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Submission to the Portfolio Committee on Justice and Correctional Services
Relating to the Criminal Law [Sexual Offences and Related Matters] Amendment Act Amendment Bill [B18-2014]

For the committee's consideration in the abovementioned matter, please accept the following two documents:

The first document is the expert opinion document compiled by myself and the late Professor Alan Flisher at the request of Ann Skelton. This document presents information about sexual development, adolescent sexual behaviour, and the potential impact of Sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act on adolescents' development in support of repealing these sections.

The second document is a publication on adolescents' sexual behaviour published in *BMC International Health and Human Rights* in 2013 that may be of interest to Members as additional background reading.

I request to do an oral presentation to your Committee in order to summarise these reports and clarify any questions to aid in the considerations of amendments to the Criminal Law [Sexual Offences and Related Matters] Amendment Act Amendment Bill [B18-2014].

Brief biographies:

Dr Aník Gevers
Dr Gevers is a specialist scientist with a background in clinical psychology and research specialising in intervention development, primary prevention of gender-based violence, child and adolescent mental health and well-being, and trauma-related mental health issues. She completed her PhD at the University of Cape Town (South Africa), masters degree at the University of Missouri-St Louis (USA), and undergraduate degree at Grinnell College (USA). Her doctoral thesis and strong focus in on-going work is on adolescent intimate relationships and sexuality. She has worked in a variety of clinical and research settings locally and internationally. Currently, she holds an honorary faculty position at the Adolescent Health Research Unit hosted by the Department of Psychiatry & Mental Health, University of Cape Town. She has skills in qualitative and quantitative research, programme evaluation, project management, intervention development, and research dissemination through publications, reports, and presentations. Aník's current research in the Gender and Health Research Unit at the MRC across multiple projects focuses on programme and intervention development and evaluation in the field of health promotion, violence prevention and response, and mental health support in the aftermath of sexual violence. In addition, Aník is a technical adviser for the Sexual Violence Research Initiative projects in eastern Africa, serves as academic supervisor for postgraduate students at several institutions, and conducts reviews of manuscripts in local and international indexed academic journals and international conference abstract selection.

Professor Alan Flisher
Professor Flisher, M.Sc. (Clinical Psychology), M.B., Ch.B., M.Med. (Psychiatry), M.Phil. (Child and Adolescent Psychiatry), Ph.D., D.C.H., F.C.Psych. (S.A.), M.A.S.S.Af., was a child and adolescent psychiatrist. He was the Sue Streungmann Professor of Child and Adolescent Psychiatry and Mental Health at the University of Cape Town (UCT); Head of the Division of Child and Adolescent Psychiatry at UCT and Red Cross War Memorial Children's Hospital; Director of the Adolescent Health Research Unit at UCT; and Director of the Mental Health and Poverty Research Programme Consortium. From 1994-1996, he was a Research Scientist at the New York State Psychiatric Institute. He had visiting appointments at Columbia University in the City of New York, the University of Oslo, and Leeds University, and was a Takemi Fellow Harvard University. His research interests included adolescent health, mental health services research and psychiatric epidemiology. His research outputs include 200 papers in peer review journals, 50 books or chapters, and 400 conference presentations. He was Editor of the *Journal of Child and Adolescent Mental Health*. He conducted extensive policy development consultancies nationally and internationally. Unfortunately, Professor Flisher passed away in 2010 after we had completed working on this expert opinion.

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INTRODUCTION

Sections 15 and 16 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act No. 32 of 2007 (referred to as "the Act" in this document), criminalise consensual sexual behaviour ranging from kissing to intercourse between youth under the age of 16 years (but older than 12 years). This document presents facts and arguments supporting the dissolution of these sections of the Act mentioned above.

During adolescence, individuals undergo significant physiological, psychological, cognitive, and social changes as they make the transition from childhood into adulthood. In addition to their personal changes, adolescents are also confronted by increasing sociocultural demands that require the acquisition of new roles and responsibilities in various domains. Although adolescents have to negotiate several risk factors during this developmental stage, it is also an exciting time with opportunities for positive growth. The experiences during this developmental period have a long-term impact on individuals and their adulthood functioning[1;2]. It is thus important to support adolescents through this transition and facilitate the opportunities for growth in positive ways.

This document begins by describing the various aspects of normative sexual development, followed by information about sexual behaviour among South African adolescents, and concludes with a discussion of the potential effects of criminalising consensual sexual behaviours between young adolescents (age 12 to 15 years).

We argue that sexual behaviour among young adolescents is developmentally normative and can contribute to positive and healthy development if it is conducted in ways that are healthy and respectful. Throughout this document "sexual behaviour" refers to a full range of sexual behaviours ranging from individual behaviour such as masturbation to sexual contact with a partner such as kissing, petting, or intercourse. However, we do not take the position that young adolescents *should* engage in the full range of behaviours, but rather that exploration of a variety of these behaviours throughout adolescence (and beginning in early adolescence) is developmentally normative and potentially healthy if conducted in ways for which the individual is emotionally and physically ready and willing. Adolescents' early sexual experiences have a significant impact on their future experiences and outcomes. Given this developmental significance and the need to guide and support adolescents in making healthy choices and creating healthy experiences, it is essential that adequate and appropriate support at various levels engage adolescents in these issues. Unfortunately, sections 15 and 16 of the Act limit the ability to provide such guidance and support to adolescents and may also prevent adolescents from seeking help because they fear being charged with a crime. Further, being charged with this crime is likely to cause significant emotional distress in adolescents as well as have a negative social impact on these individuals. In the context of high levels of sexual violence in South Africa, it is paramount that we establish healthy, safe, and respect norms for sexual behaviour from the time that individuals begin to explore their sexuality. In essence, sections 15 and 16 of the Act currently increase adolescents' risk of being involved in unhealthy, risky sexual behaviour.

CHILD AND ADOLESCENT SEXUAL DEVELOPMENT

Sexual development begins in the foetal stage during which sex differentiation takes place; infants are born with primary sex characteristics including different chromosomal/genetic structure, different levels of hormones, and different sexual organs and genitalia. Throughout childhood, physiological sexual development is usually latent and there is disagreement and controversy surrounding psychosexual development among children. During adolescence, sexual development occurs in the physiological, psychological, and social domains during the transition to adulthood. Our discussion will focus on the biological and psychosocial facets of sexual development during adolescence and the need to promote healthy sexual development among adolescents.

Biological Factors Influencing Sexual Development

Puberty is a series of biological developments during which individuals become physiologically and anatomically mature and capable of sexual reproduction. The growth spurt is one of the changes that adolescents experience as the size and shape of their bodies change. The primary sex organs enlarge and hormone levels change (e.g., growth hormone stimulates the growth of body tissue; increases in gonadotrophic hormones trigger the production of sperm in males and the release of ova in females)[3]. Menarche (beginning of menstruation) in females and semenarche (beginning of production of sperm) in males signals the beginning of physical sexual maturity. During adolescence, individuals also develop secondary sex characteristics. Females, who begin the sexual maturation process earlier than males, develop breasts, pubic and underarm hair, and rounded hips. Males develop a deeper voice and experience growth of pubic, underarm, facial and chest hair. All of these physical changes, as well as the psychological and cognitive changes that adolescents go through, also mean that they begin to understand and experience their bodies in different ways. Relevant to sexual development, adolescents begin to experience sexual pleasure and integrate a sexual identity into their self-concept and conceptualisations of their bodies[3].

Various studies have investigated the mean age at which South African youth begin puberty. Among a birth cohort of black and white female and male adolescents born in 1990 in the Soweto/Johannesburg area, initiation of puberty was assessed using the Tanner Staging System[4]. There are five stages in this scale ranging from Tanner Stage I (pre-puberty) to Tanner Stage V (sexual maturity); each stage is defined by physical measurements of external primary and secondary sex characteristics including pubic hair growth (males and females), breast development (females only), and genital development (males only). The mean age at transition from Tanner Stage I to Tanner Stage II (indicating initiation of puberty) was between 9.8 and 10.5 years for both sex and race groups. A common measure of sexual maturity among females is age at menarche, which occurs during puberty. Several studies have been conducted with racially diverse samples of South African urban adolescent girls and found that the median menarcheal age is between the ages of 12.4 years and 12.6 years[5-7]. Fewer data are available for males. One study with Tswana males measured spermaturia as an indicator of sexual maturation among boys and found that the mean age of boys with spermaturia was 14.95 years and estimated the age of onset to be between 14.10 and 15.80 years[8]. These data indicate that South African youth reach physiological sexual maturity between the ages of 12 and 16

years. The South African data of ages at these milestones in sexual development is similar to those reported in international studies. Specifically, a review of relatively recent studies in the U.S.A. have found that girls attain Tanner Stage II between the ages of 9.5 and 9.7 years[9]. In a study of 13697 individuals and 4899 sister-pairs from Australia, the Netherlands, and the UK, the mean age at menarche was found to be 13.1 years[10]. Among males, international data report the mean age of first nocturnal emission (colloquially known as "wet dream") was found to be 13.0 years among adolescent boys in Hong Kong; between 13.1 and 14.6 years among high school and undergraduate males in the U.S.A.; between 13.3 and 14.1 years among adolescent males in Nigeria; 13.7 years among young adult males surveyed in the U.K.; 14.1 years in a group of 10-19 year old males in Costa Rica; 15.6 years in 14-25 year old men in Vietnam; and 16.6 years among a sample of males in China who had not yet experienced sexual debut[11].

Psychosocial Factors Influencing Sexual Development

We cannot consider sexual development as a solely physical process. Indeed, the physical changes summarised above are only one component of child and adolescent sexual development; psychosocial and cognitive changes also play a role. Moreover, puberty has a psychological and social impact on adolescents and those around them; this impact is also influenced by the sociocultural milieu including the customs, traditions, and attitudes towards these developments, and the personality characteristics of the individual. Adolescents' sexual development may cause psychosocial distress for some adolescents or it may affect their cognitive processing as they learn a new schema to interpret information and make sexual decisions. Adolescents may also experience positive psychosocial reactions including feelings of pride and excitement about their development. The consequences of their sexual experiences also have a myriad of physiological and psychosocial effects that influence adolescents' growth and development. The physiological changes that adolescents experience require them to establish a new understanding of and relationship to their own bodies. Further, these biological changes have an impact on adolescents social functioning as they begin to explore how sexuality plays a role in their sexual and non-sexual relationships.

Socially, adolescents experience a significant reorganisation of their relationships. During adolescence individuals begin to experience different kinds of relationships and different kinds of intimacy within these relationships. For example, they spend more time with their peers outside of school than they do with their primary caregivers or other adults[2;3] and the basis of their friendships change. These relationships become closer and more intense with high importance placed on loyalty and sharing interests and attitudes. The relative influence of parents on their adolescent children decreases during this developmental stage as peers become more influential. When adolescents are in intimate relationships, the intimate partner becomes more influential than platonic friends and parents[12]. Adolescents also begin to become aware of sexual attraction, which plays a significant role in social and sexual development.

One relationship that is particularly relevant to sexual development is the intimate or dating relationship. The intimate or dating relationship provides a new context for experiential learning about emotional and physical intimacies[1]. These experiences play a significant role in adolescents' functioning as well as their development into

adults[1;13;14]. Indeed, early sexual experiences tend to have a significant impact on adult sexual behaviour and experiences. Not only are these relationships developmentally significant, they are also developmentally normative. Among a cross-sectional sample of Grade 8 and Grade 11 adolescents in Cape Town, 87% reported that they had been in or were currently in an intimate relationship[14].

It is usually within these intimate relationships that adolescents begin to explore a range of sexual behaviours including kissing, petting, oral sex, vaginal intercourse, and anal intercourse. It should be noted that sexual exploration may also occur individually (e.g., masturbation or use of sexually explicit material such as pornography) or within casual, non-dating relationships. The type of behaviours, the context in which adolescents engage in these behaviours, and the timing of sexual experimentation, is strongly influenced by sociocultural norms and attitudes related to various sexual behaviours and the scripts for them[3]. Sexual scripts are dominant sociocultural patterns of interaction that define particular roles and behaviours that people engage in during sexual interactions. Adolescents learn these scripts through social learning and observation of a variety of sources and they augment these scripts based on their own experiences[3]. These scripts also give sexual meaning to non-sexual behaviour such as hand-holding or unbuttoning a shirt and then these behaviours can elicit sexual excitement. An important aspect of adolescent sexual development involves not only the social learning and observation of sexual scripts and normative sexual behaviour, but also their own exploratory experiences with their own sexuality and sexual intimacy with a partner.

Another area of social influence on adolescent sexual development is peers. As mentioned earlier, peers and intimate partners become very influential in adolescents' lives during this developmental period. Peers (and intimate partners) also have specific influence on adolescent sexual behaviour, particularly when this topic is limited or silenced in interactions with parents, teachers, or other adults. During interviews with Grade 8 and Grade 11 adolescents[15], participants discussed peer influence on their sexual behaviour. Both boys and girls noted experiencing peer pressure to have sex and described the social status that was often ascribed to sexually active adolescents, particularly among boys. In addition, adolescents' discussions with their peers about sex seemed to largely reinforce risky sexual behaviour including having multiple partners and not using a condom (among boys) and feeling unable to negotiate sexual behaviour with partners (among girls). Often peers have little more information, particularly about safe sexual behaviour, sexual decision-making, and sexual negotiation, than one another so their pressuring and guidance is potentially misdirecting adolescents.

An Integrative Understanding of Sexual Development

Sexual development during adolescence has important biological, psychological, and sociocultural components. Beginning between the ages of 10 and 12 years, these components interact and influence one another during adolescent sexual development and form the foundation for adult sexuality. Biologically, humans experience a change in hormonal activity and the physiological maturation of sexual organs as well as beginning to discover physical sexual pleasure. On a psychological level, adolescents begin to develop the cognitive and emotional aspects of sexuality, which together with physiological feedback, motivates them to explore their sexuality to satisfy their curiosity and desire to share affection and

connection with a partner and status among peers. In addition, adolescents begin to develop the psychological and cognitive resources and skills to guide their sexual decision-making. Sexual development is closely linked with adolescent social development as peer pressure plays a significant role in adolescents' sexual choices and the intimate relationship is often the context within which sexual exploration occurs. The broader sociocultural contexts of norms and attitudes also influence the timing and type of sexual activity that adolescents will engage in during their sexual development. The links between these various domains and their influence of adolescent sexual development mean that impact on one area will affect other areas as well as sexual development as a whole.

Adolescents' motives for engaging in sexual behaviour (including a range from masturbation, kissing, or petting to oral sex, or intercourse) are complex and usually involve an interaction of physiological, psychological, and social factors. Some research has found sex differences in adolescents' motivations to initiate sexual activity; specifically, males are mostly motivated by curiosity whereas females are mostly motivated by affection for their partner[3]. Along with understanding their own sexuality, adolescents also have to learn about their partner's sexuality and how these conceptualisations interact and sexual boundaries have to be negotiated.

Promoting Healthy Sexual Development

Though exploring sexuality is developmentally normative, adolescents often experience a wide range of conflicting emotions as they navigate through the physical, psychological, and social aspects of sexuality and try to find an understanding of and language for these experiences. A common reaction, particularly in a society where sex is considered an exotic taboo and teasing adolescents about their burgeoning interest in and experience with intimate partners is relatively frequent, is for adolescents to be shy and embarrassed about these issues particularly around adults and partners. This awkwardness and discomfort often leads adolescents to avoid discussing sex and sexuality and thus not receiving any support or guidance other than from peers. Given this personal and social dynamic with regard to sexuality in adolescence, efforts need to be made to make adolescents feel more comfortable in confronting sexuality issues in safe environments with guidance from more mature individuals. Such guidance is particularly important as adolescents have underdeveloped abstract reasoning and decision-making skills. Individuals develop these cognitive skills during adolescence in addition to developing cognitive schemas related to sex and sexuality.

It is important to understand and distinguish between sexual behaviour that is *developmentally* normative and that which is *statistically* normative. It is also important to clarify what is *healthy* sexual behaviour that we want to promote and *unhealthy* sexual behaviour that we want to prevent. The discussions above have alluded to sexual behaviour as developmentally normative; that is, given their developmental stage and their developmental tasks, it is not unusual or necessarily unhealthy and harmful for adolescents to engage in sexual behaviours as they begin to learn about their sexuality and become more mature in several life domains. Data from research investigations give us information about behaviours that may or may not be statistically normative; that is, if there is a significant proportion of a group of individuals engaging in a particular behaviour. Behaviours that are statistically normative may not be developmentally normative. Further, data give us information

about specific types of behaviour. Our discussions above characterising sexual behaviour as developmentally normative does not specify the type of sexual behaviour (e.g., kissing, petting, intercourse). Another essential dimension to consider is whether the behaviour is healthy or unhealthy. With a broad view of health, promoted by the WHO, that expands the definition beyond the mere absence of illness or harm to include attention to the physiological and psychosocial factors of a state of well-being we should understand that sexual behaviours can occur along a healthy-unhealthy continuum. For the purposes of this report, we consider healthy sexual behaviour be behaviour that is mutually consensual, wanted/desired, non-violent, safe (in terms of using methods to minimise risks of STI transmission and pregnancy), and for which the individual feels emotionally and physically ready for the particular behaviour and its potential consequences,. We would want to promote such behaviour among adolescents. It is also important that we distinguish and try to prevent unhealthy sexual behaviour, which may be considered any sexual behaviour or sexual contact that would negate the criteria outlined above for healthy sexual activity. In particular, sexual behaviour that is not mutually consensual or that is violent in some way that one partner feels forced, coerced, tricked, persuaded, or manipulated into a sexual situation should be considered abnormal. no matter the statistics suggesting the wide prevalence of such sexual contact.

Promoting healthy sexual development potentially alleviates problems and distress caused by unhealthy and unsafe sexual experiences; this scenario would expect a decline in HIV and STIs, pregnancy, rape, trauma, social stigma, and emotional distress among adolescents. Reductions in these negative consequences of unsafe sexual behaviour will have an impact on multiple levels particularly as the burden of disease is alleviated within this sector. Moreover, healthy development during the adolescent developmental period is likely to have a long-lasting impact on the individual and thus on the various systems within which that individual is embedded. Thus the value of healthy development is not only reaped by the individual, but by the various social systems within which that individual interacts.

Unfortunately, the current sociocultural milieu in South Africa is marked by extremely high levels of sexual and gender violence that often mars adolescents' journey through sexual development. The current sociocultural systems at various levels do not collectively support healthy adolescent sexual development and some systems reinforce risky behaviour leaving adolescents with little guidance and support to explore their sexuality in healthful and safe ways. Individuals and organisations at all levels need to work toward creating supportive environments for youth. Adolescence is a critical developmental period because it influences outcomes and functioning in adulthood.

SEXUAL BEHAVIOUR AMONG SOUTH AFRICAN ADOLESCENTS

Several local and international studies have been conducted with adolescents assessing sexual behaviour. The majority of studies have focused on sexual risk behaviour, particularly in the context of the high rates of HIV infection among South African youth.

Prevalence of Sexual Behaviours

Research findings indicate that South Africans tend to experience sexual debut during adolescence. In a sample of 510 youth between the ages of 11 and 19 years from a peri-urban community near Cape Town, the mean age of sexual debut was 14.6 years[16]. Among a demographically representative sample (N=11904) of South African youth between the ages of 15 and 24 years who reported having had sexual intercourse (67%) the mean age at first sex was 16.7 years[17;18]. By the age of 16 years, 35% of the sample reported having had sexual intercourse[18]. In another study with a stratified sample of South African youth, the median age at sexual debut was 16.5 years for both male and female youth (N=2430) between the ages of 15 and 24 years[19]. It should be noted that the differences in mean age at debut between studies reported above may be at least in part attributed to the differences in the age of the sample. That is, the age at debut cannot be higher than the age at which a person responds to a survey and data is only available from those individuals in the sample who have experienced sexual debut. The data do indicate that a significant portion of contemporary South African youth are experiencing sexual debut before the age of 16 years.

Adolescent sexual behaviour is not limited to intercourse. Indeed, as noted earlier, there are several types of sexual behaviour in which adolescents engage. Data from two programme evaluation studies conducted in 2009 and 2004 with young South African adolescents under the age of 16 years provide information about the prevalence of various sexual behaviours. These data are presented in Table 1 below with the values indicating the percentage of youth who have engaged in the target behaviour.

Table 1. Sexual behaviour among young adolescents in South Africa

Behaviour (defined for participants)	**2009[+]**	**2004[#]**	
	Cape Town (%)	**Cape Town (%)**	**Polokwane (%)**
Had a boyfriend/girlfriend	86.5	-	-
Kissing	81.9	77.9	39.0
Light petting (touching each other's upper body under clothes or with no clothes)	28.2	33.8	25.8
Heavy petting (touching each other's private parts under clothes or with no clothes)	9.5	24.2	25.9
Vaginal sex (contact with someone during which the penis enters the vagina)	26.8	15.6	24.4
Oral sex (contact between the mouth and the penis, vagina, or anus)	6.8	12.0	10.2
Anal sex (contact with someone during which the penis enters the anus or back passage)	3.3	10.4	5.8

[+] Initial data collected in April 2009 from a small, but demographically diverse sample (N=150, 60% female) of Grade 8 learners (mean age = 14.47 years) in three Cape Town schools participating in the *Respect 4 U* study[20].

[#] Data collected in 2004 from learners in Cape Town and Polokwane area schools participating in the SATZ study. The data presented here are from a sub-group that contained only participants younger than 16 years (N = 11309, 51.1% female, mean age = 13.8 years).[21]

These data are an indication of the types and prevalence of various sexual behaviours among South African adolescents. A significant proportion of young (under 16 years old) South African adolescents are engaging in intimate relationships and exploring various sexual behaviours including kissing, light petting, heavy petting, sexual intercourse whereas oral sex and anal intercourse seem to be less common behaviours in this group.

Data from 11 to 16 year old (mean age = 13.94 years) males and females (N = 212, 50% female) from southern California document various sexual behaviours[22]. These data are presented in Table 2 below with the percentage indicating the percentage of males or females who have engaged in the target behaviour ever in their lives.

Table 2. Sexual behaviour among young adolescents in southern California, U.S.A.[22]

Behaviour	% Males	% Females
Hand holding	77	72
Brief kiss on mouth/lips	70	63
French kiss/Tongue kiss/Kissing for a long time	60	51
Let someone touch you above the waist, above clothes	-	34
Let someone touch you above the waist, below clothes	-	24
Let another person touch penis/vagina above or below clothes	46	18
Touched another person's penis/vagina above or below clothes	44	24
Oral sex (perform)	19	10
Oral sex (receive from female)	40	-
Oral sex (receive from male)	10	-
Vaginal intercourse	32	9
Anal intercourse (between males)	8	-
Anal intercourse (between male and female)	20	3

These data indicate that young adolescents tend to engage in various sexual behaviours. However, these data do not elucidate the circumstances in which youth experience sexual debut; for example, the age of the partner, the motives, and whether or not the sex was consensual are not clarified by the data presented above. Nevertheless, these data support the idea that sexual behaviour is not only theoretically developmentally normative for adolescents under the age of 16 years.

Sexual Behaviour and Risks

The high rates of HIV and sexually transmitted infections (STIs), teenage pregnancy, and rape among youth in South Africa indicate that, unfortunately, many adolescents experience sex in violent and unsafe ways. It is important to understand these problems because they require considered and collaborative responses across social systems at all levels. Intimate relationships are important contexts for sexual behaviour and sexual development during adolescence; however, these relationships can also pose a significant risk. Rape and other forms of sexual violence, particularly within intimate relationships, are also a significant issue that South African youth face. In the 1998 Demographic and Health Survey conducted in 1998, 9.7% of 15-19 year old females report being forced or persuaded to have sex against their will and 4.9% reported being physically forced to have sex[23]. In a

sample of urban female youth in South Africa, 28% reported being forced to have sex by their male partners[24]. The most frequently cited reason for sexual initiation among Xhosa females from the rural Eastern Cape was being forced to have sex by their partner[25]. Among a group of young women from KwaZulu Natal, 46% reported that their first sexual encounter was coerced[26]. Reports from males indicate perpetration of sexual violence against their female partners; 8.4% of young males living in the rural Eastern Cape reported perpetrating sexual violence against an intimate partner[27]. Only 30% of a nationally representative sample of sexually experienced young females reported that they really wanted their first sexual experience in comparison to 83% of males[18].

Intimate partner violence and sexual violence put adolescents at risk of negative outcomes including HIV or other STIs, physical injuries, pregnancy, and experiencing social and emotional trauma[28-30]. The HIV prevalence among 2-14 year old children in South Africa has been estimated to be 2.5%[31] and 4.8% among 15-19 year old youth in South Africa[18]. Unfortunately there are no available data on rates of STIs among 12-15 year old youth in South Africa. However, data from young people give us some idea of the problem of STIs among South African youth. The National HIV and Syphilis Sero-Prevalence survey of South African women attending antenatal clinics found that 3.9% of women under the age of 20 years presenting at an antenatal clinic tested positive for syphilis[32]. Nationally representative data from men over the age of 15 years showed that 12% of the men in this sample reported experiencing recent symptoms of a sexually transmitted infection[33]. Data from the Department of Health indicate that 2.4% of 15 year old women reported being pregnant at least once. This statistic increases to 7.9% of 16 year olds, 14.2% of 17 year olds, 24.6% of 18 year olds, and 35.1% of 19 year olds[33]. Research data show that 35% of women under the age of 20 years have been pregnant at least once and the first pregnancies commonly occur while these women are still in high school[34]. Though 66% of sexually active adolescent females in the same sample reported using contraceptives, only 4% used condoms[33]. Hormonal contraceptives offer fairly reliable protection against pregnancy, but they do not offer the protection against STIs that barrier methods, such as condoms, do. The concern with young adolescents is that even if they avoid the negative health outcomes discussed above, their early sexual experiences shape and influence individual norms for sexual behaviour. Therefore, if these initial experiences are negative or risky instead of healthy and positive, there is a greater likelihood of future sexual risk behaviour and experiencing the myriad of negative outcomes associated with this behaviour.

The high rates of the negative experiences and consequences of sexual behaviour discussed above suggest that adolescents need guidance and support in differentiating between such behaviour and more positive, healthy sexual behaviour. Developmentally normative, healthy sexual behaviour cannot be considered or treated the same as unhealthy, violent, risky sexual behaviour. It is important to distinguish that while consensual sexual behaviour is developmentally normative during adolescence, sexual violence is neither normative nor healthy. In the context of sexual violence in this country it becomes even more important to clearly differentiate between these behaviours and experiences such that they can be appropriately dealt with through promotion of healthy behaviour and prevention or punishment of violent behaviour. From a human rights perspective and a public health perspective, it is essential that we empower our young adolescents to make

healthful and safe sexual decisions that will promote their healthy development and well-being and prevent continued sexual violence in South Africa.

In summary, data from various sources indicate that the majority of South African adolescents between the ages of 12 and 16 years are engaging in a variety of sexual behaviours as they begin to explore their sexuality. Though initial explorations are developmentally normative, too often South African adolescents do not experience these events in healthy or positive ways because of the high levels of violence and various forms of coercion and manipulation present in the events.

POTENTIAL EFFECTS OF CRIMINALISING CONSENSUAL SEXUAL BEHAVIOUR BETWEEN ADOLESCENTS UNDER THE AGE OF 16 YEARS

We have established that exploration of and experimentation with sexual behaviours is developmentally normative among young adolescents and because of the potential long-term impact (particularly of developmental outcomes during adulthood) of sexual behaviour at this age, it is considered developmentally significant. Therefore, it is essential that we create supportive structures and systems throughout all environmental levels that will promote optimal development, particularly during the crucial stage of adolescence. A law that criminalises healthful, safe, mutually consensual, and developmentally normative behaviour does not contribute to an environment conducive to optimal sexual development for adolescents. Such a law could have both direct and indirect problematic effects on adolescents.

Emotional Distress

In the event that an adolescent is charged with violating sections 15 and 16 of the Act, it is likely that this experience will have an adverse impact on the individual and her or his development. The experience of being charged with this violation is likely to cause the individual to feel a mixture of shame, embarrassment, anger, and regret. Particularly in vulnerable youth, these feelings may exacerbate or feed into existing psychosocial difficulties including both intrapersonal and interpersonal issues. Of great concern is the likelihood that these feelings will contribute to a negative sexual schema and decreased help-seeking, both of which increase adolescents' risk for negative experiences and outcomes. It is also possible that the adolescents' caregivers may experience their own feelings of embarrassment and anger if their child is charged with this crime and these reactions may contribute to a less supportive environment for the adolescent.

Diminished Help Seeking

The emotional distress adolescents are likely to experience following being charged with this crime is likely to inhibit the individual from seeking help for issues about sex. Such inhibition is likely to have a negative impact on the individual and his or her sexual development because she or he is isolated from potentially supportive resources and systems. Moreover, adolescents may be less likely to seek help for sexual issues for fear of being charged with crime even for engaging in normative, healthy behaviour. That is, in order to avoid the emotional distress and interpersonal or social problems, adolescents will avoid seeking help or being open about issues

with their sexuality. In these situations of diminished help-seeking, existing problems will grow and future problems are unlikely to be prevented.

Adolescents often tend to be reticent in sharing their experiences and dilemmas and seeking help from appropriate sources such as parents or other adult caregivers within various social systems so work needs to be done to encourage more openness and help-seeking that will help adolescents make healthier choices during their sexual development. “Young people must be reassured that when they get into difficulty they can turn to us, and our behaviour must demonstrate that we will assist them rather than harangue and harass them. Access to services that enable adolescent boys and girls to make sexual and reproductive choices with the assistance of caring adults requires change to a mindset that is genuinely helpful”[35]. Sections 15 and 16 of the Act contribute more to silencing and isolating adolescents, which makes unhealthy behaviour and poor developmental outcomes more likely.

Inability to Educate, Empower, Guide, and Support

Not only are adolescents less likely to seek help in an environment where normative, healthy sexual behaviour is criminalised, but less adequate and appropriate help will be available to them. Caregivers (including parents, adult family members, other caregivers, healthcare practitioners, teachers, mentors, etc.), and institutions and organisations (including schools, youth centres, NGOs, etc.) are unable to help because they cannot promote behaviour that is illegal and they are legally obligated to report sexual offences involving children and young adolescents. Given that adolescents will be faced with complex sexual issues for the first time between the ages of 12 and 16 years, it is essential to support and guide them in making appropriate choices that promote their health and well-being. Further, the tragically high levels of sexual violence in South Africa indicates a need to empower and educate youth about making healthy and safe sexual choices, particularly focusing on the importance of consent. Therefore, they cannot legally offer the adequate and appropriate support and guidance to promote healthy sexual development, which leaves adolescents to navigate the complex issues with only the support of their equally immature peers. Adequate support and guidance in this area requires open discussions about sexuality as well as the promotion of healthy and safe sexual decision-making by highlighting the various issues that may arise.

Research has shown that adolescents who discuss sex and sexual health with their parents openly are less likely to engage in sexual risk behaviour[36;37]. Parent-child sexual communication that is open and includes specific information and discussion about risk and risk reduction strategies has been shown to have a positive influence on adolescent sexual behaviour[37]. Mothers have been found to be influential in their daughters’ constructions of their own sexuality and feelings of sexual agency. Specifically, daughters whose mothers limited their message to a warning against sex as dangerous had a limited sense of sexual agency and were more likely to lie to their mothers about their sexual activity[36]. This limited sense of agency and the deception of caregivers put adolescent girls at particular risk for experiencing unhealthy, unsafe, and non-consensual sex. Therefore, it is important for adolescents to feel free and comfortable to have discussions with their caregivers about sexuality issues and it is likely that caregivers will need education and support in navigating these discussions without the concern that they are colluding with their child in illegal activity.

The national need to educate, empower, and encourage safe and healthy sexual behaviour among our youth beginning at a young age is hampered by sections 15 and 16 of the Act. Under these sections of the Act, adolescents would be taught abstinence-only before the age of 16 years; and not just abstinence from sexual intercourse, but abstinence from all sexual behaviours. Such an education programme is unrealistic, disempowering, and potentially harmful. It is unrealistic because most adolescents will engage in sexual behaviour before the age of 16 years. It is disempowering and potentially harmful because adolescents know little about what to expect or how to manage it without accurate and consistent information and skill-building around sexuality issues. Abstinence-only education has been promoted in the United States and reviews of the impact of such an education programme have highlighted the problems and negative impact of such limited education. Specifically, a review comparing outcomes from abstinence-only programmes and comprehensive sex education programmes found that abstinence-only programmes had inconsistent effects and did not delay sexual debut[38;39]. In contrast, comprehensive sex education programmes showed a significant positive effect on adolescent sexual behaviour including delay in initiation of sex and increased safe sex behaviours including condom and other contraceptive use[38]. Another study comparing outcomes of adolescents who received comprehensive sex education, abstinence-only education, or no formal sex education found that the adolescents who received comprehensive sex education were less likely than the adolescents who received either abstinence-only or no formal sex education[39]. Comprehensive sex education has been found to be more effective than abstinence-only or no sex education in reducing youth sexual risk behaviour including delays in sexual debut, reductions in number of sexual partners, and reductions in pregnancy and diagnosed STIs among youth[40]. Abstinence-only education programmes have been found to have no significant impact on adolescents' values or attitudes toward sexual activity[41]. Abstinence-only or no sex education is harmful because it denies adolescents their right to important health information they need to make decisions and understand the consequences of their behaviour. Further, abstinence-only and no sex education ignores the reality that adolescents will face sexual issues and therefore need the skills to manage these issues as they arise.

When adolescents are left to sort through sexuality issues and choices among themselves, they tend to engage in more risky behaviours for a variety of reasons including poor decision-making skills and power imbalances in a relationship. Owing to adolescents' developmentally immature abstract reasoning skills, their decision-making abilities are limited. Further, their ignorance of the myriad of consequences related to particular behaviours, particularly behaviours that are considered taboo such as sexual behaviour, does not allow them to make informed decisions. Adolescents need guidance in understanding the various potential consequences of various sexual behaviours as well as how to make sexual decisions and how to deal with sexual dilemmas and sexual pressure.

Social Impact and Stereotyping

Sections 15 and 16 of the Act contribute to social taboos and silences around adolescent sexuality particularly by discouraging adolescents to seek help and disabling adults from providing appropriate and helpful guidance and support that will promote adolescents' growth and development. Individuals, particularly girls, who

are charged with this crime are likely to experience negative social consequences including stereotyping, gossip and rumours, teasing, and estranged peer relationships. Girls charged with this law may be stereotyped as “sluts,” whereas boys would be viewed more positively as “studs” within the current constructions of appropriate sexual expressions for males and females. Therefore, girls are more likely to suffer from sections 15 and 16 of the Act than boys are. These social reactions are likely to generate emotional distress in adolescents.

Such stereotyping reinforces the dominant patriarchal system in our society in which hegemonic masculinities support men’s sexual entitlement and control of women. Further, gender inequality in our society becomes particularly problematic because there is an inherent power difference between men and women. That is, men have more power than women in our society and unfortunately this power differential is exploited in demonstrating hegemonic masculinity that is abusive in its very construction[28]. Within heterosexual intimate relationships, this power differential can manifest in unhealthy ways such as boys having the decision-making power to direct the relationship, and manipulating or being violent toward their girlfriends. Such behaviour by boys is supported by social gender norms that promote constructions of masculinity based on sexual prowess and the abuse of women as sexual objects[28]. Girls who have a limited sense their own sexual agency are even more likely to accept and submit to their partner’s influence and higher levels of sexual risk behaviour are more likely in these situations[42;43]. Therefore, we need to help adolescents establish healthy norms within their relationships and effectively deal with the gendered power and other issues that arise. By creating silences around this issue, sections 15 and 16 of the Act are in effect perpetuating the status quo of gender inequality.

Inappropriate Use of the Law

Because of the nature of the behaviour targeted by sections 15 and 16 of the Act, it is possible that it may be used in unhelpful ways. For example, caregivers might report their adolescent child for breaking sections 15 and 16 of the Act because they do not want their child to be involved in intimate relationships and want to discourage or punish their chid. Other parents or educators may choose to make an example of the individuals charged with the law in an attempt to discourage others from engaging in sexual behaviour. Such actions would certainly have a detrimental effect on the young people publicly labelled and stereotyped in this way, particularly because this is unfair treatment for engaging in normative, consensual sexual behaviour. Young people could also report one another as an act of revenge or social rivalry. Further, adolescents charged with this law may report that it was non-consensual behaviour in an effort to absolve themselves. These potential misuses of sections 15 and 16 of the Act contribute to the negative impact of this law on adolescents and their development and well-being as well as negative impacts at wider societal levels.

Increasing Risk Factors

By not distinguishing between healthy and unhealthy sexual behaviour, limiting help-seeking and help provision, sections 15 and 16 of the Act will, in our opinion, contribute to adolescents’ risk of experiencing unhealthy sexual contact. It is likely to be a confusing event for the adolescent who is being punished for engaging in consensual (and potentially healthy and safe), developmentally normative behaviour.

The punishment teaches the adolescent that the behaviour is wrong and this conceptualisation is likely to disrupt the development of healthy sexuality. Being charged with a crime under this law is an inappropriate consequence for consensual sexual behaviour between two adolescents between the ages of 12 and 15 years most particularly because the behaviour may be developmentally normative and consensual. Further, inappropriate consequences are unlikely to effectively change or manage behaviour. Not only the potential punishment, but the existence of sections 15 and 16 of the Act in its current form suggest that the behaviour is harmful and that adolescents should be discouraged from engaging in any sexual behaviour. Although sexual behaviour has potential negative consequences and could be considered harmful, particularly in the case of non-consensual sexual behaviour, it can be healthy and safe. By not distinguishing between healthy, safe, consensual sexual behaviour and unhealthy, unsafe, non-consensual sexual behaviour the law is considering these opposite ends of the spectrum as one entity, which is inaccurate and potentially harmful to adolescents. Indeed, a clear distinction should be made particularly between consensual and non-consensual sexual activity where consensual sexual behaviour is acceptable and non-consensual sexual behaviour is unacceptable.

Conclusion

Sections 15 and 16 of the Act in its current form contribute more to increasing adolescents' vulnerability than to protecting them from harm by restricting caregiver and institutional support and guidance as well as contributing to lower levels of help seeking by adolescents. Moreover, these sections of the Act potentially curb healthy, normative development, which can have long-lasting impacts. In a country struggling against sexual violence, every attempt needs to be made to promote healthy, safe, consensual sexual behaviour and prevent unhealthy and violent sexual behaviour. Establishing healthy norms as early as possible is likely to avert many later problems and contribute positive to individual and community-wide health and well-being.

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