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Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Bill [B18-2014]

Submission

Submitted to

The Committee Secretary
The Portfolio Committee on Justice and Correctional Services
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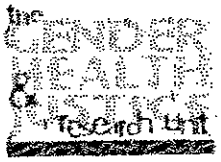

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INTRODUCTION

The Gender, Health and Justice Research Unit (GHJRU) at the University of Cape Town is an interdisciplinary research unit that unites scholars, NGOs and practitioners in pursuit of the elimination of violence against women and children in Southern Africa and beyond.

The GHJRU would like to thank the Portfolio Committee on Justice and Correctional Services for the opportunity to comment on the Amendment Bill that aims to remedy shortcomings in the Criminal Law (Sexual and Related Matters) Amendment Act 32 of 2007 highlighted in the judgment delivered in the matter of the *Teddy Bear Clinic for Abused Children and Another v Minister of Justice and Constitutional Development and Another (CCT 12/13) [2013] ZACC 35)* (hereafter the 'Teddy Bear Clinic Case').

The GHJRU welcomes the current formulation of Sections 15 (1)(b) and 16(1)(b) in the current Bill before the Parliamentary Portfolio Committee on Justice and Correctional Services, and commends the DoJ for taking these progressive steps which are in keeping with international trends in law relating to child sexuality and sexual offences.[1] We note that the current Bill has taken into serious consideration previous submissions made to the Department of Justice (DoJ) by the GHJRU and other organisations, including the Centre for Child Law (University of Pretoria), in amending Sections 15 (1)(b) and 16(1)(b) such that children in the 12 to 16 year age category who commit acts of consensual sexual penetration or sexual violation with one another are excluded from prosecution, and also goes further to exclude those aged 16 or 17 years from prosecution if the age gap between them and the adolescent concerned is less than two years, including for acts of consensual sexual penetration.

Where we have recommended changes to the Amendment Bill, we have indicated these as follows:

[ ] Words in bold type in square brackets indicate omissions from the current Bill.

— Words underlined with a solid line indicate insertions into the current Bill.

THE AMBIT OF THIS SUBMISSION

This submission focuses on four areas of the current Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Bill [B18-2014] (hereafter 'the current Bill') that was issued for comment by interested parties by 03 February 2015. These are addressed as follows:

1. Section 15(2) relating to how the decision to prosecute a child, 16 or 17 years of age, will be made, *and*
   Section 16(2) relating to how the decision to prosecute a child, 16 or 17 years of age, will be made.[2]
2. Section 50(2) relating to the addition of particulars to the National Register for Sexual Offenders.

[1] For example, Canada, Germany, and Switzerland have adopted a tiered age of consent where sex involving those under 16 years of age is not prosecuted if both partners consent and the difference in ages between those involved is no more than the allowable number of years.

[2] Given that the substance of our concern in respect of sections 15(2) and 16(2) are the same, we deal with these under one heading.

3. Section 51(2) relating to the removal of particulars from the National Register for Sexual Offenders
4. Section 67 relating to regulations necessary for the implementation of the Act.

Each section of this submission begins with a discussion of the relevant sections of the Amendment Bill, and highlights concerns therein, then provides specific recommendations for remedying these concerns.

1. SECTIONS 15(2) and 16(2): THE DECISION TO PROSECUTE A SEXUAL OFFENCE

The Amendment Bill retains the possibility of the older child being prosecuted in Sections 15 and 16, in cases of consensual sexual activity but restricts this possibility to children who were either 16 or 17 years old at the time of the commission of the offence, and in cases where the age gap between the children exceeds two years. The GHJRU welcomes the proposal that criminal liability be limited to these specific circumstances.

However, the current formulation of Section 15(2) and Section 16 (2) places decision-making power about the prosecution with the Director of Public Prosecution (DPP), and not the National Director of Public Prosecution, and further, permits the DPP to delegate that decision:

> 15.(2)(b) The **[National]** Director of Public Prosecutions concerned may **[not]** delegate his or her power to decide whether a prosecution in terms of this section should be instituted or not.
>
> 16.(2)(b) The Director of Public Prosecutions concerned may [not] delegate his or her power to decide whether a prosecution in terms of this section should be instituted or not.

These revised provisions raise some concern about the proficiency, criteria and consistency with which those decisions will be made.

Recommendation

To this end, we recommend that Section 15(2)(b) and Section 16(2)(b) of the current Bill revert to their previous formulation, where the DPP must determine whether or not to prosecute. Accordingly we recommend that Sections 15 (2) (b) and 16 (2) (b) read as follows:

> 15.(2)(b) The **[National]** Director of Public Prosecutions concerned may **not** delegate his or her power to decide whether a prosecution in terms of this section should be instituted or not.
>
> 16.(2)(b) The Director of Public Prosecutions concerned may **not** delegate his or her power to decide whether a prosecution in terms of this section should be instituted or not.

In addition, we recommend that Regulations are included that address the measures that will be put in place to limit the harm of exposure to the criminal justice system for children charged under these sections. These Regulations should include the process and procedures that will be followed in

determining whether prosecution of children should be instituted or not. For instance, the use of a social workers' report or the use of other forms of psycho-social assessment that are relevant in assessing age-appropriate sexual activities and the consequences of those activities on the children in question.

Alternately, should the Parliamentary Portfolio Committee elect to allow the DPP to 'delegate his or her power to decide whether a prosecution in terms of this section should be instituted or not', we then recommend the addition of subsection (3) in Section 67, delineating the need for the Minister to make regulations detailing:

a) To whom the decisions about whether or not to prosecute a child who committed a sexual offence in terms of Section 15(2) or 16(2)(a) of the current Bill may be delegated;
b) The factors to be considered in such determinations; and
c) What measures will be put in place to limit the harm of exposure to the criminal justice system for children charged under these sections.

See SECTION 67: THE NEED FOR REGULATIONS NECESSARY FOR THE IMPLEMENTATION OF THE ACT.

2. SECTION 50(2): THE NATIONAL REGISTER FOR SEXUAL OFFENDERS

The objectives in the Proposed Amendment Bill provide presiding officers with 'a discretion to order that the particulars of a person who was a child at the time of the commission of a sexual offence against another child or a person who is mentally disabled, may not be included in the Register' and 'a procedure in terms of which an affected person may apply to the same court, which made the original order for the inclusion of that person's particulars in the Register, for an order to remove his or her particulars from the Register'.

The Amendment Bill further proposes that Section 50 of the principal Act is amended by the substitution for subsection (2) of the following subsection:

(2) *(a)* A court that has in terms of this Act or any other law—

(i) convicted a person of a sexual offence against a child or a person who is mentally disabled and, after sentence has been imposed by that court for such offence, in the presence of the convicted person; or

(ii) made a finding and given a direction in terms of section 77(6) or 78(6) of the Criminal Procedure Act, 1977, that the person is by reason of mental illness or mental defect not capable of understanding the proceedings so as to make a proper defence or was, by reason of mental illness or mental defect, not criminally responsible for the act which constituted a sexual offence against a child or a person who is mentally disabled, in the presence of that person,

must, subject to paragraph *(c)*, make an order that the particulars of the person be included in the Register.

(b) When making an order contemplated in paragraph *(a)*, the court must explain the contents and implications of such an order, including section 45, to the person in question.

(c) Before making an order in terms of paragraph (a), the court must—

(i) inform a person, who was under the age of 18 years at the time of the commission of the offence, of the court's power to make an order in terms of paragraph (a); (ii) afford the person referred to in subparagraph (i) an opportunity to make representations why such an order should not be made,

where after the court may direct that the particulars of such a person not be included in the Register.

It also provides for the substitution for subsection (4) of the following subsection:

(4) Where a court, for whatever reason, fails to make an order under subsection (2)(a), in respect of any person other than a person referred to in paragraph (2)(c)(i), the prosecuting authority or any person must immediately or at any other time bring this omission to the attention of the court and the court must make such order.

The limitation of Section 50 (2) to young offenders aged 16 and 17 only, is welcomed. However, the authors are concerned that the Amendment Bill takes a less measured approach as the Amendment Bill no longer includes consideration of an assessment report by a registered mental health professional in order to determine whether or not to list an offender 16 or 17 years old at the time of the offence, in the Sexual Offender Register (SOR). However while the current proposed Bill does retain the opportunity for representations to be made for why an order for the registration of an offender accused of a sexual offence should not be made, the authors believe that the omission of the requirement of an assessment is a regressive step. If the option to list a child in the Register is necessary, the decision to do so must be informed by a recognised expert in the field of child sex offending.

While the provision appears to be neutral, in practice, the functioning of the section is likely to constitute indirect discrimination on the basis of race and/or ethic or social origin as a decision made solely on the basis of the child's representation is inequitable. Inevitably, a child who has access to financial means will enlist a private mental health professional and include this opinion in their representation, whereas a child who does not have the means will not be able to do this.

Hence, the GHJRU would like to reiterate its position (in the submission to the DoJ on 30 October 2014) that **the registration of a child accused and convicted of a sexual offence is not in the best interests of these children.** We provide reasons for this below.

2.1 The Intention(s) of Sexual Offender Registers (SORS):

International registers for sexual offenders fall into five broad categories:

(i) registers that create certain employment restrictions for sexual offenders, for instance, working with children or within children's institutions (similar to South Africa's Criminal Law [Sexual Offences] and Related Matters Amendment Act of 2007);

(ii) registers that impose specific post-sentence conditions or restrictions on sexual offenders such as no contact with children or victims directly victimised by the perpetrator, the location of housing that offenders occupy, or prohibitions in relation to living in proximity to a school or day care centre (similar to the types of conditions linked to parole);

(iii) registers that require sexual offenders to notify authorities of their change of address, change of employment, arrest or conviction of any other offence as well as to report at regular intervals to police authorities (similar to general conditions linked to probation);

(iv) registers that inform the public of the release of sexual offenders (notification registers); and

(v) registers that permit the routine monitoring of sexual offenders (ranging from random to regulated monitoring).

SORs also vary in terms of:

(i) the extent to which SORs may require participation in court-mandated sexual offenders' rehabilitation programmes;

(ii) the length of time that convicted sexual offenders are registered;

(iii) the conditions under which de-registration may occur, if at all;

(iv) whether the registries are made public or are maintained private by the relevant authorities; and

(v) the consequences of failing to comply with the conditions of the SOR.

While legislatures, policing and judicial authorities have rationalised SORs as mechanisms that reinforce protection of the community against sexual perpetration, research on SORs overwhelmingly demonstrates that SORs have *little to no effect* in the prevention of sexual offences. In fact, in our review of empirical and clinical literature on SORs and related mechanisms to assess young sexual offenders, there were very few empirical studies that suggested that SORs have the desired impact of prevention or reducing recidivism. In fact, there is strong evidence that SORs have little to no deterrent effects or reduce recidivism and that the majority of adolescent who are arrested for a sexual offence never commit a sex crime again.

The lifetime registration of children or young offenders on SORs has been considered tantamount to 'cruel and unusual punishment' for the reason that they violate fundamental principles that require sentencing practices to distinguish between adult and child offenders[3]. While studies on child sexual offending focus on different dimensions of offending – for instance, the nature/profile of offences, assessment and treatment of offenders, recidivism, personality and clinical profiles of offenders and comparability with child non-sexual offenders or adult offenders – the literature unfailingly reinforces one position: young sexual offenders are different from adult sexual offenders. The current law does not take into account the differences in the nature of, and motivations for, offending, factors that precipitate offending behaviour, neurobiological and social development differences between children and adults, nor the rehabilitative potential of young sexual offenders.

[3] Carpenter, C. L. (2013). Against Juvenile Sex Offender Registration. Available at: the Social Science Research Network (SSRN): http://dx.doi.org/10.2139/ssrn.2319139.

Socio-legal scholarship on the use of SORs has raised similar themes regarding child and adolescent sexual offenders as above, for instance:

- The availability of and right to procedural safeguards to protect child offenders, including: informed judicial discretion, consideration of specific circumstances, assessment of risk and privacy. Obvious arguments against registering young sexual offenders on SORs have included that SORs violate the protective principles of the International Covenant on Civil and Political Rights (ICCPR) which prohibits arbitrary interference with a child's privacy as well as the Convention on the Rights of the Child (CRC). Articles 16(1), 16(2) and 40 of the UNCRC are of relevance here. However, in some jurisdictions, the "privacy" argument has failed on the basis that conviction is (a) already a matter of public record or (b) adjudication of matters relating to the child are already confidential.

- That SORs, and other legal 'interventions' for young sexual offenders, require proper assessment measures not just 'assessments' per se. Where individual assessment of children is not part of the registration and maintenance of the registration process, "risk" and "continued" risk, an essential element of adjudicating young sexual offender for forensic and legal interventions and treatment, cannot be assessed[4].

- That SORs violate the principle of individual sentencing.

- That SORs hinder the potential for reform (by removing opportunities). They are often more punitive in nature than rehabilitative and may deter children who commit sex offenses from later becoming productive members of society[5].

2.2 Adult versus Child Sexual Offenders

The literature on child sexual offenders reinforces the notion that adolescent cognitive functions are different than those of adults, for instance, child sex offenders are less likely to use extreme forms of sexual aggression against their victims and are more compulsive (or less calculated) than adult offenders[6]. It also emphasises that very few child offenders exhibit the same long-term tendencies to commit sexual offences as chronic adult offenders[7] and that child sex offenders are more

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[4] See for example Hoge, R.D. (2012). Forensic Assessments of Juveniles Practice and Legal Considerations. *Criminal Justice and Behavior* 39(9), p. 1255-1270; Hempel, I., Buck, N., Cima, M., & van Marle, H. (2011). Review of Risk Assessment Instruments for Juvenile Sex Offenders: What is Next? *International Journal of Offender Therapy and Comparative Criminology*, 57(2), p. 208-228; Worling, J.R., & Langton, C.M. (2012). Assessment and Treatment of Adolescents Who Sexually Offend: Clinical Issues and Implications for Secure Settings. *Criminal Justice and Behavior* 39(6), p. 814-841.

[5] Grover, A (2013). Delinquency and Punishment: The Impact of State v. Williams on Juvenile Sex Offender Registration in Ohio. *University of Cincinnati Law Review* 81(1), p. 291-311; 32; Justice Policy Institute (2008). Registering Harm: How Sex Offense Registries Fail Youth and Communities 5 (2008). Available at http://www.justicepolicy.org/images/upload/08-11_RPT_WalshActRegisteringHarm_JJ-PS.pdf.

[6] See for Cauffman, E. and Steinberg, L. (2000). (Im)Maturity of Judgement in Adolescence: Why Adolescents May Be Less Culpable Than Adults. *Behavioural Sciences and the Law* 18(6), p. 741-760; Finkelhor, D., Ormrod, R., & Chaffin, M. (2009). Juveniles Who Commit Sex Offenses against Minors. *Juvenile Justice Bulletin*, December 2009, p. 1-12. US Department of Justice: Office of Juvenile Justice and Delinquency Prevention.

[7] See Lussier, P. and Blokland, A. (2013). The Adolescence-Adulthood Transition and Robins's Continuity Paradox: Criminal Career Patterns of Juvenile and Adult Sex Offenders in a Prospective Longitudinal Birth Cohort Study. *Journal of Criminal Justice*, 42(2), 153-163; Reingle, J. (2012). Evaluating the Continuity Between Juvenile and Adult Sex Offending: A Review of the Literature. *Journal of Crime and Justice* 35 (3), p. 427-434; Ronis, S., and Borduin, C. (2007). Individual, Family, Peer and Academic Characteristics of Male Juvenile Sex Offenders. *Journal of Abnormal Childhood Psychology* 35(2), p.153-163.

responsive to treatment than adult offenders due to their continuing psychological development[8]. Research has also powerfully illustrated the difference between childhood and adulthood (sexually) offending behaviours, in particular, the critical motivational, neurological, psychological and behavioural differences between young sexual offenders and adult sexual offenders, including the likelihood of children re-offending in adulthood. Research is also beginning to highlight the distinction between developmentally normative sexual behaviours and sexual offending, something that the substantive criminal law does not always take into account.

It has also been argued that registration requirements impose restrictions on young offenders that inhibit their ability to embrace a reformed life and is detrimental to young sexual offenders. Recalling that separate 'child justice' systems were universally created and are predicated on the principles of rehabilitation and reintegration rather than punishment, the registration of young offenders seems counter-intuitive to these intentions. Not only does automatic registration onto a Registry conflict with the principles of youth justice and rehabilitation[9], there is no connection – in most jurisdictions – between the prevailing laws and scientific knowledge about young sexual offenders[10]. By direct example, South Africa's Child Justice Act demonstrates a clear and undisputable recognition that child and adult offenders should be treated differently in the criminal justice system. The registration of child sex offenders contradicts this principle and, as Letourneau et al. (2010) have argued, "is antithetical to the philosophy of [a system] which strives to balance community safety with the rehabilitative needs and rehabilitative potential of juveniles" (p.566). Carpenter (2013) even suggests that "mandatory lifetime registration applied to children in the same manner as adult offenders is cruel and unusual punishment because it violates fundamental principles that require sentencing practices to distinguish between adult and child offenders" (p. i-ii).

Recommendation

In light of this evidence, and considering that South Africa currently does not use standardised instruments for young sexual offenders (and their risk of future offending or rehabilitation potential), **it is recommended that section 50 excludes the order for the registration of children under the age of 18, unless there are extremely compelling circumstances to demonstrate that a child is an exceptionally "high risk" offender, which determination needs to be made by a recognised expert in the field of child sex offending.**

In essence, we specifically recommend that the onus in these cases should be on the state to demonstrate why the young offender *should* be on the Register, as opposed to the child's representative (at the child's expense) presenting reasons for why the child *should not* be on the Register.

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[8] See Grover, A (2013). Delinquency and Punishment: The Impact of State v. Williams on Juvenile Sex Offender Registration in Ohio. *University of Cincinnati Law Review* 81(1), p. 291-311; Letourneau, E.J., and Miner, M.H. (2005). Juvenile Sex Offenders: A Case Against the Legal and Clinical Status Quo. *Sexual Abuse: A Journal of Research and Treatment* 17(3), p. 293–312; Reitzel, L. & Carbonell, J. (2006). The Effectiveness of Sex Offender Treatment for Juveniles as Measured by Recidivism: A Meta-Analysis. *Sexual Abuse: A Journal for Research and Treatment* 18(4), p. 401-421.

[9] See the UNCRC 1989, the Child Justice Act Child 75 of 2008 and child justice frameworks around the world.

[10] Vess, J., Day, A., Powell, M. and Graffam, J. (2013). International sex offender registration laws: research and evaluation issues based on a review of current scientific literature. *Police Policy and Practice* 14(3), p. 205-218.

In cases where offences are serious, but fall short of the exceptionally "high risk" category, we recommend that the court may require participation in a court-mandated sexual offender's rehabilitation programme as part of the sentence.

In light of the above, we still endorse the additional provision proposed by the Centre for Child Law et al in their previous submission to the DoJ (in October 2014), as follows:

Section 50(2):

(2A) *(a)* If a court has in terms of this Act or any other law convicted a person ("A") of a sexual offence against a child or a person who is mentally disabled and A was 16 or 17 years old at the time of the commission of such offence, the court may not make an order as contemplated in subsection (2)*(a)* unless –

(i) the prosecutor has made an application to the court for such an order;

(ii) A has been assessed, at state expense, by a suitably qualified person, as prescribed, with a view to establishing the likelihood of whether or not he or she will commit another sexual offence against a child or a person who is mentally disabled;

(iii) A has been given the opportunity to make representations to the court as to why his or her particulars should not be included in the Register; and

(iv) the court is satisfied that substantial and compelling circumstances exist, based upon such assessment and any other evidence, which justify the making of such an order.

(b) In the event that a court finds that substantial and compelling circumstances exist which justify the making of an order as contemplated in subsection (2)*(a)*, the court must enter such circumstances on the record of the proceedings.

3. SECTION 51(2)

As with the previous section, Section 51(2) of the Amendment Bill differs from the previous Bill put forward by the DoJ (in 2014) in that it does not require that a person (16 or 17 years old) who was a child at the time of the commission of the offence who wishes to be removed from the SOR be assessed by a mental health professional. In the current Bill, such a determination would be made based on the individual's own representations about he or she is rehabilitated and unlikely to reoffend, as well as an affidavit to confirm that they have indeed not committed another sexual offence relating to a child of person who is mentally disabled.

This is problematic, as in practice, the functioning of the section is likely to constitute indirect discrimination on the basis of race and/or ethic or social origin as a decision made on the basis of the child's representation and affidavit is inequitable. Inevitably, a child who has access to financial

means will enlist a private mental health professional and include their opinion in their representation; where as a child who does not have the means will not be able to do this, and will be less likely to be removed from the SOR.

Further, balancing the best interests of the child with the protection of society at large is a complex task, and in order to make a sound decision, based in the most realistic prediction about the likelihood of the person reoffending, an expert in child sexuality and/or sexual offending should be consulted.

Recommendation

As South Africa currently does not use standardised instruments to understand child sex offenders and their risk of future offending or rehabilitation potential of young sexual offenders, the authors recommend the use of an assessment at the expense of the state by a recognised expert in the field of child sex offending, in which the best interest of the child is paramount, balanced against the protection of society at large. To this end we recommend the insertion of subsection (c) into Section 51 as follows:

> (c) A has been assessed, at state expense, by a suitably qualified person, as prescribed, with a view to establishing the likelihood of whether or not he or she will commit another sexual offence against a child or a person who is mentally disabled.

4. SECTION 67: THE NEED FOR REGULATIONS ON THE REGISTRATION OF CHILD OFFENDERS

According to Section 15 and Section 16 of the Amendment Bill, children 16 and 17 years of age engaged in consensual sexual activity with other children more than 2 years younger than themselves may be prosecuted. Given their age and that their conduct is considered by experts in the field to be within the range of normal sexual exploration and development, it important to minimise their exposure to the criminal justice system as much as possible, and the authors believe that Regulations should be developed to address this.

In addition, should Section 15(2)(b) and Section 16(2)(b) of the Proposed Amendment Bill remain the same and permit delegation of decision-making responsibilities by the DPP regarding the prosecution of children aged 16 and 17 for engaging in consensual sexual activity with a child more than 2 years their junior but older than 12, it is necessary to compel the Minister to make regulations detailing:

- Who, should the DDP elect to delegate this decision, will make decisions about whether or not to prosecute a child who committed a sexual offence in terms of Section 15(2) or 16(2)(a) of the Bill;
- The basis on which such decision will be made; and
- What measures will be put in place to limit the harm of exposure to the criminal justice system for children charged under these sections.

Recommendation

To this end, we recommend the addition of subsection (3) in Section 67 as follows:

> 67.(4) The Minister must make regulations regarding what measures will be put in place to limit the harm of exposure to the criminal justice system for children 16 and 17 years old, who may be charged under Sections 15 and 16 of this Act, including their treatment before such a determination to prosecute, and their treatment before trail.

We also recommend should delegation of the decision of whether or not to prosecute, in accordance with Section 15 (2) (b) and Section 16 (2) (b), be permitted, the addition of subsection (4) and (5) in Section 67 as follows:

> 67.(4) The Minister must make regulations regarding the procedure to be followed in respect of the delegation referred to in Section 15(2)(b) of this Act, including whom the DDP may delegate to and how this party is expected to make decisions.
>
> 67.(5) The Minister must make regulations regarding the procedure to be followed in respect of the delegation referred to in Section 16(2)(b) of this Act, including whom the DDP may delegate to and how this party is expected to make decisions.

end

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

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

BACKGROUND TO THE PROJECT

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

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

THE 'TEDDY BEAR CLINIC' JUDGMENT AND REPORTING OBLIGATIONS

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

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

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

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

IN BRIEF:

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

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

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

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

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

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

A CHALLENGING LEGAL FRAMEWORK

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

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

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

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

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

METHODOLOGY

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

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

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

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

FINDINGS

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

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

INCONSISTENT KNOWLEDGE OF THE LAW

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

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

CONFUSING TERMINOLOGY

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

PERSONAL VALUES AND SERVICE PROVISION

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

The study's findings clearly show how nurses are caught in the middle of the contradictory and conflicting positions vis-à-vis teenage sexuality and reproductive rights that have become embedded in the legal framework. While they are trained as health care workers, when it comes to teenage sexuality they are expected to do far more than just provide medical care: they and are a critical source of reproductive health education and serve as trusted confidantes on matters pertaining to sex. The role of "law enforcer" - as assigned by the SOA - is therefore an uncomfortable fit.

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

RECOMMENDATIONS

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

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

LAW REFORM

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

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

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

IMPROVING SERVICE PROVISION

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

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

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

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