the previous criminal law provisions (Sexual Offences Act, 2007) concerning sexual offences against children was too broad, resulting in harmful consequences, including consensual sexual activity among adolescents. In other words, adolescents would be exposed to the criminal justice system as demonstrated in the National Prosecutorial Authority (NPA) Jules High School rape case and discussed in the Teddy Bear Clinic case. [17, 18] This has involved being charged, arrested, subjected to prosecution by the National Director of Public Prosecutions (NDPP), and, if convicted, sentenced and included in the National Sexual Offences Register.

By decriminalising consensual sexual activities between adolescent peers, the amendments in the law now aim, to some extent, to prevent such an arbitrary interface with the justice system. It means that adolescents engaged in consensual sexual activity between the age range of 12 to 15 can now also consent to specified health-related services. As provided in the South African Children's Act, 2005, from the age of 12, adolescents engaged in consensual sexual activity may access such services without fear of interaction with legal consequences for disclosing their sexual activity since:

a. there is no longer criminal sanction where children between 12 and 15 years consent to peer-to-peer sex and
b. there is no longer criminal sanction where children aged 12 to 15 years consent to sex with a person aged 16 or 17 years, provided there is no more than a two-year age gap between them.

However, despite the changes in the law, gaps remain in the legal provisions concerning adolescent sex, as some underage peer-related consensual sex is still considered a criminal offence. For example, the amendments to the criminal law indicate that the NDPP has the discretion to authorise prosecution for a sexual offence where the adolescent (aged 16 or 17) is engaged in a sexual relationship with an adolescent (aged 12 to 15) where there are more than two years in the age gap.[19] The older adolescent (16 to 17) could face criminal prosecution. In addition, the younger adolescent (12 to 15 years old) may face exposure to the criminal justice

[17]See South African Government. Media Statement. 2010. Jules high school rape case. Available at https://www.gov.za/jules-high-school-rape-case Accessed on 03 May 2023.

[18] National Prosecutorial Authority. 2010. "NPA Charges Jules High School Boys and Girl . Media Release. Available at *https://www.npa.gov.za/sites/default/files/media-releases/Nov-17_NPA-Charges-Jules-High-School-Boys-And-Girl.pdf* Accessed on 15 June 2023.

[19] This case was important in consideration of the human rights violations and the children's interface with the criminal justice system. This case demonstrated the NDPP's discretion to authorise prosecution. Once the NDPP authorises prosecution of the person(s) charged with a sexual offences, the process of criminal justice will then include the 12 to 15 year old, even if they are not prosecuted. They will still have to interact with the CJS to provide witness testimony as to their involvement with the accused. This may have the effect of psychological harm and social stigma to the adolescent as was the case in the Jules High School case.

process and, thus, experience harmful consequences associated with such a process while providing evidence against the older adolescent.

2.3 Mandatory reporting obligations in South Africa

The law is recognised as a critical component in facilitating or hindering the implementation of public health priorities. South Africa has a liberal Constitution because it refers directly to health care, including sexual and reproductive health (SRH). HIV prevention falls within the ambit of SRH.[20]

Section 27(1) of the Constitution of the Republic of South Africa (hereafter referred to as either the Constitution, 1996 or the Constitution) provides a right to access health care services (including SRHs), thus recognising sexual and reproductive health rights (SRHRs) as a priority. Further, section 12 states that everyone has a right to make decisions relating to sexual and reproductive health (SRH). These rights could only be fully realised where legal provisions indicate how these rights apply to everyone, including children, as previously discussed concerning the development of South African child consent norms. However, in some instances, these rights can be limited. Section 36 states that there are instances where rights may be limited where it is 'reasonable and justifiable' in an open and democratic society based on dignity, freedom, and equality. This means that certain provisions of child consent laws can be limited in certain 'reasonable and justifiable' circumstances. Once such instance is triggered by the legal provisions in Section 54 of the Sexual Offences Act, 2007. Section 54 specifies a mandatory reporting obligation, corresponding with Section 110 (1) of the Children's Act, 2005.[21]

The mandatory reporting obligation could be triggered when an adolescent who accesses sexual and reproductive health services discloses to a trusted health care professional information about their sexual activity with, for example, someone who is 16 or 17 and with more than a two-year age difference or an adult (over 18).[22]

The published works highlight that provisions in the law may create ethical and legal dilemmas for stakeholders, such as healthcare professionals, researchers, or service providers who work with adolescents in sexual and reproductive health, around how to interpret and implement the mandatory obligation to report sexual offences against adolescents. Throughout these works, a primary objective was to provide interpretation that would aid understanding of the amendments to the Sexual Offences Act, 2007, from a nuanced approach which reflected that:

[20] Constitution of the Republic of South Africa [South Africa].
[21] Section 110(1) of the Children's Act, 2005(Amendment Act) states that suspected child abuse must be reported to the provincial department of social development or the police or designated child protection services. See also the Criminal Law (Sexual Offences Act and Related Matters) Amendment Act 32 of 2007 in section 54(1)(a) & (b),where it states that a person who has knowledge that a sexual offence has been committed against a child must report such knowledge immediately to a police official.
[22] Section 110 and Section 134 (3) of the Children's Act, 2005.

1. there is no longer a legal obligation to report adolescents (12 to 15 years old) who are engaged in consensual peer-to-peer sexual activity; or
2. there is no longer a legal obligation to report adolescents if there is no knowledge of the age of the other partner; however,
3. in certain cases, there may still be an obligation to report adolescents if there is knowledge that the younger adolescent (who is in the age range of 12 -15) is engaged in sexual activity with an older adolescent (aged 16 or 17), where there is more than a two-year age gap between them.[23]

Where mandatory reporting obligations remain a broad provision without guidance, stakeholders may face uncertainty in their duties. On the one hand, civil law makes provision for the adolescent to legally self-consent to access specific sexual and reproductive interventions such as contraceptive condoms and HIV testing. On the other hand, a healthcare professional providing such a service might have to breach confidentiality and report illegal sexual activity to the relevant authorities in certain cases. As a result, the disclosure and subsequent reporting duty would violate the right to privacy. Such a challenge means that adolescents are unlikely to access much-needed HIV prevention services for fear of being reported, thus impeding efforts to assist adolescents in responsible sexual behaviour and reproductive health care and exacerbating the national challenge of HIV and teenage pregnancy.

Consequently, potential legal ramifications may curtail adolescents' decision-making processes, and reporting duties remain a barrier to the right to health in the context of South Africa's response to reducing the risk of HIV infection. Such barriers to adolescents' access may also be considered a violation of their right to health. They are likely to have a knock-on effect of driving adolescents away from accessing critical HIV prevention services. As such, in the body of this research, it is highlighted that while mandatory provisions are crucial to protecting adolescents from harm and exploitation, there is still potential for dealings with the criminal justice system where the younger adolescent may need to provide witness testimony in court proceedings.

The published works indicate that the HIV risk status of adolescents in South Africa will remain high unless structural mechanisms, such as the law, public health, and ethics, align adequately in the provision of adolescents' HIV protection services. Throughout this research, emphasis has been on a child-oriented, rights-based approach as a necessary means to addressing enduring tensions on the issue of the broad mandatory reporting obligation and adolescent access to HIV prevention. Selected articles have linkage and overlap concerning mandatory reporting as an

[23] See Table 4 in Appendix 1 where it provides details as to when consensual sexual activity amongst adolescents may still be a illegal where the age-gap provision does not account for circumstances where one adolescent is below 15 and the other either 16 or 17 but there is more than two years between them.

element triggered in different subject matters of the research questions when interpreting the law concerning adolescent disclosure of sexual activity[24].

[24] Declaration of Alma-Ata "Health for All" Series No. 1 Geneva: WHO, 1987: Societal dimensions emphasised health as *"...social goal whose realisation requires action of other social and economic sectors in addition to the health sector..."*

2.4 Revisions of the law within contextual realities in society

Over the past 20 years, the South African legal framework has undergone significant revisions in child law. Still, laws cannot simply be reviewed and interpreted in isolation, removed from the contextual realities in society. The nature and extent of revisions in South African law, specifically within the context of HIV prevention, must be considered alongside the many socio-economic factors that drive the rate of HIV infection in the country. For instance, the reasons for the high prevalence of teenage pregnancy and the risk of exposure to HIV infection due to unprotected sexual activity warrant serious investigation. As noted earlier, some underlying reasons for these national challenges are associated with poor socio-economic conditions, such as insufficient sexual behaviour and reproductive health education and a lack of social or family support structures. These factors contribute to poor choices, where, for example, adolescents engage in dependency-driven intergenerational sex and/or early sexual debut.

Section 7 of the South African Constitution (1996) obligates the state to "respect, protect, promote, and fulfill all rights." This means that there is an obligation on the state to ensure that regulations, strategic plans, policies, programmes, and services accompany laws. From a structural perspective, this body of work is focused on the development of the provisions in the law in realising the right to health rather than any accompanying obligations. The South African government is responsible for developing and addressing tensions in law to create an enabling framework towards fulfilling public health goals, such as the right to sexual and reproductive health expressly incorporated in section 12 and section 27 of the Constitution.

Post 1994, South Africa's shift to a democratic and constitutional framework intended to bring all existing laws and policies following a constitutional human rights-based approach, many of which did not exist before 1994. This shift requires changes to civil and criminal laws and provides an opportunity to ensure congruence between legal developments and social issues. It does, in some respects, distinguish South Africa from some other countries, where, for example, the civil law focus, such as the National Health Act, 2003 in Section 71, now provides extensive legal requirements for consent norms around "research on or experimentation with human subjects." The law thus establishes a framework that facilitates access to public health and participation in research that aims to advance the right to health.

Critical analysis of the published works reveals tensions between overlapping laws in the Children's Act 2005, the National Health Act 2003, and the Sexual Offences Amendment Act 2015. Developments in these laws have implications for adolescent sexual and reproductive health rights, and this body of work has explored the impacts of these developments within the contextual realities of South African society.

This chapter described the general background to the published work. One legal case was essential for articulating the tensions between promoting access to HIV prevention services and child protection: the Teddy Bear Clinic case.

Chapter 3 describes the Teddy Bear Clinic case, which led to changes in the Sexual Offences Act, 2007.

3 THE TEDDY BEAR CLINIC CASE

3.1 Significance of the case

In 2013, the South African (SA) Constitutional Court heard the matter of *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another* (CCT 12/13) [2013] ZACC 35 (the Teddy Bear Clinic case). The Teddy Bear Clinic case was significant in examining whether it was constitutionally valid to use the law (specifically s15 and s16 of the Sexual Offences Act, 2007) as an appropriate mechanism to impose criminal sanction on adolescents as a deterrent against early sexual debut and the related risks.

3.2 Factual background

Two South African not-for-profit organisations (represented in court by the Centre for Child Law), the *Teddy Bear Clinic for Abused Children* and *Resources Aimed at the Prevention of Child Abuse and Neglect* (RAPCAN), initially brought an application before the North Gauteng High Court against the South African Minister of Justice and Constitutional Development and the NDPP to decriminalise the prohibitive provisions contained in s15 and s16 of the Sexual Offences Act, 2007.[25,26]

The Teddy Bear Clinic case considered the constitutional validity of s15 and s16, which imposed criminal liability on adolescents for all forms of sexual conduct. The responding parties to the matter argued that the Legislature intended for these provisions to act as a deterrent to early sexual debut and related risks. The Constitutional Court examined the factual and policy considerations regarding whether constitutional rights had been limited. Considerations for Section 36 (the limitations clause) of the Constitution, 1996, means applying a proportionality test. The proportionality test includes a list of factors that need to be weighed up where competing interests result in the infringement of fundamental rights.[27] Specifically, in the Teddy Bear Clinic case, the Constitutional Court addressed whether sections 15 and 16 of the Sexual Offences Act violated adolescents' rights under sections 10 (dignity), 14 (privacy), and 28(2) (best interests of

[25] The Teddy Bear Clinic is an organisation which provides a range of medical (and related) services for abused children and coordinates diversion programmes away from the criminal justice system for young sex offenders. RAPCAN is an organisation which works on the promotion of children's rights and prevention of child victimisation.

[26] The *Teddy Bear Clinic For Abused Children v Minister of Justice and Constitutional Development* 2013 JDR 0025 (GNP)

[27] The factors included the proportionality test are divided into a two stage- process where:

1) the applicant is to **required to establish that** a fundamental right(s). In this matter all parties conceded that the rights of children pertaining to human dignity, privacy and best interests were the fundamental rights in question.
2) the respondent is to then estalish whether the infringement was justifiable in an open and democractic society. In this regard, the Constituional Court would then consider the following factors as part of the proportionality assessment, listed in Section 36 of the Constitution, 1996:
   (a) the nature of the right;
   (b) the importance of the purpose of the limitation;
   (c) the nature and extent of the limitation;
   (d) the relationship between the limitation and its purpose; and
   (e) less restrictive means to achieve the purpose.

the child) of the Constitution, 1996 and if so, then was such an infringement reasonable and justifiable in an open and democratic society.

Contextually, the court held that s15 and s16 of the Sexual Offences Act 2007 criminalised adolescent peer consensual sexual acts with children, which made adolescents (12 to 15 years old) potential sexual offenders.[28] S15 of the Sexual Offences Act, 2007 sought to criminalise any person who had consensual sexual "penetration" (regarded as statutory rape) with a child. S16 of the Sexual Offences Act, 2007, intended to criminalise consensual sexual "violation" (statutory sexual assault) against a child. On an interpretation of the legal issue before the court, the legal provisions of s15 and s16 of the Sexual Offences Act, 2007 were too broad concerning sexual offences against children (which included adolescents engaged in underage peer-to-peer sexual activity such as kissing and hugging). [29] In other words, there were some adverse implications to holding adolescents criminally liable for peer-peer consensual sexual activity, which brought them into the criminal justice system. These implications included that the mandatory reporting obligation meant that any form of adolescent sexual activity (including kissing) was a reportable offence, placing a duty on persons who had knowledge of such sexual activity to report. Also implied was that if an adolescent was prosecuted, found guilty, and convicted, their names would be included in the National Sexual Offences Register.[30,31]

In this regard, the applicants to the court argued that adolescents' rights to dignity, bodily integrity, privacy, and the child's best interests were infringed for consensual sexual acts. Expert witnesses deemed consensual sexual activity amongst adolescents a developmental normative

---

[28] Section 15 deals with the offence of "statutory rape":

"Acts of consensual sexual penetration with certain children (statutory rape)

15 (1) A person ('A') who commits an act of sexual penetration with a child ('B') is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual penetration with a child.

(2)(a) The institution of a prosecution for an offence referred to in subsection (1) must be authorised in writing by the National Director of Public Prosecutions if both A and B were children at the time of the alleged commission of the offence: Provided that, in the event that the National Director of Public Prosecutions authorises the institution of a prosecution, both A and B must be charged with contravening subsection (1).

(b) The National Director of Public Prosecutions may not delegate his or her power to decide whether a prosecution in terms of this section should be instituted or not."

[29] Justice Khampepe noted in paragraph 59 of the Teddy Bear Clinic Case: …" *National Coalition* this Court held as follows,

"Privacy recognises that we all have a right to a sphere of private intimacy and autonomy which allows us to establish and nurture human relationships without interference from the outside community. The way in which we give expression to our sexuality is at the core of this area of private intimacy. If, in expressing our sexuality, we act consensually and without harming one another, invasion of that precinct will be a breach of our privacy."

See also at paragraph 66, Justice Khampepe deliberated extensively on Section 28(2) of the Constitution provides that

"… [a] child's best interests are of paramount importance in every matter concerning the child." It is trite that section 28(2) is both a self-standing right and a guiding principle in all matters affecting children. What is in the best interests of a child is a balancing exercise and in each case various factors need to be considered."

[30] s50 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 states that the court "must make an order that the particulars of the person be included in the Register".

[31] s54 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 specifically states:

"(1) (a) A person who has knowledge that a sexual offence has been committed against a child must report such knowledge immediately to a police official.

(b) A person who fails to report such knowledge as contemplated in paragraph (a), is guilty of an offence and is liable on conviction to a fine or to imprisonment for a period not exceeding five years or to both a fine and such imprisonment."

phase of their lives. [32,33] Thus, the court had to determine whether the criminal sanction limited the rights of adolescents (between the ages of 12 and 15 years) in s15 and s16, which is reasonable and justified in a democratic society.

This determination in the Teddy Bear Clinic case required consideration of the role of the criminal law where minors are involved in the criminal justice system, specifically concerning underage, adolescent consensual sexual activities, against the backdrop of a high prevalence of HIV, teenage pregnancy, and the overall national public health response to these concerns.[34] This required balancing of competing interests, which, on the one hand, protected children from abuse and exploitation and, on the other hand, promoted children's evolving capacity.

Reviewing the justifications for s15 and s16 limiting children's rights, the Constitutional Court had to consider the proportionality between harm and the benefits to children. The approach adopted by the Constitutional Court in interpreting and applying the proportionality test draws on the following important aspects:

a. The nature and importance of the right, it was held that children are bearers of rights such as dignity and privacy, as well as the child's best interests standard, of which s15 and s16 of the Sexual Offences Act, 2007 had the effect of infringing these fundamental rights;
b. The purpose of limiting the right, the court held that it was clear that while Parliament as Legislator intended to recognise children, especially adolescents, as a vulnerable group in need of special protections and distinguish different groups of children (adolescents between 12 and 15 years old on the one hand, and 16- and 17-year olds on the other), it did not adequately distinguish adolescent normative sexual conduct from sexual predatory conduct.
c. Nature extent of the limitation, the court reasoned that s15 and s16 of the Sexual Offences Act, 2007 had significant implications for harm in violating the rights to children's human dignity and privacy, as well as the best-interests standard. This means that adolescents would exposed to the harmful effects of the criminal justice system, for example, arrested, detained, and questioned by police or other authorities about their intimate sexual conduct.

---

[32] Chapter 6 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 establishes the National Register for Sex Offenders (Register) which includes particulars of persons convicted of any sexual offence against a child.

[33] In the Teddy Bear Clinic case at paragraph 43 states:

> *"The applicants have placed reliance on a report (expert report) compiled by the late Professor Alan Flisher, a child psychiatrist at the University of Cape Town, and Ms Anik Gevers, a clinical psychologist specialising in child mental health at the same university…. The expert report was compiled to provide information about the sexual development of children and the potential impact of sections 15 and 16 of the Sexual Offences Act in this regard."*

See also The Constitution of the Republic of South Africa, 1996 for section 10 (dignity), section 12 (bodily integrity), section 14 (privacy) and section 28 (2) best interests of the child). Further, section 28 (2) of the Constitution states that the best interests of a child must be paramount in any matter relating to the child (also known as the best interests standard).

[34] Teddy Bear Clinic case at paragraph 37 indicates that the application was about three broad issues, namely

> *"(a) Are any rights limited by the impugned provisions?*
> *(b) If so, are these limitations reasonable and justifiable in terms of section 36 of the Constitution?*
> *(c) If not, what is the appropriate remedy?"*

d. The relationship between the limitation and statutory purpose (efficacy of the limitation). The respondents to the case argued that the purpose of impugned provisions was to deter adolescents from early sexual debut and protect them from risks associated with such conduct (such as teenage pregnancy and acquisition of HIV infection). Legislator thus intended promulgating sections 15 and 16 of the Sexual Offences Act,2007 to serve as a deterrent by imposing criminal sanction on adolescent consensual sexual activity.
e. Less restrictive means to achieve the same ends. The court held that less restrictive means could have been developed to achieve the same ends instead of challenged provisions set out in s15 and s 16 of the Sexual Offences Act, 2007, as the court was not convinced that criminal sanction as prohibitions could prevent risks such as teenage pregnancy, instead that, other less restrictive methods needed to be explored that did not involve the criminalising of adolescent consensual sexual conduct.

Accordingly, the Constitutional Court found that s15 and s16 provisions in the Sexual Offences Act, 2007, criminalising adolescents engaged in consensual peer-to-peer sexual activity, was inconsistent with the South African Constitution and thus invalid.[35] The court reasoned that the legal enforcement mechanisms caused more harm than good to adolescents and undermined support structures that intended to help adolescents.[36] This was based on the principle that the criminal liability imposed by s15 and s16 did not meet with Section 36 of the Constitution (known as the limitations clause) for reasonable and justifiable limitation of the best interests of the child standard, in addition to the infringement of the right to dignity, bodily integrity, and privacy.

To use the law as an enforcement mechanism to impose prohibitions on what was regarded as developmentally normative behaviour was inconsistent with the South African Constitution and had severe consequences for adolescents.

3.3 Contribution of the case to law reform

In July 2015, Parliament amended the Sexual Offences Act, 2007 into the Sexual Offences Amendment Act 5 of 2015. S15 and s16 were amended to decriminalise underage consensual sexual activity among 12 to 15-year-old adolescents. The changes in the law did not alter the general legal rule concerning the legal age to consent to sex at 16. The amended law, however, decriminalised consensual sexual activity in instances where a younger adolescent below the statutory age of consent to sex, where 12 to 15-year-olds engaged in consensual sexual activity with an older adolescent, a 16 or 17-years old (provided there is no more than a two-year age gap between them). Since full legal capacity is 18, any person over 18 is considered an adult. The

[35] The Constitution of the Republic of South Africa, 1996.
[36] Teddy Bear Clinic case at para 72.

provisions of s15 and s16 of the Sexual Offences Amendment Act, 2015 do not apply to adults, and therefore, engaging in sexual activity with a child below 16 is considered a sexual offence.

Since the Teddy Bear Clinic case served as a strategic catalyst to amend s15 and s16 Sexual Offences Act, 2007, this Constitutional Court case features significantly in certain works in this collection related to a shift in law on adolescent consensual sexual activity.[37] It is important as a scholar researching health law and ethics to understand the implications of the amendments to s15 and s16 South African Sexual Offences Act, 2007. In particular, its impact upon the public health goal addressing the issue of adolescent risk of HIV infection (and the prevalence of teenage pregnancy) from unprotected adolescent sexual activity.

A primary assumption throughout the body of work is that the law needs to be clear, unambiguous, and coherent to create an enabling environment. Additionally, laws require constant scrutiny to assess whether they meet the contextual realities of society. Chapter 4 describes the methods employed to develop the published works and my approach to reflective critical appraisal for this commentary.

[37] See further discussion in discussions in Chapter 6 with reference to Articles 1, 4, 6 and 8.

4 METHODS

4.1 A summary of the methods used to develop the body of works

Legal research methods are distinguished from other disciplines since legal scholars aim to explore, understand, and frame normative standards. Legal research methods involve finding the relevant primary sources of law (legislation and case law) and undertaking an inductive reasoning process to synthesize and determine normative standards/rules. In other words, legal researchers evaluate the current state of the law to identify gaps, tensions, and weaknesses and recommend lawful alternate or nuanced approaches to ongoing legal problems.

The Constitution, 1996, is the primary source for determining which constitutional rights may be subject to being challenged. [38] In this regard, the rights of adolescents, such as dignity, privacy, bodily integrity, and the best interests of the child standard, are derived from the South African constitutional framework and would thus be relied upon rather than the conventional methods of statutory interpretation of laws. Therefore, a research method applied throughout the published works is based upon constitutional interpretation of the law, which includes consideration of contextual realities.[39] In particular, South Africa's contextual realities concerning adolescent access to public health in HIV prevention.

The process of constitutional interpretation in the body of scholarly research focuses mainly upon three relevant South African current laws, namely:

- Sexual Offences Act 32 of 2007 was amended by the Sexual Offences Amendment Act 5 of 2015;
- Children's Act 38 of 2005; and
- National Health Act 61 of 2003.

In addition, selected articles review the impact of the constitutional court ruling concerning consensual activity between 12 and 15-year-olds in the Teddy Bear Clinic case, focused explicitly on adolescent sexuality and reproductive health.

The selected articles' legal interpretation of the legislation, case law, and common law involves review in the context of the laws as a whole, the intention of the specific legal provisions (for example, Chapter 7 of the Children's Act,2005, intended as '[p]*rotective measures relating to the*

[38] S.Taekema. (2018) 'Theoretical and Normative Frameworks for Legal Research: Putting Theory into Practice', *Law and Method* February 2018, DOI: 10.5553/REM/.000031 Available at *https://www.lawandmethod.nl/tijdschrift/lawandmethod/2018/02/lawandmethod-D-17-00010* Accessed on 15 June 2023. See also F. Dube. (2020) 'The South African Constitution as an instrument of doing what is just, right and fair', *In die Skriflig In Luce Verbi.* 54(1), a2601. *https://doi.org/10.4102/ids.v54i1.2601*. See also commentary on Article 7 on the legal method of interpretation following the court reasoning in case of *Cool Ideas 1186 CC v Hubbard and Another* (CCT 99/13) [2014] ZACC 16.

[39] Section 39 of the Constitution, 1996

health of children'), key constitutional rights identified that may be challenged (such as privacy, and the child's best interests), and the purpose of the law within the societal context (such as described in the articles concerning adolescent HIV prevention).[40]

As a legal scholar, it was helpful to explore the law using the process of constitutional interpretation because applying the conventional method of literal statutory interpretation is insufficient to address certain complex research questions. The literal and overall context included in the constitutional interpretative method used in articles 1, 2, 3, 5, 7, and 8.

Article 4 describes a different approach as it includes an empirical component. This involved semi-structured interviews with social workers in KwaZulu-Natal about their involvement in the care of children and their awareness of the recent criminal law changes regarding consensual underage sex. The data was analysed using thematic analysis, from which key themes were developed inductively. This work provided the context for Articles 1 and 5.

Article 6 includes comparative legal analysis, a legal interpretation method provided for within section 39 of the South African Constitution (1996), which was applied to investigate other countries' approaches to adolescent consent to sex age-gap defences.

Article 7 applied a combination of legal methods, including traditional statutory interpretation, constitutional interpretation, and comparative legal analysis, to evaluate whether HIV prevention interventions such as Pre-Exposure Prophylaxis (PrEP) could fall within the definition of 'medical treatment.' In addition to these legal methods, the case of *Cool Ideas 1186 CC v Hubbard and Another* 2014 (4) SA 474 (CC) was reviewed only to the extent to which the constitutional court interpreted and applied the approach to the constitutional interpretation of an undefined legal term.[41] Similarly, this approach was considered in reviewing the adolescent right to the constitutional values of human dignity, equality, freedom, and the right to access health care services.[42] Moreover, the Constitution 1996 provides that statutory interpretation may include consideration of foreign law where there is no definition of the scope and meaning of a term in the law. In such an instance, Article 7 relied on examples from a study of various other countries' approaches to interpretation of the meaning of a term.[43]

---

[40] Legal method of interpretation following the court reasoning in case of *Cool Ideas 1186 CC v Hubbard and Another* (CCT 99/13) [2014] ZACC 16.

[41] UNAIDS. (2016). 'HIV prevention among adolescent girls and young women.'states that

> *"Pre-exposure prophylaxis (PrEP) is the use of antiretroviral medicines by HIV-negative individuals to avoid HIV infection. PrEP is highly effective when taken, but it has not worked where adherence was low. In this document, the term PrEP refers to oral PrEP (which is taken in the form of pills), as research on other options is still ongoing."*

[42] Section 7 and Section 27 of the Constitution, 1996.

[43] T. Taggart, et al. (2019). 'Getting youth PrEPared: Adolescent consent laws and implications for the availability of PrEP among youth in countries outside of the United States.' *J Int AIDS Soc*. 2019; 22(7): e25363. DOI: https://doi.org/10.1002/jia2.25363.

In addition, the synoptic commentary reflects on implications for the HIV-related health research context where laws and ethical guidelines may intersect. Articles 2, 3, and 6 reflect on ethical considerations concerning adolescent consent to participate in research and access to non-specified HIV prevention interventions.

The development of this research spanned over ten years. While each article was written independently, the research reflects ethical-legal developments and challenges related to the subject matter as they emerged. In this way, the articles build upon previous works while reflecting the current contextual realities and developments in law and public health. Thus, the development of this work has been significant for developments in public health, as well as legal and ethical dilemmas that inspired the research.

4.2 The approach taken in this critical appraisal

Within the published works, my contributions focused on analysis and interpretation of the legal authority where the law intersects with public health and ethics in key research questions concerning adolescent access to HIV prevention and participation in certain HIV-related research.

This synoptic commentary is primarily written in the third person, which reflects the collaborative nature of the published work. However, this critical appraisal is grounded in my own reflections and viewpoint of the published work. Therefore, there are occasions where I shift from the third-person objective to the first-person narrative to distinguish my approach in this synoptic commentary. In Chapter 6, short citations throughout the thesis are indicated in bold and referred to by article number.

Given the types of included studies and their heterogeneity, it was not possible to use an established systematic review framework (such as PICO or SPICE, for instance). Consequently, a simple, bespoke appraisal framework was developed (Appendix 2) to help draw out the relevant information for reflection upon each article, including the aims, perspectives taken, implications, and conclusions. Formulating the appraisal framework facilitated data extraction, analysis, and critical reflection. The appraisal framework comprises key questions, which formed the basis of the themed discussions in Chapters 5 and 6, and which are as follows:

→ *Theme the findings – what are the common strands that run through them?*
→ *What is the contribution to the knowledge in this field?*
→ *What is the original element?*
→ *How has my argument evolved (against the evolving situation in SA)? Where are we now?*
→ *What is the impact/implications of the work to date?*
→ *What are the remaining problems/issues?*

→ *What are my recommendations?*

Following the completion of the appraisal framework, a mind map was developed to help refine my thoughts and provide an overarching thematic analysis (Appendix 3). This process included deductive legal reasoning, relying on the general normative standards to frame the main thematic areas.

During analysis, the centrality of the dual role of the law in advancing the right to health emerged as a key concept. My critical reflections also illustrated the need for a nuanced understanding of the intersections between law, public health, and ethics concerning adolescent access to HIV protection measures, while my perspective was grounded in a rights-based approach to promote and protect adolescents' rights to HIV protection measures. These concepts combined to form my theoretical standpoint are further described in the next chapter.

5 A THEORETICAL CONSTRUCT

Critical appraisal of this body of works has illuminated the theoretical underpinnings of the published works concerning the rights-based dual role of the law and ethics in the context of adolescent sexuality and reproductive health. This is important because it adds clarity and perspective to the analysis of ethical dilemmas. It can also enable the identification of a theoretical basis for examining future associated complexities and dilemmas. This chapter outlines the key components of the theoretical underpinnings, namely, a human rights approach and the dual role of law (and ethics) concerning:

1. *adolescent consent laws, which promote responsible sexual behaviour and reproductive health; and*
2. *adolescent consent laws, which include protective measures.*

5.1 A human rights approach

Key to the discussion in selected articles relating to the Teddy Bear Clinic case legal proceedings is whether the challenged legal provisions in the Sexual Offences Act, 2007 violated children's rights. The South African Constitution includes children when it specifies that 'everyone' is granted fundamental rights. The Constitutional Court reasoned that it was important to address legal issues concerning children in a way that recognises children as bearers of human rights.[44] The fundamental rights concern a child's right to dignity, explicitly around the impact on their value in a societal context, privacy (relating to protecting their inner sanctum of personhood), and the child's best interests. [45,46]

In line with the approach adopted in the Teddy Bear Clinic case and the subsequent amendments in legislation, the body of research thus reflects children as bearers of rights such as dignity and privacy, as well as the child's best interests. Therefore, the research is consistent with a human rights approach in advancing the right to health. A rights-based approach in South Africa's public health efforts to combat HIV among adolescents includes promoting access to HIV prevention services and HIV/AIDS-related research to improve prevention strategies. However, in some instances, this rights-based approach requires balancing competing interests, where tensions occur, in line with the contextual realities of South Africa. The Teddy Bear Clinic case provided a clear demonstration where, on the one hand, the law intends to protect children from sexual predators but creates sexual offences and broad mandatory reporting obligations which infringe

[44] See Articles 1 of the Committee on the Rights of the Child concerning the evolving autonomy of the child. See also Article 14 and 15 of the CRC, recognised evolving capacities of the child. See also Section 28 of the South African Constitution, 1996 on a range of child-specific rights.
[45] Sections 10, 14 and 28 (2) of the South African Constitution, 1996.
[46] Section 28 of the South African Constitution (1996) section defines a 'child' as a person under the age of 18 years.

on the rights of children and where other laws aim to promote access to certain health measures in line with key public health objectives to reduce HIV.

Such tensions in the law were highlighted on review of the Teddy Bear Clinic case. As such, the principle of proportionality was used in this case to assess whether government, by imposing criminal sanctions in sections 15 and 16 of the Sexual Offences Act, 2007, infringed the rights of adolescents and whether this infringement was justified in an open and democratic society. In this regard, section 36 of the Constitution, 1996 (the limitations clause) was applied to determine whether the legal provisions enacted by Parliament were proportionate to justify the limitations of adolescents' right to dignity, privacy, and best interests. The Teddy Bear Clinic case had important implications for law reform applying the principle of proportionality and balance within South Africa's contextual realities that adolescents are bearers of rights (such as dignity, privacy, and the child's best interests) but as a special group, children are still in need of protection against sexual predatory conduct and high-risk sexual behaviour. Thus, less restrictive measures need to be considered rather than punitive laws.

Reflective critical analysis of the published works revealed two key human rights-based suppositions, namely:

1. adolescent consent laws (and ethics) ought to promote responsible sexual behaviour and reproductive health; and
2. adolescent consent laws (and ethics) ought to include protective measures related to responsible sexual behaviour and reproductive health.

5.2 The dual role of law and ethics in advancing the right to health

To advance the right to health, laws that recognise children as bearers of rights must be developed from a child-oriented, rights-based perspective. In this way, laws can better facilitate public health strategies to meet the needs, well-being, and values in a societal context. The published works in this collection interpret laws and ethics using a child-oriented human rights approach determined by the child's best interest standard, as indicated in the following.

First, the right to health is recognised globally.[47] Since the 1966 International Covenant on Economic, Social, and Cultural Rights, the issue of how to realise this right has been debated widely. For the World Health Organisation:

[47] UN General Assembly, CRC, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3. Available at https://www.refworld.org/docid/3ae6b38f0.html Accessed on 18 June 2023. Article 24 provides that States are to provide for the "*right of the child to the highest attainable standard of health.*"

> *"The right to the highest attainable standard of health" implies a clear set of legal obligations on states to ensure appropriate conditions for the enjoyment of health for all people without discrimination."*[48]

Second, the Convention of the Rights of the Child (CRC) in General, Comment No. 3: *"HIV/AIDS and the rights of the child*" provides that:

> *"The Committee is concerned that health services are generally still insufficiently responsive to the needs of children under 18 years of age, in particular adolescents. As the Committee has noted on numerous occasions, children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential and non-judgemental, do not require parental consent and are not discriminatory. In the context of HIV/AIDS and taking into account the evolving capacities of the child, States parties are encouraged to ensure that health services employ trained personnel who fully respect the rights of children to privacy (art. 16) and non-discrimination in offering them access to HIV-related information, voluntary counselling and testing, knowledge of their HIV status, confidential sexual and reproductive health services, and free or low-cost contraceptive, methods and services, as well as HIV-related care and treatment if and when needed, including for the prevention and treatment of health problems related to HIV/AIDS."*[49]

However, theoretically advancing and realising the right to health (specifically in the context of HIV/AIDS) requires a clear linkage to developing child-oriented, rights-based laws.[50] In particular, child-oriented, rights-based laws (and ethics) have a dual role that must be constantly weighed to assess the balancing of the two fundamental human rights principles: promoting and protecting children's rights.

Since the Teddy Bear Clinic case judgment, changes in the criminal law have had implications for the provisions in civil law concerning South Africa's adolescent HIV prevention strategies.

Chapter 4 sets out the two tracks, namely the research methods of interpretation in the published works and my method in developing an appraisal framework to draw out relevant themes from the published work. Chapter 5 articulates the theoretical construct for analysing the appraisal framework. In chapters 4 and 5, the synopsis reflects a key feature derived from interpretations of the Teddy Bear Clinic case: a child-oriented, rights-based approach is important, primarily using the child's best interests in developing, interpreting, and applying the law.

---

[48] World Health Organisation (WHO). Human Rights – Key Facts. (2022) Available at *https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health* Accessed on 04 April 2023.

[49] UN Committee on the Rights of the Child (CRC), General comment No. 3 (2003): *HIV/AIDS and the Rights of the Child,* 17 March 2003, CRC/GC/2003/3. Available at *https://www2.ohchr.org/english /bodies/crc/ docs/gc/crc_c_gc_14_eng.pdf* Accessed on 8 April 2023. Also available at *https://www2.ohchr.org/english/bodies/crc/docs/gc/crc_c_gc_14_eng.pdf*

[50] In J.M. Mann, et al.(1994). "Health and human rights." *Health and Human Rights.* 1:6. Mann proposes
> *"…a three-part framework for considering linkages between health and human rights; all are interconnected, and each has substantial practical consequences."*

It should be noted that the best interests of the child standard is a right that is firmly entrenched in the South African Constitution and used routinely for resolving legal disputes concerning child matters.

This is relevant from the perspective of fulfilling adolescent sexual and reproductive health rights, as there needs to be a constant balance in law and ethics linked to a rights-based approach. This balance can be achieved by promoting children's evolving capacity and protecting children from harm or exploitation. In this regard, I have drawn from the three relevant laws (Children's Act, 2005; Sexual Offences Act, 2015; and National Health Act, 2003). Sub-chapters below (5.3 and 5.4) describe where in these three laws, legal provisions run parallel in promoting the evolving capacity and/or providing protective measures for responsible adolescent sexual and reproductive health.

The body of research interrogates interpretations in multiple interactions between consent laws in civil and criminal law, and this appraisal draws upon that work to formulate a thematic focus featuring child consent laws. Further, Chapter 6 includes a cross-examination of how the published writings influence certain deductions and contribute knowledge on adolescent HIV-related sexual and reproductive health.

5.3 Adolescent consent laws promoting responsible sexual behaviour and reproductive health

South Africa's Children's Act, 2005, sets the general age for a child's full legal capacity without proxy consent/assistance at 18 years old. However, Chapter 7 of the Children's Act, 2005, entitled *'[p]rotective measures relating to health of children*,' sets the normative age of consent at 12 years old to access specified health-related interventions (such as medical treatment, HIV testing (and counselling), confidentiality on HIV status and condoms).[51] In this regard, the collection of works investigates the legislation concerning consent laws in the context of facilitating South Africa's public health priority for adolescents' access to HIV prevention interventions.

South Africa's Sexual Offences Act, 2007, includes the statutory age to consent to sex is 16. However, the law has been amended to decriminalise consensual peer (12 to 15) sexual activity. Further, this law creates an exception in potential criminal liability of a sexual offence concerning a younger adolescent (between 12 to 15) engaged in sexual activity with an older adolescent (16 or 17). This means the older adolescent may raise a legal defence that the law decriminalised sexual activity where there is no more than two years between them. In this regard, the published works examine these two key amendments, interpreting that these changes to adolescent consent to sex laws promote adolescent evolving capacity, thereby enabling public health objectives in adolescent sexual and reproductive health (established in the Children's Act, 2005).

[51] s129 to s134 of the Children's Act, 2005

The National Health Act, 2003 does not specify an age of consent for a child to participate in medical research. This is discussed further in sub-chapter 5.4 concerning these provisions' strong protective measures approach. However, the law does, at first glance, provide for child participation in research provided prescribed informed consent to research norms and additional criteria are met[52]. In this regard, the published works interpret that this law does, to a very limited extent, promote evolving capacity.

Sub-chapter 5.4 focuses on the theoretical construct, including protective measures for adolescent responsible sexual behaviour and reproductive health. These measures are evaluated against the three same laws set out in this section and the same linked legal provisions for adolescent consent norms.

[52] Including proxy parental consent, that the study is in the child's best interests, and that the minor must consent and be capable of understanding.

5.4 Adolescent consent laws protective measures related to responsible sexual behaviour and reproductive health

Despite the acceptance of adolescent evolving capacity, consent laws aim to provide protective measures because adolescents are still developing and have not reached full legal capacity. Thus, they require protection from various forms of harm or exploitation (in the context of sexual and reproductive health matters).

For instance, while the Children's Act 2005 establishes the age of 12 as the normative age of consent to access specified HIV health-related interventions, other legal provisions in this law have not adopted the same approach. For example, section 13 of the Children's Act, 2005 does not specify a set age of consent to access health care (including HIV prevention) information. However, it does include that the information must be relevant and accessible to children.

Another example can be seen with voluntary medical male circumcision (VMMC), which is an accepted HIV prevention method in South Africa.[53] However, males can only independently self-consent to VMMC from age 18 (once they have the full legal capacity as adults). Section 12 of the Children's Act, 2005 prohibits male circumcision below 18 unless it is for religious, medical, or cultural reasons. In this regard, proxy parental consent is a legal requirement, except that a male may self-consent to circumcision for cultural reasons from 16. However, this consent norm includes parental involvement for local anaesthetic. Furthermore, according to the Children's Act 2005, even where the normative age for self-consent is 12, to access a range of health-related HIV prevention interventions, VMMC is not included as an option. In addition, some of the specified HIV prevention interventions that adolescents may self-consent from 12 years include criteria to support age-related decision-making processes. [54]

For instance, an adolescent may self-consent to medical treatment from 12 and have

> "*…sufficient maturity … mental capacity to understand the benefits, risks, and social and other implications of the treatment*".[55]

Similarly, although consent to an HIV test is from age 12 years, the law states that children are prohibited from being subjected to an HIV test unless it is in their best interests. The works interpret these laws as facilitating adolescent access to critical HIV prevention tools. In this appraisal, I rely on a nuanced understanding that there is acceptance of adolescents' evolving capacity, balanced with provisions for protecting adolescents.

While the Sexual Offences Amendment Act, 2015 decriminalises adolescent consent to peer sexual activity, the law retains the broad legal provision on mandatory reporting obligations. The

[53] J.M. Grund, et al. (2018). 'Effectiveness of an "Exclusive Intervention Strategy" to increase medical male circumcision uptake among men aged 25–49 years in South Africa.' BMC Public Health, 18(1), 1-10.
[54] Section 7 of the Children Act 38 of 2005. Available at: *https://www.justice.gov.za/legislation/acts/2005-038%20childrensact.pdf*
[55] Section 129 (2) of the Children's Act, 2005.

published works investigate the legal duty to report, which intersects with the public health objective to ensure adolescent access to HIV prevention services and ethical dilemmas around adolescents' participation in HIV-related health research. In this regard, the articles articulate that the law maintains an overly broad mandatory reporting obligation in the Sexual Offences Act 2007, which can be a barrier to adolescent sexual and reproductive health. However, a reflective analysis of the law's dual role has highlighted that the legal obligation to report sexual offences should be understood as a protective measure for adolescents responsible for sexual and reproductive health. Contextually, this is important where South African adolescent girls may engage in sexual activity with adult partners.[56]

The South African National Health Act, 2003, provides consent norms for all persons participating in research/experimentation as described in the published work. However, where it concerns a child's participation in research, the law includes protective measures that stipulate:

1) written informed consent,
2) the best interests of the child,
3) parent/legal guardian consent, and
4) child consent and understanding of the nature of the research.

The body of research interprets these legal provisions as stringent, creating ethical-legal dilemmas for researchers and thus limiting child participation in health research where there is a need for child-specific, evidence-based data. However, adopting the theoretical construct that law (and ethics) have a dual role and highlighting the need for a nuanced understanding might help to ensure a balanced balance between promoting the evolving capacity and implementing protective measures for adolescents in the context of sexual and reproductive health.

Chapter 6 aims to draw out and reveal links between elements in the body of works where there are intersections between law, public health, and ethics, as described in Chapters 2, 3, 4, and 5. This exercise also helps to show how the works make a significant and original contribution to knowledge in the field.

[56] M.C. Stoner, et al. (2019). 'Age-disparate partnerships and incident HIV infection in adolescent girls and young women in rural South Africa: An HPTN 068 analysis'. *AIDS (London, England)*, *33*(1), 83.

6 HOW THIS BODY OF WORK MAKES A SIGNIFICANT AND ORIGINAL CONTRIBUTION TO KNOWLEDGE IN THIS FIELD.

Synthesis and reflective analysis of the published works have helped uncover the nuanced approaches embedded within the research investigating key questions in adolescent HIV prevention. In the South African context, the selected articles had a scholarly impact on the discourse about the existing South African legal framework and other country settings where the law intersects with the public health goal of combatting HIV infection. This scholarly work has:

6.1 Contributed to debates on ethical-legal issues in South Africa

The body of works has contributed to debates about reform in South Africa's criminal law system, distinguishing decriminalising adolescent consensual peer sex from the original intention behind the Sexual Offences Act, which is to protect all children (including adolescents) from all forms of harm and exploitation. Contributions address interlinked elements, including:

1. adolescent consent laws,
2. access to HIV prevention services,
3. participation in HIV-related research,
4. proxy parental consent, and
5. mandatory reporting obligations.

In all instances, the debate concerns the dual role of criminal law in promoting the evolving capacity of adolescents and establishing protective measures for responsible sexual and reproductive behaviour. The articles highlight that there are instances where protective measures create ethical-legal dilemmas, such as mandatory reporting obligations, for example, whether/when to breach adolescent confidentiality or proxy parental consent, like deterring adolescents from access or participation in HIV-related prevention strategies (and thus limiting the right to sexual and reproductive health and ultimately undermining the public health objectives to reducing adolescent HIV). The specific contributions were as follows:

6.1.1. Initially, ***poster presentation 1*** was prepared in 2007 based on concerns raised by researchers about ethical-legal dilemmas concerning mandatory reporting of maltreatment, abuse, and neglect of children. ***Article 1*** was a follow-up on the issue of mandatory reporting obligations linked to a review of the constitutional court findings in the Teddy Bear Clinic case since there are implications for health workers and researchers to do with reporting obligations about adolescent consent to sex.

6.1.2. ***Articles 2 and 3*** reflect upon the South African National Health Act, 2003, concerning child participation in research as relevant to the current debate on consent laws in adolescent participation in HIV (or related) research in sexual and reproductive health. Eligible research participant inclusivity criteria might include 'adolescents engaged in sexual activity,' whereby certain disclosures trigger mandatory reporting obligations. The published works acknowledge a global trend to facilitate research involving children requiring special protection measures, including proxy parental consent and assessing the reasons for parental consent to participate in research. ***Article 2,*** catalyzed by a July 2013 submission to the Director-General of Health on the draft Regulation on Human Subjects by the Southern African HIV Clinicians Society (SAHCS), focused on an evaluation of three consent norms found in the National Health Act, 2003 (see Appendix 1, Table 1).[57] The published work highlights the conservative approach, potentially limiting research on sexual abuse or sexual experiences/behaviour due to the parental consent requirement.[58]

6.1.3. ***Article 3*** investigates S71 (3)(a)(iii) of the National Health Act, 2003, relating to the requirement of Ministerial consent delegated to RECs. RECs reviewing non-therapeutic research involving adolescent participation must be scrutinised to assess reasons for parental proxy consent to the child's participation in research and whether they are not against public policy (*contra bonos mores*). In this article, it is noted that van Wyk proposes '…non-therapeutic research with children should only be possible if classified as observational in nature, and pose no more than a minor increase over minimal risk'.[59] The article asserts that applying the *boni mores* test is complex and onerous for RECs to assess legal considerations of black letter law.

[57] South African Clinicians Society. 2013. Submission on the 'Regulations Relating to Research on Human Subjects' Available at *https://sahivsoc.org/Files/Submission%20on%20NHA%20Regs_final.pdf* Accessed on 19 June 2023.

[58] NSP, 2017-2022 (updated version still to be published) provides for a combination of intervention to combat HIV which includes evidence-based behavioural, biomedical socio-behavioural and structural interventions. The NSP makes provision for the 2016 NDoH Health Sector HIV Strategy which refers to *'combination prevention*' as the

> *"strategic, simultaneous use of different classes of prevention interventions (biomedical, behavioural and structural) that operate on multiple levels (individual, couple, community and societal) to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritising partnerships and engagement of affected communities."*

Additionally, the NSP includes that biomedical refers to current proven techniques such as male circumcision, HIV testing services and condom programming and also future biomedical techniques such as HIV vaccines, microbicides, fixed-dose medicines, diagnostics and prevention technologies.

See also Article 3 which states:

> "*It is worth noting that in all of the above examples, children in these examples are likely to be considerably more vulnerable and at risk of ill health than their peers. Thus ethical acceptable and responsible research could assist with critical evidence-based intervention with these groups."*

See also UNAIDS. 2015. '*Terminology Guidelines' UNAIDS. Available at https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf* , which refers to combination HIV prevention:

> *"seeks to achieve maximum impact on HIV prevention by combining human rights-based and evidence informed behavioural, biomedical and structural strategies in the context of a well-researched and understood local epidemic. Combination HIV prevention also can be used to refer to an individual's strategy for HIV prevention—combining different tools or approaches (either at the same time or in sequence), according to their current situation, risk and choices."*

[59] ***Article 3*** cites C. Van Wyk. (2005). 'HIV preventative vaccine research on children: Is it possible in terms of South African law and research guidelines?' *Tydskrif vir Hedendaagse Romeins Hollandse* 2005; 68:35-50.

6.1.4. *Article 4* investigated amendments to the South African Sexual Offences Act, 2007, via an empirical investigation into the perspectives of a sample of social workers in KwaZulu-Natal, South Africa.[60] Vital insights emerged from this stakeholder group, who serve as an essential entry point for adolescents, to understand the nature of some contextual realities in implementing laws. Key findings included that social workers perceived the changes in the Sexual Offences Act, 2007 as too liberal and too permissive, holding conservative views on consent to sex and access to sexual and reproductive health interventions. Thus, the study findings revealed stakeholders' ethical-legal dilemmas on upholding professional duties rather than personal views on adolescent consent laws promoting evolving capacity. This article contributed significantly to the collection of works providing insight into how balancing the dual role of the law has multiple complications. In addition, implementation can be problematic if not linked to contextual realities in South African society concerning adolescent sexual and reproductive health.

6.1.5. *Poster presentation 2* served as foundational work for *Article 5* on male circumcision. *Article 5* analysed legal provisions concerning male circumcision (see Appendix 1, Table 2), contributing to ethical-legal debates on adolescent consent laws to male circumcision as a form of HIV prevention intervention. The Children's Act prohibits male circumcision below the age of 18 unless it is for one of three reasons for which male circumcision is allowed: medical, religious, and cultural. However, Article 5 highlights that the Children's Act, 2005, when read together with the General Regulations Regarding Children 2010 (General Regulations) and the NDOH guidelines on male circumcision, are not aligned. There is no coherence concerning the age of self-consent, procedural requirements (specifically concerning local anaesthetic), and when parental consent is required.

The articles highlight that while protective measures are in the provisions, these are not consistently and uniformly applied across the law, regulations, and national guidelines to accommodate the protective measure for each form of male circumcision. Further, healthcare providers may be unclear on whether parental consent is required for adolescent access to male circumcision as a form of HIV prevention. This is an important contribution to the body of knowledge in this field because the law is interpreted to mean that boys (aged between 12 and 15) seeking circumcision for HIV prevention cannot self-consent. Additionally, it is not clear whether male circumcision for HIV prevention can legitimately be regarded as a health reason or interpreted as a form of medical treatment (an issue discussed in Article 7). Thus, the article contributes to the ethical-legal debate on whether adolescent boys engaged in consensual sexual activity could access circumcision as a form of HIV prevention.

[60] Notably, KwaZulu-Natal remains the highest number of HIV infections of all nine provinces in South Africa: KZN Department of Health. N.d. 'HIV and AIDS.' Available at *http://www.kznhealth.gov.za/publicity/HIV.pdf*. Accessed on 14th May 2023.

6.1.6. Article 6 focuses specifically on the amended law decriminalising consensual sexual activity between younger adolescents (12 to 15 years) and older adolescents (16 or 17 years), where there is no more than a two-year age gap between them (see Appendix 1, Table 3). This article contributed to knowledge in this field by providing a comparative study of age-span provisions in South Africa and other jurisdictions. For example, in the USA, the age of consent varies between 16 and 18 years across different states, with most including fixed age-gap provisions decriminalising sexual relations between younger and older adolescents, provided the age gap is within 2 to 6 years (typically four years). Canada has two types of close-in-age provisions where sex is decriminalised: 1. where a younger adolescent (12 to 13 years) is no more than two years younger and 2. where the younger adolescent (14 to 15 years) must be no more than five years younger than the older adolescent.

The main contribution to this debate is that in South Africa and other countries, irrespective of their approach, the younger the adolescent, the narrower the age gap. The article asserts that the investigation into this legal provision considers the contextual realities in South Africa concerning intergenerational sex, exploitation sex, or even coercive adolescent peer sexual relationships. Thus, the narrow, conservative approach of a 2-year age-gap provision is needed. The article interprets that prosecutorial risk is possible for adolescents whose age gap in sexual activity between 12 to 15 year olds and 16/17 year old is more than two years. On cross-examination with the previous articles in this body of work, the implication is clear that healthcare professionals and researchers need to be aware that disclosure by an adolescent of this kind of sexual relationship can trigger mandatory reporting obligations. This could breach the adolescent's right to confidentiality and have negative implications by deterring adolescents from accessing sexual and reproductive health services.

6.1.7. *Article 7* discusses whether the term 'medical treatment' in the Children's Act, 2005 is broad enough to include prevention interventions such as the Human papillomavirus vaccine (HPV) and other health interventions like pre-exposure prophylaxis (PrEP). The Children's Act and the SA Clinicians' guidelines do not provide consent law to adolescents' access to oral PrEP by persons under 18 years old. Hence, while PrEP has been proven effective as an HIV prevention intervention, it could be denied for at-risk adolescents.[61]

6.1.8. *Article 8* reviewed the South African legal framework concerning adolescent access to specified health-related measures for adolescent HIV prevention. The article asserted

[61] These include adherence to daily intake, only being prescribed for youth at risk of HIV infection, weighing more than 35kg, over 12 years or older, and mature enough to understand risks, benefits and associated implications of using PrEP.

that the Children's Act 2005 accepts adolescent evolving capacity promoting consent laws (Appendix 1, Table 4). However, the article indicates weaknesses in the legal framework where the criminal law (mandatory reporting obligations) intersects with the civil law (consent to access HIV prevention services). Article 8 infers a gap in international norms requiring countries to ensure that legal protections support good adolescent decision-making. The South African regulatory framework is scattered across various documents, sometimes not comprehensive, and provides overly broad legal norms with no further detail accompanying policy choices. Across the examined law, there is a lack of a coherent child-oriented, rights-based approach. The laws do not always reflect society's contextual realities to promote the evolving capacity of adolescents and protective measures to aid age-appropriate decision-making for the effective implementation of public health objectives.

6.2 Made recommendations for nuanced approaches, including South African-specific law reform

6.2.1 ***Article 1*** suggested an alternative approach to Professor McQuoid-Mason's (suggesting reporting obligations for adolescents, 12 to 15 years, were no longer required). While legal provisions on reporting obligations remained open, they were overly broad and needed further legal clarification. ***Article 1*** recommended a nuanced approach to reporting obligations for:

a. health care professionals and researchers who know about adolescent sexual activity but are no longer obliged to automatically report all consensual sexual activity amongst 12 to 15-year-olds or instances where a younger adolescent (12 to 15) engaged in sexual activity with an older adolescent (16/17) provided no more than a two year age gap was evident;
b. health care professionals and researchers, if there is no knowledge of the age of the sexual partner, the healthcare professional or researcher does not have a duty to report;
c. adolescents (12 to 15) who disclose they are sexually active with a person over 18 or an age gap of more than two years of an older adolescent (over 16). In these instances, healthcare providers or researchers need to know that there is still a legal duty to report.

A key recommendation is that policymakers clarify instances of mandatory reporting obligations through guidance documents to establish effective protective measures for adolescents at risk of harm and exploitation or arbitrary interface with the criminal justice system. However, healthcare professionals and researchers no longer need to

fear legal penalty for not reporting certain instances of adolescent (12 to 15) peer-peer consensual sexual activity. Additionally, a focus on providing access to critical HIV prevention interventions and maintaining their ethical duty to confidentiality is important.

6.2.2 *Article 2* recommends that adolescent independent self-consent to participate in research should be driven by the type and nature of the research rather than a blanket approach to proxy parental consent for all research involving minors. However, this issue remains contentious in ethical and legal debates, even for low-risk research, where some have argued that participation in research may never be in children's best interests.

6.2.3 *Article 3* recommends a set of key questions when considering the reasons for proxy parental consent in non-therapeutic research, including:

a. whether the reasons for proxy parental consent are ethical;
b. whether the research is lawful;
c. whether the study would violate a child's constitutional rights (such as dignity, privacy, bodily integrity, and best interests of the child standard); and
d. whether the research is acceptable to the mores of society.

The article acknowledges that the requirement for written parental consent and the reasons for the consent are important protective measures for adolescents who are a vulnerable group. Parental consent (along with child consent) should facilitate participation in HIV-related research, together with risk mitigation and REC oversight.

6.2.4 *Article 4* recommends developing and updating training programmes to enhance stakeholders' critical thinking in resolving conflicting ethical-legal dilemmas. A more balanced approach to understanding and applying consent laws in promoting adolescent evolving capacity and protective measures for responsible adolescent sexual and reproductive health is required.

6.2.5 *Article 5* recommends that law, policy, and regulation reform require coherence and clarity about access to adolescent male circumcision as an HIV-prevention tool.

6.2.6 *Article 6* recommends law reform and the development of guidelines to include a more nuanced approach to the legal provision of the two-year age-gap defence. The article suggests considerations should include adolescents' ages, maturity, and relationship dynamics (e.g., whether there are harmful or exploitative factors at play, such as power dynamics of undue influence, force, coercion, procurement, etc.), and be guided by the 'best interests of the child' standard.

6.2.7 ***Article 7 recommends*** two actions:

a. Within the Children's Act 2005's legal provisions, PrEP should be included as a specified HIV-health intervention with an established age for self-consent. However, this critical appraisal acknowledges that scholarly work often suggests law reform, but this is a slow process and does not keep up with contextual realities in adolescent health care and research developments; or
b. PrEP could be considered a form of 'medical treatment' as a non-specified HIV prevention intervention, where adolescent consent would be from 12 years old.

Regardless of the approach, this HIV prevention intervention requires protection measures to aid age-appropriate decision-making. [62]

6.2.8 ***Article 8*** recommends legal reform to support a *coherent approach* to adolescent access and age-appropriate decision-making around responsible sexual behaviour and reproductive health. While the law ought to create an enabling environment to facilitate public health responses, advancing the right to sexual and reproductive health for adolescent HIV prevention can be complex. Thus, the article uses child-oriented, rights-based generic markers between public health, law, and ethics within the context of adolescents' contextual realities of South African society[63].

6.3 Established a set of generic markers as a possible useful model beyond South Africa for developing laws to enable access for adolescents to HIV prevention interventions

6.3.1 ***Article 8*** was a comprehensive review of HIV international guidelines on adolescent HIV prevention to identify and extract a set of norms to determine whether the selected South African laws:

a. *set a non-discriminatory age of consent to contraceptives, medical treatment, and sex*– of which the research findings indicate none of the laws include a discriminatory age to consent to contraceptives, medical treatment, and sex;

[62] Article 7, notes an article written by T. Taggart, et al. (2019). 'Getting youth PrEPared: Adolescent consent laws and implications for the availability of PrEP among youth in countries outside of the United States.' *Journal of the International AIDS Society.* 22 (7):e25363, states that:

"France is the only country to explicitly include PrEP as part of medical treatment, but their law requires parental consent for medical treatment in people under 18 years."

[63] As stated in earlier in Chapter 4, Article 24 of the CRC of the General Comment No. 3 on HIV/AIDS and the rights of the child includes:

"…strengthening understanding of child specific HIV related issues, promoting the realization of children's human rights, identifying measures and good practices to combat the scourge of HIV among children, and contributing to the formulation and promotion of child oriented responses to the HIV crisis, at both the national and international level, in the context of HIV/AIDS prevention."…"Children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential and non-judgmental, do not require parental consent and are not discriminatory."

b. *created a right to sexual and reproductive health services – the review found that* s27 of the Constitution establishes a right to health care services, which includes sexual and reproductive health services; [64]
c. *created a right to access information* – here, the research results indicate that s27 of the Constitution, 1996, and s13 of the Children's Act, 2005 create a right to health care information (including age-appropriate prevention information on the treatment of sexual and reproductive health);
d. *protected adolescent privacy rights* – the investigation indicated that the right to adolescent privacy is protected in s14 of the Constitution, 1996, and key legal provisions in the corresponding child laws related to HIV prevention interventions.

These four criteria are recommended as standard generic markers to assess the effectiveness of a country's legal framework in promoting and protecting adolescents' sexual and reproductive health.

6.4 *Applied these general norms to promote and protect adolescent rights in the health research context*

The published works indicated that the South African ethical-legal framework regulating HIV prevention research is multidimensional. However, this synoptic commentary asserts that the approach in the published works concerning a nuanced understanding of the intersection between law, public health, and ethics to adolescent access to HIV prevention interventions has relevance for consideration of adolescent participation in the HIV-health research context.

Articles 2, 3, and 6 highlight that various issues in the context of adolescent access to HIV prevention interventions do overlap with those in research. For instance, adolescent self-consent to research and the corresponding legal requirement for parental consent can raise ethical-legal dilemmas, where, for example, research focuses on understanding adolescent sexuality, sexual abuse, or sexual practices. While the law is interpreted to provide a protective measure, including parental consent, for participation in such forms of research, this could be exclusionary for adolescents who do not want parental involvement. In addition, researchers must comply with mandatory reporting obligations when adolescents disclose sexual activity that reveals sexual offences or sexual abuse.

[64] UN High Commissioner for Human Rights. (2006). *The International Guidelines on HIV/AIDS and Human Rights.* suggests governments review and reform laws to ensure that they adequately address public health issues raised by HIV.

6.5 Been widely cited in other academic research publications[65]

→ Article 2 cited 21 times in Google Scholar and 14 citations in Scopus
→ Article 3 cited 5 times in Google Scholar
→ Article 4 cited 19 times in Google Scholar and 5 citations in Scopus
→ Article 5 cited 2 times in Google Scholar and 2 citations in Scopus
→ Article 6 cited 10 times in Google Scholar
→ Article 7 cited 7 times in Google Scholar and 2 citations in Scopus
→ Article 8 cited 1 time in Google Scholar and 1 citation in Scopus.

Final thoughts

The works in this Ph.D. by publication began during my role as a research assistant in 2007. At the time, I could not have envisaged this research in its entirety. The works have evolved over time as laws and societal conventions have changed, and efforts to reduce the spread of HIV/AIDs have increased, especially in the last decade. Nevertheless, the trajectory that my work has followed has rarely deviated from the intersection between law, ethics, and public health objectives for adolescent sexual and reproductive health in South Africa.

Reflective critical appraisal of my published works has helped to reveal that the law (and ethics) have a dual role in advancing the right to health. Adoption of this theoretical underpinning highlights the need for a nuanced understanding. It might help to ensure a balance between promoting the evolving capacity and implementing protective measures for adolescents in the context of sexual and reproductive health.

Importantly, a nuanced understanding also requires consideration of adolescent contextual realities underpinned by what is in the child's best interests. In other words, this critical appraisal suggests an approach where adolescent consent laws in advancing the right to health (sexual and reproductive) can be realised where there is a balance between promoting the evolving capacity of the adolescent and ensuring protective measures for adolescents that factor in the child's best interests.

[65] All Google Scholar citation details accessed from my Google Scholar profile. Available at *https://scholar.google.com/citations?user=QgZ5HVoAAAAJ* . Accessed on 19 June 2023.

7 BIBLIOGRAPHY

International Laws and Treaties

Treaty Series, *1577*(3), 1-23. Available at *https://www.refworld.org/ docid/3ae6b38f0.html* Accessed on 18 June 2023.

United Nations Committee on the Rights of the Child (CRC). General comment No. 3 (2003): *HIV/AIDS and the Rights of the Child,* 17 March 2003, CRC/GC/2003/3. Available at *https://www.refworld.org/docid/4538834e15.html.* Accessed on 8 April 2023.

World Health Organisation. (1987). 'Declaration of Alma-Ata "Health for All" (Series No. 1). Geneva: WHO.

National Law

Constitution of the Republic of South Africa, 1996

Section 10
(Right to dignity)
Section 12
(Right to bodily and psychological integrity)
Section 14
(Right to privacy)
Section 27
(Right to have access to health care services, including reproductive health care)
Section 28(2)
(Child's best interests)
Section 28(3)
(A child is a person under the age of 18)
Section 36
(Limitation on rights, to the extent reasonable and justifiable)
Section 39
(Interpretation of the Bill of Rights)

Children's Act 38 of 2005

Section 129
(Consent to medical treatment and surgical operations)
Section 130
(HIV testing)
Section 132
(Counselling before and after HIV-testing)
Section 133
(Confidentiality of information on HIV/AIDS status of children)
Section 134
(Access to contraceptives)

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

Section 15
(Criminal acts of consensual sexual penetration (by adults and children) with a child regarded as statutory rape)
Section 16
(Criminal acts of consensual sexual violation with (by adults and children) with a child regarded as statutory sexual assault)
Section 50
(Persons whose names must be included in Register and related matters)
Section 54
(Mandatory reporting obligations concerning sexual offences)

Criminal Law (Sexual Offences and Related Matters) Amendment Act 5 of 2015

Substitution of section 15 of Act 32 of 2007
*(*Criminal acts of consensual sexual penetration with a child are regarded as statutory rape unless both children are between 12 and 15 years)
Substitution of section 16 of Act 32 of 2007
(Criminal acts of consensual sexual violation with a child are regarded as statutory sexual assault unless both children are between 12 and 15 years)

National Health Act 61 of 2003

Section 71 (1)
(Consent norms for all health research)
Section 71 (2)
(Consent norms for therapeutic research involving children)
Section 71 (3)
*(*Consent norms for non-therapeutic research involving children)

Case Law

Christian Lawyers Association v National Minister of Health and Other, Case No: 7728/2000, 2004 (10) BCLR 1086 (T) (South Africa, High Court, Transvaal Provincial Division.

Cool Ideas 1186 CC v Hubbard and Another (CCT 99/13) [2014] ZACC 16.

Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another (CCT 12/13) [2013] ZACC 35.

Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development 2013 JDR 0025 (GNP).

National Strategic Plans and Guidelines

National Strategic Plan (NSP) 2017 – 2022. Available at *https://www.gov.za/sites/default/files/gcis_document/201705/nsp-hiv-tb-stia.pdf*. Accessed on 04 May 2022.

South African Clinicians Society. 2013. Submission on the 'Regulations Relating to Research on Human Subjects.' Available at *https://sahivsoc.org/Files/ Submission% 20on%20NHA% 20Regs_final.pdf* Accessed on 19 June 2023.

South African Law Reform Commission. 2002. *Review of the Child Care Act*. Pretoria: SALRC. Available at *http://www. justice.gov.za/salrc/reports/r_pr110_01_2002dec.pdf*

Secondary sources

Barr-DiChiara, M., Tembo, M., Harrison, L., Quinn, C., Ameyan, W., Sabin, K., ... & Johnson, C. (2021). Adolescents and age of consent to HIV testing: an updated review of national policies in sub-Saharan Africa. *BMJ Open*, 11(9), e049673

Dube, F. (2020). 'The South African Constitution as an instrument of doing what is just, right and fair.' *In die Skriflig?In Luce Verbi* 54(1): a2601. *https://doi.org/10.4102/ids.v54i1.2601*.

Grund, J. M., Chetty-Makkan, C. M., Ginindza, S., Munyai, R., Kisbey-Green, H., Maraisane, M., & Charalambous, S. (2018). 'Effectiveness of an "Exclusive Intervention Strategy" to

increase medical male circumcision uptake among men aged 25–49 years in South Africa.' *BMC Public Health*, 18(1): 1-10.

Joint United Nations Programme on HIV/AIDS (UNAIDS). (2016). 'South Africa takes bold step to provide HIV treatment for all.' Available at *https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/may/20160513_UTT#:~:text=On%2010%20May%202016%2C%20the,with%20HIV%20by%20September%202016.* Accessed on 09 May 2023.

Joint United Nations Programme on HIV/AIDS. (2015). 'UNAIDS terminology guidelines 2015.' Geneva: UNAIDS.

KZN Department of Health. N.d. 'HIV and AIDS.' Available at *chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/ http://www.kznhealth.gov.za/publicity/HIV.pdf.* Accessed on 14 May 2023.

Lansdown, G. (2005). 'The evolving capacities of the child.' *No. innins* 05/18. 2005. Available at *https://ideas.repec.org/p/ucf/innins/innins05-18.html.* Accessed on 09 May 2023.

Likierman, A. (2020). The elements of good judgment. *Harv Bus Rev,* 98(1): 102-111

Mabaso, M., Maseko, G., Sewpaul, R., Naidoo, I., Jooste, S., Takatshana, S., ... & Zungu, N. (2021). Trends and correlates of HIV prevalence among adolescents in South Africa: evidence from the 2008, 2012 and 2017 South African National HIV Prevalence, Incidence and Behaviour surveys. AIDS Research and Therapy, 18(1), 97.

Mann, J. M., Gostin, L., Gruskin, S., Brennan, T., Lazzarini, Z., & Finebuerg, H. V.et al. (1994). 'Health and human rights.' *Health & Hum Rts*, 1(6): 6-23.

McQuoid-Mason, D. J. (2013). 'Decriminalisation of consensual sexual conduct between children: What should doctors do regarding the reporting of sexual offences under the Sexual Offences Act until the Constitutional Court confirms the judgement of the Teddy Bear Clinic case?' *South African Journal of Bioethics and Law*, *6*(1): 10-12.

Mollel, Loveday, M., Goga, A., Dhai, A., Labuschaigne, M., Roussouw, T., Burgess, T., ... & Bekker, L. G. (2022). Ethically acceptable consent approaches to adolescent research in South Africa. Southern African Journal of HIV Medicine, 23(1).

Shah, S. K., Essack, Z., Byron, K., Slack, C., Reirden, D., van Rooyen, H., ... & Wendler, D. S. (2020). Adolescent barriers to HIV prevention research: are parental consent requirements the biggest obstacle?. *Journal of Adolescent Health*, 67(4), 495-501

Statista. 'Population of South Africa in 2022, by age group and gender.' Available at *https://www.statista.com/statistics/1330839/population-of-south-africa-by-age-group-and-gender/* Accessed on 09 May 2023.

Stoner, M. C. D., Nguyen, N., Kilburn, K., Gomez-Olive, F. X., Edwards, J. K., Selin, A., Hughes, J. P., Agyei, Y., Macphail, C., Kahn, K., & Pettifor, A. (2019). Age-disparate partnerships and incident HIV infection in adolescent girls and young women in rural South Africa: An HPTN 068 analysis. *AIDS (London, England)*, *33*(1): 83-91.

Strode, A., & Slack, C. (2009). 'Sex, lies and disclosures: Researchers and the reporting of under-age sex: opinion.' *Southern African Journal of HIV Medicine*, 10(2): 8-10.

Taekema, S. (7 March 2018). 'Theoretical and normative frameworks for legal research: Putting theory into practice,' *Law and Method.* DOI: 10.5553/REM/.000031.2023.

Taggart, T., Bond, K. T., Ritchwood, T. D. & Smith, J. C. (2019). 'Getting youth PrEPared: Adolescent consent laws and implications for the availability of PrEP among youth in countries outside of the United States.' *J Int AIDS Soc*., 22(7): e25363. doi: 10.1002/jia2.25363

UNAIDS. 'Global HIV & AIDS statistics. Fact sheet.' Available at *https://www.unaids.org/en/resources/fact-sheet.* Accessed on 22 April 2022.

UNICEF. (2021). 'HIV and AIDS in adolescents.' Available at *https://data.unicef.org/topic/hiv-aids/* Accessed on 22 April 2022.

United Nations High Commissioner for Human Rights. 2006. *The International Guidelines on HIV/AIDS and Human Rights.* Geneva

van Wyk, C. (2005). 'HIV preventive vaccine research on children: Is this possible in terms of South African law and research guidelines.' *THRHR*, 68(1): 35-50.

World Health Organization. (1984). *Glossary of terms used in the" Health for All" series, no. 1-8*. Geneva: WHO.

World Health Organisation. 10 December 2022. 'Human Rights – Key Facts.' Available at *https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health* Accessed on 04 April 2023.

World Population Review. 'HIV Rates by Country 2022.' Available at *https://worldpopulationreview.com/country-rankings/hiv-rates-by-country*. Accessed on 04 May 2022.

Media Statements

Macupe, B. (7 September 2021). 'Every week, 1 300 adolescent girls and young women are infected with HIV.' *City Press*, Available at *https://www.news24.com/citypress/news/every-week-1-300-adolescent-girls-and-young-women-are-infected-with-hiv-20210907* Accessed on 04 May 2022.

National Prosecutorial Authority. 17 November 2010. 'NPA charges Jules High School boys and girls.' Media Release. Available at *https://www.npa.gov.za/sites/default/files/media-releases/Nov-17_NPA-Charges-Jules-High-School-Boys-And-Girl.pdf* Accessed on 15 June 2023.

South African Government. Media Statement. 2010. 'Jules High School rape case.' Available at *https://www.gov.za/jules-high-school-rape-case* Accessed on 03 May 2023.

8 APPENDICES

Appendix 1: Tables from selected articles

Name of study	Ethically approved consent requirements	Reasons why obtaining parental consent would be difficult or impossible	Health benefits to children
HIV-related knowledge, attitudes and behaviour among SA street youth: reflections on power, sexuality and the autonomous self[28]	Independent consent	The child research participants were street children living away from adult supervision	Better understanding of the HIV risk of children living on the street
A systemic approach to the experiences of adolescents, with regard to terminating their pregnancies[29]	Participants aged 13 - 22 years; independent consent obtained	The study explored experiences of pregnancy termination. In many cases, participants may not have disclosed their pregnancy or their decision to terminate to their parent/legal guardian. Only 5 of 19 participants had disclosed their pregnancy to their mothers	Better understanding of adolescent experiences could inform policy and practice – particularly regarding school support and processes, as well as health and community services
Persisting mental-health problems among HIV-orphaned children in SA[30]	The mean age of the participants was 13.4 years at the study outset; consent was obtained from participants and caregivers	By definition, participants did not have a parent to provide consent, and it was unlikely that all caregivers would have been designated as legal guardians	The identification of the impact of psychological distress due to AIDS orphanhood over time in comparison with other groups, and highlighting the need for a focus on addressing the specific psychosocial needs of children

SA = South Africa.

Table 1. "Examples of completed studies that would in the future be difficult to undertake with the requirement of parental/legal guardian consent." Extract from Article 2: Strode, A., Richter, M., Wallace, M., Toohey, J., and Technau, K. (2014). Failing the Vulnerable: Three new consent norms that will undermine health research with children. Southern African Journal of HIV Medicine, 15(2), p48.

Reason	Consent to be provided by	Procedure performed by	Requirements for the procedure
Any reason	Boy himself (age 16 - 17) (CA[6]); and documented on Form 2 (Regulations[9])	Not prescribed (Regulations[7])	Not prescribed (Regulations[7])
Social or cultural practice	Boy himself (age 16 - 17) (CA[6]); 'assisted' by parent or guardian and documented on Form 2 (Regulations[9])	Trained practitioner (Regulations[7])	Prescribed equipment (Regulations[7])
Medical	Boy himself (age 16 - 17) (CA[6]); parent or legal guardian if regarded as surgery (NDoH guidelines[8])	Medical practitioner (NDoH guidelines[8])	Detail (NDoH guidelines[8])

CA = Children's Act.

Table 2. "Existing norms for male circumcision of 16-and-17year old boys." Extract from Article 5: Strode, A., Toohey, J., and Slack, C. (2016). Addressing Legal and Policy Barriers to Male Circumcision for Adolescent Boys in South Africa. *South African Medical Journal*, 106(12), p1174.

Partner A age, years	Partner B age, years	Current legal provisions on underage consensual sex
12 - 15	12 - 15	Not an offence
12	16 or 17	Offence; age gap >2 years
13	16 or 17	Offence; age gap >2 years
14	16	Not an offence
14	17	Offence; age gap >2 years
15	16 or 17	Not an offence

Table 3. "Current legal provisions on underage consensual sex." Extract from Article 6: Essack, Z., & Toohey, J. (2018). Unpacking the 2-Year Age-Gap Provision in Relation to the Decriminalisation of Underage Consensual Sex in South Africa. *South African Journal of Bioethics and Law,* 11(2), p86.

Category	Age of consent	Protections, if any
Sex	16 (heterosexual and homosexual)	-
VMMC	16	'Proper' counselling before the circumcision
Medical treatment (to include PrEP)	12	Adolescent must display 'sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of the treatment'
HIV testing	12	HIV testing must be in the best interests of the child and accompanied by pre-and post-test counselling
Contraceptives (condoms)	12	-
Virginity testing	16	'Proper' counselling

SA = South Africa; VMMC = voluntary male medical circumcision; PrEP = pre-exposure prophylaxis.

Table 4. "Age of consent to sex and sexual reproductive health services in SA." Extract from Article 8: Toohey, J. D., and A. Strode. (2021). A critical review of the South African legal framework on adolescent access to HIV prevention interventions. South African Journal of Bioethics and Law 14.1 (2021). p17

Appendix 2: Completed appraisal framework for developing synoptic commentary

Title 1	*Strode, A., and Toohey, J., et al. (2013). Reporting underage consensual sex after the Teddy Bear Clinic case: A different perspective. South African Journal of Bioethics and Law, 6(2): 40-42.*
Aims	*What were the stated aims?* This article aimed to interpret the Constitutional Court findings in the case of *Teddy Bear Clinic for Abused Children and Resources aimed at the Prevention of Child Abuse and Neglect (RAPCAN) v. Minister of Justice and Constitutional Development.* The Constitutional Court confirmed aspects of sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (hereafter the Sexual Offences Act), which infringed on the constitutional rights of adolescents (aged 12 to 15 years) which originally proscribed all forms of sexual activity against children as illegal (included consensual underage peer-peer sexual activity).
Need for	*Why did you write the article? What was the gap?* The article was written to clarify whether/when healthcare workers (HCWs) and researchers were required to report underage consensual peer-to-peer sexual activities.
Interpretation and perspective taken	*How did you approach the argument? How did your perspective influence the argument?* A statutory interpretation was taken in this article, which supports the argument that despite the changes in the law, ambiguity remains for HCWs and researchers concerning whether/when to report consensual peer sexual activity.
Conclusion	*What did you conclude?* It was concluded that an alternate nuanced approach is taken in determining whether/when to report sexual activity to the extent that: 1. it is no longer applicable to report to the police peer-peer adolescent consensual sexual activity if both are 12 to 15 yrs old or if one is 16 or 17, provided no more than 2 yrs between them; and 2. it is not a requirement to report where there is no knowledge of the age of the older partner; however 3. there may still be reporting requirements where there is knowledge that an older partner (over 16) is involved with an adolescent (12 to 15 yrs) with an age gap of more than 2 years between them.

Implications	*What are the implications of your study for the legal system? For adolescents? For society?* HCWs and researchers could use these guiding interpretations when an adolescent seeks access to SRHSs and a determination is required as to whether to report sexual activity. This means adolescents may access SRHS without fear of legal repercussions or breach of confidentiality. This is significant for addressing the public health priority in combatting HIV/AIDS in adolescents. HCWs or researchers do not need to fear the legal penalty for not reporting certain instances of peer-peer adolescent consensual sexual activity.
Shortcomings	*How reliable is your conclusion? Have others argued against it? Have you since developed your argument?* This conclusion is reliable, and the argument has developed further in two other related articles discussed in this synoptic commentary. These articles further develop the concept of how service providers are approaching the changes in the law by: *1.* evidence that social workers are not reporting all forms of adolescent sexual activity but instead making use of alternative approaches to deal with adolescent peer-peer consensual sex; and *2.* a better understanding of why the 2-year age gap defence is in place, compared with other countries' approaches.
Discussion/Analysis	*Theme your findings – what are the common strands that run through them? Contribution to the knowledge in this field/ What is original added to knowledge? How has your argument evolved over time (against the evolving situation in SA)? Where are we now?* *Impact/implications of the work to date* *Remaining problem/issue. Recommendation.* While reporting underage sexual activity as a sexual offence was decriminalised and thus no longer applied to adolescent consensual sex, some reporting requirements remained a challenge. The issue was when healthcare professionals would then violate the right to privacy and when they would act in the child's best interests. In this context, violating the right to privacy and the best interests of the child standard was the underlying key feature from a statutory framework that takes into account South Africa's constitutional rights-based approach to promote evolving capacity and protect children from harm and exploitation is not adequately considered.

	This article was written in 2013 in response to an article published by Professor David McQuoid-Mason concerning the case *Teddy Bear Clinic for Abused Children and Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) v. Minister of Justice and Constitutional Development*. The recommendation intended within the context of health law was that the legal provisions did not account for certain factors that remained a challenge in the law despite decriminalising underage sex amongst adolescents 12 to 15 years. There are still instances where health professionals or those who work with adolescents report instances of sexual offences. Impact/implications of the work to date – the work to date has informed healthcare workers, researchers and service providers in respect to their reporting obligations. Since it is no longer a legal duty to report sexual activity amongst adolescents, service providers can make key HIV prevention interventions such as condoms, HIV testing and counselling, and sexual and reproductive health care information (including HIV prevention information) available to adolescents without fear of conflict with the legal and their ethical duty to confidentiality in patient-health care professional relationships. Remaining problem/issue – some forms of consensual sexual activity are still illegal. Adolescents who access HIV prevention interventions may disclose the nature and age of the relationship with their partner. There may be instances where the partner is an adult, or there is more than a two-year age gap between the adolescents. This means healthcare professionals, researchers, or service providers may have to report such sexual activity under Section 54 of the Sexual Offences Act, 2007. HCWs and researchers could use these guiding interpretations when an adolescent seeks access to SRHSs and a determination is required as to whether to report sexual activity. This means adolescents may access SRHS without fear of legal repercussions or breach of confidentiality. This is significant for addressing the public health priority in combatting HIV/AIDS in adolescents. HCWs or researchers do not need to fear the legal penalty for not reporting certain instances of peer-peer adolescent consensual sexual activity.

	While much has been debated on the topic, this was one of the first articles, along with Professor McQuoid-Mason's article, to publish on this issue. Mandatory reporting obligation remains an important issue for healthcare workers, practitioners, researchers, and anyone who works with adolescents to ensure young people's protection from sexual crimes. This work adds value to the knowledge base on when to respond to the legal requirement of a legal duty to report sexual offences. Recommendation - policymakers need to clarify instances of mandatory reporting obligations by means of policy or guidance documents to best inform protective measures for adolescents from harm and exploitation but also arbitrary interface with the criminal justice system.
Contribution as a co-author to this publication	As a co-author of this publication, I provided legal analysis, information, and expert opinion based on my original and independent research on the Constitutional Court challenge known as the Teddy Bear Clinic case. My contributions were also based on my knowledge and research of the relevant legal provisions to the legal challenges in reporting adolescent consensual sex in South African law, namely the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. My contributions included the overall legal research, analysis, and manuscript writing.
Title 2	***Strode, A., Richter, M., Wallace, M., Toohey, J., and Technau, K. (2014). Failing the vulnerable: Three new consent norms that will undermine health research with children. Southern African Journal of HIV Medicine, 15(2), 46-49.***
Aims	*What were the stated aims?* This article aimed to research the legal provisions of Section 71 of the South African National Health Act (NHA), 2003, concerning three consent requirements for child participation in health research.
Need for	*Why did you write the article? What was the gap?* The article explored the implications of S71 NHA's consent provisions.
Interpretation and perspective taken	*How did you approach the argument? How did your perspective influence the argument?* The interpretation and perspective taken in this article was a constitutional legal interpretation of s71 of the NHA, which supports the argument that the existing legal provisions infringe on the constitutional right to access health care and healthcare services and

	are not harmonised with national ethical guidelines for research involving minors.
Conclusion	*What did you conclude?* *T*hese legal provisions appear restrictive and out of step with other statutory requirements and national ethical guidelines concerning child participation in health research. The nature and form of consent are often driven by the type of research, its benefits, risks, costs, and consequences. The article concludes that the consent requirements are restrictive and limit most health research requiring child participation. The law also creates ambiguity for RECs around the country who oversee research, particularly concerning research with minors.
Implications	*What are the implications of your study for the legal system? For adolescents? For society? Etc.* There are some implications for the overly restrictive approach of s71 of the NHA since it restricts child participation in health research. It means certain types of research cannot take place, resulting in a lack of child-specific data on drug safety and efficacy. The strict approach set out in S71 of the NHA, therefore, limits obtaining consent to just the parent/legal guardian (and consent of the child, if the child is capable of understanding) 1. to only written informed consent, which excludes other forms of consent health research such as telephonic, electronic, or postal questionnaires/surveys); 2. independent consent below the age of 18 years, which excludes certain groups such as adolescents LGTBQI+, certain legal but morally questionable conduct (e.g., teenage sex), or illegal activities (e.g., drug use or prostitution); and 3. proxy consent of the biological parents, legal guardians, adoptive parents, or court-appointed persons only.
Shortcomings	*How reliable is your conclusion? Have others argued against it? Have you since developed your argument?* An assessment of s71 of the NHA is reliable as there is evidence that the NHA and the national ethical guidelines are not aligned concerning the consent requirements for child participation in research. To date, there have been no further developments in this area of the law, and thus, S71 of the NHA remains contentious concerning child participation in health research.

Discussion/Analysis	*Theme your findings – what are the common strands that run through them? Contribution to the knowledge in this field/ What is original added to knowledge? How has your argument evolved over time (against the evolving situation in SA)? Where are we now? Impact/implications of the work to date Remaining problem/issue. Recommendation.* This article is based on a July 2013 submission to the Director-General of Health on the draft Regulation on SAHCS. The SAHCS funded a consultative meeting to discuss critical points based on the submission. The consultative meeting prompted this article for legal research on Section 71 of the South African National Health Act (NHA). While the NHA provides strict consent requirements for child participation in therapeutic research, it must be in writing, in the best interests of the child, and be consented to by the parent/legal guardian. At the time of writing the article, there was limited literature providing clarity of S71 of the NHA. Article 12 of the CRC states that state parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child. Council for International Organizations of Medical Sciences (CIOMS) guidelines make provisions for waiver of parental consent in some research where, for example, it is not feasible or desirable to obtain consent. There has been further discussion on this issue in the South African context. However, it has not moved beyond the point of the original call in this article for the Minister of Health and Parliamentary Portfolio Committee to address the need for law reform as a matter of urgency since these restrictions hinder child participation in research. The recommendation remains that depending on the nature, the form of consent should be driven by the research rather than a blanket approach to all forms of research involving minors. To date, there have been no further developments in this area of the law. Thus, it remains contentious concerning child participation in health research and is considered not in the best interests of children where, for example, it concerns low-risk studies involving children. The article calls for support for advocacy on the restrictive legal provisions for the Minister of

	Health and the Health Portfolio Committee to undertake urgent law reform.
Contribution as a co-author to this publication	As co-author of this peer-reviewed article, I provided information and analysis based on my research and expertise. This article is based on a July 2013 submission to the Director General (D-G) of Health, which I contributed to, concerning the draft Regulation on Human Subjects by the Southern African HIV Clinicians Society (SAHCS). The SAHCS funded a consultative meeting where I presented key points on the submission to D-G of Health. Following the consultative meeting, this article, for which I conducted legal research on the implications of the legal provisions in Section 71 of the South African National Health Act (No. 61 of 2003). My contribution to the development of the manuscript included legal analysis, interpretation, and writing.
Title 3	***Strode, A. E., Toohey, J., Singh, P., and Slack, C. M. (2015). Boni mores and consent for child research in South Africa. South African Journal of Bioethics and Law, 8(1), 22-25.***
Aims	*What were the stated aims?* This article investigates an additional statutory requirement found in s71 (3) (a) (iii) to the consent norms found in the NHA, which requires ministerial consent for non-therapeutic research with minors by) assessing whether the reasons for consent are consistent with *boni mores.*
Need for	*Why did you write the article? What was the gap?* The concept of *boni mores,* which has roots in Roman-Dutch law, may be challenging to apply to health research in practice. While there has been some discussion as to when health research could be *contra bonos mores*, there is limited discussion on determining when the reasons for the consent to research would be *contra bonos mores*. While s71 (2) of the NHA provides proxy parental consent, s71 (3) provides for delegated authority by the Minister of Health (for non-therapeutic research involving minors) to Research Ethics Committees (RECs).
Interpretation and perspective taken	*How did you approach the argument? How did your perspective influence the argument?* The assessment as to whether the reasons for the consent are consistent with the *boni mores* (public policy) requires several factors: 1. South Africa's constitutional values where consent promotes dignity, equality, human rights and freedoms, non-racialism, non-

	sexism, and the child's best interest is paramount in every matter concerning that child; 2. Prevailing legal norms for obtaining legally valid consent set out in the NHA; 3. Community morals where consent needs to reflect the community's legal convictions, e.g., stakeholders might disapprove of research exploring factors that impact risky sexual practices of adolescents, but this does not mean it is against the legal framework. In many instances, ethical guidelines are essential indicators of public policy that reflect the community's moral convictions.
Conclusion	*What did you conclude?* This article focuses on the additional requirement found in S71 (3)(a)(iii) of the NHA, where the delegated authority (RECs) must assess the reasons for proxy consent of child participation in non-therapeutic research. The article concludes that the reasons for proxy consent for non-therapeutic research with minors require an assessment of SA's constitutional values, prevailing legal norms, and community morals. The NHA requires proxy consent, but proxy consent cannot be assumed to be in the child's best interests since the REC would need to establish whether the reasons for the proxy consent are acceptable/appropriate. The assessment would rely on a subjective assessment of each consenter rather than a general consideration of the reasons for enrolling minors in the study. The article concludes that an assessment based on *boni mores* limits the proxy consenter's autonomy by assessing the reasons for the consent to the research.
Implications	*What are the implications of your study for the legal system? For adolescents? For society? Etc.* The assessment of *boni mores* requires RECs to consider approving non-therapeutic research involving children; both researchers and RECs would need clear guidance to determine whether the consent reasons align with the legal order (*boni mores*). The requirement in law for applying the *boni mores* assessment appears to be a narrow approach and could be challenging to apply. The reason for this is that the law seems to have taken divergent approaches within the civil law; where on the one hand, the Children's Act recognises children's evolving legal capacity to independent consent to specific health interventions, and on the other hand, the

	NHA limits children's autonomy to proxy consent by the parent and in instances of non-therapeutic research, the additional requirement of the delegated authority to assess the reasons for the consent being consistent with *boni mores.*
Shortcomings	*How reliable is your conclusion? Have others argued against it? Have you since developed your argument?* The conclusion is reliable, has not been argued against by others, and has not been developed further. The article does not describe the restrictive nature of the NHA's current consent norms in s71(2), as this has been done in the previously discussed article on consent norms concerning minors in research. The article indicates that placing an obligation to establish whether the health research is consistent with the *boni mores* in the hands of the research regulators rather than the proxy consenters as a protective measure is an outdated, paternalistic, and an intrusive principle. This assessment could be very subjective when RECs assess proxy consent to research with minors where there is a constitutional mandate to protect children from harm and to act in their best interests and an obligation on researchers and RECS to ensure the study is ethical.
Discussion/Analysis	*Theme your findings – what are the common strands that run through them? Contribution to the knowledge in this field/ What is original added to knowledge? How has your argument evolved over time (against the evolving situation in SA)? Where are we now?* *Impact/implications of the work to date* *Remaining problem/issue. Recommendation.* The article describes the principle of *boni mores,* the factors for consideration in establishing the reasons for the non-therapeutic research for consent to be consistent with public policy, and how this could possibly be applied to health research when granting ministerial consent for non-therapeutic health research with minors. It is important to note that the article does not describe the restrictive nature of the current consent norms, as this has been dealt with in the previously discussed article on consent norms. The common strand in this article, as with the other articles, is that the best interests of the child standard needs to be considered when determining whether the reasons for proxy parental consent to the non-therapeutic research is not *contra bonos mores*. In other words,

	whether the reasons for parental consenting to non-therapeutic research are in the child's best interest. *Boni mores* test is a Roman-Dutch concept used in law to test the wrongfulness of one's action in civil law. The *boni mores* test must not be against the legal convictions of the community and must uphold South African constitutional values. Thus, this article presents original knowledge in that there is limited or no knowledge on this concept being explored in research. There have been no further developments, both in law and in this work, on determining whether the reasons for the parental consent would be regarded as *contra bonos mores.* The article concludes that parental consent for non-therapeutic research is insufficient and cannot always be assumed to be in the best interests of the child, b*oni mores* may act as a limit on proxy parental autonomy, and to determine when consent to health research is consistent with public policy may require an assessment of South Africa's constitutional values, prevailing norms concerning children (including the legal convictions of the community). The implication is that researchers and RECs would have to deliberate on these reasons before approving or carrying out research of a non-therapeutic nature. While the *boni mores* test in law is intended to be an objective, reasonable assessment, it may not be the case in an ethics review, which primarily focuses on fulfilling ethical oversight for responsible and acceptable research. This may be too onerous or undue expectation on REC members to delve into matters of the law. This is problematic as different RECs may apply the boni mores test differently. This article focuses mainly on consent, which is required for all health research. However, in order for consent to be valid, it must meet a number of requirements. This includes that consent must not b*e contra bonos mores* (against public policy*).* It is thus recommended in the article that there be a set of key questions when considering the involvement of children in non-therapeutic research concerning the reasons for the parental proxy consent, for children as a group requiring special protection and not an individual child includes a. whether is it ethical; b. whether the research is lawful;

	c. whether the study violates a child's constitutional rights (such as dignity, privacy, bodily integrity, and best interests of the child standard); and d. whether the research be acceptable to the community?
Contribution as a co-author to this publication	My substantial contributions to the development of the manuscript were to conceptualise the idea, formulate the writing team, conduct the background research, and write up on how *the boni mores* test is currently used in our legal framework concerning child consent to health research.

Title 4	*Essack, Z., Toohey, J., and Strode, A. (2016). Reflecting on adolescents' evolving sexual and reproductive health rights: canvassing the opinion of social workers in KwaZulu-Natal, South Africa. Reproductive Health Matters, 24(47), 195-204.*
Aims	*What were the stated aims?* This article aimed to document the findings from an empirical study that canvassed the perspectives on adolescents evolving capacity to access SRHRs and knowledge or awareness of changes in law decriminalisation of consensual underage sex (i.e. (s15 & s16 of the Sexual Offences Act)).
Need for	*Why did you write the article? What was the gap?* In South Africa, a person under 18 is regarded as a child, and consent to sex remains at 16. Sexual activity with a minor below 16 is a criminal offence (whether consensual or not). However, changes in the law, such as the constitutional review in the Teddy Bear Clinic case, intended that s15 and s16 of the Criminal Law Sexual Offences Act decriminalise consensual peer-peer sexual activity between 12 to 15 year-olds. There are a number of implications due to this change in the law. 1. Adolescents could access SRHSs for HIV prevention and reproductive health care owing to the decriminalisation of sexual activity between 12 to 15 years. 2. HCWs and doctors have a legal obligation to report underage sexual activity. 3. HCWs and researchers could provide critical SRH interventions without grappling with ethical-legal dilemmas such as the penalty for not reporting or breach of patient-doctor confidentiality. This article, however, shifts the focus from HCWs and researchers to other service providers who engage adolescents, such as social workers. Since social workers provide a pivotal entry point for adolescent awareness and access to SRH services through schools, healthcare facilities, information-sharing, and counseling activities, it is important to understand challenges in their experiences with the law and also to identify how to enhance service delivery through training on policy/law.
Interpretation and perspective taken	*How did you approach the argument? How did your perspective influence the argument?* This was a study of purposively sampled participants in semi-structured interviews of selected social workers in KwaZulu-Natal based on their

	involvement in the care of children. The data was analysed using thematic analysis. Key themes were developed inductively based on listening to audio-recorded interviews and summarising each interview based on emerging issues relevant to the research questions.
Conclusion	*What did you conclude?* Key conclusions drawn based on the findings were that social workers: 1. have conservative views about sex, adolescent access to SRH advice and services; 2. were critical of the recent decriminalisation of underage consensual sex; these changes in the law were an overreach by the state intruding into family space; 3. were concerned about adolescents' lack of capacity to make SRH care decisions, that parental involvement was important, and that liberal laws promote underage sex rather than protect adolescents; and 4. felt that they could uphold their professional rather than personal views in their work concerning the application of the law.
Implications	*What are the implications of your study for the legal system? For adolescents? For society? Etc.* Social workers view the changes in the law are seen as liberal and permissive. There is a gap in training (including counselling and communication skills that address issues on confidentiality, adolescents' dignity, privacy, and best interests of the child) on adolescent SRH issues to understand better and promote SRHs and need to be engaged in critical thinking about conflicting cultural, moral and personal judgments around adolescent sexuality. As long as these challenges remain, a significant barrier will persist to adolescents' access to SRHSs.
Shortcomings	*How reliable is your conclusion? Have others argued against it? Have you since developed your argument?* The article is reliable and has confirmed previous discussion points in other articles in this series of published works. This article notes that the court case of *Christian Lawyers Association vs. Minister of Health and others* held that children's capacity is an intrinsic element of consent to a health intervention, even if the legislature has set an age at which they are presumed to have the capacity to consent to sex is based on age rather than decision-making capacity. This concept was not explored in this article and could be researched further in the future as part of the development of this argument.

Discussion/Analysis	*Theme your findings – what are the common strands that run through them? Contribution to the knowledge in this field/ What is original added to knowledge? How has your argument evolved over time (against the evolving situation in SA)? Where are we now?* *Impact/implications of the work to date* *Remaining problem/issue. Recommendation.* This article canvassed social workers' perspectives since they are key stakeholders in interfacing with young people and providing information regarding health services. It was thus important to understand whether social workers understood the law in relation to access to HIV prevention services, the changes in the laws concerning sexual offences against children, and whether these laws were adequately implemented. In this publication, emphasis was held on the constitutional rights of children concerning sexual and reproductive health in relation to adolescent confidentiality, dignity, privacy, and best interests. While there is much literature on the levels of uptake in public health programmes such as HIV prevention in the country, it was not clear how service providers or professionals who interact with adolescents, such as social workers, were managing the intersections of the law, public health, and ethical obligations. The article thus provided new knowledge in regard to such an interaction. The arguments and impact of this work to date indicate that there is more research and discourse required around how best to develop mechanisms which could address some of the issues raised in this article, such as training workshops to promote awareness and understanding, coach sessions to train social workers on how best to manage their ethical dilemmas concerning the 'liberal' laws which promote responsible sexual behaviour and reproductive health versus conservative views on adolescent sexual activity. The implication is that there is a nationwide issue concerning gaps in healthcare professionals, social workers, researchers, or any service provider's understanding and awareness of the consent laws relating to adolescent sexual activity, reporting obligations, access to HIV prevention services, and participation in research. This research aligns with recommendations in other research to develop programmes to enhance critical thinking about how best to resolve ethical dilemmas on cultural and personal

	moral norms versus legal norms, to better address adolescent sexual and reproductive health. Updates provided on adolescent's sexual and reproductive health issues, laws, and rights to promote and protect measures for responsible sexual behaviour and reproductive health.
Contribution as a co-author to this publication	As co-author, I worked closely with a co-author, Z. Essack, to conduct interviews, collect data, assist with the thematic analysis, and draw out the key themes explored in the article. I contributed substantially to providing information and analysis based on my independent legal research and contribution to conceptualising, preparing, and writing the first draft and subsequent versions.
Title 5	***Strode, A., Toohey, J., and Slack, C. (2016). Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa. South African Medical Journal, 106(12), 1173-1176.***
Aims	*What were the stated aims?* This article aims to review whether the law is a barrier to adolescent boys (below the age of 18) access to male circumcision as a form of HIV prevention intervention.
Need for	*Why did you write the article? What was the gap?* There is a need to understand better the distinctive features within the law, which aims to protect boys from potentially harmful circumcisions but also promote rights such as bodily integrity. Male circumcision is legally permissible for boys under 18, but the law appears to distinguish: 1. between boys over 16 but under 18 and below 16; 2. certain age ranges for 'religious,' 'cultural,' or 'medical reasons'; 3. between the law, regulations, and NDOH national guidelines on adolescents' state self-consent and parental involvement.
Interpretation and perspective taken	*How did you approach the argument? How did your perspective influence the argument?* The approach was to assess the Children's Act, 2005 concerning male circumcision against the following criteria, which are also broadly stated in the Children's Act, 2005: 1) every child has the right not to be subjected to social, cultural, and religious practices that are detrimental to his/her well-being; and 2) a child, depending on their age, maturity, and stage of development, has the right to participate in any matter concerning them.

	Against this backdrop, an analysis was conducted on male circumcision provisions in the Children's Act, associated Regulations on male circumcisions, and NDOH guidelines, focused on the human rights principles and taking into account that there is an issue in the practice of cultural male circumcisions have resulted in harm (botched circumcisions) to young boys.
Conclusion	*What did you conclude?* The article concludes that the law sets out a protective normative framework for male circumcision of adolescent boys (under 18 yrs) but also facilitates some self-consent access to male circumcision from the age of 16. This serves to facilitate decision-making processes at an older age. However, the law appears more restrictive on 'religious' and 'cultural' circumcision for boys than on 'medical circumcisions.' Children's Act No. 38 of 2005 regulates male circumcision for boys under 18 and is read together with General Regulations Regarding Children 2010, which set out the legal procedures for male circumcisions. There is uncertainty about applying the consent process in the Children's Act. Further, there is a lack of clarity in the NDOH guidelines (addressing male circumcision performed under local anesthetic) and interactions between the Children's Act, regulations, and NDOH guidelines. This article concludes that where the Children's Act allows for independent consent for male circumcision for 'any reason' should prevail over the conflict in the national guidelines, which introduce parental consent when it involves local anesthetic. The article also calls for reform to clarify these conflicts and ambiguities.
Implications	*What are the implications of your study for the legal system? For adolescents? For society? Etc.* The ambiguity in the law creates uncertainty as to whether HIV prevention can be regarded as a medical reason, and thus, HCWs may not be clear on whether circumcision for HIV prevention can be regarded as a legitimate health reason and thus unsure whether to rely on the law (self-consent) or the NDOH guidelines (implies parental consent). Parental involvement, where boys want this as a form of HIV prevention, may deter these adolescents. The article recommends reform to further clarify, harmonise, and thus enable access concerning self-consent and the procedures for adolescent boys who are at-risk of HIV infection.

Shortcomings	*How reliable is your conclusion? Have others argued against it? Have you since developed your argument?* The conclusion is reliable. Some authors have argued that circumcision for medical reasons can only apply to current medical treatment, not future treatment (HIV prevention). Others have argued that HIV is a serious public health crisis in the country, so the application of male circumcision as a medical treatment as prevention against future/potential HIV infection is justified.
Discussion/Analysis	*Theme your findings – what are the common strands that run through them? Contribution to the knowledge in this field/ What is original added to knowledge? How has your argument evolved over time (against the evolving situation in SA)? Where are we now? Impact/implications of the work to date* *Remaining problem/issue. Recommendation.* In this article, the right to bodily integrity is the overarching focus where it concerns the two legal principles in the Children's Act. 1) every child has the right not to be subjected to social, cultural, and religious practices that are detrimental to his/her well-being; and 2) a child, depending on their age, maturity, and stage of development, has the right to participate in any matter concerning them. In this regard, the article is original in that, to date, there is no other research on the issue of legal barriers to adolescent access to male circumcision in South Africa and thus adds new knowledge in this field. The argument has not evolved over time since the laws in South Africa remain a challenge in terms of younger boys' access to male circumcision as a form of HIV prevention. Currently, there are no new developments/tabled changes in the law; this remains a problem as it has been reported in a recent journal article that 'voluntary medical male circumcision (VMMC) is associated with an approximately 60% reduction in the risk for female-to-male transmission of HIV.' Further, '…the VMMC program is a critical component to ending the AIDS epidemic and reaching the Joint United Nations Programme on HIV/AIDS 2025 target of 90% of eligible males having access to VMMC in prioritized countries.' Uptake in the national rollout HIV prevention programme in South Africa has been slow. The implications in this

	regard are that adolescent boys who want to undergo VMMC cannot do so on independent self-consent if they are below the age of 16. It means that the age range of 12 to 15-year-olds who are engaged in consensual sexual activity cannot access this intervention as a form of HIV prevention, along with other health-related interventions such as condoms, HIV testing and counselling, and HIV prevention information. The published work recommends law and policy reform to ensure better access to this valuable HIV-prevention tool for this at-risk group. Specifically, it was recommended that the Regulations specify minimum standards that should be followed in the procedure for medical circumcisions carried out in the same manner for circumcisions for religious or cultural reasons and include a form specifically designed to document consent to circumcisions for a health reason. In addition, the national guidelines provide that HIV prevention is a valid medical reason for the circumcision of boys under 16.
Contribution as a co-author to this publication	I contributed independent information and analysis to this peer-reviewed article based on my legal research and expertise. My significant and original contributions were to conceptualise the need for the paper, prepare a first draft, and work with all co-authors in preparing subsequent and final drafts.
Title 6	***Essack, Z., & Toohey, J. (2018). Unpacking the 2-year age-gap provision in relation to the decriminalisation of underage consensual sex in South Africa. South African Journal of Bioethics and Law, 11(2), 85-88.***
Aims	*What were the stated aims?* The article was written to interpret and clarify the implications for researchers, service providers, and policymakers on the 2-year age-gap legal provision in SA legislation, including the rationale and potential implication of this law for adolescents compared to other countries.
Need for	*Why did you write the article? What was the gap?* It is essential to understand the changes to the law concerning children's evolving capacity to access certain SRH interventions and ensure their protection as children as a vulnerable group in society against sexual predators.
Interpretation and perspective taken	*How did you approach the argument? How did your perspective influence the argument? The approach that I took in the argument influenced my conclusion. e.g., human rights approach.* This argument was approached using a statutory interpretation of South African law and a comparative analysis of other developed

	countries. The article provided a critique of the law as to whether the law provides adequate safeguards to protect adolescents from sexual predators but also assessed whether the need to address public health and social challenges such as HIV infection and teenage pregnancy are not undermined.
Conclusion	*What did you conclude?* The article concludes that SA has taken a conservative approach in selecting a 2-year age gap compared to developed countries. Therefore, a more nuanced approach is recommended to interpret the age-gap provision as the focus is narrowly based only on the age difference. The age-gap provision should be considered along with other criteria, including maturity, stage of development, and relationship to authority (e.g., where one party in the relationship has some authority over the other).
Implications	*What are the implications of your study for the legal system? For adolescents? For society? Etc.* Consensual peer-peer sex among adolescents (between 12 and 15) is decriminalised. Still, HCWs and researchers need to be aware that they may be legally obliged to report to authorities if they engage an adolescent who is 12 to 15 and has a sexual partner who is 16 to 17 with an age gap of more than 2 yrs between them. This is substantiated by research suggesting an increased risk of sexual intercourse when young girls have older partners (especially if it is assumed that age disparities are a proxy for power asymmetry and thus for coercion and exploitation). This provision does not factor in multiple aspects of adolescent sexual relationships, including power relations, gender norms, and sexual and social experiences. It also does not factor in that similarly aged relationships could be coercive. Therefore, healthcare providers will need to assess a host of factors when making determinations (not just the conservative/narrow 2-year age gap between an older and younger adolescent). An age difference cannot inherently reveal whether a sexual relationship is coercive or not, and such a reductionist approach may inadvertently deflect from potentially coercive relationships among similarly aged peers. The article concludes that the intention to protect adolescents from predatory sex with adults is maintained. However, it has a punitive

	consequence for consensual adolescent peer-peer sex (between adolescents aged 16 - 17 engaging in sexual activity with adolescents aged 12 – 15) when there is more than a 2-year age gap. Adolescents within this dynamic are at risk of statutory rape prosecutions, exposing them to the criminal justice system. In addition, adolescents of more than two years between them but were both within the 12 to 15 yr age range at one stage, then one move within the 16-17 age range becomes problematic. Other countries, such as Canada and Australia, have taken nuanced approaches to close-in-age provisions, taking into account adolescents' evolving decision-making capacity.
Shortcomings	*How reliable is your conclusion? Have others argued against it? Have you since developed your argument?* The article critiques age-gap provisions as a simplistic reliance on age difference as a proxy for coercion, with larger differences assumed as indicative of coercion, exploitation, or undue influence, with the suggestion of empirical research to better understand the dynamics of coercive and exploitative adolescent sex in the SA context. However, the article does not answer the question as to whether researchers and service providers will be required to actively identify the exact ages of both partners and what factors to take into account when making determinations on whether to report to authorities if they reasonably believe the age gap to be larger than 2 yrs. However, other SA authors have argued in favour of explicit knowledge of the age difference when reporting underage consensual sex. There is the issue of national challenges to provide safeguards for adolescents from adult sexual predators and instances where young girls seek out relationships with older partners for security, given the socio-economic issues. In both instances, they may not be in a position to negotiate safer sex, which affects HIV/AIDS risk, and this has not been discussed further in the article. Here, empirical research may be a challenge since the research into a sexual relationship with older partners (whether coercive, exploitative, or consensual) is a criminal offence. Thus, research into such sexual activity may be questionable since it places researchers in the same position as service providers concerning reporting obligations, and consent and confidentiality may be undermined in the process.

	The article is not able to explore issues of self-determination and social challenges linked to these kinds of sexual relationships.
Discussion/Analysis	*Theme your findings – what are the common strands that run through them? Contribution to the knowledge in this field/ What is original added to knowledge? How has your argument evolved over time (against the evolving situation in SA)? Where are we now? Impact/implications of the work to date* *Remaining problem/issue. Recommendation.* The article provided a description of the changes in legal provisions in the Sexual Offences Amendment Act 2015 concerning the two-year gap between a younger adolescent (12 to 15 years) and an older adolescent (16 or 17 years). The consent to sex remains from the age of 16. However, legal provisions in the law have been decriminalised to accommodate for instances where adolescents engaged in consensual underage sex between 12 and 15 are prosecuted. The common theme in this article is the recognition for promotion of adolescent evolving capacity but also protection from sexual predators and what this means for key service providers such as health care professionals and researchers. The argument relies on the interpretation and comparison against other countries' approaches that the age-gap provision in South Africa is conservative. In that, the two-year gap appears to be protective against various forms of sexual exploitation and harm that are problematic in the country. While this is a good approach, the article argues that there are some context realities that the law does not account for, which leaves healthcare professionals and researchers in difficult ethical-legal dilemmas when working with adolescents who are engaged in sexual activity. For instance, the service provider may be required to breach confidentiality if it becomes known that the older adolescent partner is more than two years older. In addition, young girls who may be involved in such relationships may have to interact with the criminal justice system should the older partner be prosecuted. There have been no changes in the law or guidelines for key stakeholders on how best to address these situations. Guidance should thus include law reform to include a more nuanced approach to age-gap provisions, or if a more conservative age difference remains, then the age together with other factors such as

	maturity and relations of authority (e.g., where one party in the relationship has some authority over the other)in line with consideration of the 'best interests of the child.'
Contribution as a co-author to this publication	I made significant and original contributions in conducting legal research on the developments leading up to legal amendments to South African law, background comparative legal research on selected country examples on their approach, and providing analysis and interpretation of the laws based on my own research and expertise. I worked closely with Dr Z Essack on developing the content in the first draft and subsequent versions of the article.

Title 7	*Strode, A., Slack, C. M., Essack, Z., Toohey, J. D., & Bekker, L. G. (2020). Be legally wise: When is parental consent required for adolescents' access to pre-exposure prophylaxis (PrEP)? Southern African Journal of HIV Medicine, 21(1), 1-5.*
Aims	*What were the stated aims?* This article aimed to examine the legal and policy framework concerning adolescent access to an HIV prevention tool such as pre-exposure prophylaxis (PrEP).
Need for	*Why did you write the article? What was the gap?* Service providers may not be sure whether adolescents may self-consent independently to prevention interventions such as vaccines like HPV and other non-therapeutic health interventions such as PrEP and if this is legally permissible under the Children's Act or whether it requires parental consent. At the time of writing this article, there was no policy dealing with independent sel-consent to oral PrEP. The SA Clinicians' guidelines did not deal with adolescent access/consent to oral PrEP, and it was anticipated that an updated version of these guidelines (approx. November 2020) would recommend a consent approach for persons under 18 yrs. The law, however, does make provision for children 12 years and older to self-consent to 'medical treatment' in the Children's Act, 2005. This article established whether the term ‘medical treatment’ is broad enough to include prevention interventions such as PrEP.
Interpretation and perspective taken	*How did you approach the argument? How did your perspective influence the argument? The approach that I took in the argument influenced my conclusion. e.g., human rights approach.* The approach taken in this article was based on a statutory interpretation of the legal framework (and a comparison of the policy framework) based on the Constitutional Court case, *Cool ideas 1186 CC v Hubbard and Another,* which identified three interconnected elements: 1. the examination of the purpose of the legal provision; 2. a review of its legislative context; and 3. identifying a meaning consistent with the values underlying the constitution.

	This statutory interpretative approach was applied in this article to clarify the term 'medical treatment' since there is no definition in the Children's Act.
Conclusion	*What did you conclude?* It was concluded that PrEP should be regarded as a medical treatment since it falls within the ambit of one of the consent norms of the Children's Act as both therapeutic and preventative health interventions. This article recommends that service providers ensure that adolescents who meet the age requirement for self-consent (12 years and older) also meet the capacity requirement and that best practices are shared in this regard. Furthermore, policymakers should ensure that national PrEP guidelines are updated to reflect that the adolescent consent approach is well articulated to enable at-risk adolescents to access much-needed interventions to reduce their HIV risk.
Implications	*What are the implications of your study for the legal system? For adolescents? For society? Etc.* If it is accepted that PrEP is interpreted as 'medical treatment,' then adolescent self-consent to PrEP is legally permissible for persons over 12 years if they have the mental capacity and maturity to understand the benefits, risks, social and other implications such as the need to effective adherence and ongoing assessment of drug levels of the proposed treatment but also the risk status of the adolescent. PrEP is licensed for access to persons over 35 kg. This means that even if a child is 12 years old and is over 35kg, they may still be unable to self-consent if capacity requirements are unmet. Implementing a self-consent approach and decisional support and adherence support is critical to ensure that adequate considerations have been factored in for PrEP to be recognised as medical treatment.
Shortcomings	*How reliable is your conclusion? Have others argued against it? Have you since developed your argument?* A comparison with other jurisdictions found limited assistance for statutory interpretation. However, *Taggard et al. (2019)* found that France explicitly includes PrEP to fall within the definition of medical treatment. Similarly, where some have argued that circumcision can only be applicable for current medical treatment and not future treatment (as a form of prevention), others have argued that HIV is a serious public health crisis in the country and, therefore, the

	application of male circumcision as a form of medical treatment (prevention against future/potential HIV infection) is justified. It could have been argued that the same approach may be taken concerning PrEP, but this was not discussed further in this article.
Discussion/Analysis	*Theme your findings – what are the common strands that run through them? Contribution to the knowledge in this field/ What is original added to knowledge? How has your argument evolved over time (against the evolving situation in SA)? Where are we now? Impact/implications of the work to date* *Remaining problem/issue. Recommendation.* Similar to the discussion concerning adolescent access to male circumcision, the Children's Act is silent on whether adolescent consent to Pre-exposure Prophylaxis as a form of HIV prevention under the term 'medical treatment'. This article researched whether the term 'medical treatment in the Children's Act, 2005 is broad enough to include prevention interventions such as vaccines such as HPV and other non-therapeutic health interventions. Key issues explored in this article concerning whether adolescents can self-consent independently for PrEP in terms of the current legal framework included 1) the appropriateness of PrEP for adolescents as a form of HIV prevention (but has broader application for other types of interventions such as HPV and some non-therapeutic interventions in research. Within this body of work, this article asserts that human rights and public health are imperative to ensure that adolescents have access to tools to minimise their HIV risk. This article compares PrEP to the specified health interventions with a set age in the Children's Act. The review included consideration of the implications of self-consent on PrEP as a non-specified form of HIV prevention intervention since there is no age set for which adolescents may access non-specified health interventions, except to imply that this would be over the age of 18 when they are an adult. Currently, there is no policy document to guide the consent approach should adolescents be allowed to access PrEP. It was also noted in the South African Law Reform Commission's (SALRC) Review of the Child Care Act: Final Report. The final SALRC report indicates that the previous approach to consent to 'medical treatment' was set at the age of 14 years, thus limiting access; thus below this age meant parental

	consent was required.[66] This legal provision was amended to 12 years of age, which implies the legislator intended to take into account the evolving capacity of the children to consent independently to certain specified health interventions. Further, the *Cool Ideas 1186 CC v Hubbard and Another* 2014 (4) SA 474 (CC) was discussed as an approach to the method of interpretation of an undefined term in law to consider the adolescent right to constitutional values of human dignity, equality and freedom and section 28 of the Constitution concerning the right of access to health. Moreover, if there is no definition in the law to determine the meaning of whether, for example, a health intervention fits within the scope of that definition, then we could consider foreign law, in which case it was noted by Taggart et al. that France at the time of writing the article has legal provision for PrEP as medical treatment. The article makes recommendations for the Department of Health to amend and include clarity on adolescent self-consent in its guidelines; this position still stands. To date, no changes have been made to the law, which means that adolescents who are at-risk of HIV infection will not be able to self-consent to PrEP below the age of 18 years. Two approaches have been suggested; firstly, if the age of self-consent is set for non-specified interventions such as PrEP, parental consent may be required. Secondly, is to consider PrEP under 'medical treatment', although it is not clear whether non-therapeutic interventions are within the scope of this term to enable self-consent from the age of 12 with additional requirements such as the capacity to consent and clinical guidelines that the child must be over 35 kgs needs to be met. Other authors support this approach to include HIV prevention as a form of medical treatment, which would thus support the idea that PrEP as a form of HIV prevention could fall within this definition. The issue of whether health interventions of a non-therapeutic nature to prevent future HIV infection remains an issue to be addressed in the law and thus could still serve as a barrier to combatting HIV in the country.

[66] South African Law Reform Commission. Review of the Child Care Act 2002 [homepage on the Internet]. [cited 2020 Jun 9] Available at http://www. justice.gov.za/salrc/reports/r_pr110_01_2002dec.pdf

Contribution as a co-author to this publication	As co-author of this peer-reviewed article, I developed the legal and policy section of the article with Prof. A Strode. More specifically, I developed the legal and policy section by conducting background research, reviewing the rules applied by the Constitutional Court case on statutory interpretation, and drawing on three key principles, applying this to the terminology in the Children's Act, 2005, relating to medical treatment. I also worked on the legal and policy background and context. Together with co-authors, I contributed to the article's development, editing, and analysis.

Title 8	*Toohey, J. & Strode, A. A critical review of the South African legal framework on adolescent access to HIV prevention interventions. South African Journal of Bioethics and Law, [S.l.], v. 14, n. 1, p. 16, Apr. 2021. ISSN 1999-7639.*
Aims	*What were the stated aims?* The article aims to review SA's legal framework for adolescent access to HIV prevention services such as HIV testing and HIV education. This review sets out relevant legal norms regarding adolescent rights to sexual and reproductive health, describes the methodology used, and makes findings on the extent to which the SA legal framework meets international standards.
Need for	*Why did you write the article? What was the gap?* South Africa (SA) may be a good case study to review a country with an enabling legal environment to facilitate adolescent access to public health HIV prevention programmes and compare with key international norms such as the right to health care services, including reproductive health care covering SRHS, which includes HIV prevention).
Interpretation and perspective taken	*How did you approach the argument? How did your perspective influence the argument? The approach that I took in the argument influenced my conclusion. e.g., the human rights approach* The approach in this article was based on the systematic review of all SA laws that could impact adolescent access to these 5 HIV prevention modalities. This perspective was weighed against international norms relating to ensuring adolescent access to HIV prevention services based on key human rights protection to support enabling laws: 1. set a non-discriminatory age of consent to contraceptives, medical treatment, and sex; 2. facilitate the right to access sexual and reproductive health services, including SRH information; 3. protected adolescent privacy rights and confidentiality; and 4. Ensure that appropriate goods, services, and information for HIV prevention are available.
Conclusion	*What did you conclude?* The conclusions drawn in the article indicate that there is a clear recognition of adolescent evolving capacity; the inclusion of such protections aimed at enhancing decision-making in SA child law has essentially created an enabling legal environment for adolescent access to HIV prevention with a clear recognition of evolving capacity (with different ages of consent for various health interventions) and

	enhancing decision-making. There are some weaknesses in the SA legal framework, such as the divergent approaches between criminal (sexual offences and mandatory reporting obligations) and civil law (independent self-consent) concerning evolving capacity/capacity.
Implications	*What are the implications of your study for the legal system? For adolescents? For society? Etc.* Even though the law creates an enabling framework, the law may pose direct or indirect barriers to accessing sexual and reproductive health services for adolescents. Direct barriers are laws that expressly exclude adolescents from accessing services. In contrast, indirect barriers are seemingly neutral laws but disparate impact access to SRHSs. For example, where sex below the age of 16 is a criminal offence, it can make the distribution of condoms to young persons difficult, as service providers may be charged with aiding and abetting a crime for not reporting (when they should have). The article recommended that further research be conducted on legal reform toward a coherent approach to support adolescent access to HIV prevention services. The article also implies a gap in international norms, i.e., no norm requiring countries to ensure that legal protections support good decision-making and are linked to access rights.
Shortcomings	*How reliable is your conclusion? Have others argued against it? Have you since developed your argument?* The review found that SA created an enabling legal environment for adolescent access to HIV prevention by legislating the ages of adolescent self-consent to condoms, medical treatment, and sex. The age of consent is dealt with in the Children's Act and Sexual Offences and Related Matters Act. SA meets the minimum norm by having an age of consent to sex of 16 yrs and an age of consent to medical treatment, HIV testing, and contraceptives set at 12 yrs. While the article indicates that the framework is enabling, many legal provisions are scattered through various documents.

	There is no suggestion as to a remedy for harmonisation or how the legislature could improve on this. Key aspects that require further research or clarification on the divergent approaches include: 1. whether the criminal and/or civil law be used to enforce and/or regulate consensual underage sex. 2. how ages of consent to sex, ages of consent to access HIV prevention services, or participation in research could be better coordinated across the various laws. 3. a clear set of international norms to guide states in legislating on adolescent access to HIV prevention and other sexual and reproductive rights to support implementing public health programmes).
Discussion/Analysis	*Theme your findings – what are the common strands that run through them? Contribution to the knowledge in this field/ What is original added to knowledge? How has your argument evolved over time (against the evolving situation in SA)? Where are we now? Impact/implications of the work to date* *Remaining problem/issue. Recommendation.* This article is a desk review of the South African legal framework that ought to create an enabling legal environment to facilitate the public health responses to sexual and reproductive health services for adolescents. The International Guidelines on HIV/AIDS and Human Rights suggest that governments review and reform laws to ensure that they adequately address public health issues raised by HIV. Firstly, to assess whether the following five key health-related HIV prevention interventions, which are listed in the South African NSP 2017-2022, were included in legislation: 1. voluntary medical male circumcision (VMMC); 2. information and education on HIV; 3. pre-exposure prophylaxis (PrEP); 4. HIV testing and counselling services; and 5. provision of contraception (condoms). Secondly, the law was assessed on four key criteria, drawn from the Guidelines on HIV/AIDs and Human Rights, to determine whether they create direct barriers which exclude adolescents from accessing HIV services and indirect barriers which appear neutral but may have an

	impact on access to adolescent sexual and reproductive health services: 1. set a non-discriminatory age of consent to contraceptives, medical treatment, and sex; 2. facilitate the right to access sexual and reproductive health services, including SRH information; 3. protected adolescent privacy rights and confidentiality; and 4. ensure that appropriate goods, services, and information for HIV prevention are available. Thirdly, the underlying human rights factors were considered to determine whether the law creates an enabling legal environment to facilitate the public health response to sexual and reproductive health services for adolescents in HIV Prevention. This included: a) Section 27 of the Constitution provides that 'everyone has the right to have access to health care services, including reproductive health care.' This provision does not expressly state adolescents but does include everyone, which is inclusive of adolescents. Thus, the government has an obligation to develop laws that respect, protect, promote, and fulfill such a right for adolescents in the country; b) the South African Constitution in the Bill of Rights (section 28(2)) states that the best interests of the child are of paramount importance in every matter concerning the child at every child. These two human rights provisions are the underlying factors which the SA laws were measured in relation to the following four international benchmarks for an enabling legal environment to facilitate a public health response to sexual and reproductive health. Together, these three components were used to develop a generic set of markers which could provide a useful model beyond South Africa for developing laws to enable access for adolescents to HIV prevention modalities. The article makes a number of recommendations. This article determined that South Africa meets all four international norms and the two human rights provisions. In other words, the ages of consent are dealt with in the Children's Act, 2005, Sexual Offences Act, 2007, and Amendment Act, 2015. The legal framework creates a

	right to access and make available all five of the key interventions, and there are no discriminatory provisions relating to access; however, depending on the type of intervention, the law attaches further criteria to support age-appropriate decision-making which on the one hand promotes and on the other hand, provides some protective measures in relation to responsible sexual behaviour and reproductive health. There are provisions for privacy and confidentiality in the law. The review indicates that the concept of an enabling environment in the context of HIV prevention is complex in that the elements are scattered through various sources of the law, and there is no comprehensive, coherent, and synchronised set of legal norms, rather broad normative framework. This would create challenges at the implementation level for key stakeholders such as healthcare professionals, researchers, and service providers to have an adequate awareness and understanding of the law to comply with prevailing norms. For example, how would key stakeholders be able to know and apply the age of consent to sex, which is set at 16 but also decriminalised for 12 to 15-year-olds who engage in sex where their older partner is an adult? Is the health care professional still to provide the HIV prevention service but warn the adolescent of the breach of confidentiality to report if they have knowledge of such circumstances? In this regard, the article offers new knowledge to the field of law and health sciences. Healthcare professionals and researchers are still grappling with mandatory reporting issues, making it difficult to advance the right to health. In other words, the provisions in the criminal law concerning mandatory reporting may make it difficult to enforce the civil law where there are instances of reporting obligations. As such, the article recommends that measures be put in place to remove barriers to access to key HIV prevention interventions. In addition, further research should be conducted on the legal reform to develop a coherent approach to support adolescent access and age-appropriate decision-making on responsible sexual behaviour and reproductive health.
Contribution as a co-author to this publication	This peer-reviewed article was based on my own independent research and legal expertise. I conceptualised and developed the first

	draft of the article. I worked with Prof A. Strode on the manuscript's subsequent drafts, analysis, and final version.

Appendix 3: Mind map

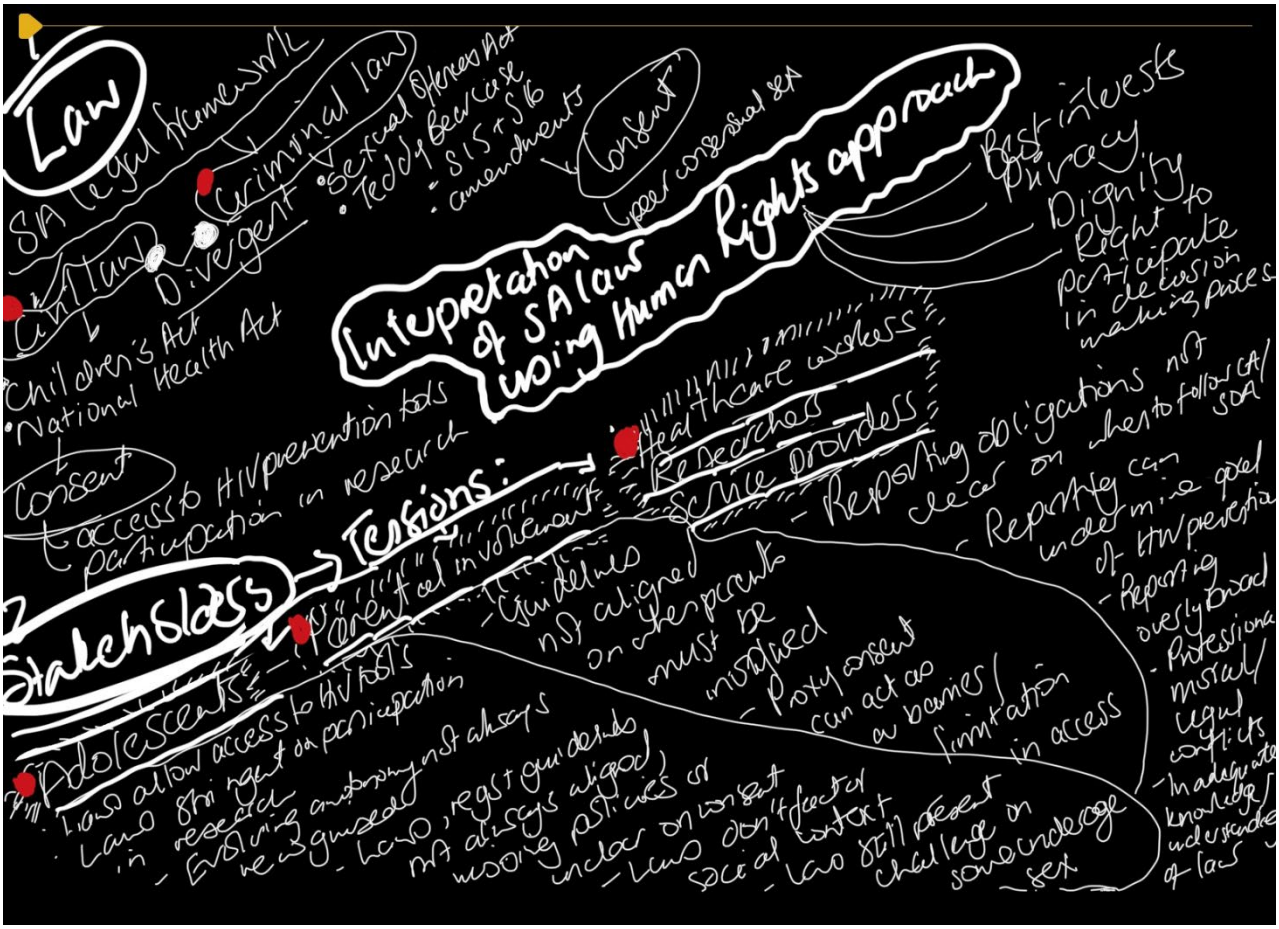


Figure 1: Mind map drawing out key themes in developing the critical appraisal narrative

Appendix 4: Curriculum Vitae

NAME Jacintha Deleane Toohey
School of Law, University of Kwazulu-Natal, South Africa

USEFUL LINKS AND AFFILIATIONS
ORCID 0000-0002-8464-9098
https://law.ukzn.ac.za/jacintha-toohey/
https://trust-project.eu/team/jacintha-toohey/

EDUCATION/QUALIFICATIONS

TBC *PhD Candidate, University of Central Lancashire (UCLAN), UK*
2017 LLM (Medical Law), University of KwaZulu-Natal, SA
2013 LLB, University of KwaZulu-Natal, SA

OTHER TRAINING

2022 Certificate, Fundamentals of Research Ethics, African Bioethics Network
2021 Research Ethics Training, University of Pretoria
2021 Research integrity – Online Practical Course: Research Ethics in Medicine Study Group (REMEDY), Jagiellonian University Medical College
2021 Online Certificate, E-learning Course: Introduction to Informed Consent, The Global Health Network
2021 Online Certificate, E-learning Course: Data Governance, Policies, And Data Access Committees, The Global Health Network
2014 Certificate, Intellectual Property Workshop for Researchers. Southern African Research & Innovation Management Association (SARIMA), National Intellectual Property Management Office (NIPMO), SA
2016 Interactive Training Seminar, How to Design Research & Development Contracts in Practice. European Academy for Taxes, Economics & Law. The European Knowledge Network. Berlin, Germany
2001 Diploma, Project Management, Varsity College, SA
2000 Diploma, Information Studies, Varsity College, SA

EMPLOYMENT HISTORY

Feb 2019 to ***current*** Lecturer, University of KwaZulu-Natal (UKZN), Faculty of Law
Jan 2018 to Dec 2021 Deputy Programme Manager, Part-time LLB, University of KwaZulu-Natal (UKZN)
Jul 2017 to Dec 2019 Course Coordinator, UKZN, Discipline of Psychology
Jul 2017 to Dec 2018 Ad Hoc Lecturer, University of KwaZulu-Natal (UKZN), Faculty of Law
Oct 2017 to Dec 2018 Consultant, Legal Advisor, South African Medical Research Council
Jan 2016 to Dec 2017 Director, Council on Health Research for Development, Africa

Jan 2016 to Dec 2017	Deputy Director, Council on Health Research for Development
Jul 2014 to Dec 2017	Project Manager, Council on Health Research for Development
Jul 2013 to Jun 2014	Project Policy Advisor, Council on Health Research for Development
Apr 2002 to Dec 2016	Project Assistant Coordinator, HIV AIDS Vaccines Ethics Group, UKZN

AWARDS, HONOURS AND COMMITTEES/TECHNICAL WORKING GROUPS

*2021 to **current***	*Council for Scientific and Industrial Research: Research Ethics Committee Member*
2021 to current	*Financial and Fiscal Commission: Research Ethics Committee Member*
*2021 to **current***	*SARIMA/Community of Practice: Research Ethics and Integrity Committee Member*
*2021 to **current***	*Member: South African Research and Management Association*
*2020 to **current***	*UKZN representative partner to AMRH (African Medicine Regulatory Harmonisation)-NEPAD, UKZN Partnership Platform*
*2019 to **current***	*School of Law Research and Higher Degrees Committee Member*
*2021 to **current***	*African Scientists Directory: Member*
*2021 to **current***	*African Academy of Sciences: Mentor, MentorNet*
*2019 to **current***	*International Forum of Teachers (IFT) of the UNESCO Chair in Bioethics: Member*
2017 to 2018	Faculty of Law, UKZN: Honorary Research Fellow
2016 to 2017	Council on Health Research for Development, Research Fairness Initiative - Domain 5: Technical Working Group,
2005	Faculty of Law, UKZN: Dean's Commendation.

SELECTED PUBLICATIONS

1. Strode, A., and ***Toohey, J.***, et al. (2013).Reporting underage consensual sex after the Teddy Bear Clinic case: A different perspective. *South African Journal of Bioethics and Law*, 6(2): 40-42.
2. Marais, D., ***Toohey, J*** and IJsselmuiden, C. (2013). Where there is no lawyer: Guidance for fairer contract negotiation in collaborative research partnerships. COHRED. Geneva & Pietermaritzburg. P1-46. ISBN: 978-92-9226-059-0. Guidance booklet.
3. Edwards, D., ***Toohey, J.*** and IJsselmuiden, C. (2014). Negotiating Research Contracts: Creating Opportunities for Stronger Research and Innovation Systems. COHRED. Geneva & Pietermaritzburg. P1-39. ISBN: 978-92-9226-062-0. Guidance Booklet.
4. Strode, A., Richter, M., Wallace, M., ***Toohey, J.***, and Technau, K. (2014). Failing the vulnerable: Three new consent norms that will undermine health research with children. *Southern African Journal of HIV Medicine*, 15(2), 46-49.
5. Strode, A. E., ***Toohey, J.***, Singh, P., and Slack, C. M. (2015). Boni mores and consent for child research in South Africa. *South African Journal of Bioethics and Law,* 8(1), 22-25.

6. Musolino, N., Lazdins, J., ***Toohey, J.***, and IJsselmuiden, C. (2015). COHRED Fairness Index for international collaborative partnerships. *The Lancet*, 385(9975), 1293-1294.
7. Essack, Z., ***Toohey, J.***, and Strode, A. (2016). Reflecting on adolescents' evolving sexual and reproductive health rights: canvassing the opinion of social workers in KwaZulu-Natal, South Africa. *Reproductive Health Matters*, 24(47), 195-204.
8. Strode, A., ***Toohey, J.***, and Slack, C. (2016). Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa. *South African Medical Journal,* 106(12), 1173-1176.
9. Kombe F, Toohey J, Ijsselmuiden C. Research Ethics Capacity Building For The Next Decade – 'Beyond Training' – Rhinno Ethics as Model to Improve and Accelerate Ethics Review of Health Research. *BMJ Global Health* 2017; 2:A55. Abstracts of The Eighth EDCTP Forum, 6–9 November 2016. Abstracts of Poster Presentations. PA-118
10. Essack, Z., & ***Toohey, J.*** (2018). Unpacking the 2-year age-gap provision in relation to the decriminalisation of underage consensual sex in South Africa. *South African Journal of Bioethics and Law*, 11(2), 85-88.
11. Strode, A., Slack, C. M., Essack, Z., ***Toohey, J. D.,*** & Bekker, L. G. (2020). Be legally wise: When is parental consent required for adolescents' access to pre-exposure prophylaxis (PrEP)? Southern African Journal of HIV Medicine, 21(1), 1-5.
12. Toohey, J. D., and A. Strode. "A critical review of the South African legal framework on adolescent access to HIV prevention interventions." *South African Journal of Bioethics and Law* 14.1 (2021): 16-19.

SELECTED CONFERENCE ATTENDANCE/MEETING PRESENTATIONS/FACILITATED WORKSHOPS

1. ***Toohey, J.,*** Strode, A. & Slack, C. (2007). *Poster presentation.* Legal obligations on researchers to report maltreatment, abuse, and neglect of children: implications and complexities. 3rd SA AIDS Conference. June 2007. Durban, South Africa.
2. ***Toohey, J.,*** Strode, A., & Slack, C. (2015). *Poster presentation.* Does South Africa's law facilitate the mass rollout of medical circumcision for adolescent boys? June 2015. 7th SAAIDS Conference, Durban, South Africa.
3. ***Toohey, J.*** (2016). *Session Chair.* Human Sciences Research Council. Pietermaritzburg. Adolescent sexual and reproductive health rights: Implications for researchers and service provider's information session. Session Chair, Sweetwater's, Pietermaritzburg, South Africa. http://www.hsrc.ac.za/uploads/pageContent/7306/Essack_adolescent%20SRHR%20(13%20Sep).pdf
4. ***Toohey, J.*** (2018). *Oral Presentation.* A Review of South Africa's Legal and Policy Framework: Key considerations for harmonization of pharmacovigilance. Drug Safety, Efficacy & Clinical Trials Conference. 21 – 23 February 2018 at the Kopanong Hotel & Conference Centre, Johannesburg, South Africa.

5. Harmonizing African and globally accepted Voluntary Informed Consent practices with your networks. Applying the principle of autonomy in an Afro-global context: Workshop: Informed consent: Applying the principle of autonomy: 29 April 2021.
6. SARIMA- Regional Expert Workshop: Ethics Guidelines and Toolkit Experts validation meetings 1-2 September 2021.
7. Faculty of Science and Agriculture Research Ethics Workshop. Use of secondary data and related ethical considerations. Ethics of indigenous resources. 09- 10 November 2021.
8. Advancing Paediatric Clinical Research-time to listen: hearing from young people in clinical research. February 2, 2022. Virtual conference series to advance the design, review, conduct, and oversight of global paediatric clinical research.
9. *Toohey. J.* Guest lecture session. The human rights implications of health research. SARETI, UKZN. 5th April 2022.
10. Virtual session: 1st Regional workshop of the VolREthics initiative on the risk of exploitation of Healthy Volunteers in biomedical research in Africa, co-organized by Inserm, University of Cape Town, and Universidade Eduardo Mondlane. 24 May 2022.
11. *Toohey, J.* Virtual session. Eastern Region Community of Practice meeting- Research Ethics for SARIMA. 26 May 2022.
12. Indigenous communities, 'vulnerability,' and the COVID-19 pandemic. The Global Health Network. June 20, 2022.
13. *Toohey, J.* Online workshop: Introduction to Research Ethics: Why is ethics important in research? University of Zululand. 23 June 2022
14. *Toohey, J.* Virtual Research Ethics Workshop: Ethics and Science – Data, Privacy and Ethics management. SARIMA, 20 July 2022.
15. *Toohey, J. et al.* SARIMA Research Ethics Course: Ethics and Science. 2022 SARIMA Pre-Conference Workshop, held 1 August 2022
16. *Toohey, J and Strode, A.* UCDP, Research Ethics & Plagiarism Workshop, UKZN, 20 September 2022.

SELECTED ACADEMIC TEACHING EXPERIENCE AND MODULE COORDINATION

1. Intellectual Property Law (4th Year module)
2. Bioethics (4th year module)
3. Human Rights (4th year module)
4. Jurisprudence (3rd year module)
5. Psychology and the Law (3rd Year module)
6. Interpretation of Statutes (Legal Hermeneutics, 2nd year module)
7. Law of persons (2nd year module)
8. Legal, Research, Writing, and Reasoning (2nd year module)

INVITED REVIEWS, EXAMINATION AND SUPERVISION

Supervision

2019: Graduated: Coursework LLM (Enigbokum). Victim precipitation in the crime of rape: Does it still feature as an evidentiary tool and barrier to reporting and conviction in South Africa. A case analysis.
2021: Graduated: Completed full research dissertation (LLM) (Phiri).The right to privacy in health research- a critical review of the ethical- legal framework in both South Africa and the United States of America.
2021: Completed LLB Research project (Mkwanazi).A Review of the South African legal framework on adolescent access to HIV prevention interventions compared to the legal standards of Botswana.
2021: Completed: LLB Research Project (Magubane). POPI Act implications for researchers in cross-border/transboundary collaborative research
2022 In progress: Coursework Masters (South African Research Ethics Training Initiative): Couch. An Exploratory study of vaccinations amongst staff at a Research Institution: Personal choice or Mandatory?

Postgraduate Examinations

2020: Completed: LLM examination (Damburu). An examination of child sex offenders and their constitutional rights with regard to the National Register for sex offenders in South Africa
Reviews
2021: Completed Review: Draft Guideline for Responsible and Ethical Research in the Southern African Development Community – developed by Northern Regions Community of Practice for Ethics and Integrity in South Africa in collaboration with the Southern African Research Innovation and Management Association.
2021: Completed Review. Research Ethics, Access and Benefit Sharing Within the Southern African Development Community – Toolkit – developed by Northern Regions Community of Practice for Ethics and Integrity in South Africa in collaboration with the Southern African Research Innovation and Management Association
2021: Completed Review. South African Journal of Bioethics and Law - Informed consent during pandemics: Experimental medicine, experienced consent. Manuscript Draft.
2022: Completed Review. Turning the moral compass towards transformative research ethics: an inflection point for humanized pedagogy in higher education. Manuscript Draft.

RELEVANT PROJECT CONTRIBUTIONS

1. *Oct 2013-Mar 2014: KwaZulu-Natal Legislature Social Development Portfolio Committee and School of Law*, UKZN. Appointed as a researcher in a collaborative effort with senior researchers at the Social Development Portfolio Committee, Kwa-Zulu-Natal Legislature and the School of Law, UKZN, to provide research, interview participants, transcribe data, and contribute to the manuscript, develop the research findings as well as co-author the report and subsequent peer-reviewed publication from the study.
2. *Jan 2012-Sept 2013:* South African AIDS Vaccine Initiative: Strengthening the Ethical-Legal Framework for South African HIV Vaccine Trials (HVTs): Development of an online Module on Adolescent Enrolment. Appointed as Research Assistant to conduct conceptual research and edit overall drafts in developing an online, 'certificate-generating' module on ethical-legal issues in adolescent HIV prevention trials in a co-sponsored collaboration with the TRREE programme.
3. *Apr 2012-Jun 2017: NIH/ UCT: Choices of Methods of Adolescent Prevention Study (CHAMPS) - HAVEG* Research Grant - Choices of Methods of Adolescent Prevention Study (CHAMPS). Appointed as Research Consultant to conduct legal research, review, and analyse relevant South African legislation and policy framework, specifically on legal issues concerning adolescent access to HIV prevention methods. Prepared legal memos and drafted and edited journal publication manuscripts in close collaboration with team members.

PROFESSIONAL SUMMARY

I am a Lecturer at the University of KwaZulu-Natal School of Law. I am a School of Law Research and Higher Degrees Committee committee member. My qualifications include a Research Master's Degree in Law (Medical Law), an LLB Honours Degree in Law, a Diploma in Project Management, and a Diploma in Information Systems. I am currently working toward completing my Ph.D.

Before joining the School of Law, I worked for approximately 17 years within the academic environment in externally funded health research-related projects, namely for the HIV AIDS Vaccines Ethics Group (HAVEG) as Assistant Project Coordinator and later for the Council on Health Research for Development (COHRED). These research projects included funding from Wellcome Trust, EDCTP, Horizon 2020, South African Medical Research Council, University of Toronto, and Doris Duke Charitable Foundation.

As a developing academic, my journey has been split to focus on providing an income in my home, my part-time legal qualification studies, and developing my research on the intersection of health law and research ethics. The research includes issues spanning the ethical, legal, and policy considerations in sexual and reproductive health rights. I have also contributed to scholarly works,

including good practice guidance in equitable North-South collaborative research contracting, where I co-authored and contributed to a number of publications and resource materials.

Appendix 5: The published works (full-text articles)

Reporting underage consensual sex after the Teddy Bear case: A different perspective

A Strode,[1] BA, LLB, LLM; **J Toohey**,[2] LLB; **C Slack**,[2] BA, BA Hons, MA (Clinical Psychology); **S Bhamjee**,[1] LLB, LLM

[1] *School of Law, College of Law and Management Studies, University of KwaZulu-Natal, Pietermaritzburg, South Africa*
[2] *HIV/AIDS Vaccines Ethics Group, School of Applied Human Sciences, College of Humanities, University of KwaZulu-Natal, Pietermaritzburg, South Africa*

Corresponding author: *A Strode (strodea@ukzn.ac.za)*

Doctors and researchers face a complex dilemma regarding the mandatory reporting of consensual underage sex, because of contradictions between the Children's Act and the Sexual Offences Act. When providing underage children with sexual and reproductive health services, they have had to decide whether to provide these confidentially, in terms of the Children's Act, or thereafter report the consensual but illegal sexual behaviour to the police, in terms of the Sexual Offences Act. The recent *Teddy Bear Clinic for Abused Children, and Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) v. Minister of Justice and Constitutional Development* case addressed whether consensual underage sex ought to be a criminal offence and thus reported. The court held that aspects of sections 15 and 16 of the Sexual Offences Act infringed on the constitutional rights of adolescents (aged 12 - 15 years) by proscribing many consensual sexual activities. McQuoid-Mason has described this case in detail. He submits that following the judgement, doctors are no longer under a reporting obligation in relation to consensual underage sex. We respectfully disagree. This article critiques McQuoid-Mason's approach, sets out our views on the mandatory reporting obligations after the *Teddy Bear* case and concludes with some comments on the judgement's implications for researchers and medical practitioners.

S Afr J BL 2013;6(2):45-47. DOI:10.7196/SAJBL.289

In the previous issue of the *SAJBL*, McQuoid-Mason discussed the recent *Teddy Bear Clinic for Abused Children, and Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) v. Minister of Justice and Constitutional Development* case,[1] in the article 'Decriminalisation of consensual sexual conduct between children: What should doctors do regarding the reporting of sexual offences under the Sexual Offences Act until the Constitutional Court confirms the judgement of the *Teddy Bear Clinic* case?'.[2] He submits that, following the judgement, doctors are no longer obliged to report consensual underage sex. We respectfully disagree. Our article critiques his approach and proposes an alternative interpretation of the judgement. Finally, it suggests a more nuanced reporting approach for doctors and researchers in the post-*Teddy Bear* era.

In the last few years many doctors and researchers have faced a complex dilemma regarding the mandatory reporting of consensual underage sex.[3] On the one hand, the Children's Act[4] provides that children from the age of 12 are entitled, without parental consent, to access a range of sexual and reproductive health services such as contraceptives, HIV testing and treatment for sexually transmitted infections.[5] However, until recently, the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 (the 'Sexual Offences Act')[6] provided that sex under the age of 16, even if consensual, was a criminal offence.[6]

Section 54(1) of the Act also provided that any person 'who has knowledge that a sexual offence has been committed against a child' must report this 'immediately' to the police.[6] Accordingly, this placed an obligation on all service providers, including doctors, nurses and health researchers, to report consensual underage sex or sexual activity.[3] This broad reporting obligation meant, for example, that any healthcare provider assisting an adolescent (under the age of 16) with a termination of pregnancy would be obligated to report that a sexual offence had occured (i.e. consensual sexual penetration) even though this could have the unintended consequence of undermining the adolescent's rights in terms of the Choice of Termination of Pregnancy Act.[7]

Given that many researchers and healthcare providers could, intentionally or by inference, become aware of a child's sexual activity (because they lawfully asked adolescents questions about their sexual activity, identified sexually transmitted diseases, or provided HIV testing, pregnancy services or access to contraceptives) they had to decide how to respond to underage sex or sexual activity and its accompanying mandatory reporting requirements. They could either provide children with confidential sexual and reproductive health services, thus complying with the Children's Act but ignoring the Sexual Offences Act, or they could comply with the criminal law and report to such behavior to the police, thus breaching the doctor/patient relationship and adversely affecting the researcher/participant relationship, as well as undermining a child's sexual and reproductive rights according to legislation such as the Children's Act.[3]

These provisions, and their implications for both health researchers and providers, have led to considerable debate. For example, McQuoid-Mason[8] argues that the duty to report sexually active adolescents is unconstitutional, as it encroaches on the best interests of the child and limits the child's constitutional right to privacy. Based on similar arguments, other authors proposed ways of mitigating this overly broad mandatory reporting requirement. Strode and Slack[3] suggest that only 'exploitative' underage consensual sex should be reported, while Bhana *et al*.[9] suggest that in such situations researchers should

work with a non-governmental organisation (NGO), such as Childline, that could act as an intermediary in the reporting process.

Against this backdrop, the outcome of the recent *Teddy Bear Clinic* is significant, as it addressed whether consensual underage sex ought to be criminal offence and thus reported.

McQuoid-Mason's recommended approach

McQuoid-Mason refers to his earlier work, in which he argued that, although doctors were under a legal duty to report underage sex, this duty 'may be unconstitutional if it violates the constitutional "best interests of the child" principle, and unreasonably and unjustifiably limits the constitutional rights of children to bodily and psychological integrity and privacy.'[8] Furthermore, he had earlier argued that this duty undermined the purpose of other sexual and reproductive rights granted by the Children's and Choice of Termination of Pregnancy Acts.[7]

He submits that although the *Teddy Bear* case declared Sections 15 and 16 of the Sexual Offences Act (which criminalise underage consensual sex and sexual activity) to be unconstitutional, it left open the issue of the mandatory reporting of underage consensual sexual intercourse.[2] Nevertheless, he submits that as underage sex has been decriminalised, the duty to report such conduct falls away as children are no longer committing a sexual offence.[2]

Accordingly, McQuoid-Mason states that the only remaining reporting obligation is to report sexual abuse in accordance with the Children's Act.[2]

McQuoid-Mason concludes that although the Constitutional Court has yet to confirm this decision, doctors would be justified in not reporting consensual underage sex because (*i*) the High Court has judged the criminalisation of such conduct unconstitutional (and this is likely to be upheld by the Constitutional Court); and (*ii*) because there is no duty to report consensual sexual activities involving children if doing so would violate the constitutional 'best interests of the child' principle.[1]

Critique of the McQuoid-Mason approach

It is submitted that McQuoid-Mason's argument fails to recognise the nuances of the approach taken by Justice Rabie in the *Teddy Bear* case. Firstly, it does not recognise that even post the *Teddy Bear* case, there are certain forms of consensual sexual activity with children that remain illegal. These include sex between an adult (a person over 18) and an adolescent (aged 12 - 15). In a society with high levels of intergenerational sex,[10] it is possible that many healthcare workers or researchers would become aware that a sexual offence is being committed against a child if they ask them questions about their sexual partner. Likewise, not all forms of peer sex are legal. If a child aged 12 - 15 has sex with an older partner aged 16 - 17 there may not be more than a 2-year age gap between them or the older person will still be committing a criminal offence. Accordingly, again, reporting will be required.

Secondly, Justice Rabie specifically found that there is no need to address the constitutionality of Section 54(1)(a) of the Sexual Offences Act dealing with the mandatory reporting of sexual offences against children, as he had already found that Sections 15 and 16 were inconsistent with the Constitution (paragraph 121).[1] This means that these sections will remain in place for the foreseeable future.

An alternative approach

We submit that there are a number of mandatory reporting implications for healthcare providers and researchers working with adolescents following the *Teddy Bear* case.

Firstly, the case has eased some of the reporting burdens, and researchers and healthcare providers are no longer automatically required to report underage sex. In the past, if an adolescent aged 12 - 15 declared that they were sexually active or indicated such through their actions, for example, if they tested positive for herpes, the mandatory reporting requirements were triggered. Following the *Teddy Bear* case this is no longer the situation, as only the older partner (either the person over 18 or the older adolescent of 16 - 17) is an offender. Therefore, there is not always an obligation to report, as the researcher or healthcare worker may not have 'knowledge' of the person who committed the sexual offence with the 12 - 15-year-old.

Secondly, the decision facilitates access to sexual and reproductive health services for 12 - 15-year-olds. Consensual sex where both parties are aged 12 - 15 is now no longer a sexual offence and the adolescent cannot be charged. This takes away the reporting dilemma that healthcare providers and researchers faced in the past, where they had to elect to either comply with the criminal law or the Children's Act. This was a key problem with the provisions in the Sexual Offences Act, as pointed out by McQuoid-Mason.[2,8]

Thirdly, we submit that the judgment is narrow in its scope. As a result, researchers and healthcare providers must be aware that certain forms of consensual, underage sex or sexual activity with 12 - 15 year olds will still have to be reported if one of the participants is:

- Over the age of 18
- Aged 16 - 17, with more than a 2-year age gap between the participant and their younger sexual partner
- Under the age of 12.

Resultantly, the judgment raises many reporting complexities: Firstly, many adolescents (12 - 17) may disclose that they are sexually involved with persons 18 years and older. Secondly, younger adolescents (12 - 15) may reveal sexual involvement with adolescent partners who are older by more than 2 years, for example, a 13-year-old with a 16-year-old. Thirdly, older adolescents (16 - 17) may inform healthcare workers that they are sexually involved with children who are younger by more than 2 years.

If researchers or doctors report sex or sexual activity in this context, it may well have the same harmful consequences that were identified in the *Teddy Bear* case. For example, adolescents, particularly girls, will be dragged into the criminal justice system as they will have to give evidence against their older partner, who faces a criminal record and being entered onto the sexual offenders register. This may inadvertently place adolescents at risk of negative consequences, such as domestic violence, and will undermine the trust within both therapeutic and research relationships.

Therefore, even these more relaxed provisions provide ethical challenges: both researchers and healthcare providers are still under a legal duty to report consensual underage sex in certain circumstances and they have not been accorded any discretion in this regard. This is particularly problematic in settings where intergenerational sex or sex between partners of different ages is a social reality. Accordingly, we assert that even after the *Teddy Bear* case, a more nuanced approach may be required.

Conclusion

Addressing underage consensual sex is a key public health issue. The *Teddy Bear* case is significant as the court recognised that adolescents aged 12 - 15 have a right to engage in 'healthy sexual behaviour' (paragraph 107).[1] Thus, for the first time, a court recognised that the disparate approaches to adolescent sexuality in the Sexual Offences Act and Children's Act were not in the best interests of children. It is argued that this is the first step towards developing a more coherent approach to adolescent sexuality which has both public health and human rights benefits.

However, doctors and researchers are still left with a reporting dilemma where the child is under the age of 12; or where a 12 - 15-year-old is having consensual sex with a much older partner; where a 16 - 17-year-old is having consensual sex with a partner more than 2 years younger; or where the child is having sex with a person over 18. Further debate is required on this issue, and must consider either (*i*) law reform to limit the nature of the mandatory reporting obligations, or alter them to give service providers some discretion in determining when reporting a consensual sexual offence would be in the best interests of the child (aged 12 - 15); Or (*ii*) a constitutional challenge attacking the excessive broadness of these mandatory reporting obligations.

Acknowledgements. This paper was made possible by funding from the National Institute of Health (NIH) awarded to the HIV AIDS Vaccine Ethics Group (HAVEG) via the Desmond Tutu HIV Foundation (DTHF). The views expressed herein are not necessarily the views of the NIH or the DTHF. The authors would like to thank Professor Anne Pope (University of Cape Town) and Dr Harry Moultrie (Wits Reproductive Health Institute), for comments on an earlier draft of this paper.

References

1. Teddy Bear Clinic for Abused Children, and Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN) v. Minister Of Justice And Constitutional Development Case (Case Number 73300/10)
2. McQuoid-Mason D. Decriminalisation of consensual sexual conduct between children: What should doctors do regarding the reporting of sexual offences under the Sexual Offences Act until the Constitutional Court confirms the judgement of the Teddy Bear Clinic case? South African Journal of Bioethics and Law 2013;6(1):10-12.
3. Strode A, Slack C. Sex, lies and disclosures: Researchers and the reporting of underage sex. Southern African Journal of HIV Medicine 2009;10(2):8-10.
4. South African Government. Children's Act No 38 of 2005. Pretoria: Government printer, 2005.
5. Strode A, Slack C, Essack Z. Letter to the Editor: Child consent in South African law: Implications for researchers, service providers and policy-makers. S Afr Med J 2011;101(9):604-606.
6. South African Government. Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. Pretoria: Government Printer, 2007.
7. South African Government. Choice of Termination of Pregnancy Act No 92 0f 2007. Pretoria: Government Printer, 1996.
8. McQuoid-Mason D. Mandatory reporting of sexual abuse under the Sexual Offences Act and the 'best interests of the child'. South African Journal of Bioethics and Law 2011;4(2):74-78.
9. Bhana A, Swartz S, Davids A. Standards for reporting of sex/sexual activity of minors in a research context. S Afr Med J 2010;100(10):642-644.
10. Leclerc-Madlala, S. Age-disparate and intergenerational sex in southern Africa: the dynamics of hypervulnerability. Pretoria: Human Sciences Research Council, 2008. http://www.hsrc.ac.za/en/research-data/view/4170#sthash.u9zSn7W8.dpuf (accessed 13 September 2013).

McQuoid-Mason responds: I have no problem with most of this article, as it confirms what I have written. I also have no issue with most of the 'critique', save as to say, as I mentioned in my original paper, that as the Constitutional Court still has to confirm the invalidation of certain provisions of the Sexual Offences Act, and they are therefore still in place. In the meantime, health practitioners should be guided by the Constitutional 'best interests of the child' principle, when deciding whether or not to report an offence involving children under the Act.

This does not mean that they must never report such offences – if it is 'in the best interests of the child', they must comply with the law and report them. Guidelines for what is 'in the best interests of the child' are spelled out in some detail in the Children's Act[1] and my earlier article[2] referred to by the authors. While it is a pity that the authors do not explain what a 'more nuanced approach' may be, I have no issue with their conclusions about the need for guidelines for reporting, and perhaps a Constitutional challenge regarding the reporting obligations. My article was intended to give some interim guidance to health professionals who are daily confronted by the dilemmas described above, and my suggestion is that we rely on the 'best interests of the child' provisions in the Children 's Act and the Constitution to guide our actions.

Meanwhile, on 3 October 2013, the Constitutional Court ruled in the follow-up Teddy Bear Clinic appeal case (*The Teddy Bear Clinic for Abused Children and RAPCAN and others v. Minister of Justice and National Director of Public Prosecutions)*.[3] The Court held that:

- Sections 15 and 16 of the Sexual Offences Act were invalid to the extent that they impose criminal liability for sexual offences on children under 16 years of age
- the declaration of invalidity is suspended for a period of 18 months from the date of the judgment, to allow Parliament to correct the defects
- from the date of the judgment there is a moratorium on all investigations into, arrests of, prosecutions of, and criminal and ancillary proceedings regarding such Section 15 and 16 offences – including the duty to report such consensual sexual conduct between children under 16 years of age under Section 54 of the Act (Teddy Bear Clinic case para. 111) – pending Parliament's correction of the Act
- any convictions or diversion orders made as a result of such offences committed by children under 16 years of age in terms of Sections 15 and 16 of the Act shall be expunged from the National Register for Sex Offenders.

1. The Teddy Bear Clinic for Abused Children and RAPCAN and others v. Minister of Justice and National Director of Public Prosecutions Case CCT 12/13 [2013] ZACC 35.
2. McQuoid-Mason D. Decriminalisation of consensual sexual conduct between children: What should doctors do regarding the reporting of sexual offences under the Sexual Offences Act until the Constitutional Court confirms the judgement of the Teddy Bear Clinic case? South African Journal of Bioethics and Law 2013;6(1):10-12.
3. South African Government. Choice of Termination of Pregnancy Act No 92 0f 2007. Pretoria: Government Printer, 1996.

Failing the vulnerable: Three new consent norms that will undermine health research with children

A Strode,[1] BA, LLB, LLM, PhD; **M Richter**,[2] BA (Hons), MA, LLM, PhD; **M Wallace**,[3] BSoc Sci (Hons), MSc, PhD; **J Toohey**,[4] LLB; **K Technau**,[5] MBBCH, MSc

[1] *University of KwaZulu-Natal and HIV/AIDS Vaccines Ethics Group, Durban, South Africa*
[2] *International Centre for Reproductive Health, Department of Obstetrics and Gynaecology, Ghent University, Belgium; School of Public Health and Family Medicine, University of Cape Town, South Africa; and African Centre for Migration and Society, University of the Witwatersrand, Johannesburg, South Africa*
[3] *Desmond Tutu HIV Foundation, University of Cape Town, South Africa*
[4] *HIV/AIDS Vaccines Ethics Group, Durban, South Africa*
[5] *Empilweni Services and Research Unit, Department of Paediatrics and Child Health, Rahima Moosa Mother and Child Hospital, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa*

Corresponding author: *A Strode (strodea@ukzn.ac.za)*

The South African National Health Act (No. 61 of 2003) provides a legal framework for the regulation of the health system across the country. Within the Act, section 71 introduces a number of legal norms relating to research or experimentation with human subjects, including research on HIV prevention and treatment. These norms have been criticised for the negative impact they will have on research involving children. This article describes three of the new consent requirements in section 71 of the Act. It shows, using a range of case studies, how important HIV-related research will be halted or undermined if the current provisions are implemented. The article argues that the new consent requirements are out of step with other statutory provisions and ethical guidelines, and as a result they will exclude a large population group – children in diverse settings – from much-needed evidence-based healthcare interventions. The article concludes with a clarion call for support of advocacy on this issue with the Minister of Health and the Health Portfolio Committee.

S Afr J HIV Med 2014;15(2):46-49. DOI:10.7196/SAJHIVMED.1014

Section 71 of the South African (SA) National Health Act (NHA),[1] which deals with research on or experimentation with human subjects, was put into operation on 1 March 2012.[2] This section fundamentally changes the way in which research with children may be undertaken across the country by introducing highly restrictive and inflexible standards into the current SA ethical-legal framework.[3,4] As a result, it has come under heavy criticism for limiting important research with children and containing impractical and unrealisable provisions.[3-9]

The full impact of section 71 has yet to be felt, as very few research ethics committees (RECs) require researchers to comply with its standards. However, this grace period may be coming to an end; on 29 May 2013, draft *Regulations Relating to Research on Human Subjects*[10] were published for public comment, indicating that the full implementation of section 71 is imminent.

This article focuses on three aspects of section 71, which we believe will have far-reaching consequences for research on children. It shows, using a range of case studies, how important research will be halted or undermined if the current provisions are implemented. The article concludes with a call to support advocacy in law reform.

The importance of health research with children

There is a global trend towards greater inclusivity in research practices and to facilitate research with children, while recognising that they need to be protected.[12] This approach flows from a recognition of the following:

- The number and severity of diseases that affect children is growing: for example, 17% of all 15 - 49-year-olds are HIV-positive.[13] Furthermore, mortality among children is unacceptably high, with one out of every ten deaths in the entire population being a child under the age of 14.[14]
- Some disorders occur only in children or are more common in children; for example, type 1 diabetes[15] and juvenile rheumatoid arthritis.[16,17]

A note on terminology: This article uses the term 'children' to refer to persons under the age of 18.[11] However, the NHA uses the term 'minors' in section 71; therefore, when we refer directly to this section we use 'minors' rather than children. We also limit our discussion to 'health research' on a 'living person', as the regulations in section 71 only apply to these types of studies.

- The dynamics in some diseases are different in children compared with adults. For example, 20% of untreated HIV-infected infants will die within 90 days of birth,[18] 40% within their first year of life, and 52% by the end of their second year.[19] This type of rapid mortality does not occur among newly infected adults.
- Certain medication has a different impact on children as opposed to adults, as they have differing biokinetics, metabolism, physiology and immunology, and metabolise medicines differently. This results in children needing different dosages, which can only be established through research.[20] Without research, limited information is available on the efficacy and safety of many of the medicines commonly used in children.[20]
- There is a developing trend against allowing the licensing of drugs, vaccines and other interventions for children before testing their safety and efficacy in this age group. There is also concern about the 'off label' use of medicines in children.[20]
- Using the results from clinical trials on children has resulted in significant health benefits for them.[21] For example, human papilloma virus (HPV) vaccine studies on children have enabled them to receive the vaccine, which can prevent cervical cancer and genital warts.[22]
- Laws such as the Children's Act emphasise that children have the right to participate in decision making.[11] Likewise, 'their participation in research is akin to respecting and promoting their entitlement to have their opinions heard. It assumes that they are persons of value, their experiences are of interest to themselves, and to others, and that they have a valuable contribution to make.'[23]

Against this backdrop, it is argued that an approach that excludes children from health research, including research related to HIV prevention and treatment, infringes on their constitutional rights to both 'basic health care' and access to 'healthcare services'.[24] For example, their exclusion results in ineffective and even harmful interventions being used owing to the lack of evidence on drug efficacy or dosage.[21] This also has unintended consequences, such as research being delayed or risking lack of funding due to extended enrolment periods that may be required in order to comply with a restrictive legal framework. This may result in research being undertaken in other countries, where the ethical-legal framework is more flexible.

New restrictive regulations for all forms of health research with human subjects

New standards on health research with children have been introduced, which will limit the circumstances in which they may participate in research. Three of the new consent regulations in section 71 are described and critiqued below.

Requiring written consent

Section 71 of the NHA provides that research participants must give written, informed consent to health research.[1] This will have serious implications for certain types of health research, such as telephonic interviews and postal or electronic studies, in which the voluntary completion of a questionnaire is commonly regarded as consent.[25] It also excludes the use of passive consent (informing parents of a study and assuming they have agreed to their child participating, unless otherwise instructed) – a practice frequently used with adolescent school-based studies.[9]

This approach is out of step with the more flexible approach in the National Health Research Ethics Council (NHREC) guidelines, which provide that consent may be given verbally or in writing. Consent may also, in certain circumstances, be waived, if prior approval of the REC is obtained.[26]

Prohibiting independent consent from minors

The NHA[1] provides in section 71 that consent must be obtained from parents or legal guardians, and minors if they have understanding. In other words, children under the age of 18 do not have the capacity to consent independently to any form of health research, but they may in certain circumstances provide dual consent alongside that of their parents or guardians.

Mandatory parental consent means that it will no longer be possible to undertake health research where it involves the following:

- *Certain socially marginalised groups*. For example, adolescent men who have sex with men are highly stigmatised in SA, and may face social harms if they are required to seek parental consent to participate in research focusing on their sexuality or sexual practices.
- *Behaviour that is legal, but which may incur parental disapproval or reprisal*. An example is termination of pregnancy in young girls, as it is likely that very few teenage girls would be willing to approach their parents for consent to a study on a decision they had made autonomously to terminate a pregnancy. Even though this is a lawful decision, studies have confirmed that teenagers will not use such services if they have to obtain parental consent for fear of disapproval.[27]
- *Illegal behaviours*. For example, studies into illegal practices such as child drug use or child prostitution would be complicated by concerns that: (*i*) children would not be prepared to seek parental consent, or (*ii*) parents are in fact not available to provide such consent.
- *Minimal or no-risk research with children over the age of 12, using a passive consent approach.*[9] For example, this could include completing surveys about drug, alcohol or sexual abuse, eating disorders, attitudes towards oral hygiene, exercise behaviour or even experiences of healthcare provision.
- *Orphaned and vulnerable children (OVCs) who do not have parents or legal guardians who are able to consent.* This is discussed further below.

It is worth noting that in all of the above examples, the children are likely to be considerably more vulnerable and at risk of ill health than their peers, and research and consequent evidence-based intervention with these groups is particularly pertinent (Table 1).

Prohibiting independent consent from minors is also problematic, in that it conflicts with the consent provisions in the Children's Act,[11] which recognises the evolving capacity of children, and allows them to consent to a range of health interventions before the age of 18.[31] Furthermore, this regulation in the NHA is diametrically opposed to those in the NHREC ethical guidelines, which, for example, allow for independent consent by children in certain circumstances.[26]

Limiting the authority to provide proxy consent to parents or legal guardians

Section 71 of the NHA limits the authority to provide proxy consent to either parents or legal guardians. Generally, parents are the biological

Table 1. Examples of completed studies that would in the future be difficult to undertake with the requirement of parental/legal guardian consent

Name of study	Ethically approved consent requirements	Reasons why obtaining parental consent would be difficult or impossible	Health benefits to children
HIV-related knowledge, attitudes and behaviour among SA street youth: reflections on power, sexuality and the autonomous self[28]	Independent consent	The child research participants were street children living away from adult supervision	Better understanding of the HIV risk of children living on the street
A systemic approach to the experiences of adolescents, with regard to terminating their pregnancies[29]	Participants aged 13 - 22 years; independent consent obtained	The study explored experiences of pregnancy termination. In many cases, participants may not have disclosed their pregnancy or their decision to terminate to their parent/legal guardian. Only 5 of 19 participants had disclosed their pregnancy to their mothers	Better understanding of adolescent experiences could inform policy and practice – particularly regarding school support and processes, as well as health and community services
Persisting mental-health problems among HIV-orphaned children in SA[30]	The mean age of the participants was 13.4 years at the study outset; consent was obtained from participants and caregivers	By definition, participants did not have a parent to provide consent, and it was unlikely that all caregivers would have been designated as legal guardians	The identification of the impact of psychological distress due to AIDS orphanhood over time in comparison with other groups, and highlighting the need for a focus on addressing the specific psychosocial needs of children

SA = South Africa.

or adoptive parents of a child, while a guardian is a 'person with guardianship of a child'.[11] Unmarried, biological mothers over the age of 18 are automatically the guardian of their child, and in certain circumstances an unmarried father will be a co-guardian. If the biological parents are married, they will be joint guardians. A guardian may also be appointed by the High Court or nominated by a parent in a will.[11] Persons caring for children but not falling into any of the categories above will, in the future, not be able to provide consent for children to participate in health research. This will affect a significant number of children, given that it is estimated that by 2015, ~5 700 000 children would have lost one or both parents to AIDS.[32]

In essence, this means that future studies with children who do not have parents or legal guardians will no longer be possible. Furthermore, such children may not volunteer for health research, as they do not have an adult with the legal authority to provide proxy consent. This principle will also apply to mothers under the age of 18 who have lost parental support but who are at particular risk of both HIV acquisition and transmission. There are also far-reaching implications for research on child-headed households, OVCs and undocumented migrant children. OVCs are increasingly recognised as a special population in terms of HIV risk and transmission, yet they will not be able to inform research.[33] OVC and child-headed households present unique and contemporary issues that must be responded to.

Limiting the authority to provide proxy consent to parents and legal guardians is also out of step with the Children's Act, which recognises that caregivers may consent to certain health interventions such as medical treatment and HIV testing on behalf of children.[34]

Conclusions

Given the principled nature of many of the concerns set out above, we call on the Minister of Health and the Parliamentary Health Portfolio Committee to address the need for law reform as a matter of urgency. If research institutions are required to comply with these regulations, child research in SA will grind to a halt, and this will ultimately harm the population it purports to protect. Ensuring and supporting rigorous and equitable review by RECs, and promoting clear communication to children and their caregivers during consent and study processes, should be the emphasis of developments in this field rather than restrictive legislation that reduces access to research participation. The nature and form of consent should be driven by the research itself, its benefits, risks, costs and consequences, rather than a blanket one-size-fits-all approach.[25]

Acknowledgements. This article is based on a July 2013 submission to the Director General of Health, on the draft *Regulation on Human Subjects* by the Southern African HIV Clinicians Society.[35] The Society funded a consultative meeting at which many of the points made in the submission were workshopped, and we would like to acknowledge, in particular, the contributions of Kelly Blanchard, Sumaya Mall, Nataly Woollett, Naomi Lince-Deroche, Belinda Alport, Linda-Gail Bekker, Denise Evans and Andy Gray, who all assisted with written input into the final submission. Thanks are also due to Catherine Slack of the HIV/AIDS Vaccines Ethics Group, University of KwaZulu-Natal, for a critical read of the first draft of this article. The article was in part made possible by funding from the National Institute of Health awarded to the HIV/AIDS Vaccine Ethics Group via the Desmond Tutu HIV Foundation (DTHF) (1RO1 A1094586) CHAMPS (Choices for Adolescent Methods of Prevention in South Africa). The opinions expressed herein are the views of the authors. They do not represent any position or policy of the NIH.

References

1. South African Government. National Health Act 61 of 2003. Pretoria: Government Printer, 2003.

2. South African Government. Government Gazette No. 35081, 27 February 2012. Pretoria: Government Printer, 2012.
3. Slack CM, Strode AE, Grant K, et al. Implications of the ethical-legal framework for adolescent HIV vaccine trials: Report of a consultative forum. S Afr Med J 2005;95(9):682-685.
4. Stobie M, Strode AE, Slack CM. The dilemma of enrolling children in HIV vaccine research in South Africa: What is in 'the child's best interests'? In: van Niekerk A, Kopelman L, eds. Ethics and AIDS in Africa. Cape Town: David Philip Publishers, 2005:190-207.
5. Strode AE, Slack CM, Wassenaar DR, et al. One step forward, two steps back – requiring ministerial approval for all forms of non-therapeutic health research with minors. S Afr Med J 2007;97(3):200-202.
6. Abdool Karim Q, Khamny ABM, Frohlich JA, et al. HIV incidence in young girls in KwaZulu-Natal South Africa – public health imperative for the inclusion in HIV biomedical intervention trials. AIDS Behav 2012;16(7):1870-1876. [http://dx.doi.org/10.1007/s10461-012-0209-y]
7. Pope A. HIV preventative research with minors. SALJ 2007;124(1):167-187.
8. Singh JA, Abdool Karim SS, Abdool Karim Q, et al. Enrolling adolescents in research on HIV and other sensitive issues: Lessons from South Africa. PLoS 2006;2(7):0001-0005. [http://dx.doi.org/10.1371/journal.pmed.0030180]
9. Zuch M, Mason-Jones AJ, Mathews C, Henley L. Changes to the law on consent in South Africa: Implications for school-based adolescent sexual and reproductive health research. Biomed Central 2012;12(3):1-5. [http://dx.doi.org/10.1186/1472-698X-12-3]
10. South African Government. R 378: Regulations Relating to Research on Human Subjects (published for public comment). In: Government Gazette No. 36508, 29 May 2013. Pretoria: Government Printer, 2013.
11. South African Government. Children's Act 38 of 2005. Pretoria: Government Printer, 2005.
12. Fraser S, Lewis, V, Ding S, et al (eds). Doing Research with Children and Young People. London: SAGE, 2004:1-294.
13. Rehle TM, Hallett TB, Shisana O, et al. A decline in new HIV infections in South Africa: Estimating HIV incidence from three national HIV surveys in 2002, 2005 and 2008. PLoS One 2010;5(6):e11094. [http://dx.doi.org/10.1371/journal.pone.0011094]
14. Statistics South Africa. Mortality and Causes of Death in South Africa, 2010: Findings from Death Notification. South Africa: Statistics South Africa, 2013.
15. Maahs DM, West NA, Lawrence JM, et al. Chapter 1: Epidemiology of type 1 diabetes. Endocrinol Metab Clin North Am 2010;39(3):481-497. [http://dx.doi.org/10.1016/j.ecl.2010.05.011]
16. Gabriel SE, Michaud K. Epidemiological studies in incidence, prevalence, mortality, and comorbidity of the rheumatic diseases. Arthritis Res Ther 2009;11:229. [http://dx.doi.org/10.1186/ar2669]
17. Hahn YS, Kim JG. Pathogenesis and clinical manifestations of juvenile rheumatoid arthritis. Korean J Pediatr 2010;53(11):921-930. [http://dx.doi.org/10.3345/kjp.2010.53.11.921]
18. Marston M, Becquet R, Zaba B, et al. Net survival of perinatally and postnatally HIV-infected children: A pooled analysis of individual data from sub-Saharan Africa. Int J Epidemiol 2011;40(2):385-396. [http://dx.doi.org/10.1093/ije/dyq255]
19. Obimbo EM, Mbori-Ngacha DA, Ochieng JO, et al. Predictors of early mortality in a cohort of human immunodeficiency virus type 1-infected African children. Pediatr Infect Dis J 2004;23(6):536-543.
20. Jaspan HB, Cunninghame CR, Tucker TJB, et al. Inclusion of adolescents in preventive HIV vaccine trials: Public policy and research design at a crossroads. Acquired Immune Defic Syndr 2004;47(1):86-92. [http://dx.doi.org/10.1097/QAI.0b013e31815d2f27]
21. Caldwell PH. Children in clinical trials. Lancet 2004;364(9436):803-811. [http://dx.doi.org/10.1016/S0140-6736(04)16942-0]
22. Reisinger KS, Block SL, Lazcano-Ponce E, et al. Safety and persistent immunogenicity of a quadrivalent human papillomavirus type 6, 11, 16, 18 L1 virus-like particle vaccine in preadolescents and adolescents. Pediatr Infect Dis J 2007;26(3):201-209. [http://dx.doi.org/10.1097/01.inf.0000253970.29190.5a]
23. Graham A, Fitzgerald R. Children's participation in research: Some possibilities and constraints in the current Australian research environment. J Sociol 2012;46(2):133-135. [http://dx.doi.org/10.1177/1440783309355065]
24. South African Government. Constitution of the Republic of South Africa, 1996. Pretoria: Government Printer, 1996.
25. Jack CL, Mars M. Informed consent for telemedicine in South Africa: A survey of consent practices among healthcare professionals in Durban, KwaZulu-Natal. S Afr J BL 2013;6(2):55-59. [http://dx.doi.org/10.7196/sajbl.287]
26. South African National Department of Health. Ethics in health research: Principles, structures and processes. South Africa: National Department of Health, 2004. www.doh.gov.za (accessed 8 August 2013).
27. Jackson S, Hafemeister TI. Impact of parental consent and notification policies on the decisions of adolescents to be tested for HIV. J Adolesc Health 2001;29(2):85. [http://dx.doi.org/10.1016/S1054-139X(00)00178-6]
28. Swart-Kruger J, Richter LM. AIDS related knowledge, attitudes and behaviour among South African street youth: Reflections on power, sexuality and the autonomous self. Soc Sci Med 1997;45(6):957-966. [http://dx.doi.org/10.1016/S0277-9536(96)00417-0]
29. De Lange N, Geldenhuys, JL. A systemic approach to adolescents' experiences of terminating their pregnancies. Society in Transition 2001;32(2):246-259. [http://dx.doi.org/10.1080/21528586.2001.10419045]
30. Cluver LD, Orkin M, Gardner F, et al. Persisting mental health problems among AIDS-orphaned children in South Africa. J Child Psychol Psychiatry 2012;53(4):363-70. [http://dx.doi.org/10.1111/j.1469-7610.2011.02459.x]
31. Strode A, Slack C, Essack Z. Norms for child consent in South African law: Implications for researchers, service providers and policy-makers. S Afr Med J 2010;100(4):247-249.
32. Holborn L, Eddy G. First Steps to Healing the South African Family. SAIRR. Johannesburg: South Africa, 2011.
33. Cluver L, Orkin M, Boyes M, Gardner F, et al. Transactional sex amongst AIDS-orphaned and AIDS-affected adolescents predicted by abuse and extreme poverty. J Acquir Immune Defic Syndr 2011;58(3):336-343. [http://dx.doi.org/10.1097/QAI.0b013e31822f0d82]
34. Strode A, Slack C. Using the concept of parental responsibilities and rights to identify adults able to provide proxy consent to child research in South Africa. S Afr J BL 2010;3(2):69-72.
35. Southern African HIV Clinicians Society. Draft Regulation on Human Subjects. http://www.sahivsoc.org/upload/documents/Submission%20on%20NHA%20Regs_final.pdf (accessed 27 September 2013).

Boni mores and consent for child research in South Africa

A E Strode,[1] BA LLB, LLM, PhD; **J Toohey**,[2] LLB; **P Singh**,[1] BCom, LLB, LLM; **C M Slack**,[2] BA Hons, MA, PhD

[1] *School of Law, University of KwaZulu-Natal, Pietermaritzburg, South Africa*
[2] *HIV/AIDS Vaccines Ethics Group, School of Applied Human Sciences, University of KwaZulu-Natal, Pietermaritzburg, South Africa*

Corresponding author: *A E Strode (strode@ukzn.ac.za)*

Consent is required for almost all health research. In order for consent to be valid a number of requirements must be met including that the consent cannot be *contra bonos mores* or contrary to public policy. This principle has its roots in the common law and it is used to ensure that the consent to harm, or the risk of harm, is permitted or ought to be permitted by the legal order. Recently, it has also become a statutory requirement embedded in the consent obligations relating to non-therapeutic health research with minors. Section 71 of the National Health Act provides that the Minister of Health (or potentially his or her delegated authority) must provide consent to non-therapeutic research with minors. However, such consent may not be granted if 'the reasons for the consent to the research or experimentation are contrary to public policy'. Limited work has been done on how to determine when consent to health research with children would be contrary to public policy. This article attempts to begin the debate by describing the *boni mores* principle, setting out some of the general factors that could be used to assess whether consent is consistent with it and suggesting how they could be applied to health research.
The article concludes by stating that simply requiring proxy consent for non-therapeutic health research with children is insufficient as it cannot always be assumed that proxy consenters will act in the best interests of the child. Thus the *boni mores* principle acts as a limit on autonomy in order to protect the child participant. It is further submitted that establishing when consent to health research is consistent with public policy requires an assessment of whether the research is consistent with constitutional values, prevailing legal norms regarding children, and an assessment of the legal convictions of the community.

S Afr J BL 2015;8(1):22-25. DOI:10.7196/SAJBL.346

It is a well-established international law principle that participation in most forms of health research is dependent on participants or their proxies providing informed consent.[1,2] Likewise, South African law provides that consent is required for almost all health research.[3,4] Section 71 of the National Health Act (NHA) requires that if the participants in health research are minors, proxy consent must be provided by their parent or legal guardian[4] and minors who are 'capable of understanding' may also provide consent alongside their parent or guardian.[4] If participants or their proxies have consented to the health research, the legal maxim *volenti non fit injuria* (to one consenting no harm is done) applies, and this can be used as a defence by researchers or sponsors. However, in order for it to operate as a defence, four statutory and common law requirements must exist:[5]

- the consent should have been provided in writing[4]
- it should have been voluntarily given[6]
- the consent should have been informed by an appreciation of any possible negative or positive health consequences that the research may pose[7]
- the consent may not be *contra bonos mores* (against good morals or public policy)[8]

The fourth requirement for informed consent – that of requiring it not to be *contra bonos mores*, i.e. contrary to the legal convictions of the community or inconsistent with public policy – has its roots in the common law principles which were adopted from Roman and Roman Dutch law.[8] It applies to all forms of consent and is used to ensure that the consent to harm, or the risk of harm, is permitted or ought to be permitted by the legal order.[8]

Recently, it has also become a statutory requirement embedded in the consent obligations relating to non-therapeutic health research with minors.[4] Section 71 of the NHA provides that the Minister of Health (or potentially his or her delegated authority in terms of section 92 of the NHA) must provide consent to non-therapeutic research with minors.[4] However, such consent may not be granted if 'the reasons for the consent to the research or experimentation by the parent or guardian and, if applicable, the minor are contrary to public policy'.[4] Although these sections in the NHA were operationalised on 1 March 2012 they were not accompanied by regulations so some Research Ethics Committees (RECs) did not require compliance with them. However, on 19 September 2014 the Minister of Health published regulations relating to research with human participants.[9] These regulations included a potential delegation of his authority to provide ministerial consent to non-therapeutic research with minors to RECs.[9] This means that further legislative consent requirements have now been introduced and added to the current requirements described above and RECs must comply with all of them.

This article attempts to address the *lacunae* of research into when consent is contrary to public policy by describing the *boni mores* principle, setting out some of the general factors used to assess whether consent is consistent with it and also suggesting how these factors could be applied to the issue of granting ministerial consent for non-therapeutic health research with children. This article does not critique the restrictive nature of current consent norms as that has been done elsewhere.[10,11]

Contra bonos mores

Our courts have long held that consent can only validly operate as a defence if the act being consented to is not *contra bonos mores*.[8] At the heart of this principle is an acceptance that consent – even voluntarily given – must be consistent with public policy. For example, the courts have held that consent to a caning as a form of discipline in the workplace was invalid.[12] Likewise, consent to dangerous car racing in the street was considered *contra bonos mores*.[13] In essence, this principle places a limit on individual decision-making by requiring the reason for the consent to meet an objective legal standard – regardless of voluntariness. In this context, the perception of the consenter regarding the validity of their consent is not relevant.[8]

Key factors used to establish whether the consent is valid include constitutional values, prevailing legal norms and public opinion, discussed in more detail below:

Constitutional values

The constitution is founded on a number of values – including human dignity, the achievement of equality and the advancement of human rights and freedoms, non-racialism, and non-sexism.[3] These values are used as both a tool of interpretation (with courts having to favour an approach which protects the constitutional values) and as an objective standard against which conduct can be measured.[14] The courts have held that the concept of *boni mores* is 'now deeply rooted in the constitution and its underlying values'.[15]

Prevailing legal norms

Consent must be consistent with prevailing legal norms.[12] This requires consideration of the legal norms governing the act being consented to – in order to establish whether the consent is lawful.[12]

Public opinion

In some instances the courts take note of public opinion or morality, in establishing whether consent is *contra bonos mores*. In other words the principle is partially shaped by religious, ethical and moral perceptions of right and wrong. The courts will, however, only consider public opinion when the views of the society strongly require legal sanction for the type of behaviour that was consented to.

Using the *boni mores* principle to establish the validity of consent to health research

There has been limited academic discussion about when health research would be *contra bonos mores*. At a macro level, it has been argued that participants should not be allowed to consent to research if it is likely to result in the discovery of knowledge that is inappropriate for human beings to process,[16] or when such knowledge may be misused in human hands, for example, developing instruments for killing or injuring humans.[16] At a more micro level, it has been argued that research would be *contra bonos mores* if it is not being conducted properly, or the risks to participants are unacceptably large and not sufficiently offset by the benefits to participants or society.[7,17-19] Others submit that if researchers do not comply with substantive and procedural requirements for approving research – for example, if a study does not obtain ethical approval for consent to participation – this would be *contra bonos mores*.[7]

Boni mores and child research

The issue of when research with children would be contrary to public policy has been rigorously debated, with most writers focusing on the vexing issue of non-therapeutic research given that it does not typically offer participants any direct benefit and requires them to act altruistically. Key issues have included:

- Whether parental consent to research investigating illegal activity would be *contra bonos mores?*[19]
- Whether unacceptable levels of risk are illegal?[18]
- Whether proxy consent for non-therapeutic research should be limited?[20,21]

For example, prior to the NHA, Van Wyk submitted that non-therapeutic research with children should only be possible if it was classified as being observational in nature and did not pose more than a minor increase over minimal risk.[18]

We submit that when assessing whether consent to health research with children is contrary to public policy RECs should consider the nature of the study, how it will be carried out and make an assessment of whether consent would be appropriate in the broad circumstances. Possible concerns could include, among others: consent to research investigating illegal behaviours (such as drug use or prostitution) or legal but sensitive behaviour (such as adolescent same-sex activity); or the possible motivation of potential consentors. We argue that the general principles articulated above could form a useful framework for evaluating the validity of such consent. We suggest that these principles could be applied in the following way:

Constitutional values

The consent would need to be consistent with constitutional values. In other words, the research should not violate the basic constitutional and human rights of child participants – including their rights to dignity and equality (especially on the grounds of race and gender). It is hard to imagine research that could be ethical but still violate these constitutional values – given that a core part of an REC's mandate is to protect the rights of participants. National ethical guidelines require RECs to ensure that human subjects are treated with dignity, that their well-being is promoted, and that consent procedures are adequate.[22] Key questions that could be asked to establish if the study is consistent with constitutional values – and hence public policy – would include the following:

- To what extent does the study treat the child participants with respect, and protect their constitutional rights?
- Does the study select potential child participants fairly and avoid the unjustified targeting of a particular sub-group?
- Does the study include appropriate and justified incentives for enrolment of child participants?

Prevailing legal norms

The consent needs to be consistent with prevailing legal norms governing research with children – which are established in the constitution, the NHA, and other relevant legislation such as the Children's Act.[3,4,23]

A key legal norm in this context is the concept of the best interests of the child. Section 28(2) of the constitution states that a child's best interests are of paramount importance in every matter concerning the child.[3] Our courts have generally held that in applying this

principle a wide range of factors should be considered to establish if a decision concerning a child will promote their physical, moral, emotional and spiritual welfare. Section 7 of the Children's Act contains a non-exhaustive list of the factors that ought to be used when applying this principle.[23] None of these principles are research specific but many are broad enough to be useful in this context.

Other relevant legal norms are those in the NHA which provide that both therapeutic and non-therapeutic research with minors is lawful if the requirements in the Act are met.[4] The NHA requires children to be scientifically indispensable to the non-therapeutic study and an obligation is placed on researchers to demonstrate why the data cannot be obtained from adults.[4] It also sets a standard of acceptable risk by stating that the non-therapeutic research with minors must not pose a significant risk to their health.[4]

The other key piece of legislation describing children's health rights is, as mentioned above, the Children's Act.[23] It requires adults to promote a child's well-being and to protect children from discrimination, exploitation and any other physical, emotional or moral harm.[23] It also describes a number of other health rights of children, such as the age at which they may consent for example to medical treatment, HIV testing, and use contraceptives.[23]

It is possible that other legal norms would also have to be considered – depending on the nature of the study. For example, if researchers are investigating child labour, consideration may need to be given to the norms in employment laws. It is worth noting that consent to research that does not comply with legal norms may be inconsistent with public policy if we follow the approach in English law[24] where courts have consistently held that one can never consent to illegal activity as this is by its nature *contra bonos mores*. For consent to health research to be accepted as legal consent it must be permitted by the legal order. The complexity with applying this principle is that the approach to children's health rights in the NHA and the Children's Act are divergent. For example, while the Children's Act recognises the evolving capacity of children to consent independently to certain health interventions the NHA does not.[11]

Key questions that could be used to establish whether consent is consistent with prevailing legal norms include:

- Has the child research met all the procedural requirements established by law – such as ethical approval?
- Will all substantive requirements that need to be met – such as compliance with mandatory reporting requirements – be complied with?
- Is it in the best interests of the child?
- What are the potential risks and harms of research participation, and do they fall below the accepted legal standards?
- Will children be exploited by, for example, asking them to assume an unfair level of risk in relation to the expected benefit for them or the group they represent?

Public opinion or community morals

The consent would need to be acceptable to community morals, as reflected by the community's legal convictions – i.e. its laws. This is a complex factor and it cannot be equated to public opinion. For example, even though public opinion may be opposed to terminations of pregnancy (TOP) below the age of 18, this would not necessarily mean that research into TOP would be inconsistent with public policy. Likewise, research *per se* into illegal or 'immoral' behaviours is not necessarily against public policy – even though the community may disapprove of the behaviour. For example, research exploring factors that impact on risky sexual practices of adolescents might be frowned upon by some stakeholders but this would not mean that research on the topic would be against public policy if conducted in accordance with the legal framework.

Furthermore, ethical guidelines form an important indicator of public policy, as in many instances they reflect the moral convictions of the community. Therefore, if the research complies with current national ethical guidelines it is likely to be consistent with the *boni mores* principle. The complexity with applying this principle is that in some instances research may comply with key ethical norms but not with legal norms, for example, current ethical guidelines allow caregiver consent for certain forms of child research while the NHA prohibits such an approach.

Key questions that could be used to establish whether consent is consistent with community morals include:

- Is it ethical?
- Is the research lawful?
- Will the study violate a child's constitutional rights?
- Would the research be acceptable to the community?

Using the *boni mores* principle to determine whether ministerial consent may be granted for non-therapeutic research in children

Section 71(3) of the NHA provides that ministerial consent for non-therapeutic research with minors may not be given if the reasons for 'the consent to the research or experimentation by the parent or guardian and, if applicable, the minor are contrary to public policy'[4] Form A in the regulations (the application for ministerial consent) simply states that researchers ought to 'explain why consent would be acceptable, for example, that the study poses acceptable risks and promotes the rights of minors'.[9] Although no further detail is provided it would appear from the wording of this section of the NHA that the drafters were concerned about the potential motivations consenters may have for agreeing to research participation.[4] We interpreted this to mean that the minister or their delegated authority should consider possible reasons consenters may have for enrolling children in the study, for example the appropriateness of incentives for study participation, and their potential influence on consent. This assessment cannot be an individual, subjective assessment of each individual consenter's motivation but should rather be a general consideration of possible reasons potential participants may have for joining the study. We would argue further that the general principles articulated above would apply to this assessment. It is, however, a narrower approach because for the purposes of ministerial consent there is no need to establish that the study itself is consistent with public policy, just the reasons for the consent.

Conclusions

Requiring consent to be consistent with the *boni mores* principle or public policy acts as a limit on the personal autonomy of the consenter or proxy consenter. It is not uncontroversial in our constitutional era, as it limits autonomy which is an inherent part of the right to bodily integrity. While it may be argued that the principle is outdated, paternalistic and intrusive regarding adults – such arguments are

less likely to be justified when considering proxy consent to research with minors. There is a constitutional obligation to protect children from harm and to act in their best interests. Simply requiring proxy consent is insufficient as it cannot always be assumed that proxy consenters will act in the best interests of the child when electing whether to enrol them in health research.[25] Hence, it appears that the NHA places the obligation to establish whether the health research is consistent with the *boni mores* in the hands of the regulators of research rather than the proxy consenters as a protective measure. It is submitted that establishing when consent to health research with minors is consistent with public policy requires an assessment of whether the research is consistent with constitutional values, prevailing legal norms regarding children, and the legal convictions of the community. This assessment is inextricably wound up in the review of whether the study is ethical. It is likely that a study judged by an independent REC to comply with prevailing national ethical standards would be consistent with public policy. Also, given that the public policy requirement in the granting of ministerial consent has been limited to a consideration of the potential reasons for consenting, it simply requires an assessment of whether agreeing to be in such a study would be consistent with the legal convictions of the community.

Acknowledements and disclaimer: The work described here was supported by the South African AIDS Vaccines Initiative (SAAVI) and the National Institutes of Health award (1RO1 A1094586) CHAMPS (Choices for Adolescent Methods of Prevention in South Africa). The content is solely the responsibility of the authors and does not necessarily represent the official views of SAAVI or the National Institutes of Health. This paper does not necessarily reflect the views of any institution or committee or council with which the authors are affiliated.

References

1. Nuremburg Code, 1946. http://www.state.nj.us/health/irb/documents/nuremburg_code.pdf (accessed 1 June 2015).
2. International Convention on Civil and Political Rights, 1966. http://ec.europa.eu/justice/policies/privacy/docs/16-12-1996_en.pdf (accessed 1 June 2014).
3. Republic of South Africa. Constitution of the Republic of South Africa, Government Gazette 1996;17678.
4. Republic of South Africa. National Health Act No. 61. Government Gazette 2003; 26595. http://www.info.gov.za/gazette/acts/2003/a61-03.pdf (accessed 2 June 2014).
5. R v. McCoy (1953) 1 All SA 459 at 11 D-H.
6. Esterhuizen v. Administrator, Transvaal 1957 (3) SA 710 (T) at 722.
7. Van Oosten F. The law and ethics of information and consent in medical research. Tydskrif vir Hedendaagse Romeins-Hollandse 2000;63:18-31.
8. Neethling J, Potgieter JM, Visser PJ. The law of delict. 6th ed. Durban: LexisNexis Butterworth, 2010:36-40.
9. Republic of South Africa. Regulations relating to Research with Human Participants No. R719. Government Gazette 2014. http://www.google.co.za/url?url=http://www.gov.za/documents/download.php%3Ff%3D214372&rct=j&frm=1&q=&esrc=s&sa=U&ei=K9cuVI7lOczB7AbZvoDgDQ&ved=0CBMQFjAA&usg=AFQjCNFzstJM- YYP30mB55vAvWrZyCfWA (accessed 9 January 2015).
10. Strode A, Richter M, Wallace M, Toojey J, Technau K. Failing the vulnerable: Three new consent norms that will undermine health research with children. S Afr J HIV Med 2014;15(2):46-49.
11. Strode A, Slack C, Wassenaar D, Singh J. One step forward, two steps back – requiring ministerial approval for all forms of non-therapeutic health research with minors. S Afr Med J 2007:97(3):200-202.
12. S v. Collett 1978 (3) SA 206 (RA).
13. Santam Insurance Co v. Vorster 1973 4 SA 764 (A).
14. United Democratic Movement v. President of the Republic of South Africa and Others, (African Christian Democratic Party and Others Intervening; Institute for Democracy in South Africa and Another as amici curiae) (No 2) 2003 (1) SA 495 (CC) para 19.
15. African Dawn Property Finance 2 (Pty) Ltd v. Dreams Travel and Tours CC and Others 2011 (3) SA 511 (SCA) at paragraph 22.
16. Shapiro MH, Spece R.G. Bioethics and the law: Cases, materials, and problems. West, Supplements 1981;118.
17. Kennedy I, Grubb A. Medical Law: Text and Materials. 3rd ed. Durban: Butterworth, 2000:1727.
18. Van Wyk C. HIV preventative vaccine research on children: Is it possible in terms of South African law and research guidelines? Tydskrif vir Hedendaagse Romeins Hollandse 2005;68:35-50.
19. WHO/UNAIDS/AAVP International Expert Group, Osmanov, S. Executive summary and recommendations from WHO/UNAIDS and AAVP consultation on: 'The inclusion of adolescents in HIV vaccine trials'. 16-18 March 2006 in Gaborone, Botswana. AIDS 2007;21(14):W1-W10. [http://dx.doi.org/10.1097/QAD.ob013e3282f086f5]
20. Smit RC. Clinical trials, children and the law. S Afr Med J 1977;2:155.
21. Burchell J. Non therapeutic medical research on children. S Afr Law J 1978;95(part 2):193-216.
22. Republic of South Africa. Department of Health. Ethics in health research: principles, structures and processes, 2004:59. http://ww.doh.gov.za (accessed 1 June 2014).
23. Republic of South Africa. Children's Act, No. 38. Government Gazette 2005; 28944. http://ci.org.za/depts/ci/plr/pdf/bills/childrensAct38-2005.pdf (accessed 2 June 2014).
24. R v. Brown [1993] 2 All ER 75 http://www.cirp.org/library/legal/UKlaw/rvbrown1993// (accessed 1 April 2015).
25. Coyne I. Research with children and young people: The issue of parental (proxy) consent. Children & Society 2010;24:227.

Taylor & Francis
Taylor & Francis Group

Reproductive Health Matters

An international journal on sexual and reproductive health and rights

ISSN: 0968-8080 (Print) 1460-9576 (Online) Journal homepage: https://www.tandfonline.com/loi/zrhm20

Reflecting on adolescents' evolving sexual and reproductive health rights: canvassing the opinion of social workers in KwaZulu-Natal, South Africa

Zaynab Essack, Jacintha Toohey & Ann Strode

To cite this article: Zaynab Essack, Jacintha Toohey & Ann Strode (2016) Reflecting on adolescents' evolving sexual and reproductive health rights: canvassing the opinion of social workers in KwaZulu-Natal, South Africa, Reproductive Health Matters, 24:47, 195-204, DOI: 10.1016/j.rhm.2016.06.005

To link to this article: https://doi.org/10.1016/j.rhm.2016.06.005

REPRODUCTIVE HEALTH matters

Reflecting on adolescents' evolving sexual and reproductive health rights: canvassing the opinion of social workers in KwaZulu-Natal, South Africa

Zaynab Essack,[a] Jacintha Toohey,[b] Ann Strode[c]

a Senior Researcher, KwaZulu-Natal Legislature at the time the data was collected. Honorary Research Fellow at the School of Law, University of KwaZulu-Nata, Senior Research Specialist for the Human and Social Development Programme at the Human Sciences Research Council, Sweetwatres, South Africa. *Correspondence*: zaynab.essack@gmail.com

b Assistant Co-ordinator, HIV AIDS Vaccine Ethics Group, University of KwaZulu-Natal, South Africa

c Senior Lecturer, Faculty of Law, University of KwaZulu-Natal

Abstract: *In South Africa children under the age of 18 are legal minors and considered not fully capable of acting independently. However, in certain defined circumstances the law has granted minors the capacity to act independently, including regarding their sexual and reproductive health (SRH). This study explored the perspectives and practices of 17 social workers from KwaZulu-Natal on legislation relevant to adolescents' evolving sexual and reproductive health and rights and the decriminalisation of consensual underage sex. A key finding was that many social workers have conservative views about adolescent access to SRH advice and services and many were critical of the recent decriminalisation of underage consensual sex. In the main, social workers were concerned that adolescents lack the capacity to make SRH care decisions and that liberal laws promote underage sex rather than protect adolescents. Despite antagonistic views of SRH laws related to adolescents, many social workers felt that they are able to uphold their professional rather than personal views in their work.These findings are important given that a key barrier to adolescent access and uptake of SRH advice and services relates to concerns that they will be judged. Therefore service providers need to be regularly updated on adolescent SRH issues (including rights, laws, and policies) and be engaged in critical thinking about conflicting cultural, moral and personal judgements around adolescent sexuality. Such training should include counselling and communication skills that address issues on confidentiality, adolescents' dignity, privacy and best interests.*

Introduction

Children below 18 years of age are considered vulnerable and deserving of special protections due to their youth, inexperience,[1] and susceptibility to peer pressure, amongst other reasons.[2] In South Africa, children under the age of 18 are legal minors and considered not fully capable of acting independently without the assistance of parents/legal guardians. However, in certain defined circumstances the law has granted minors the capacity to act independently, including regarding their sexual and reproductive health (SRH).[3] Children's sexual and reproductive health and rights (SRHR) are set out in the *Children's Act*, *Choice of Termination of Pregnancy Act*, the *Sterilisation Act* and the *Sexual Offences Amendment Act*. These various legislations provide that children have the right to decide independently whether to confidentially access contraceptives (12 years and older), terminate a pregnancy (at any age, granted that they have sufficient maturity to consent), and access treatment for sexually transmitted infections (STIs), including the diagnosis of HIV status.[3]

Significant progress has been made toward the development and promotion of SRHR for all South Africans.[4] Adolescents, however, remain vulnerable to HIV/AIDs, STIs and pregnancy due to a number of risk factors, including high-risk sexual behaviour, physical and social challenges, and limited access to key primary SRH care services.[5] Although the South African government has developed a more comprehensive adolescent SRHR framework, it is still unclear whether adolescents are able to fully realise these rights. There are also

challenges with the implementation of this framework, including adolescents' right to access information and SRH care services.[6] For these reasons it is timely to reflect on perspectives regarding SRHR of adolescents in South Africa, particularly from service providers who enable access to these rights and services.

Recently, *the Criminal Law [Sexual Offences and Related Matter] Amendment Act, 2007*[7] (hereafter the SORMA) came under constitutional review, specifically regarding sections 15 and 16 which related to consensual sex/sexual activity between 12-16 year olds. Consensual sexual acts ranging from kissing and caressing to sexual penetration were deemed as sexual offences, although some argue that such acts are developmentally normative.[2,8] The constitutional review did not include the age of consent to sex which remains at 16 years old; nor did it address sexual offences related to adults who engage in consensual or non-consensual sex or sexual activity with adolescents below the age of 16, as this is still a crime. The review did not focus on non-consensual sexual conduct of similarly aged adolescents but rather only on consensual sexual conduct of adolescents (12-16 years old) who engage in sexual activity with each other. Under the old law both participants were criminally liable; and in age-discordant couples with more than a two-year age gap between them, engaging in sexual activity, such as kissing, was considered a statutory offence where only the older partner would be charged with a crime.[8] The potential repercussions for adolescents engaging in such behaviours included exposure to the criminal justice system including being reported, charged, arrested, prosecuted and sentenced.[9] Adolescents convicted of a sexual offence would, according to the Act, have their names entered onto the National Register for Sex Offenders, which holds dire implications.[2] Besides the immense stigma and shame associated with being convicted of a sexual offence, there are impacts on future work prospects, including that offenders are prohibited from working with children.

In the matter between the *Teddy Bear Clinic for Abused Children and Prevention of Child Abuse and Neglect (RAPCAN) v Minister of Justice and Constitutional Development* (Case number 73300/10),[10] an application was brought before the Constitutional Court to confirm an order of constitutional invalidity made by the North Gauteng High Court, Pretoria. The constitutional court held that aspects of sections 15 and 16 of the SORMA[7] that criminalised consensual sexual conduct of adolescents aged 12-16, infringed adolescents' constitutional rights to privacy, dignity and bodily integrity.[11] Furthermore, imposing criminal liability for consensual sexual activities amongst adolescents was not in their best interests.[10,11] Consequently, sections 15 and 16 of the SORMA[7] were declared to be inconsistent with the constitution and the offending sections were referred to parliament for amendment.[9–12] In July 2015, the *Criminal Law [Sexual Offences and Related Matters] Amendment Act Amendment Act (No. 5 of 2015)*[13] was signed into law. The amendment decriminalised consensual sexual activity and sexual penetration insofar as it relates to adolescents aged 12-15 who engage in such conduct with each other; and when one child was 12-15 and the other 16-17, granted that there is not more than a two-year age difference between them.[12] Of relevance is that the courts concluded that "adolescents are entitled to explore their sexuality and engage in consensual sexual activities. This 'sexual right' is quite far-reaching and will impact upon the manner in which schools, parents and other adolescent caregivers engage with the issue".[14]

The apparent contradiction in laws impacting on adolescents, the consequences of criminalising consensual underage sex and of imposing mandatory duties on service-providers to report knowledge of sexual activity have been extensively interrogated.[1,11,15,16] Healthcare providers' views on adolescent SRHR and access to services have also been explored in South Africa[17,18] and elsewhere.[19–21] However, to date, there has been little effort to canvas the perspectives of other South African service providers, including social workers, on adolescent-related SRH laws. This qualitative study explored social workers' perspectives on adolescents' evolving SRHR and the decriminalisation of consensual underage sex. As the implementers of relevant legislation, the perspectives of service providers are important since they can help identify gaps and challenges with the law as well as where service delivery can be strengthened through improved policies and/or further provider training.

The urgency of this issue arises because of the high levels of teenage pregnancy and HIV in South Africa. With regard to teenage pregnancy, statistics indicate that 36,702 learners were pregnant in 2010, with KwaZulu-Natal being the province with the highest number of pregnant school-goers (14,340).[22] In 2012 the national household survey found a national HIV prevalence of 7.1% among youth between the ages of 15 and 24 years nationally and 12.0% in KwaZulu-Natal.[23] While sexual

debut of adolescents in South Africa is consistent with international norms and on average occurs between the ages of 17 and 20, 10.9% of youth reported their sexual debut was before they were 15 years old.[23]

Social workers provide core counselling and support services to adolescents and the Department of Social Development has various structured programmes for adolescents that address teenage pregnancy, HIV/AIDS, sexual awareness and youth empowerment. Social workers are a key interface between young people and information regarding health services – therefore, it is important for social workers to both understand the law and bring high quality counseling skills to bear in order to service adolescents' needs. The parliamentary committee responsible for Social Development, which employs South Africa's social workers in the public sector, is tasked with undertaking focused research on targeted priorities. In the period the research was conducted children's issues were identified as a key priority for the Committee. One of the core aspects of the Legislature's oversight mandate relates to the implementation of relevant legislation. Furthermore, at an oversight visit to a Children's Court in KwaZulu-Natal, one of the key challenges reported by staff was with the interpretation and implementation of certain pieces of legislation pertaining to children, particularly in relation to recent amendments to sexual offences legislation. This study was considered as critical in understanding the challenges experienced in implementing laws, for identifying where laws are unclear, for making recommendations for improved legislation and service delivery, including training and capacity building needs.

Methods

Sample, procedure and instruments

Almost 40% of the country's teenage pregnancies among school-going adolescents are in KwaZulu-Natal, hence this study focused on social workers in that province. Seventeen social workers from KwaZulu-Natal were purposively sampled to participate in semi-structured interviews based on their involvement in the care of children. Potential participants were recommended by district managers and invited to participate in a telephone or face-to-face interview (depending on proximity to researchers and/or participant availability).

Interviews were conducted by the researchers between November 2013 and January 2014 and lasted 45 minutes to an hour long. Although most interviewees spoke isiZulu as a first language, interviews were conducted in English as all participants utilise English in the course and scope of their work. All participants provided their informed consent for interviews and the audio-recording thereof. This study received ethical approval from the University of KwaZulu-Natal's Human and Social Sciences Ethics Committee (HSS/0945/013).

In terms of demographic characteristics, 16 interviewees were female and one interviewee was male, all ranging between 26 and 47 years of age. All interviewees were qualified social workers, having completed an undergraduate degree at the minimum (n = 15), with two possessing post-graduate qualifications. Interviewees were selected across rural and urban contexts.

Data were analysed using thematic analysis.[24] Key themes were developed inductively by listening to audio-recorded interviews and summarising each interview. Emerging issues of relevance to the research questions were identified and portions of the interview that illustrated these issues were transcribed verbatim. These emerging issues informed the development of a coding framework, which was refined in team discussions. Interview transcripts were coded according to this framework on QSR NVIVO 10 (a qualitative software package). A sample of transcripts was co-coded by two researchers (ZE & AS) to ensure reliability.

Given the small sample size, social workers' perspectives on adolescent SRHR and the decriminalisation of underage consensual sex may not be representative of all social workers in KwaZulu-Natal or South Africa more broadly. Nevertheless, it is possible that perspectives identified in this study may be identified in the general context of adolescent SRH provision in South Africa.

Results

The following section presents three broad thematic categories; 1) social workers' perspectives on adolescents' evolving SRHR 2) the impact of SRHR laws on social work practices, and 3) managing personal views while meeting legal obligations. Quotes are included to support each of these sub-headings.

Social workers' perspectives on adolescents' evolving SRHR

Laws providing adolescents with the capacity to consent independently to SRH services undermine the age of majority

Most participants disapproved of laws that enable children to independently access SRH services such as terminations of pregnancy, access to contraceptives and HIV testing. Such disapproval was often linked to concerns that adolescents are incapable of making mature and well-considered decisions and therefore should be guided by their parents, for example:

"Personally, I feel that a 12-year old is too young to make such major decisions like the termination of pregnancy. I mean those children they still need the guidance of their parents. I think it's just too much for them to have to do such a major decision… they may make a decision that they will later regret in life when they get older." (P15)

"I think if you are 12 years old you are still a child, so I don't think they should be given rights to get contraceptives or terminate pregnancy at that age. So they shouldn't be indulging themselves into sex at that age. So I think that right and that law should be terminated as well because a child is still a child and up until they reach a certain age of maybe 18." (P10).

"Some of the Acts are also controversial. Just like that if the children are 16 years old, she can do whatever she likes… as far as I'm concerned, a child is still a child until she reaches 18 years old." (P5)

The above extracts suggest that some participants disapproved of adolescent access to a range of SRH services. Generally, these participants do not recognise adolescents' evolving capabilities. In this study the ability to make well-considered, mature decisions, and appreciate the consequences of such decisions, was associated with the crude age of 18. This age has reference to the legal age of majority in South Africa, and many other countries. These social workers did not reflect on the reality of high levels of sexual violence or the possibilities that young women may become pregnant as a result of incest, in which cases the right to access services without parental involvement would be essential. Such issues did not surface in their responses.

Liberal laws promote underage sex

Liberal laws permitting adolescent access to SRH services were seen to promote underage sexual activity, rather than protect adolescents. This was worrying to participants given the high prevalence of HIV and teenage pregnancy among adolescents:

"… it's encouraging them to have sexual intercourse… it's exposing children to a higher risk of HIV and AIDS and also it is destroying the children's future." (P7)

"Ay this law. It's like they are promoting that the children must be involved in sexual offences if they are saying you must take contraceptives at the age of 12, and that you can terminate. It's like the children must do sexual acts at a younger age..." (P4)

Liberal laws were also perceived to result in adolescents not having to take responsibility for their actions. Rather than ensure that adolescents who are involved in underage sex get access to healthcare services, it was argued by one participant that adolescents should face the consequences of their decisions. This appears to be underpinned by contradictory emotions: that is, adolescents are not mature enough to engage in sex but they should be mature enough to deal with the consequences of such activity, without outside intervention:

"…I don't believe children should be given such rights. I feel that children should be children until … they are old enough … [to] make informed decisions … We are promoting them to have sex, to experience more, because they know that I can still get tested for HIV, I can still get a condom, I can terminate pregnancy even if I fall pregnant. I feel it's too much for them. We as the country, I feel, … are failing our children because we are supposed to raise them in such a way that they make informed decisions. Even if a child does something …, which I feel [is] wrong, [for example, when] you find out that the child is engaged in premature sex, that child should be promoted to stop that, rather than being equipped with uh skills on how to [access services]. I feel that if the child has [had] sex, he/she should deal with the consequences so he will know that if I do this, … this is what will happen." (P3)

Some social workers perceived "liberal laws" as barriers to their implementation of services to both adolescents and families. They felt that these laws undermined the social norms by framing access to certain services as rights. It is unclear whether the participants would be opposed to SRHR laws addressing the health needs of

adolescents generally or just the norms in the current South African legal framework.

Liberal laws protect adolescents by increasing access to SRH services

A few participants supported laws enabling adolescents' SRHR. Since the reality is that many adolescents are engaging in underage sex, these laws were perceived to protect adolescents by ensuring access to SRH services:

"I personally think you can't stop them from having sex. You can't look after them 24/7. So I think it's good that they are given the right to go for contraceptives, access HIV services and everything." (P11)

"My professional view is because they are already experiencing with it, this will help. If the child is sexually active, it will help to test." (P3)

This smaller group of participants qualified their support of these laws as based on pragmatic reasons. They, therefore, did not view the legal provisions as reflecting the constitutional rights of children based on their evolving capacity but rather as something born from necessity.

The decriminalisation of underage consensual sex was inappropriate

Most participants were unaware of changes to the law regarding consensual underage sex[15] and very critical of the decriminalisation of underage consensual sex, arguing that these changes promote early sexual debut and activity:

"…my personal view is that children should not be engaged in sex when they are young…now that the law has changed, they will feel it's ok and they've been provided with everything to ensure that they don't get pregnant, even if they do get pregnant, they can abort the baby…they are promoting early sexual behaviour." (P3)

"I'm against it. In looking at the way things are happening. What if the 12-year-old falls pregnant, who's going to be responsible? And a 12 year old, I think that one is doing Grade 7 or Grade 8, I'm not sure and what are we saying?...I am against it due to the consequences." (P9)

"This is a difficult one because I totally disagree with the change, I'm sorry. I do. As much as [I] know that the government is trying to protect the children from criminal charges but it's also creating gaps because at the end of the day the parents…of the minors, they end up suffering because I do know in our community, the community which I work in, there's a high rate of teen pregnancy and you find that the children are left with the grandmothers..." (P12)

Three participants were more ambivalent towards the changes, understanding that it brings the various laws into harmonisation and protects adolescents from the consequences of criminal charges. However, they were also concerned about whether adolescents as young as 12 possess the decision-making capacity to appreciate the consequences of sexual activity:

"Firstly the government was saying that children who are 12 years [old], they can access contraceptives and what not, but if you engage in sex below the age of 16, it is illegal. So the government, because it's already passed these laws, it had to sort of amend [it] 'cause it was contradicting itself." (P13)

The impact of the SRH laws on social work practices

Decriminalisation of underage sex undermines the authority of social workers to counsel adolescents on delaying sexual debut

Some participants objected to the decriminalisation of some forms of underage sex as they felt that criminal sanctions previously served as a deterrent to underage sex and that adolescents do not have the capacity to deal with the consequences of underage sex such as HIV and pregnancy:

"It's encouraging a lot of children to continue with […] sex because it is consensual sex and they are minors… So it's going to [be] encouraging them to do more because they are not going to be arrested, or they are not going to be dealt with accordingly, it's giving them the freedom to do what they like to do." (P7)

This approach contrasts with some of the views set out below in this paper in which the sexual and reproductive rights of adolescents were seen as encroaching into the private realm of families, as here participants were endorsing the use of a state sanction to establish a particular set of sexual norms.

Laws providing adolescents with the capacity to consent independently to SRH services undermine family relationships and complicate interventions

Some participants saw SRH laws as undermining the role of the family, for example:

"Personally I'm not happy and I don't like that…parents must guide their children accordingly." (P17)

While some participants disapproved altogether of adolescent access to a range of SRH services, others just felt that parental involvement in decisions to access SRH services was imperative. Interestingly, it appears that some participants perceived these laws as an over-reach by the state, which in establishing such norms had intruded into a family space by taking away the powers of parents to guide their children.

Managing personal views while meeting legal obligations

Despite the majority of respondents having antagonistic perspectives on adolescent SRH laws, most argued that they are able to manage this conflict between their personal views and practice social work within the liberal prescripts of the law.

"…for me, if I'm at work, I have to take my personal things aside and do according to the Act." (P7)

"I just put … my views and my beliefs behind, you know when I'm at work… I was told that when you are at work, you just implement the laws. You don't interfere and you don't put in your own thinking… you just tell the person what the law says and you just give that direction." (P16)

"…as a social worker we were taught at university that...your professional views are more important that your personal views." (P17)

Some conceded that while the law is considered, values and cultural mores are also important factors. These sometimes conflicting perspectives were noted to be difficult to reconcile and it was considered imperative to acknowledge where personal and professional views differ to ensure that professional views are upheld:

"…it becomes difficult…you have to deal with what the act says and forget what you perceive as wrong." (P14)

"It's very hard especially because I'm working in that community, it's a rural one." (P4)

"No, always we have to put our professional obligation first. I mean, that is something that we learn even at university, to be objective at all times and not to let our personal values interfere with our work. So we have to remain impartial at all times and treat situations objectively… Of course, it is challenging at times, but as I say you are obligated to render the service as required by the law." (P15)

"…my personal view always differs from my professional because as supervisor even if… I don't believe children should be given such rights until they are old enough that they can make informed decisions that they can access such rights." (P3)

It was noted that training at university and frameworks and policies put in place by the Department of Social Development (e.g., structured assessments for probation officers) facilitate compliance. However, one participant articulated that ongoing values training would be imperative for social workers.

Discussion

This study explored social workers' practices and perspectives on legislation relevant to adolescents' evolving SRHR and the decriminalisation of consensual underage sex. It is timely given the recent decriminalisation of underage consensual sex amongst certain categories of adolescents.[12] Furthermore, commentators have identified that several gaps remain regarding the promotion of adolescents' SRHR.[6]

"The understanding and promotion of sexual and reproductive rights are essential in the social work profession".[25] Social workers provide a pivotal entry point for adolescent awareness of SRHR and access to services through schools, healthcare facilities and service offices. This mostly occurs through support, information-sharing and counselling activities. Such in-depth counselling and education provides a valuable adjunct to services offered by healthcare providers who have limited opportunities to discuss in detail or counsel adolescents on SRH services.[17]

Liberal laws promoting access to SRH services and the new less stringent provisions regarding underage consensual sex amongst adolescents were perceived by some participants in a positive light as they are protective of adolescents and bring various laws into harmonisation. However, the majority of participants were very critical of the law. It appeared that most participants did not oppose adolescent sexual and reproductive rights per se, but were concerned that as legal minors, children below the age of 18 are too young and inexperienced to make SRH decisions independently of their parents/guardians. The capacity to consent to SRH services has been a contentious issue that has been considered by the courts in South Africa and abroad. In the case of *Christian Lawyers Association vs Minister of Health and others*,[26] the court held that capacity is an intrinsic element of consent and a child without capacity cannot consent to a

health intervention even if the legislature has set an age at which they are presumed to have capacity. However, determination of the capacity to consent to sex is based on age rather than decision-making capacity.[27] Mackenzie and Watts[27] use examples of children's capacity to consent to medical treatment, to argue that "some children under sixteen may be able to understand and to consent to some sexual acts". This latter position appears to be consistent with those of the courts and policymakers regarding the decriminalisation of underage consensual sex among adolescent peers.

Socio-cultural taboos around discussing sex and sexuality with minors and general stigma attached to youth sexuality, may contribute to concerns that laws promoting access to SRHR and services promote promiscuity.[17] Social workers in this study were concerned that adolescents may not have the cognitive capacity to appreciate the consequences of their decisions and that SRH laws may promote immoral behaviour. Likewise, Buthelezi and Bernard[28] noted that the court judgement is likely to be criticised by various sectors of society as promoting adolescent sexual promiscuity, largely due to an inadequate understanding of the judgement. A key concern for participants was whether the decriminalisation of underage sex eliminates a state enforced penalty for "inappropriate" behaviour. This leads to broader questions about the role, if any, of the criminal law in enforcing morally-based sexual norms. It may also reflect the complexities faced by social workers who may experience difficulties in finding novel ways to encourage adolescents to delay sexual debut when there is no sanction attached to such behaviour. Social workers appeared to favour criminal sanctions simply because it meant that there would be consequences for reckless behaviour. Nevertheless, "while one may be morally opposed to two teenagers having sexual relations with each other, 'sex' is not the proper area for expansive legislation on morality. There is a fine line between immorality and criminality".[2] Such concerns also reflect the lack of understanding of the amendments to the SORMA[7] which have not altered the age of consent to sex, which remains at 16. This means that social workers do still have the moral authority of the law when counselling adolescents on delaying sexual debut.

Furthermore, many may oppose the judgement from a morality standpoint in that underage sex may amplify risks of pregnancies, HIV and other STIs.[2] Similar sentiments were identified by participants in this study, many of whom work in contexts where the discussion of sex and sexuality with adolescents is considered taboo.[29] Previous research conducted in a rural community in KwaZulu-Natal found that discussions about sex between younger and older people are largely prohibited, outside certain cultural contexts such as rites of passage (puberty or preparation for marriage).[29] Given that such discussions would be essential in social work practice, it is not surprising that many social workers frowned on adolescents' expanding SRHR.

Such paternalistic views, however, are not in keeping with empirical research which indicates that restrictive laws may be counter to the best interests of children as they create significant barriers to adolescents' willingness and ability to access formal information, advice and SRH services that are crucial to healthy and autonomous decision-making about sex.[30] The criminal law is not an effective or ethical means to deter adolescents from engaging in sex,[31] especially since it is unlikely that adolescents are even aware that sexual conduct with peers could warrant criminal sanction.[32]

Access to advice, information and SRH services is critical for the promotion of healthy sexual behaviours among adolescents. However, research has identified several barriers to the uptake of such services, including concerns about confidentiality and judgemental attitudes of service providers.[19,29] Previous ambiguities across SRH laws relevant to adolescents, limited their ability to access confidential SRH services by imposing legal obligations on service providers to report underage consensual sex and sexual activity to the authorities.[29] Importantly, decriminalisation of underage consensual sex brings various laws into harmonisation and removes the blanket mandatory reporting obligation placed on service providers, particularly where it created a conflict in terms of confidentiality requirements and obligations to report peer-related consensual sexual activity disclosed by adolescents.[15]

Research suggests that the personal values and perspectives of services providers may also affect accessibility, uptake and quality of services.[21] Like nurses offering adolescent SRH services,[21] social workers are at a critical juncture between conservative community values about adolescent sexuality and the reality of adolescent sexuality. Findings from this study that many social workers have conservative views on teenage sexuality coalesce with research indicating that the fear of being judged, reprimanded or asked difficult questions by providers is a key barrier to acceptability and uptake of SRH services.[17,19,20,29] In addition, social workers' reported

limited knowledge on SRH laws for children.[15] This suggests that they may be unable to navigate between ensuring that their clients are knowledgeable about the law and providing appropriate sexuality communication to help clients clarify their own needs, sexual and reproductive desires, and capacities to protect their own health.

Social workers in this study reported that despite having strong personal views against "permissive" laws, they are able to implement the laws in their work with adolescents. However, it is not impossible for providers to unwittingly or otherwise, prioritise their personal views over their legal obligations – as has been demonstrated elsewhere.[32,33] Furthermore, social workers considered a multitude of factors when deciding to report underage consensual sex, despite the law at the time being unequivocal that all cases should be reported,[15] suggesting that it may not always be the law that prevails in decision-making.

Conclusion

This study found that most participants were critical about the enabling laws for adolescents to independently access SRH services and of the amended law that decriminalised consensual underage sex. Only a few participants agreed that the liberal laws protected adolescents who are sexually active to access necessary SRH services. Given that judgemental perspectives of providers are a major disincentive to access SRH information and services, it is critical that social workers who deal with children receive continuing education on adolescent sexuality and reproduction, on evolutions in relevant laws and on sexuality counselling being about enabling clients to explore their own feelings and plan what actions they will take. Research has shown that healthcare providers with higher levels of education adopt a more youth-friendly approach, as do those who have received further training on adolescent SRHR.[21] This research echoes previous recommendations[21] that undergraduate social work programmes should promote critical thinking about the cultural and moral dimensions to help providers better deal with adolescent sexuality. Specifically, providers should be frequently updated on SRH issues, relevant legislation, confidentiality, adolescents' dignity, privacy and best interests, sexual and reproductive rights, and communication and counselling skills.[19] Such training should clearly detail the rationale for laws and include values training so that social workers are able to carry out their duties devoid of personal value-laden judgments. Key stakeholders, including social workers and other providers who enable access to adolescent SRH services, should be engaged in critical thinking about conflicting cultural, moral and personal judgments around adolescent sexuality.

Acknowledgements

This study was undertaken as part of the oversight activities of the Social Development Portfolio Committee at the KwaZulu-Natal Legislature. The views expressed in this paper do not necessarily reflect those of the Social Development Portfolio Committee or the KwaZulu-Natal Legislature. Sincere thanks go to all the participants and to Dr Ngcongo of the Department of Social Development for assistance with access to social workers.

References

1. Strode A, Slack C. Sex, lies and disclosures: Researchers and the reporting of under-age sex: opinion. Southern African Journal of HIV Medicine, 2009;10(2):8–10.
2. Stevens P. Decriminalising consensual sexual acts between adolescents within a constitutional framework: The Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Others Case: 73300/10 [2013] ZAGPPHC 1 (4 January 2013). South African Journal of Criminal Justice, 2013;26(1):41–54.
3. Strode A, Slack C, Essack Z. Child consent in South African law: Implications for researchers, service providers and policy-makers. South African Medical Journal, 2010;100(4):247–249.
4. Ramkissoon A, Searle C, Burns C, et al. Sexual and reproductive health and rights. South African Health Review, 2010:33–47.
5. Beksinska ME, Pillay L, Milford C, et al. The sexual and reproductive health needs of youth in South Africa-history in context. South African Medical Journal, 2014;104(10):676–678.
6. Department of Social Development (DSD). National Adolescent Sexual and Reproductive Health and Rights Framework Strategy. 2015. Available from http://www.dsd.gov.za/index2.php?option=com_docman&task=doc_view&gid=578&Itemid=39 [Accessed 9th August 2015].

7. Criminal Law [Sexual Offences and Related Matter] Amendment Act 32 of 2007
8. Gevers A, Mathews C, Cupp P, et al. Illegal yet developmentally normative: a descriptive analysis of young, urban adolescents' dating and sexual behaviour in Cape Town, South Africa. BMC International Health and Human Rights, 2013;13(1):31.
9. Jamieson L, Proudlock P, Nhenga-Chakarisa T. Legislative developments in 2011/2012. Available from http://scholar.google.co.za/scholar?q=jamieson+Legislative+developments+in+2011%2F2012&btnG=&hl=en&as_sdt=0%2C5 [Accessed 20th February 2014].
10. Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another 2013 (12) BCLR 1429 (CC).
11. Strode A, Toohey J, Slack C, et al. Reporting underage consensual sex after the Teddy Bear case: A different perspective. South African Journal of Bioethics and Law, 2013;6(2):45–47.
12. Bhamjee S, Essack Z, Strode AE. Amendments to the Sexual Offences Act dealing with consensual underage sex: Implications for doctors and researchers. South African Medical Journal, 2016;10(3):256–259.
13. Criminal Law [Sexual Offences and Related Matter] Amendment Act Amendment Act No. 5 of 2015.
14. Lutchman S. 'Child savers 'v' kiddie libbers': the sexual rights of adolescents. South African Journal on Human Rights, 2014;30(3):555–571.
15. Essack Z, Strode A. The mandatory reporting of consensual, underage sex: Knowledge, practices and perspectives of social workers in KwaZulu-Natal. South African Journal of Bioethics and Law, 2015;8(2):21–25.
16. McQuoid-Mason DJ. Decriminalisation of consensual sexual conduct between children: What should doctors do regarding the reporting of sexual offences under the Sexual Offences Act until the Constitutional Court confirms the judgement of the Teddy Bear Clinic case? South African Journal of Bioethics and Law, 2013;6(1):10–12.
17. Alli F, Maharaj P, Vawda MY. Interpersonal relations between health care workers and young clients: Barriers to accessing sexual and reproductive health care. Journal of Community Health, 2013;38(1):150–155.
18. Wood K, Jewkes R. Blood blockages and scolding nurses: barriers to adolescent contraceptive use in South Africa. Reproductive Health Matters, 2006;14(27):109–118.
19. Kennedy EC, Bulu S, Harris J, et al. "Be kind to young people so they feel at home": a qualitative study of adolescents' and service providers' perceptions of youth-friendly sexual and reproductive health services in Vanuatu. BMC Health Services Research, 2013;13(1):455.
20. Tilahun M, Mengistie B, Egata G, et al. Health workers' attitudes toward sexual and reproductive health services for unmarried adolescents in Ethiopia. Reproductive Health, 2012;9(1):19.
21. Warenius LU, Faxelid EA, Chishimba PN, et al. Nurse-midwives' attitudes towards adolescent sexual and reproductive health needs in Kenya and Zambia. Reproductive Health Matters, 2006;14(27):119–128.
22. Department of Basic Education. Annual Schools Surveys: Report for Ordinary Schools 2010 and 2011. 2013. Available from http://www.education.gov.za/LinkClick.aspx?fileticket=TAaLF9pu6JU%3D&tabid=57&mid=2632 [Accessed 21 March 2016].
23. Shisana O, Rehle T, Simbayi LC, et al. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: HSRC Press, 2014 . Available from http://heaids.org.za/site/assets/files/1267/sabssm_iv_leo_final.pdf [Accessed 5 May 2014].
24. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology, 2006;3(2):77–101.
25. Alzate MM. The role of sexual and reproductive rights in social work practice. Affilia, 2009;24(2):108–119.
26. *Christian Lawyers Association v. Minister of Health* 2005 1 SA 509 (T)
27. Mackenzie R, Watts J. Capacity to consent to sex reframed: IM, TZ (no 2), the need for an evidenced-based model of sexual decision-making and socio-sexual competence. International Journal of Law and Psychiatry, 2015;40:50–59.
28. Buthelezi MC, Bernard RB. The court knows the law. Journal of South African Law, 2014;3:625–639.
29. Yarrow E, Anderson K, Apland K, et al. Can a restrictive law serve a protective purpose? The impact of age-restrictive laws on young people's access to sexual and reproductive health services. Reproductive Health Matters, 2014;22(44):148–156.
30. Franklin J. Where Art Thou, Privacy: Expanding Privacy Rights of Minors in Regard to Consensual Sex: Statutory Rape Laws and the Need for a Romeo and Juliet Exception in Illinois. The John Marshall Law Review, 2012;46:309–332.
31. Meiners-Levy S. Challenging the Prosecution of Young Sex Offenders: How Developmental Psychology and the Lessons of Roper Should Inform Daily Practice. Temple Law Review, 2006;79:499–514.
32. Essack Z, Strode A. "I feel like half a woman all the time": The impacts of coerced and forced sterilisations on HIV-positive women in South Africa. Agenda, 2012;26(2):24–34.
33. Strode A, Mthembu S, Essack Z. "She made up a choice for me": 22 HIV-positive women's experiences of involuntary sterilization in two South African provinces. Reproductive Health Matters, 2012;20(39):61–69.

Résumé
En Afrique du Sud, les enfants de moins de 18 ans sont mineurs aux yeux de la loi qui considère qu'ils ne sont pas en possession de la pleine capacité d'agir indépendamment. Néanmoins, dans certaines circonstances définies, la loi donne aux mineurs la capacité d'agir indépendamment, notamment concernant leur santé sexuelle et génésique. Cette étude a abordé les perspectives et pratiques de 17 travailleurs sociaux du KwaZulu-Natal sur l'évolution de la législation applicable aux droits des adolescents dans le domaine de la santé sexuelle et génésique et la dépénalisation des rapports sexuels avec des mineurs. L'une des principales conclusions est que beaucoup de travailleurs sociaux ont des idées conservatrices sur l'accès des adolescents aux conseils et services de santé sexuelle et génésique et beaucoup n'approuvaient pas la récente dépénalisation des relations sexuelles consensuelles avec des mineurs. Dans l'ensemble, ils craignaient que les adolescents ne soient pas capables de prendre des décisions dans ce domaine et que les lois libérales encouragent les relations sexuelles précoces au lieu de protéger les adolescents. Malgré leur opposition aux lois de santé sexuelle et génésique relatives aux adolescents, beaucoup de travailleurs sociaux pensaient qu'ils pouvaient défendre leurs idées professionnelles plutôt que personnelles au travail. Ces résultats sont importants car un obstacle majeur qui entrave l'accès des adolescents aux conseils et services de santé sexuelle et génésique et leur utilisation est la crainte d'être jugés. Il faut donc informer régulièrement les prestataires de services des questions relatives à la santé sexuelle et génésique des adolescents (notamment les droits, les lois et les politiques) et ces acteurs centraux doivent prendre part à une réflexion critique sur les jugements culturels, moraux et personnels conflictuels autour de la sexualité des adolescents. Cette formation devrait inclure des compétences sur les conseils et la communication qui abordent la question de la confidentialité, la dignité des adolescents, le respect de leur vie privée et leur intérêt supérieur.

Resumen
En Sudáfrica los niños de menos de 18 años son menores de edad y considerados no totalmente capaces de actuar independientemente. Sin embargo, en ciertas circunstancias definidas, la ley ha otorgado a los menores la capacidad para actuar independientemente, incluso con relación a su salud sexual y reproductiva (SSR). Este estudio exploró las perspectivas y prácticas de 17 trabajadores sociales de KwaZulu-Natal sobre la legislación pertinente a los derechos evolutivos de SSR de la adolescencia y la despenalización del sexo consensual por menores de edad. Un hallazgo clave fue que muchos trabajadores sociales tienen puntos de vista conservadores acerca del acceso de adolescentes a consejos y servicios de SSR, y muchos criticaron la reciente despenalización del sexo consensual por menores. En general, a los trabajadores sociales les preocupaba que la adolescencia carece de la capacidad para tomar decisiones sobre servicios de SSR y que las leyes liberales promueven las relaciones sexuales de menores en lugar de proteger a la adolescencia. A pesar de puntos de vista antagonistas acerca de las leyes sobre SSR relacionadas con adolescentes, muchos trabajadores sociales creían que podían defender sus puntos de vista profesionales, y no personales, en su trabajo. Estos hallazgos son importantes, ya que una de las principales barreras al acceso de adolescentes a consejos y servicios de SSR, y su aceptación de estos, está relacionada con inquietudes de que serán juzgados. Por lo tanto, los prestadores de servicios deben ser actualizados con regularidad sobre asuntos de SSR de adolescentes (incluidos los derechos, leyes y políticas relacionados con SSR) y se debe motivar a estos actores clave a que piensen de manera crítica sobre prejuicios culturales, morales y personales conflictivos respecto a la sexualidad en la adolescencia. Este tipo de capacitación debe incluir habilidades de consejería y comunicación que aborden asuntos de confidencialidad, dignidad, privacidad y los intereses superiores de adolescentes.

MEDICINE AND THE LAW

Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa

A E Strode,[1,2] LLM, PhD; **J D Toohey**,[2] LLB; **C M Slack**,[2] MA Clin Psyc, PhD

[1] *School of Law, University of KwaZulu-Natal and member of the HIV/AIDS Vaccines Ethics Group, School of Applied Human Sciences, University of KwaZulu-Natal, Pietermaritzburg, South Africa*

[2] *HIV/AIDS Vaccines Ethics Group, School of Applied Human Sciences, College of Humanities, University of KwaZulu-Natal, Pietermaritzburg, South Africa*

Corresponding author: *A Strode (strodeA@ukzn.ac.za)*

With millions of adolescents becoming infected with HIV globally, it is essential that barriers to much-needed interventions are reduced for at-risk adolescents. In this article we review the legal and policy framework in South Africa for adolescent access to male circumcision. We are of the view that the framework does confer protection for adolescent boys while enabling access to male circumcision; however, we identify ambiguities and tensions that exist between the Children's Act, regulations and national guidelines. We recommend reform to further enable access by this vulnerable group to this prevention modality.

S Afr Med J 2016;106(12):1173-1176. DOI:10.7196/SAMJ.2016.v106i12.11215

There are many valid religious, cultural and public-health benefits to male circumcision. In South Africa (SA), it is often practised for religious reasons (generally performed shortly after the birth of a baby boy) or as part of cultural initiation practices (adolescent boys). Recently, there has been increased attention to male circumcision for another purpose, that of reducing the risk of HIV infection.[1,2] Clinical trials have demonstrated that male circumcision is an effective strategy to reduce the risk of HIV transmission from HIV-positive women to uninfected men.[1,2] Male circumcision is a key component of SA's national strategic plan.[3]

Many parents or legal guardians may elect to have boys in their care circumcised, and older boys themselves may wish to be circumcised; however, some human rights concerns have been raised regarding the practice. Firstly, how can children be protected from possible adverse consequences, such as botched cultural circumcisions?[4] Secondly, how can the bodily integrity and autonomy rights of young boys be promoted, given that their parents or legal guardians may make the decision on their behalf in many instances? Thirdly, how can the involvement of older children in such decisions be facilitated where this is appropriate?[5]

Male circumcision of boys under 18 years is regulated by the Children's Act (No. 58 of 2005) – hereafter referred to as the Act.[6] The procedures that should be followed to implement these provisions are detailed in the General Regulations Regarding Children of 2010 (hereafter referred to as the Regulations).[7] This creates a protective, normative framework for when and how circumcisions may take place involving boys under 18.[6] The legislative framework is to be read with the National Department of Health (NDoH)'s national guidelines, which address medical male circumcision performed under local anaesthetic.[8] A critical question is whether and to what extent this legal and policy framework facilitates medical male circumcisions of adolescent boys. This article describes the legal and policy framework, and critically reviews the approach it takes. It concludes with recommendations for law and policy reform to ensure better access to this valuable HIV-prevention tool for this at-risk group.

Legal and policy framework for medical male circumcision of boys under 18

The Act deals expressly with male circumcision of boys under 18 by providing when and how it may take place.[6] There are several protections for all male children, as well as some additional restrictions for boys under 16 who have less legal capacity.[6] The Act's approach is guided by two broad principles: *(i)* that 'every child has the right not to be subjected to social, cultural and religious practices that are detrimental to his/her well-being'[6] (this includes the right, in certain circumstances, to choose not to be circumcised);[6] and (*ii*) that a child, depending on his/her age, maturity and stage of development, has the right to participate in any matter concerning him/her.[6]

Circumcision of boys over 16 but under 18 years of age

Reason

The Act allows 16- and 17-year-old boys to be circumcised *for any reason* provided several requirements are met.

Consent

The Act requires that a 16- or 17-year-old boy must have consented (in the prescribed manner) to his own circumcision.[6] The boy has the right to refuse to be circumcised.[6] This clearly indicates that the drafters of the Act intended boys of 16 and over to be able to consent independently to a circumcision, regardless of the method used. For circumcision for cultural reasons, this consent should be documented using a form supplied in the Regulations.[9] If the circumcision is being done for another reason, there is no official form that must be used to record the consent. We hold this to mean that, generally, there is no requirement in the Act for parental involvement in the circumcision of boys aged 16 and 17.[10,11]

However, if the circumcision is being done for social-cultural reasons, or for medical reasons and is being performed under local anaesthetic, then the Regulations and the national guidelines,

respectively, introduce parental involvement. More specifically, where circumcision is being done for *social or cultural reasons*, Form 2 of the Regulations provides that the parent or legal guardian should sign the circumcision consent form to confirm that they have 'assisted' the child in making the decision, and that the boy is over 16 and has capacity to understand the risks and benefits of the procedure. More specifically, where circumcision is being done for *medical reasons* and is being performed under local anaesthetic, the NDoH guidelines do not clearly state that over-16s can provide self-consent (without parental involvement),[8] and the rationale given in the guidelines about the consent approach seems anchored in consent for treatment or, alternatively, consent for surgery at various places in the document, which is confusing for those trying to apply the guidelines.

Counselling

The Act requires that 16- or 17-year-old boys must have been given 'proper' counselling.[6] The Regulations provide that if the circumcision is for social or cultural reasons, then the counselling should be provided by a parent, legal guardian or a person providing social services.[7]

Prescribed manner

The Act requires that 16- or 17-year-olds must be circumcised in the manner prescribed.[6] The Regulations only set out norms for procedures to be followed for social or cultural circumcision,[7] namely that it must be performed in accordance with the accepted cultural practices of that boy.[7] Furthermore, it must be done by a medical practitioner or person with knowledge of the social or cultural practice, who is properly trained to conduct such circumcisions.[7] The national guidelines also detail the procedures and equipment that should be used for a medical circumcision.[8] For a social or cultural circumcision, the person performing the procedure must use the prescribed equipment, including sterilisation and universal infection control procedures.[7]

Table 1 outlines the existing norms. If we apply these norms to the issue of 16- and 17-year-old boys wishing to access medical male circumcision for HIV prevention, there is no potential 'reason' barrier because any reason for circumcision is acceptable. However, there is potential conflict about the consent process because the Act has a self-consent approach that allows 16- and 17-year-old boys to consent independently, whereas the national guidelines for medical circumcision involving local anaesthetic appear to introduce parental involvement in the decisions of 16- and 17-year-olds. We argue that the Act should prevail over the policy.

Boys must receive counselling before the circumcision. The Act requires 'proper' counselling but no detail is provided on who should provide this service or its content. Nevertheless, there is some practical guidance in the national guidelines on the purpose and the issues that should be raised during counselling.[8] These include helping clients to identify their HIV risk, exploring the benefits of knowing one's HIV status and ensuring they know circumcision may not provide full protection against HIV acquisition;[8] therefore, persons involved in offering male circumcision for HIV prevention should include these topics in counselling.

The circumcision of boys under 16 years

Reason

The Act prohibits male circumcision of boys under 16 unless it can be shown that the circumcision will be performed for 'religious' purposes or 'medical' reasons.[6] The Act does not expressly refer to, or define, cultural circumcisions[12] (even though the former provisions are all under the sub-heading of 'social, cultural and religious practices'). This omission implies that boys should only be circumcised for a cultural reason when they reach the age of 16.[13]

The circumcision of boys under 16 for 'religious purposes'

Reason

The Act does not define the term 'religious purposes', yet it provides that such circumcisions be carried out in accordance with the *practices* of that religion.[6] The Regulations state further that such a circumcision must be part of the *doctrines* of that religion.[7] Neither the Act nor the Regulations define the term 'religious doctrine' but dictionary definitions are available.[12]

Consent

The Regulations (in 6(3)) provide further that religious circumcision with under-16s must be undertaken with the consent of both parents or guardians, and documented on Form 3 of the Regulations.

Other

In addition, such circumcisions must be performed by a medical practitioner or a person from that religion, who has been trained to perform such circumcisions, and carried out using the prescribed equipment, sterilisation and universal infection-control procedures.[7]

The circumcision of boys under 16 for 'medical reasons'

Reason

The Act does not define the term 'medical reasons' but it is assumed that the rationale is to address either an immediate health condition such as a urinary tract infection,[8] or a condition the child may be at risk for in the future, such as HIV infection, other sexually transmitted infections, genital cancers and balanitis.[1,8]

Table 1. Existing norms for male circumcision of 16- and 17-year-old boys

Reason	Consent to be provided by	Procedure performed by	Requirements for the procedure
Any reason	Boy himself (age 16 - 17) (CA[6]); and documented on Form 2 (Regulations[9])	Not prescribed (Regulations[7])	Not prescribed (Regulations[7])
Social or cultural practice	Boy himself (age 16 - 17) (CA[6]); 'assisted' by parent or guardian and documented on Form 2 (Regulations[9])	Trained practitioner (Regulations[7])	Prescribed equipment (Regulations[7])
Medical	Boy himself (age 16 - 17) (CA[6]); parent or legal guardian if regarded as surgery (NDoH guidelines[8])	Medical practitioner (NDoH guidelines[8])	Detail (NDoH guidelines[8])

CA = Children's Act.

Consent

The Act does not specifically state who should provide consent for circumcisions of boys under 16 when they are done for medical reasons.[13] The Regulations also do not give any further details on this issue, or provide any accompanying form to be completed to document the consent process. This creates some ambiguity. However, we submit that useful guidance is implied in the Act, which provides that over-16s provide independent consent, therefore implying that under-16s need proxy consent.[14] Furthermore, the medical procedure used could provide some direction on the consent norms. If circumcision is considered an invasive surgical procedure performed under local anaesthetic, i.e. an 'operation' (as in fact it is defined by the national guidelines[8]), then the norms in the Act would be that the 'assistance' of a parent or legal guardian is required in addition to the consent of persons from the age of 12.[6,13]

Other

'Medical' circumcisions must be done on the recommendation of a medical practitioner.[6] The Regulations do not detail how such medical circumcisions should be done, but this is detailed in the NDoH guidelines.[8]

Table 2 summarises the norms for circumcision of boys under 16. If we apply these norms to the issue of under-16-year-old boys wishing to access medical male circumcision for HIV prevention, it is important to recognise that adolescents should ideally have access to HIV-prevention tools before sexual debut, which makes younger adolescents a key sub-sample for accessing circumcision. We argue that HIV prevention is a valid medical reason for a circumcision. Other commentators have also asserted that the term 'medical reasons' is broad enough to include HIV prevention.[15] In contrast, McQuoid-Mason[16] has argued that a circumcision has to be for a current medical reason and not a possible future one. We recommend following Vawda and Maqutu's[15] approach because, given the severity of the HIV epidemic and the HIV risk adolescents face, taking steps to minimise such risk is a critical health issue.[13] If circumcision is to be offered to boys under 16 as part of HIV-prevention strategies, then the health reason for the circumcision should be documented, i.e. to lower their current or future risk of HIV infection. A parent or guardian should give permission for medical circumcisions for boys under 16, as implied by the Act. National guidelines could be consulted for the form to be used. National guidelines should be consulted for how to implement the procedure.

Conclusions

There is a protective framework for male circumcision of adolescent boys. There are more restrictions on 'religious' and 'cultural' circumcisions for boy children than on 'medical' circumcisions, perhaps because the former are done at birth when child participation principles cannot be applied, and the latter because of the adverse consequences observed each year.[4]

However, tensions and ambiguities remain in this protective framework. Roll-out of medical male circumcision may be even further facilitated if these were addressed. We recommend some reforms to strengthen the framework to facilitate access by at-risk adolescents in SA to this one component of a comprehensive portfolio of HIV-prevention options.

Regarding consent

HIV-prevention providers trying to ensure access for boys aged 16 and 17 may experience confusion about whether to seek consent from the adolescent alone, or to seek involvement from a parent as well. This is because the Act implies self-consent and the national guidelines imply parental involvement. Adopting a parental consent approach may deter some 16- and 17-year-olds from seeking this prevention service. The **national guidelines** should be revised to be much clearer about the consent approach, and should mirror the consent approach implied in the Children's Act (i.e. self-consent at 16, parental consent for under-16s). Also, HIV-prevention providers trying to ensure access for boys aged 12 - 15 may be uncertain of the consent procedures. For under-16s, **the Act or Regulations** should spell out which adults are required to consent for health-related circumcisions, and include a form designed to document this.

Regarding reasons

All HIV-prevention providers may breathe more easily if it were understood that HIV prevention is a legitimate health reason for male circumcision.[13] Also, we recommend that the **Regulations** should specify the minimum standards that should be followed in the procedure so as to ensure that medical circumcisions are treated equally to those done for religious or cultural reasons.[13] The **Regulations** should also include a form specifically designed to document consent to circumcision for a health reason. Lastly, we recommend that the **national guidelines**[8] should provide that HIV prevention is a valid medical reason for circumcision of boys under 16.[13]

With 2.1 million adolescents infected with HIV globally,[17] and adolescents showing some of the highest incidence rates in the world,[18] it is essential that any barriers hindering access to prevention modalities be addressed – including possible legal/policy barriers. In SA, we hope that amendments to the legal and policy framework could further expand access by this much-affected group to a much-needed intervention in the form of male circumcision.

Table 2. Existing norms for male circumcision of boys under 16 years of age

Reason	Consent to be provided by	Procedure performed by	Requirements for the procedure
Religious purposes as it is part of the religious doctrines of that religion (CA[6])	Both parents/guardians documented on Form 3 (Regulations[7])	Medical practitioner or trained person from that religion (Regulations[7])	Using prescribed equipment (Regulations[7])
Medical reasons (CA[6])	A parent/ guardian (implied by CA[6]) *'With the assistance of a parent/guardian and with the consent of a boy child himself if over 12 (alternatively with the consent of the parent/ guardian* if under 12) (applying norms of the CA for 'operations')	Specified (NDoH guidelines[8])	Specified (NDoH guidelines[8])
Any other reason (CA[6])	Circumcision is prohibited (CA[6])	Procedure is prohibited	Procedure is prohibited

Acknowledgements. This article was made possible by funding from award number 1RO1 A1094586 from the National Institutes of Health (NIH) entitled CHAMPS (Choices for Adolescent Methods of Prevention in South Africa). The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH, or the views of any council or committee with which the authors are affiliated. Many thanks also to Mr Amin Matola for assistance with referencing and formatting.

1. Auvert B, Taljaard D, Lagarde E, et al. Correction: Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial. PLoS Med 2006;3(5):e226. http://dx.doi.org/10.1371/journal.pmed.0030226
2. Weiss HA, Quigley MA, Hayes RJ. Male circumcision and risk of HIV infection in sub-Saharan Africa: A systematic review and meta-analysis. AIDS 2000;14(15):2361-2370.
3. National Department of Health, South Africa. National Strategic Plan on HIV, STIs and TB 2012 - 2016. Pretoria: NDoH. http://www.gov.za/documents/national-strategic-plan-hiv-stis-and-tb-2012-2016 (accessed 29 February 2016).
4. Child Rights International Network (CRIN). South Africa: Clamping down on botched circumcisions, 2007. https://www.crin.org/en/library/news-archive/south-africa-clamping-down-botched-circumcisions (accessed 21 December 2015).
5. Svoboda JS. Circumcision of male infants as a human rights violation. J Med Ethics 2013;39(7):469-474. http://dx.doi.org/10.1136/medethics-2012-101229
6. South Africa. Children's Act No. 38 of 2005. Government Gazette No. 28944, 2005. http://www.plusto.com/uploads/5780/docs/Childrens-Act.pdf (accessed 29 February 2016).
7. South Africa. Children's Act No. 38 of 2005. Regulations: General Regulations Regarding Children. Pretoria: Government Gazette No. 33076, Notice No. 261, 2010.
8. National Department of Health, South Africa. South African National Guidelines for Medical Male Circumcision under Local Anaesthesia (2010). Pretoria: NDoH, 2010.
9. South Africa. Children's Act No. 38 of 2005. Regulations: General Regulations Regarding Children. Form 2. Pretoria: Government Gazette No. 33076, Notice No. 261, 2010.
10. Strode A, Slack C, Essack Z. Child consent in South African law: Implications for researchers, service providers and policy-makers. S Afr Med J 2010;100(4):247-249.
11. Strode A, Slack C, Essack Z. Child consent in South African law: Implications for researchers, service providers and policy-makers (Letter to the Editor). S Afr Med J 2011;101(9):604-606.
12. The Free Dictionary - Medical Dictionary. http://medical-dictionary.thefreedictionary.com/medical+treatment (accessed 21 December 2015).
13. University of Washington. Department of Global Health. AIDS Law Brief Background Paper: Age of Consent to Voluntary Male Medical Circumcision in South Africa. June 2015. Seattle: University of Washington, 2015.
14. Strode A, Slack C. Child research in South Africa: How do the new regulations help? S Afr Med J 2015;105(11):899-900. http://dx.doi.org/10.7196/SAMJ.2015.V105I11.9838
15. Vawda YA, Maqutu LN. Neonatal circumcision – violation of children's rights or public health necessity? S Afr J Bioethics Law 2011;4(1):36-41.
16. McQuoid-Mason DJ. Is the mass circumcision drive in KwaZulu-Natal involving neonates and children less than 16 years of age legal? What should doctors do? S Afr Med J 2013;103(5):283-284. http://dx.doi.org/10.7196/SAMJ.6701
17. World Health Organization. Maternal, newborn, child and adolescent health: Adolescent development. Geneva: WHO, 2016. http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en (accessed 29 February 2016).
18. Bekker L-G, Gill K, Wallace M. Pre-exposure prophylaxis for South African adolescents: What evidence? S Afr Med J 2015;105(11):907-911. http://dx.doi.org/10.7196/SAMJ.2015.v105i11.10222

Accepted 19 October 2016.

Unpacking the 2-year age-gap provision in relation to the decriminalisation of underage consensual sex in South Africa

Z Essack,[1,2,3] MSocSci (Research Psychol), PhD; **J Toohey**,[1,3] LLM (Medical Law)

[1] *HIV/AIDS Vaccines Ethics Group (HAVEG), University of KwaZulu-Natal, Pietermaritzburg, South Africa*
[2] *Human and Social Development Programme, Human Sciences Research Council, Pretoria, South Africa*
[3] *School of Law, University of KwaZulu-Natal, Pietermaritzburg, South Africa*

Corresponding author: *Z Essack (zessack@hsrc.ac.za)*

Over the past 24 years, the South African criminal justice system has undergone major transformations in relation to sexual offences, including sexual violence against children. More recently, there have been a number of developments to certain provisions in the law relating to sexual offences involving children. In response to the Teddy Bear Clinic Court Case and Constitutional Court ruling, sexual offences legislation related to underage consensual sex was amended. In this regard, the legislation now decriminalises underage consensual sexual activity between adolescent peers aged 12 - 15-year-olds. In addition, the law provides broader definitions for consensual sexual activity, including decriminalising consensual sex and sexual activity between older adolescents (above age of consent for sex, i.e. 16 - 17-year-olds) and younger adolescents (below the age of consent for sex, i.e. 12 - 15-year-olds), granted that there is no more than a 2-year age gap between them. One of the reasons for decriminalising consensual sexual activities between adolescent peers was because the expanded legislation cast the net for sexual offences so wide that the effects had far-reaching harmful impacts, particularly for girls, who would then be exposed to the criminal justice system. This paper focuses on unpacking the 2-year age-gap provision in SA legislation relative to selected better-resourced countries, including the rationale and the potential implications for adolescents (outside of the 2-year age gap provisions), for researchers, service providers and policy-makers. It concludes with some recommendations for law reform and further research.

S Afr J Bioethics Law 2018;11(2):85-88. DOI:10.7196/SAJBL.2018.v11i2.657

South African (SA) sexual offence legislation, like that of many other countries, has undergone numerous revisions, increasingly adopting a more liberal tone. This evolution in the law has aimed to ensure the protection of children from predatory sex with adults, while reflecting the realities of adolescent sexual experimentation.[1]

Some countries include age gap or close-in-age provisions to protect individuals who engage in consensual sexual activity with an adolescent below the age of consent, provided that the age difference is within the prescribed age range.[2] In July 2015, the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 5 of 2015[3] was enacted (the Sexual Offences Act), decriminalising underage consensual sexual activity (including penetrative sex) among adolescent peers aged 12 - 15. Additionally, the amended law, decriminalises consensual sexual activity between older adolescents (above age of consent for sex, i.e. 16 - 17-year-olds) and younger adolescents (below the age of consent for sex, i.e. 12 - 15-year-olds), provided that there is no more than a 2-year age gap between them. These changes in the law do not affect the age of consent to sex, which remains at 16 years old.[4]

This article describes current legislation regarding age-gap provisions in SA and selected better-resourced countries. It considers the rationale for and objections to these provisions, and the implications for adolescents outside of these provisions, for researchers, service providers, and policy-makers. It concludes with recommendations for law reform and further research.

Age-gap provisions for underage consensual sex

Across the USA, the age of consent to sex varies between 16 and 18 years old. Most states have fixed age-gap provisions decriminalising sexual relations among adolescents, granted that they are within a certain age range. Age-gap provisions range from 2 to 6 years across the USA, but are typically 3 or 4 years.[5] Some states also have Romeo-and-Juliet provisions for sexual activity between adolescents when one participant is below the age of consent; such provisions either reduce penalties associated with such an offence or exculpate the crime.[5,6]

Countries such as Canada and Australia have nuanced approaches to close-in-age provisions. For example, Canada prescribes the age of consent to sex at 16, with two close-in-age provisions. Firstly, sex with adolescents aged 12 - 13 years old is decriminalised if the older partner is no more than 2 years older. Secondly, sex with adolescents aged 14 - 15 years old is decriminalised if the older partner is no more than 5 years older.[7] It appears that the underlying principle is that of

narrow age gaps for younger adolescents (closer to 12 years old) and wider age gaps for older adolescents. Such nuanced approaches take into account adolescents' evolving decision-making capacity.

Other countries, such as Finland, set the age of consent at 16 with no close-in-age provisions, but qualify that underage consensual sex is not punishable if the adolescents are similar in age and development.

Despite the variation across countries, it appears that legislators recognise the need to distinguish between (*i*) predatory adults who engage in sexual activity with adolescents below the age of consent, and (*ii*) adolescents (above the age of consent) who engage in consensual sexual activity with adolescents below the age of consent.

Approach to the age-gap provision in SA's current sexual offences legislation

Amendments to sections 15 and 16 of the Sexual Offences Act[3] pertain to the decriminalisation of underage consensual sexual activity (including penetrative sex) (*i*) where both are between 12 and 15 years old; and (*ii*) between a 12 - 15-year-old and a 16 - 17-year-old, provided there is no more than 2-year age difference between them.[4,8,9] Prior to these amendments, the law specified that a 17-year-old who engaged in consensual penetrative sex with a 15-year-old (despite not more than a 2-year age gap) could potentially be charged with statutory rape; this is no longer the case. However, if a 17-year-old has consensual penetrative sex with a 14-year-old, this could potentially be considered a sexual offence (statutory rape) because the age gap is more than 2 years.

It is important to note that the amendments to the Sexual Offences Act[3] provide that if the Director of Public Prosecutions authorises prosecution for such an offence, the older adolescent (16 - 17-year-old) could be prosecuted. Consequently, children <18 years old are at risk of exposure to the criminal justice system and the associated harmful consequences, including having their names entered onto the sexual offences register.[10] However, it may be argued that the fact that the Director of Public Prosecutions has discretion to prosecute provides an additional level of screening as protection for adolescents.

Table 1 below describes age spans for underage consensual sex and sexual activity, indicating where the risk of prosecution lies.

Rationale for age-gap provisions

The rationales for particular age-gap provisions vary – different contexts rely on different rationales (e.g. protecting the victim, decriminalising normative adolescent behaviour, protecting children from the criminal justice system) when specifying the age-span parameter.[11] Generally, age-gap provisions rely on the premise that sexual activity between similarly aged peers is more likely to be consensual than predatory.[1,2] Age differences may arguably be used as a proxy to indicate power differentials between older and younger partners, with smaller differences indicative of more balanced power dynamics.[12]

Table 1. Current legal provisions on underage consensual sex

Partner A age, years	Partner B age, years	Current legal provisions on underage consensual sex
12 - 15	12 - 15	Not an offence
12	16 or 17	Offence; age gap >2 years
13	16 or 17	Offence; age gap >2 years
14	16	Not an offence
14	17	Offence; age gap >2 years
15	16 or 17	Not an offence

In addition, adolescent sexual experimentation is considered developmentally normative,[13] and fairly common; in fact, many adolescents, including in SA, may have sex before age 16.[14] The task of legislators, therefore, is to protect adolescents from adult sexual predators, while ensuring adolescents' right to autonomy to participate in self-determined sexual activity.[15] Age-gap provisions transfer criminal sanctions from the moral dilemma of underage sex *per se*, to a focus on the ages of the parties involved – capturing the sentiment that adolescent sexual experimentation is not fundamentally wrong.[16]

SA has taken a conservative approach in its selection of a 2-year age gap, reinforcing the idea that close-in-age consensual relationships are less likely to be coercive.[2] This is substantiated by research which suggests an increased risk of sexual intercourse when young girls have older partners.[17] The choice of a conservative age gap may also reflect public opinion. Empirical research in the USA indicates that respondents were more critical of scenarios involving larger age differences between partners, specifically 4- to 5-year (and greater) age gaps.[2] Still, liberal age-span provisions arguably minimise the number of unjust prosecutions,[18] and the US Model Penal Code proposes a 4-year age gap when decriminalising underage consensual sex.[19]

A major critique of age-gap provisions is the simplistic reliance on age difference as a proxy for coercion, with larger differences assumed as indicative of coercion, exploitation or undue influence.[20] The narrow focus on age difference ignores the fact that multiple factors contribute to coercion and exploitation in adolescent sexual relationships, including power relations, gender norms and sexual and social experiences.[20] Recent SA research with social workers found that in practice, the age difference between adolescent peers was one of several factors considered when making decisions about whether to report underage sex to authorities.[21] However, under the law, age difference is the only consideration.[8]

An age differential cannot inherently reveal whether a sexual relationship is coercive or not – such a reductionist approach may inadvertently deflect from potentially coercive relationships among similarly aged peers.[22] Recently published research with SA adolescents found that 'coerced sexual debut among young adolescents occurred mostly through sexual intercourse with peers, older adolescents and young adults, rather than with older adults'.[23] Despite these concerns, using age difference as a proxy for coercion has pragmatic benefits – it would be much more difficult to qualitatively explore consent in each case of underage sex.[22]

The amended law maintains the goal of protecting adolescents from predatory sex with adults, but inadvertently preserves a punitive measure for consensual peer sex where adolescents aged 16 - 17 engage in sexual activity with adolescents aged 12 - 15, when there is more than a 2-yea r age gap. Resultantly, this leaves adolescents at risk to statutory rape prosecutions, exposing them to the criminal justice system.[9] Furthermore, while a sexual relationship between a 12- and a 15-year-old carries no criminal sanction, if the couple continue their relationship until the older adolescent turns 16, this relationship would be considered a criminal offence that should be

reported to authorities, resulting in the older adolescent being liable for prosecution. The 2-year age gap does not consider that adolescent relationships often begin during high school, where the ages of teens vary by 3 to 4 years.[24]

Further, in some countries age-discordant relationships are non-normative; however, in SA, such relationships are a social reality.[24] While the social and economic power imbalances arising from age discordancy may affect abilities to negotiate safer sex with older partners, some contend that not all relationships with large age spans are problematic.[8] Some young girls specifically seek out older partners for security, as a result of the perception that older men make better lovers or for transactional sex purposes, which affects their HIV/AIDS risk.[9]

Implications for SA researchers/service providers

A key implication of age-gap provisions for researchers and service providers (e.g. psychologists, social workers, doctors) is that amendments have been expanded to include sexual penetration – this absolves providers of some of their mandatory reporting responsibilities.[8] However, even when sex among minors under 18 is consensual, researchers and service providers need to be aware that they are legally obliged to report to the authorities where an adolescent is 12 - 15 and the partner is 16 - 17 with an age gap of more than 2 years at the time of the act.[9]

The question then is whether researchers and service providers will be required to actively identify the exact ages of both partners and report to authorities if they reasonably believe the age gap to be larger than 2 years, as is the case elsewhere.[25] SA authors have argued in favour of explicit knowledge of the age difference when reporting underage consensual sex.[26]

Researchers and service providers will also be ethically required to discuss with adolescents the limits to confidentiality, including regarding mandatory reporting responsibilities where there is more than a 2-year age gap between adolescents.[21] This may have implications for research and for service provision, as adolescents may be reticent to disclose the age of their partners. In a service-delivery context, this could mean that adolescents do not bring their partner in for sexually transmitted infection (STI) treatment (or other healthcare services), owing to concerns that they will be reported, therefore heightening the chance of their own reinfection.

Conclusions and recommendations

The amendment to SA sexual offences legislation pertaining to underage consensual sex is appropriate and in keeping with the Constitutional Court ruling. It also provides expansion of the close-in-age defence to sexual penetration. The 2-year age-gap provision does not, however, consider that many young girls are involved in age-disparate relationships,[14] nor does it protect all minors engaged in consensual sex from prosecution.

The conservative approach appears to be based on the rationale of protecting victims, especially if it is assumed that age disparities are an adequate proxy for power asymmetry and thus for coercion and exploitation. However, the reality is that even similarly aged relationships can be coercive, and healthcare providers will need to assess a host of other factors when making determinations.

The inclusion of a conservative age-gap provision leaves minors (children <18 years) vulnerable to prosecution, and may create barriers for adolescents in intergenerational relationships, especially young girls, from accessing sexual and reproductive healthcare services.

It is therefore recommended that law reform include a more nuanced approach to age-gap provisions, or that if the more conservative age difference is favoured, age be considered along with other criteria, such as maturity and relations of authority (e.g. where one party in the relationship has some authority over the other). This more flexible, holistic approach reflects some consideration of the 'best interests of the child' principle, including considering 'the child's age, maturity and stage of development, gender, background and any other relevant characteristic of the child'.[21] It is also recommended that more empirical research be conducted to better understand the dynamics of coercive and exploitative adolescent sex in the SA context.

The task of developing legislation to provide safeguards for adolescents from adult sexual predators, ensuring adolescents' engagement in sexual activity is self-determined and addressing social challenges related to high risk of HIV/STIs and teenage pregnancy is a national challenge.

Acknowledgements. The authors would like to thank the reviewers for their helpful feedback. Thanks also to Prof. Ann Strode and Dr Catherine Slack for their comments on drafts of this manuscript.

Author contributions. ZE conceptualised the paper. ZE and JT both contributed to the content of the paper and revisions of drafts.

Conflicts of interest. None.

Funding. The work described here was supported by the SA AIDS Vaccines Initiative (SAAVI) and the National Institutes of Health award (1RO1 A1094586) CHAMPS (Choices for Adolescent Methods of Prevention in SA). The content is solely the responsibility of the authors and does not necessarily represent the official views of SAAVI or the National Institutes of Health. This article does not necessarily reflect the views of any institution or committee or council with which the authors are affiliated.

1. Cocca C. Jailbait: The politics of statutory rape laws in the United States. Albany: SUNY Press, 2004.
2. Koon-Magnin SL. Adolescent sexual activity and statutory rape: A multi-method investigation. MA thesis. Pennsylvania: Pennsylvania State University, 2008.
3. South Africa. Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act No. 5 of 2015.
4. Mahery P. The 2015 Sexual Offences Amendment Act: Laudable amendments in line with the Teddy Bear clinic case. S Afr J Bioethics Law 2015;8(2):4-6. https://doi.org/10.7196%2FSAJBL.375
5. Davis NS, Twombly J. State legislators' handbook for statutory rape issues. Washington: American Bar Association Center on Children and the Law, 2000.
6. Kern JL. Trends in teen sex are changing, but are Minnesota's Romeo and Juliet laws? William Mitchell Law Rev 2013;39(5)1607-1622. http://open.mitchellhamline.edu/wmlr/vol39/iss5/7
7. Wong JP. Age of consent to sexual activity in Canada: Background to proposed new legislation on "age of protection". Canadian J Human Sexual 2006;15(3-4):163-169.
8. Bhamjee S, Essack Z, Strode AE. Amendments to the Sexual Offences Act dealing with consensual underage sex: Implications for doctors and researchers. S Afr Med J 2016;106(3):256-259. https://doi.org/10.7196%2FSAMJ.2016.v106i3.9877
9. Strode A, Toohey J, Slack C, Bhamjee S. Reporting underage consensual sex after the Teddy Bear case: A different perspective. S Afr Bioethics Law 2013;6(2):45-47.
10. Essack Z, Toohey J, Strode A. Reflecting on adolescents' evolving sexual and reproductive health rights: Canvassing the opinion of social workers in KwaZulu-Natal, South Africa. Reprod Health Matters 2016;24(47):195-204. https://doi.org/10.1016/j.rhm.2016.06.005
11. Koon-Magnin S, Ruback RB. The perceived legitimacy of statutory rape laws: The effects of victim age, perpetrator age, and age span. J Applied Soc Psychol 2013;43(9):1918-1930. https://doi.org/10.1111/jasp.12131

12. Raiford JL, Wingood GM, DiClemente RJ. Prevalence, incidence, and predictors of dating violence: A longitudinal study of African American female adolescents. J Womens Health 2007;16(6):822-828. https://doi.org/10.1089/jwh.2006.0002
13. Gevers A, Mathews C, Cupp P, Russell M, Jewkes R. Illegal yet developmentally normative: A descriptive analysis of young, urban adolescents' dating and sexual behaviour in Cape Town, South Africa. BMC Int Health Hum Rights 2013;13(1):31. https://doi.org/10.1186/1472-698X-13-31
14. Shisana O, Rehle T, Simbayi LC, et al. South African National HIV Prevalence, Incidence and Behaviour Survey, 2012. Cape Town: HSRC Press, 2014.
15. Graupner H. Sexuality and human rights in Europe. J Homosexuality 2005;48(3-4):107-139. https://doi.org/10.1300/J082v48n03_07
16. Fischel JJ. Per se or power – age and sexual consent. Yale J Law Feminism 2010;22(2):279-341.
17. Gowen LK, Feldman SS, Diaz R, Yisrael DS. A comparison of the sexual behaviors and attitudes of adolescent girls with older vs. similar-aged boyfriends. J Youth Adolescence 2004;1;33(2):167-175. https://doi.org/10.1023/B:JOYO.0000
18. Warner K. Setting the boundaries of child sexual assault: Consent and mistake as to age defences. Melb Uni Law Rev 2012;36:1009-1036.
19. Smith BL, Kercher GA. Adolescent Sexual Behavior and the Law. Texas: Sam Houston State University, 2011.
20. Brand D. Sugar, spice and criminalised consent: A feminist perspective of the legal framework regulating teenage sexuality in South Africa. S Afr J Human Rights 2013;29(2):193-218.
21. Essack Z, Strode A. The mandatory reporting of consensual, underage sex: Knowledge, practices and perspectives of social workers in KwaZulu-Natal. S Afr J Bioethics Law 2015;8(2):21-25. https://doi.org/10.7196%2FSAJBL.435
22. Oberman M. Regulating consensual sex with minors: Defining a role for statutory rape. Buff Law Rev 2000;48:703-784.
23. Richter L, Mabaso M, Ramjith J, Norris SA. Early sexual debut: Voluntary or coerced? Evidence from longitudinal data in South Africa – the Birth to Twenty Plus study. S Afr Med J 2015;105(4):304-307. http://dx.doi.org/10.7196%2FSAMJ.8925
24. Leclerc-Madlala S. Age-disparate and intergenerational sex in southern Africa: The dynamics of hypervulnerability. Aids 2008;22(Suppl 4):S17-S25. https://doi.org/10.1097/01.aids.0000341774.86500.53
25. The Northern Territory Government Department of Health. Under Age Sexual Activity. PHC Remote Guideline, 2015. Darwin: NTGDoH, 2015.
26. Bhana A, Swartz S, Davids A. Standards for the reporting of sex/sexual activity of minors in a research context. S Afr Med J 2010;100(10):642-644.

Accepted 21 October 2018.

Southern African Journal of HIV Medicine
ISSN: (Online) 2078-6751, (Print) 1608-9693

Be legally wise: When is parental consent required for adolescents' access to pre-exposure prophylaxis (PrEP)?

Authors:
Ann Strode[1,2]
Catherine M. Slack[2]
Zaynab Essack[1,3]
Jacintha D. Toohey[1]
Linda-Gail Bekker[4]

Affiliations:
[1]School of Law, College and Law and Management Sciences, University of KwaZulu-Natal, Pietermaritzburg, South Africa

[2]HIV/AIDS Vaccines Ethics Group, School of Applied Human Sciences, College of Humanities, University of KwaZulu-Natal, Pietermaritzburg, South Africa

[3]Center for Community-Based Research, Human and Social Capabilities Division, Human Sciences Research Council, Pietermaritzburg, South Africa

[4]The Desmond Tutu HIV Centre, University of Cape Town, Cape Town, South Africa

Corresponding author:
Ann Strode,
strodeA@ukzn.ac.za

Dates:
Received: 13 July 2020
Accepted: 20 Aug. 2020
Published: 10 Nov. 2020

Background: South African adolescents (12–17 years) need an array of prevention tools to address their risk of acquiring the life-long, stigmatized condition that is HIV. Prevention tools include pre-exposure prophylaxis (PrEP). However, service providers may not be clear on the instances where self-consent is permissible or when parental consent should be secured.

Aim: To consider the legal norms for minor consent to PrEP using the rules of statutory interpretation.

Setting: Legal and policy framework.

Results: We find that PrEP should be interpreted as a form of 'medical treatment'; understood broadly so that it falls within the ambit of one of consent norms in the *Children's Act*. When PrEP is interpreted as 'medical treatment', then self-consent to PrEP is permissible for persons over 12 years, if they have the mental capacity and maturity to understand the benefits, risks, social and other implications of the proposed treatment. Currently, PrEP is only licensed for persons over 35 kg. Reaching the age of 12 years is a necessary but not sufficient criteria for self-consent and service-providers must ensure capacity requirements are met before implementing a self-consent approach. Decisional support and adherence support are critical.

Conclusions: We recommend that *service-providers* should take steps to ensure that those persons who meet an age requirement for self-consent, also meet the capacity requirement, and that best practices in this regard be shared. We also recommend that *policy makers* should ensure that PrEP guidelines are updated to reflect the adolescent consent approach articulated above. It is envisaged that these efforts will enable at-risk adolescents to access much needed interventions to reduce their HIV risk.

Keywords: parental consent; self-consent; HIV; prevention; minors' capacity.

Adolescent human immunodeficiency virus risk and pre-exposure prophylaxis

Globally young people are especially vulnerable to human immunodeficiency virus (HIV).[1,2,3,4] Human immunodeficiency virus prevalence amongst adolescents and young adults in South Africa remains skewed. In 2017, the HIV prevalence amongst females was higher than their male counterparts (5.8% vs. 4.7% amongst 15–19 year olds and 15.6% vs. 4.8% amongst 20–24 year olds).[5] In the same year, 66 000 new HIV infections occurred amongst adolescent girls and young women in South Africa.[5] Likewise, young men having sex with men (MSM) in South Africa are highly vulnerable to HIV infection.[5]

There is now good evidence that oral pre-exposure prophylaxis (PrEP) taken daily, as part of a combination prevention package, can protect HIV-negative adults against HIV acquisition.[6,7,8,9] The US Federal Drug Administration has, based on safety data, licensed oral combination of Tenofovir (TDF)/Emtricitabine (FTC) for HIV prevention for at-risk adolescents with body weights above 35 kg (Bekker, personal communication, 9 Jun 2020). The South African Health Products Regulatory Authority (SAHPRA) has similarly approved a fixed-dose combination of tenofovir disoproxyl fumarate and emtricitabine for PrEP (for adults and adolescents > 35 kg).[7]

How to cite this article: Strode A, Slack CM, Essack Z, et al. Be legally wise: When is parental consent required for adolescents' access to pre-exposure prophylaxis (PrEP)?. S Afr J HIV Med. 2020;21(1), a1129. https://doi.org/10.4102/sajhivmed.v21i1.1129

In addition to oral PrEP, which is proven and registered for use as HIV prevention, there are additional PrEP options that have different routes of administration and less frequent dosing including long-acting injectable PrEP and vaginal rings. These are at various stages in the development pipeline, with the dapivirine vaginal ring furthest along also currently under review by regulatory agencies. This means adolescents may soon have more choices about the form of PrEP available to them (Bekker, personal communication, 9 Jun 2020).

Providing at-risk populations with access to PrEP is described as a key objective within the South African National Strategic Plan on HIV, tuberculosis (TB) and sexually transmitted infections (STIs): 2017–2022.[9] Initially, the Department of Health operationalised this objective by targeting sex workers and MSM, but this has now been expanded to include other at-risk populations such as university students and young women.[10] To date public sector roll-out has lagged, and PrEP is mostly available through demonstration projects, clinical research sites and the private healthcare sector.[11,12] However, South Africa is now in the process of expanding access, with 3000 facilities being able to provide oral PrEP. Within this community-based approach, self-presenting adolescents who are > 35 kg and are deemed to be at risk of HIV acquisition will be eligible to access oral PrEP.

Although PrEP is registered for use in persons > 35 kg, there is no policy that deals with consent to this product by persons under 18 years. For example, the current South African HIV Clinicians guidelines do not address the consent approach for adolescent access to PrEP. These guidelines are currently being updated, and it is understood that the new version which will be published in November 2020 will include a recommended consent approach for persons under 18 years.[12] The unintended consequences of this lack of policy on adolescent consent to PrEP is that it is unclear whether adolescents can self-consent or require parental consent for access to PrEP.

In this article, we describe the current legal framework for adolescent consent to health interventions including 'medical treatment'. We examine whether adolescents can consent independently for PrEP in terms of the current legal framework. We conclude with our position on an appropriate consent strategy and recommend that the Department of Health revise current PrEP policies to provide certainty on this issue.

It should be noted that although this article focusses on adolescent consent to PrEP, it has a broader application. As described here, a key issue in the current legal framework is whether the term 'medical treatment' in the *Children's Act*, 2005[13] is broad enough to encompass prevention interventions such as vaccines. This has implications for adolescent consent to the human papillomavirus (HPV) vaccine and other non-therapeutic health interventions.

The public health and human rights imperative to ensure adolescent access to pre-exposure prophylaxis

It is both a human rights and public health imperative to ensure that adolescents have access to tools to minimise their HIV risk.[4] Access requires an evaluation of barriers, including legal barriers in the form of parental consent requirements.[2] Research from the United States of America has shown that parental consent may act as a legal barrier to adolescents accessing sexual and reproductive health services.[14] One study indicated that up to one-fifth of adolescents who were surveyed did not want their parents to be involved in the consent process.[15] Other studies have shown, for example, that a greater number of adolescents volunteered for services such as HIV testing once they were able to provide independent consent.[15] Furthermore, many adolescents are deterred from accessing abortion and contraception services by parental consent because they fear parental disappointment, sanction or retaliation.[15] Similarly, there are concerns that parental consent might impede access to HIV prevention packages for adolescents for similar reasons.[4,16]

The current legal framework for child consent to health interventions

Self-consent to specified health interventions

The *Children's Act* states that full legal capacity is attained at 18 years; however, persons below this age may, in certain circumstances, legally self-consent to a range of specified health services, as we have noted elsewhere.[2,3,16] Sections 12 and 129–135 of the *Children's Act*[13] deal with the consent requirements for medical treatment, surgical operations, HIV testing, male circumcision and contraceptives.[2,3] The *Children's Act* refers expressly to three current forms of HIV prevention, namely male circumcision, condoms (under contraceptives) and HIV testing, and sets ages at which adolescents may self-consent to the intervention.

As set out in earlier articles, consent to 'medical treatment' is a general category in the Act that covers a range of non-specified health interventions.[13] Section 129 provides that a child may consent independently to 'medical treatment' if they are older than 12 years and they have the 'mental capacity to understand the benefits, risks, social and other implications' of the proposed treatment.[2,3] If a child is below the age of 12 years or lacks capacity, proxy consent must be provided by a parent, guardian or care-giver amongst others.[2,3]

Self-consent to non-specified health interventions

Whilst the *Children's Act* provides clarity on consent to most medical interventions for children under 18 years, *it does not directly address the age at which adolescents might self-consent to non-specified preventive interventions* such as PrEP. There are

two implications of this lacuna. Firstly, if the *Children's Act* or any other legislation does not set an age of independent consent to a health service or if the child is below the age specified in law for independent consent, then parental or guardianship consent will be required.[2,3] Or, secondly, if the intervention is not listed, one could examine any of the other specified health interventions and establish whether they could encompass it. In this instance, the only broad health service that an adolescent can self-consent to is 'medical treatment'. Thus, one must ask whether something that is not directly therapeutic in nature falls within the ambit of term 'medical treatment'.

Establishing the meaning of a statutory term

Where the breadth of a statutory term is unclear, it requires a process of interpretation to establish its scope. There are various approaches to statutory interpretation. Firstly, one can use internal aids such as definitions in the Act. The *Children's Act* does not contain a definition of 'medical treatment' nor does it list a gamut of the therapies that may fall under its umbrella. Furthermore, there is no definition of the term in other legislation.

If we use external aids to statutory interpretation such as a dictionary, there are variations in the way they define 'medical treatment'. Some recognise medical treatment as an 'action or manner of treating a patient medically or surgically'.[17] 'Medically' is further defined as 'a way that relates to medicine',[18] And others define the term around the objectives of the treatment, for example 'the use of drugs, exercises, etc. to improve the condition or an ill, injured person, or to cure disease'.[19] Neither definition refers expressly to medical treatment including preventing an illness that a healthy person is at risk of contracting.

Where there is limited assistance from internal or external aids the general principles of statutory interpretation must be used. In the Constitutional Court judgement of *Cool Ideas 1186 CC v Hubbard and Another*, the court identified three interconnected elements of statutory interpretation.[20] Firstly, an examination of the purpose of the provision.[21] Secondly, a review of its legislative context.[20] Thirdly, identifying a meaning, which is consistent with the values underlying the Constitution.[20] The Constitution also provides in section 39 that courts may consider foreign law when interpreting rights.[19]

Firstly, if we apply the principles established in the *Cool Ideas* case, one must establish the purpose of the provision. The term is used within Chapter 7 of the *Children's Act*, which is headed 'protective measures relating to health of children'.[13] As stated here, this section deals largely with consent to a range of health interventions. In the Preamble to the Act, one of its stated purposes is to 'make provision for structures, services and means for promoting and monitoring the sound physical, psychological, intellectual, emotional and social development of children' and 'to promote the protection, development and well-being of children'.[13] It is submitted that in the light of this discussion, the primary purpose of the consent provisions are to protect children from being treated without informed consent and to ensure their physical well-being is promoted.

Secondly, regarding the context of the provision within the Act - the term is used in a chapter on the protection of the health rights of children.[13] The historical context of the consent provisions were documented in the *South African Law Reform Commission's Review of the Child Care Act*: *Final Report*.[21] This report noted that the previous approach to consent to 'medical treatment' served as a barrier to children obtaining appropriate medical care as the age of consent was set at the older age of 14 years and only a limited number of persons could provide proxy consent.[21] A further contextual issue is that (as we have set out in earlier articles) adolescents are able to consent to various other *specified health prevention interventions*, such as contraceptives and HIV testing.[13] With regard to both contraceptives and HIV testing, adolescents from the age of 12 are able to access them without parental consent. It is submitted that in this instance the context indicates that the legislator recognised that adolescents did have the capacity to consent to certain preventative health interventions. It would, therefore, be consistent with this approach if medical treatment was interpreted broadly to include other non-specified prevention interventions.

The last consideration from the *Cool Ideas* case is when interpreting a statutory provision one must find an interpretation that is consistent with the constitutional values of human dignity, equality and freedom.[19] The Constitutional Court has held that the recognition of a child's dignity requires an acceptance that they have their own, independent and distinctive personalities.[22] As such, it is argued that a child's right to inherent dignity requires a recognition of their other rights such as the rights of access to basic healthcare services in section 28 of the Constitution.[19] A narrow interpretation of the term 'medical treatment', which restricts it to therapeutic interventions, would undermine an adolescent's access to various preventative interventions such as the HPV vaccine or PrEP. This is not consistent with the constitutional value of dignity as it undermines fundamental rights.

Finally, a factor to consider is the approach in foreign jurisdictions. Here, there is limited assistance. A recent review by Taggart et al. found that at present, the only country to explicitly include PrEP as falling within the definition of medical treatment is France.[23]

We submit that based on the interpretation principles described here, it is possible to argue that 'medical treatment' ought to be understood broadly as meaning the treatment of a person for a current or *a future condition that they may be at risk of contracting*. Just as, for example, counselling an obese child on the need for a healthier diet and exercise programme could be seen as preventative treatment to reduce their future risk of Type 2 diabetes. We

submit that this interpretation is consistent with the purposes and context of the *Children's Act* and is also consistent with constitutional values.

Implications of pre-exposure prophylaxis falling within the scope of medical treatment for adolescent consent approaches

Based on the given reasoning, we submit the term 'medical treatment' should be interpreted to encompass *interventions to prevent an at-risk person from acquiring a disease*. This means that the term would cover both therapeutic and preventative health interventions. It would also include but not be limited to, for example, the provision of antiretrovirals to prevent HIV acquisition (PrEP). We submit that this is in line with a careful statutory interpretation of the term and it reflects its ordinary practical meaning. As suggested here, many practitioners already provide preventative interventions within the scope of medical treatment such as contraceptive counselling, advice about the HPV vaccine and assistance with healthy diets. In short, this broad interpretation of medical treatment enables doctors to provide more holistic healthcare independently for qualifying adolescents.

With regard to the implication for PrEP being viewed as a form of 'medical treatment', there are two requirements for adolescent self-consent. Firstly, they must be ≥ 12 years old, and secondly they must have 'capacity'. Capacity is the law's recognition of a person's ability to perform a juristic act – any action that has legal consequences – such as consenting to medical treatment requires capacity. A person will have capacity if he or she is able to exercise their judgement based on an understanding of the nature and consequences of the decision.[2,5] In this context the *Children's Act* provides that a child will have capacity to consent if he or she can understand three elements of the proposed treatment; its 'benefits, risks, social and other implications'.[2,3,13]

If we apply these factors to consent for PrEP we recommend that in order for an adolescent to self-consent the following criteria should be met, the adolescent would need to be:

- at risk of HIV infection
- weigh more than 35 kg
- 12 years or older
- able to understand the benefits of using PrEP to reduce their risk of HIV, relative to other HIV prevention tools
- mature enough to understand and accept that there are risks attached to using PrEP
- informed that there may be social or other implications associated with taking PrEP such as stigmatisation for being in an 'at-risk' category
- able to understand the need for adherence and how this will be integrated into their lives, including the possible need for parental or other support to ensure adherence.

This means that qualifying adolescents will be entitled to privacy regarding their medical treatment choice of HIV prevention.[24] Given the evolving capacity of adolescents it will be easier for older children to meet these criteria. With younger children, additional decisional supports will need to be put in place to ensure that they are able to exercise sound judgement regarding this form of HIV prevention. If they do not meet these capacity requirements, consent for PrEP will have to be provided by a parent, guardian or caregiver.

Regarding adherence for adolescents, there is not yet robust evidence on effective adherence interventions specifically tailored for adolescents; however, the early demonstration projects have provided some lessons. Access to refills should be as easy as possible, enhanced by regular provider-contact, during and between visits, for example, with a navigator or counsellor.

Support from family and close friends including an intimate partner can be positive, but disclosure of PrEP use has also resulted in social harms such as intimate partner violence. Providers should advise adolescents to seek counselling on safe disclosure.

Short-term incentives to maintain drug levels and plasma drug level feedback have also been studied with varying levels of effectiveness (Bekker, personal communication, 9 Jun 2020). Further implementation research is warranted before this is widely adopted.

Conclusions and recommendations

South African adolescents need an array of HIV prevention tools to address their risk of acquiring the life-long, stigmatised condition, that is HIV.[1] This public health crisis requires us to consider current legal norms for consent to prevention tools by adolescents and ensure that service providers *are clear on the instances where self-consent is permissible* or when parental consent should be secured.

We recommend that PrEP should be interpreted as being a form of 'medical treatment' so that it falls within the ambit of one of consent norms in the *Children's Act*. This recommendation is consistent with earlier recommendations for self-consent for adolescents over 12 years to HPV vaccination from Tathia and colleagues[27] and builds on recommendations from Vawda and colleagues[28] that the term 'medical reasons' is broad enough to include HIV prevention.[28] We elaborate on earlier recommendations by outlining and using tools of statutory interpretation to justify it.

Following this interpretation, self-consent to medical treatment – understood broadly to include PrEP – is permissible for persons over 12 years only when they have the mental capacity to understand the benefits, risks, social and other implications' of the proposed treatment.[2,3]

We recommend that service providers should take steps to ensure that those persons who meet the age and capacity requirement for self-consent have access to PrEP.

We also recommend that *policy makers* should ensure that PrEP guidelines are updated to reflect the adolescent consent approach articulated here. Hopefully these efforts will enable at-risk adolescents to access much needed interventions to reduce their risk of HIV.

Acknowledgements

Competing interests

There were no competing interests in the development of this article.

Authors' contributions

A.S. and J.D.T. developed the legal section of the article. Z.E. and C.M.S. drafted the background and context and assisted with the analysis. L.-G.B. added the specialist information on PrEP. All authors contributed to the editing and analysis of the article.

Ethical consideration

This article followed all ethical standards for a research without direct contact with human or animal subjects.

Funding information

This article was made possible by funding from award number 1RO1 A1094586 from the National Institutes of Health (NIH) entitled Choices for Adolescent Methods of Prevention in South Africa (CHAMPS).

Data availability statement

Data sharing is not applicable to this article as no new data were created or analysed in this study.

Disclaimer

The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH. It does not necessarily represent the views of any council or committee with which the authors are affiliated.

References

1. Bekker L, Gill K, Wallace M. Pre-exposure prophylaxis for South African adolescents: What evidence? S Afr Med J. 2015;105(11):907–911. https://doi.org/10.7196/SAMJ.2015.v105i11.10222
2. Strode A, Essack Z. Facilitating access to adolescent sexual and reproductive health services through legislative reform: Lessons from the South African experience. S Afr Med J. 2017;107(9):741–744. https://doi.org/10.7196/SAMJ.2017.v107i9.12525
3. Strode A, Slack C, Essack Z. Child consent in South African law: Implications for researchers, service providers and policy-makers. S Afr Med J. 2010;100(4):247–249. https://doi.org/10.7196/samj.3609
4. Pettifor A, Nguyen NL, Celum C, Cowan FM, Go V, Hightow-Weidman L. Tailored combination prevention packages and PrEP for young key populations. J Int AIDS Soc. 2015;18(2 Suppl 1):19434. https://doi.org/10.7448/IAS.18.2.19434
5. Simbayi L, Zuma K, Zungu N, et al. South African National HIV prevalence, incidence, behaviour and communication survey, 2017. Cape Town: HSRC Press; 2019.
6. World Health Organisation (WHO). WHO expands recommendation on oral pre-exposure prophylaxis of HIV infection (PrEP). Policy Brief. Geneva: World Health Organisation; 2015.
7. Bekker L-G, Rebe K, Venter F, et al. Southern African guidelines on the safe use of pre-exposure prophylaxis in persons at risk of acquiring HIV-1 infection. S Afr J HIV Med. 2016;17(1):455. https://doi.org/10.4102/sajhivmed.v17i1.455
8. Jiang J, Yang X, Ye L, et al. Pre-exposure prophylaxis for the prevention of HIV infection in high risk populations: A meta-analysis of randomized controlled trials. PLoS One. 2014;9(2):e87674. https://doi.org/10.1371/journal.pone.0087674
9. South African National AIDS Council. National strategic plan on HIV, TB and STIs 2017–2022 [homepage on the Internet]. 2017 [cited 2018 Feb 4]. Available from: http://nsp.sanac.org.za/
10. Mbatha JN, Taylor M, Kleppa E, et al. High-risk human papillomavirus types in HIV-infected and HIV-uninfected young women in KwaZulu-Natal, South Africa: Implications for vaccination. Infect Dis. 2017;49(8):601–608. https://doi.org/10.1080/23744235.2017.1312513
11. Mbatha T. Spotlight [homepage on the Internet]. 2017 [cited 2019 Aug 11]. Available from: https://www.spotlightnsp.co.za/2017/12/17/state-prep-access-sa/
12. Bekker LG, Rebe K, Venter F. Southern African guidelines on the safe use of pre-exposure prophylaxis in persons at risk of acquiring HIV-1 infection. S Afr J HIV Med. 2016;17(1):455. https://doi.org/10.4102/sajhivmed.v17i1.455
13. Republic of South Africa. Children's Act, No. 38 of 2005. 2005. Government Gazette, Cape Town, South Africa.
14. Jackson S, Hafemeister TL. Impact of parental consent and notification policies on the decisions of adolescents to be tested for HIV. J Adolesc Health. 2001;29(2):81–93. https://doi.org/10.1016/S1054-139X(00)00178-6
15. Delany-Moretlwe S, Cowan FM, Busza J, Bolton-Moore C, Kelley K, Fairlie L. Providing comprehensive health services for young key populations: Needs, barriers and gaps. J Int AIDS Soc. 2015;18(2 Suppl 1):19833. https://doi.org/10.7448/IAS.18.2.19833
16. Strode A. A critical review of the regulation of research involving children in South Africa: From self-regulation to hyper-regulation. J S Afr Law. 2015;2015(2):334–346.
17. Merriam Webster Medical Dictionary [homepage on the Internet]. [cited 2018 March 14]. Available from: http://www.merriam-webster.com/medical/treatment.
18. Cambridge Dictionaries Online [homepage on the Internet]. [cited 2019 March 22]. Available from: http://dictionary.cambridge.org/us/dictionary/english/treatment.
19. Republic of South Africa. Constitution of the Republic of South Africa. 1996. Government Gazette, Cape Town, South Africa.
20. Cool Ideas 1186 CC v Hubbard and Another 2014 (4) SA 474 (CC)
21. South African Law Reform Commission. Review of the Child Care Act 2002 [homepage on the Internet]. [cited 2020 Jun 9] Available from: http://www.justice.gov.za/salrc/reports/r_pr110_01_2002dec.pdf
22. South African Law Reform Commission. Review of the Child Care Act 2002. [cited 2020 June 09]. Available from: http://www.justice.gov.za/salrc/reports/r_pr110_01_2002dec.pdf.
23. Taggart T, Bond KT, Ritchwood TD, Smith JC. Getting youth PrEPared: Adolescent consent laws and implications for the availability of PrEP among youth in countries outside of the United States. J Int AIDS Soc. 2019;22(7):e25363. https://doi.org/10.1002/jia2.25363
24. Strode A, Slack C. Child privacy rights: A 'Cinderella' issue in HIV-prevention research. S Afr J HIV Med. 2013;14(3):108–110. https://doi.org/10.7196/SAJHIVMED.897
25. Tathiah N, Naidoo M, Moodley I. Human papillomavirus (HPV) vaccination of adolescents in the South African private health sector: Lessons from the HPV demonstration project in KwaZulu-Natal. S Afr Med J. 2015;105(11):954. https://doi.org/10.7196/samj.2015.v105i11.10135
26. Vawda YA, Maqutu LN. Neonatal circumcision – Violation of children's rights or public health necessity?. S Afr J Bioethics Law 2011;4(1):36–41. https://doi.org/10.7196/sajbl.119
27. Strode A, Toohey J, Slack C. Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa. S Afr Med J. 2016;106(12):1173–1176. https://doi.org/10.7196/SAMJ.2016.v106.i12.11215
28. Reddy DM, Fleming R, Swain C. Effect of mandatory parental notification on adolescent girls' use of sexual health care services. JAMA. 2002;288(6):710–714. https://doi.org/10.1001/jama.288.6.710

ARTICLE

A critical review of the South African legal framework on adolescent access to HIV prevention interventions

J D Toohey, LLB, LLM; **A Strode,** BA, LLB, LLM, PhD

School of Law, College of Law and Management Studies, University of KwaZulu-Natal, Pietermaritzburg, South Africa

Corresponding author: *J D Toohey (tooheyj@ukzn.ac.za)*

HIV remains a leading cause of death globally, with adolescents continuing to be one of the most at-risk population groups. Effective public health responses require an enabling legal environment to facilitate adolescent access to HIV prevention tools. South Africa (SA) is a good case study of a country with legislative reforms supporting public health HIV prevention programmes. A desktop review was conducted of relevant SA laws compared with key international norms such as age of independent consent and the right to confidentiality. This article reflects on whether the SA legal framework is a facilitator or barrier to adolescent access to key HIV prevention services such as HIV testing and HIV education. The findings indicate a clear recognition of evolving capacity and the inclusion of protections aimed at enhancing decision-making. International legal norms are, however, scattered, and not comprehensive enough to inform certain national policy choices. As such, developing a coherent approach to the evolving capacity and protection relating to age-appropriate decision-making can be a challenge for states legislating on adolescent access to HIV prevention interventions. This article highlights the fact that SA has largely created an enabling legal environment for adolescent access to HIV prevention. Nevertheless, there are a number of weaknesses in the SA legal framework, such as the divergent approaches between criminal and civil law regarding sexual activity among adolescents. It is recommended that further research be conducted on legal reform toward a coherent approach to support adolescent access to HIV prevention services.

S Afr J Bioethics Law 2021;14(1):16-19. https://doi.org/10.7196/SAJBL.2021.v14i1.716

It is estimated that there are 37.9 million people living with HIV worldwide, and it remains one of the leading causes of death.[1] Within this epidemic, adolescents continue to be an at-risk population, with an estimated 510 000 young people aged between 10 and 24 years newly infected with HIV in 2018.[2,3] South Africa (SA) accounts for a third of all new HIV infections in the southern African region.[3]

In this context, public health responses targeted at assisting adolescents to reduce their risk of HIV infection are critical. It has been suggested that the law ought to create an enabling environment to facilitate public health responses to sexual and reproductive health services for adolescents.[4] However, the law may pose direct and indirect barriers to adolescent access to sexual and reproductive health services.[5-7] Direct barriers are laws that expressly exclude adolescents from accessing services, while indirect barriers are laws that are seemingly neutral but have a disparate impact on access to sexual and reproductive health services.[5] For example, if sex below the age of 16 is a criminal offence, it can make the distribution of condoms to young persons difficult, as service providers may be charged with aiding and abetting a crime. In light of the possibility that the law can act as both a facilitator and a barrier, the International Guidelines on HIV/AIDS and Human Rights recommend a review and reform of laws to ensure that they adequately address public health issues raised by HIV.[8] Furthermore, it has been recommended that measures be taken to remove all barriers hindering adolescents' access to information and preventive measures.[9]

This article reflects on a desk review of SA's legal framework dealing with adolescent access to HIV prevention services. It sets out the relevant international norms regarding adolescents' rights to sexual and reproductive health, describes the methodology used, makes a number of findings and discusses the extent to which the SA framework meets the international norms.

International sexual and reproductive health norms on adolescent access to HIV prevention

The Convention on the Rights of the Child provides that every person under the age of 18 is a bearer of rights.[10] Likewise, SA's Constitutional Court has ruled that children are entitled to all the fundamental rights in the Bill of Rights except for those from which they are expressly excluded, or where the limitation of such rights can be justified.[11]

Sexual and reproductive health rights are regarded as part of the right to the 'highest attainable' standard of health in international law.[12] Likewise, s27 of our Constitution, which deals with health, provides that 'everyone has the right to have access to – (a) health care services, including reproductive health care.'[13]

What, then, are the implications of 'everyone' having a fundamental constitutional right to reproductive healthcare in terms of adolescent access to HIV prevention? It is submitted that interventions to prevent HIV transmission fall squarely within the context of sexual and reproductive health, as the primary mode of transmission among this age group is sexual. Following the approach in the Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development case, children are entitled to this right, as they are not expressly excluded from s27 of the Constitution. Any limitation of this right would have to be justified.

Our Constitution requires the state to 'respect, protect, promote and fulfil the rights in the Bills of Rights'.[13] One of the state's obligations is to ensure that the legislative framework creates such an enabling environment.[4] A review of the international norms relating to ensuring adolescent access to HIV prevention services revealed five key obligations on the state, which are to:

(*i*) set an age at which adolescents can access contraceptives (this would include access to condoms) and medical treatment without parental consent,[6] and set an age for consent to sex that is the same for both girls and boys;[9]
(*ii*) ensure that legal norms do not discriminate on the basis of sex, sexual orientation and health status;[6,9]
(*iii*) facilitate access to health information, including sexual and reproductive information (e.g. family planning, contraceptives, the prevention of HIV/AIDS and the prevention/treatment of sexually transmitted diseases);[6,8,9]
(*iv*) respect adolescents' right to privacy and confidentiality;[9] and
(*v*) ensure that appropriate goods, services and information for HIV prevention are available.[9]

This article submits that a gap exists in the international norms, i.e. there is no norm that requires states to ensure that legal protections to support good decision-making by adolescents are linked to access rights.[7]

Methodology

The SA National Strategic Plan for HIV, TB and STIs, 2017 - 2022[14] was used to create a list of the HIV prevention interventions provided by the state. These are:

(*i*) voluntary medical male circumcision (VMMC);
(*ii*) information and education on HIV;
(*iii*) pre-exposure prophylaxis (PrEP);
(*iv*) HIV testing and counselling services; and
(*v*) provision of contraception (condoms).[14]

This was followed by a review of all SA laws that could potentially impact on adolescent access to these HIV prevention modalities. The review first examined relevant laws to establish whether they met the international norms described above. This required an examination to see whether the laws:

(*i*) set a non-discriminatory age of consent to contraceptives, medical treatment and sex;
(*ii*) created a right to access to information;
(*iii*) protected adolescent privacy rights; and
(*iv*) created a right to sexual and reproductive health services.

Secondly, the review examined whether the norms offered any special protections.

Results

The present review found that SA has to a large extent created an enabling legal environment for adolescent access to HIV prevention. It has done this through legislating ages of adolescent self-consent to condoms, medical treatment and sex.[15] The Children's Act No. 38 of 2005[16] also creates a right to information on the prevention of disease, and on sexuality and reproduction. The Act further enhances access to services through providing specific rights to privacy regarding contraceptive services and HIV testing. There are no differential or discriminatory requirements for access to HIV services or regarding the age of consent to sex. In essence, the SA legal framework meets four of the five international legal norms.

On examination of the ages of consent to sex and HIV prevention services, these are dealt with in the Children's Act and the Sexual Offences and Related Matters Amendment Act No. 5 of 2015[17] (Table 1). SA meets the minimum norm by having an age of consent to sex of 16 years, i.e. below the age of 18. It also meets other age-of-consent norms by having an age of consent to both medical treatment and contraceptives. The Children's Act separated HIV testing as its own category, rather than letting it fall within the general ambit of medical treatment.[15] This has facilitated the setting of special protections relating to when and how HIV testing may be undertaken.[18] SA has gone further than the minimum international law requirement by also setting ages of consent to VMMC and virginity testing (Table 1). Virginity testing is a cultural practice that has been revived in some areas as a form of HIV prevention.[15]

It is submitted that in light of the above, the framework provides adolescents with a right to independently access VMMC, PrEP, HIV testing and condoms. Although PrEP is not expressly referred to in the Children's Act, it is argued that it could be accessed independently by adolescents from the age of 12 onwards as a form of medical treatment.[19]

Regarding discrimination, the review found that there were no discriminatory provisions in relation to the accessing of HIV prevention services. The Sexual Offences Act does not discriminate against adolescents based on their sex or sexual orientation. In other words,

Table 1. Age of consent to sex and sexual and reproductive health services in SA

Category	Age of consent	Protections, if any
Sex	16 (heterosexual and homosexual)	-
VMMC	16	'Proper' counselling before the circumcision
Medical treatment (to include PrEP)	12	Adolescent must display 'sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of the treatment'
HIV testing	12	HIV testing must be in the best interests of the child and accompanied by pre-and post-test counselling
Contraceptives (condoms)	12	-
Virginity testing	16	'Proper' counselling

SA = South Africa; VMMC = voluntary male medical circumcision; PrEP = pre-exposure prophylaxis.

there is a single age of consent for both heterosexual/homosexual sex and between girls and boys. Furthermore, the Children's Act requires every child to be treated 'fairly and equitably'.[16]

The norm regarding the right to information on HIV prevention is also met by the Children's Act, which provides that every child has the right to access to age-appropriate health/sexual and reproductive prevention information.[16] Although this section does not specifically refer to HIV prevention, it is broad enough to encompass education on HIV.

The Children's Act provides that every child has a right to 'confidentiality regarding his or her health status', unless this is not in his or her best interests.[16] It also expressly provides for an adolescent's right to privacy regarding contraceptive advice and HIV testing.[16]

There is no provision in the Children's Act or any other legislation creating a legal right to HIV prevention services. However, s28 of the Constitution provides that every child has the right to 'basic health care'.[13] It is submitted that the term 'basic' refers to primary healthcare services, which would include HIV prevention.

Finally, the law creates a number of protections to support adolescent decision-making. For example, in terms of VMMC, these protections include: (*i*) circumcision is prohibited in those <16 years old, unless it is undertaken for religious or medical reasons;[16] (*ii*) the adolescent boy must self-consent;[16] and (*iii*) prior to providing consent, the adolescent must receive counselling.[16]

Discussion

The concept of an enabling legal environment in the context of HIV prevention is complex for a number of reasons. Firstly, the elements of such a legal environment are scattered through various documents. Secondly, they are not comprehensive, often providing very broad norms, such as setting an age of consent to sex below adulthood, without any further detail on the complexities that accompany such a policy choice. For example, should the criminal or civil law be used to enforce or regulate consensual underage sex? How does one ensure synchronicity between the age of consent to sex and the ages at which adolescents can access HIV prevention services? Thirdly, there is more of a focus on barriers to adolescent access to sexual and reproductive health services than on other issues, such as developing a coherent approach to the evolving capacity of adolescents, and support or protection relating to age-appropriate decision-making. It is submitted that the lack of a set of international norms to guide states in legislating on adolescent access to HIV prevention and other sexual and reproductive rights is a key failing. More research is needed in this area if the law is to support the implementation of public health programmes.

This review has found that the strengths of the SA framework are fourfold. Firstly, there is a clear recognition of evolving capacity, with different ages of consent set for various interventions. The age of 12 years is generally considered the youngest age at which adolescents would have the capacity to consent to HIV testing, contraception (condoms) and medical treatment, whereas VMMC, virginity testing and sex are all set at the higher age of 16.[15] Secondly, creating ages of independent consent to various HIV prevention tools has facilitated access to such services at a structural level. Thirdly, the inclusion of protections aimed at enhancing decision-making, such as mandatory counselling, are an innovative approach. Fourth, the framework does not discriminate against adolescents on the basis of sex or sexual orientation. There is the same age of consent to both heterosexual and homosexual sex,[17] and service providers may not discriminate against an adolescent on the basis of his or her sexual orientation.[16] Importantly, this enables the provision of services to adolescent men having sex with men.

There are some weaknesses in the framework, which include, firstly, that while the age of consent to sex is 16 years, and the Sexual Offences Act[17] provides that consensual sex between the ages of 12 and 15 years will not be prosecuted if both parties are aged between 12 and 15, or if one party is older but there is not more than a 2-year age gap between the partners, there are still many adolescents who might fall foul of the criminal law.[20,21] The narrowing of the circumstances in which consensual underage sex is criminalised has been welcomed, but it remains inadequate. Current law continues to have a disparate impact on adolescent girls, who are more likely to have older sexual partners. A further problem with the Sexual Offences Act is that it requires service providers to report consensual sex.[20] This means that when adolescents lawfully access services such as condoms or HIV testing, the service provider is required to report any disclosures of underage sex that fall into the protective categories described above.[15] This undermines the ability of service providers to offer confidential HIV prevention services.[20] Secondly, setting the age of consent to VMMC at 16 years means that boys aged<16 need parental consent for circumcision as a form of HIV prevention. This may well be a barrier to younger boys wishing to access this service.[22] Using a similar argument, Savage-Oyekunle and Nienaber[23] argue that setting 12 years as the age at which it is legal to access contraceptives is arbitrary, and undermines the public health imperative of ensuring that all adolescents (aged 10 - 19) are able to access such services.[23] Thirdly, while it has been argued that requiring HIV counselling before testing is an important decisional support, if it is not interpreted broadly, it may act as a barrier to new forms of HIV testing such as self-testing.[24,18]

Conclusions

This review has found a number of enabling elements in the SA framework. While there is no specific provision creating a right to HIV prevention services, the Constitution provides a general right for every child to access basic healthcare. All laws reviewed indicate that the legal framework recognises evolving capacity, and balances this approach with special protections. The law does not discriminate or differentiate based on sex or sexual orientation in relation to age of consent to sex or sexual and reproductive services. There is a general right to information on prevention of disease, sexuality and reproduction, and an express right to access information on HIV testing and contraceptives.

It is concluded that the SA legal framework does, to a large extent, support adolescent access to HIV prevention. However, there are some barriers to adolescent access to critical HIV prevention tools. These include the issue of divergent approaches between the criminal and civil law regarding sexual activity among adolescents, which creates implementation problems, and the legalisation of an outdated customary practice, virginity testing, which is not a form of HIV prevention and has been used to discriminate against young women.[15]

Acknowledgements. None.
Author contributions. JT prepared the first draft of the article. AS assisted with the editing and analysis.
Funding. None.
Conflicts of interest. None.

1. Joint United Nations Programme on HIV and AIDS. Global HIV & AIDS statistics 2019 – Fact Sheet 2019. Geneva: UNAIDS, 2019. https://www.unaids.org/en/resources/fact-sheet (accessed 6 December 2019).
2. United Nations International Children's Emergency Fund. Adolescent HIV prevention 2019. Geneva: UNICEF, 2019. https://data.unicef.org/topic/hivaids/adolescents-young-people/ (accessed 6 December 2019).
3. Avert. HIV and AIDS in South Africa 2019. Horsham: Avert, 2019. https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/south-africa (accessed 6 December 2019).
4. United Nations Development Programme. HIV and the law: Risks, rights and health 2012. Geneva: UNDP, 2012. https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/hiv-and-the-law--risks--rights---health.html (accessed 6 December 2019).
5. International Planned Parenthood Federation. Over-protected and under-served: A multi-country study on legal barriers on young people's access to sexual and reproductive health services 2013. London: IPPF, 2013. https://www.ippf.org/sites/default/files/ippf_coram_uk_report_web.pdf (accessed 6 December 2019).
6. United Nations Population Fund. Harmonising the legal environment for adolescent sexual and reproductive health and rights: A review of twenty-three countries in eastern and southern Africa. Geneva: UNFPA, 2017. https://esaro.unfpa.org/sites/default/files/pub-pdf/2017-08-Laws%20and%20Policies-Digital_0.pdf (accessed 6 December 2019).
7. Strode A, Sarumi R, Essack Z, et al. A feminist critique of legal approaches to adolescent sexual and reproductive health rights in eastern and southern Africa: Denial and divergence versus facilitation. Agenda 2018;32(1):76-86. https://doi.org/10.1080/10130950.2018.1433363
8. United Nations Office of the High Commissioner for Human Rights, Joint United Nations Programme on HIV/AIDS. UNAIDS international guidelines on HIV/AIDS and human rights – second international consultation on HIV/AIDS and human rights, Geneva, 1996. Geneva: UN, 1998. https://www.unaids.org/en/resources/documents/2006/20061023_jc1252-internguidelines_en.pdf (accessed 6 December 2019).
9. UNICEF. Committee on the Rights of the Child, General Comment No. CG. 3: HIV/AIDS and the right of the child, UN Doc. CRC/GC/2003/3; 2003 - HIV/AIDS and the rights of the child, CRC/GC/2003/3, United Nations, Geneva, 2003. https://www.unicef.org/publications/files/Implementation_Handbook_for_the_Convention_on_the_Rights_of_the_Child_Part_3_of_3.pdf (accessed 6 December 2019).
10. United Nations International Children's Emergency Fund. Convention on the Rights of the Child, 1989. Geneva: UNICEF, 1989. https://www.unicef.org/child-rights-convention (accessed 6 December 2019).
11. Teddy Bear Clinic For Abused Children and Another v Minister of Justice and Constitutional Development 2014 (2) SA 168 (CC).
12. United Nations Office of the High Commissioner on Human Rights. General comment No. 22 on the right to sexual and reproductive health: Article 12 of the International Covenant on Economic, Social and Cultural Rights, 2016. Geneva: UN OHCHR, 2016. https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fGC%2f22&Lang=en (accessed 21 July 2019).
13. Constitution of the Republic of South Africa, 1996.
14. South African National AIDS Council. National Strategic Plan for HIV, TB and STIs 2017 - 2022. Pretoria: SANAC, 2016. https://www.gov.za/sites/default/files/gcis_document/201705/nsp-hiv-tb-stia.pdf (accessed 21 July 2019).
15. Strode A, Essack Z. Facilitating access to adolescent sexual and reproductive health services through legislative reform: Lessons from the South African experience. S Afr Med J 2017;107(9):741-744. https://doi.org/10.7196/samj.2017.v107i9.12525
16. South Africa. Children's Act No. 38 of 2005. Government Gazette, 492:28944.
17. South Africa. Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 5 of 2015. Government Gazette, 601:38977.
18. Van Rooyen HE, Strode AE, Slack CM. HIV testing of children is not simple for health providers and researchers: Legal and policy frameworks guidance in South Africa. S Afr Med J 2016;106(5):451-453. https://doi.org/10.7196/samj.2016.v106i5.10484
19. Strode A, Slack CM, Essack Z, Toohey JD, Bekker LG. Be legally wise: When is parental consent required for adolescents' access to pre-exposure prophylaxis (PrEP)? South Afr J HIV Med 2020;21(1):1-5.
20. Bhamjee S, Essack Z, Strode AE. Amendments to the Sexual Offences Act dealing with consensual underage sex: Implications for doctors and researchers. S Afr Med J 2016;106(3):256-259. https://doi.org/10.7196/SAMJ.2016.v106i3.9877
21. Essack Z, Toohey J. Unpacking the 2-year age-gap provision in relation to the decriminalisation of underage consensual sex in South Africa. S Afr J Bioethics Law 2018;11(2):85-88. https://doi.org/10.7196/SAJBL.2018.v11i2.657
22. Strode AE, Toohey JD, Slack CM. Addressing legal and policy barriers to male circumcision for adolescent boys in South Africa. S Afr Med J 2016;106(12):1173-1176. https://doi.org/10.7196/samj.2016.v106.i12.11215
23. Savage-Oyekunle OA, Nienaber A. Female adolescents' evolving capacities in relation to their right to access contraceptive information and services: A comparative study of South Africa and Nigeria. Comp Int Law J Southern Afr 2015;48(1):98-123.
24. Makusha T, Strode AE, Van Rooyen H. Is it lawful to offer HIV self-testing to children in South Africa? South Afr J HIV Med 2013;14(4):151-154. https://doi.org/10.4102/sajhivmed.v14i4.49

Accepted 10 November 2020.