AGE OF CONSENT: LEGAL, ETHICAL, CULTURAL AND SOCIAL REVIEW
SOUTH AFRICA COUNTRY REPORT
FOREWORD

There is one barrier to health access and a major impediment to national and regional development across the globe that could be removed within a few days if only the policy decisions would be made. The removal of this barrier would promote gender equality, help end child marriage, reduce teenage pregnancy and girl dropout rates from secondary school, lower HIV incidence rates, and achieve the prerequisite for the demographic dividend. Let me explain.

As the Sustainable Development Goals (SDGs) become the world’s compass towards development and a better life for all people on the planet, sub-Saharan Africa faces a potential demographic disaster that could undermine many of the SDGs.

Many sub-Saharan countries have some of the highest fertility rates in the world which, if unaltered, will see those countries’ population, rising from 17 million to 43 million by 2050. Another country’s population that is currently at 27 million will more than double to 65 million by 2050, with yet another going from 53 million to 137 million. Not one of these countries will have reached the population turnaround required as an inescapable prerequisite for achieving a demographic dividend by 2050.

With increases like these on the same available land area, with the same or less access to drinking water, potentially less arable land available due to global warming, and services and GDP increasing at a far slower rate than population, it will be impossible to achieve the SDGs and improbable to even maintain the human development index achieved thus far by 2017. These are not scenarios or ‘maybes’. This is the inevitable future of the region unless something significant, such as the fertility rates, changes. Slowing and reversing population acceleration is essential to development in sub-Saharan Africa.

And yet, the world has a dark and shameful history of ‘population control’, legislating women’s rights to decide on having children away and forcing and coercing sterilisation. These restrictions on agency and autonomy have no place in a democratic, sustainable development world in the 21st century and the vast majority of nations achieving the demographic dividend have not resorted to such dark methods.

Increasing gender equality, keeping girls in safe schools for longer, reducing sexual and gender based violence, and increasing the sexual and reproductive health knowledge of young people are also factors. And of course, it is the increased access to modern contraceptives and women making choices about their own reproductive health that have turned the tide.

So this research report turns its attention to this access to modern contraceptive methods, as well as all other sexual and reproductive health (SRH) services. There are many barriers for adolescents around the globe - the majority of citizens in many countries – to access SRH services. Distance from services, lack of transport, lack of available commodities, poverty, inherited beliefs, harmful practices, and hostile staff attitudes can all be barriers to access. But only one barrier is self-inflicted by countries. And this barrier could disappear tomorrow, creating massive access for adolescents. It is the barrier of legal restrictions on adolescents’ access to SRH. The majority of countries in the region have placed arbitrary legal barriers to adolescent access by creating policies or laws with a number of parental consent and other restrictions, preventing adolescents from initiating their own healthcare.

In some cases, these have been gradually added to laws or policies with well-intentioned reasons to protect adolescents. In many cases, however, they reflect an idealised view of what older people think younger people should or should not be doing. Primarily, these idealised views revolve around sex. Older people, sometimes forgetting their own youth, think that the best protection for younger people is to abstain from sex until they are, perhaps 16, or even 18. Reality is, in many cases different, and by ignoring reality and locking adolescents out of the health system when it comes to sexual and reproductive health and rights (SRHR), adults are doing irreparable damage to their children and other children, as well as directly contributing to a looming demographic disaster for their nation.
Because this seems so obvious, recent global guidelines have called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of all SRH services. To assist in this process, the SRHR Africa Trust (SAT) in collaboration with the Thomson Reuters Foundation, 20 global law firms, and UNICEF, has reviewed Age of Consent laws in 22 countries: Botswana, Kenya, Ivory Coast, Malawi, Morocco, Nigeria, South Africa, Swaziland, Tanzania, Zambia, Zimbabwe, Brazil, Jamaica, India, Indonesia, Thailand, Vietnam, Canada, United Kingdom, France, Sweden, and Ukraine.

The range of countries was chosen to highlight a spread of geography, cultures, development status, nonachievement, in-transition and achievement of the demographic dividend, and adolescent health outcomes. In addition, SAT and UNICEF also undertook an Ethical, Cultural and Social review in nine countries (seven being from the 22 countries above, plus two others - Uganda and Philippines) to look at ethical cultural and social barriers impacting adolescent access to health and services including SRH services.

The data revealed some game-changing recommendations apparent to SAT:

1. Desexualise SRHR services and treat them as you would any other health system access;
2. Base both access and restriction decisions on child and adolescent development, competence and maturity to make decisions about their own health;
3. Do not make the age of sexual consent older than 16 years, and do not distinguish between young men and young women;
4. Have statutory rape provisions in place to protect adolescents from predatory adults;
5. Put ‘close in age’ exceptions to the age of sexual consent in place so that young adolescents having consensual sex with one another do not have to go to jail – a travesty affecting young men aged 13-16 years.

We offer this report and its insights to policymakers, legislators, development agencies, international cooperating partners, and activists wherever they may be. A thinking and action tool is currently being designed to accompany this report. If you wish to receive it or an electronic copy of this report, please send an e-mail to ageofconsent@satregional.org. Please also feel free to share ways in which you may have used this report or the action tool to create positive change with us and with one another.

Our hope is that these resources will create dialogue and action that will remove all legal barriers to adolescent access to SRH services and allow attention and resources to focus on the remaining and more intractable barriers.

Jonathan Gunthorp

Executive Director - SAT
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SOUTH AFRICA

AGE OF CONSENT
LEGAL, ETHICAL, CULTURAL
AND SOCIAL REVIEW
ACRONYMS

AIDS  Acquired Immune Deficiency Syndrome
ANC  Antenatal Care
ART  Antiretroviral Therapy
EHP  Essential Health Package
GDP  Gross Domestic Product
HCT  HIV Counselling and Testing
HIV  Human Immunodeficiency Virus
HPV  Human Papillomavirus
MMC  Medical Male Circumcision
MPR  Multiple-perpetrator Rape
MSP  Multiple Sexual Partners
PLWHA  People Living with HIV/AIDS
PLWHIV  People Living with HIV
PEP  Post-exposure Prophylaxis
PrEP  Pre-exposure Prophylaxis
SRHS  Sexual and Reproductive Health Services
UNAIDS  Joint United Nations Programme on HIV/AIDS
UNICEF  United Nations International Children’s Fund
UNFPA  United Nations Population Fund
WHO  World Health Organization
YFS  Youth-friendly Services
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EXECUTIVE SUMMARY

In South Africa the age of sexual consent is 16 years and Sexual intercourse with a person under the age of 12 years is illegal. Sexual intercourse between persons aged 12-17 years may be illegal depending on the age gap between the partners. There are rules which allow persons aged 12-17 years to engage in consensual sexual intercourse depending on the age gap between the partners.

Persons older than 12 years can consent to medical treatment on their own behalf if they have sufficient maturity and mental capacity. The Age of Consent for access to contraception is 12 years or older. Contraceptives that are not condoms can be provided to children 12 years or older without parental consent following provision of medical advice and a medical exam.

Children aged 12-17 years can consent to medical treatment on their own behalf if they have sufficient maturity and mental capacity. On Antiretroviral Therapy South Africa has a policy for access.

The country does not have an age restriction for HIV Post-Exposure Prophylaxis (PEP). The Sexual Offences Act enables access to PEP. There is no prohibition on HIV Pre-Exposure Prophylaxis (PrEP).

South Africa law and policies allow for safe and post care abortion. Women under 18 years of age are advised to consult their parents when considering safe abortion but they do not require parental consent to obtain an abortion.

The Age of Consent to access HIV testing without parental consent is 12 years. Younger children can be tested without parental consent if they have sufficient maturity. HIV test results are reported to the person who consented to the testing.
Chapter One: Introduction

The world's attention has moved beyond HIV and AIDS, yet it remains the leading killer of adolescents in Southern Africa, presenting a major impediment to healthy communities and a significant factor in the health and status of women and girls in the region.

According to a report by the Joint United Nations Programme on HIV/AIDS (UNAIDS) on prevention of HIV (2013), Eastern and Southern Africa is home to half the world’s population living with HIV, even if the region is only 5% of the world’s population. Today the region continues to be the most infected and affected by the HIV/AIDS epidemic, with 48% of the world’s new HIV infections among adults, 55% among children, and 48% of AIDS-related deaths.

Research conducted in many parts of the world shows that several legal and human rights barriers hinder access to, and uptake of, HIV services for adolescents. Key among these barriers are Age of Consent legislation and policies. Recent global guidelines have, therefore, explicitly called on countries to examine their current policies and consider revising them to reduce age-related barriers to access and uptake of the overall SRH services, HIV Counselling and Testing (HCT) and to linkages to prevention, treatment and care.

HIV is the most severe in the Southern Africa sub-region which includes Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe, with each having an adult HIV prevalence of over 10%. UNAIDS reports that Swaziland have the highest HIV prevalence in the world (26.0%), followed by Botswana (23.4%).

In 2011, there was an estimated 1.2 million adolescents aged 10-19 years old living with HIV, more than half of all HIV positive adolescents globally. Eastern and Southern Africa now have 10.5 million children who have lost one or both parents to AIDS.

The risk of becoming infected with HIV is higher for girls and young women and currently, HIV prevalence among young women aged 15-24 years stands at 4.8%, which is two and a half times higher than among men of the same age. In Swaziland, 15.6% of young women are HIV positive, compared to 6.5% of young men.

The advocacy campaign ‘All In To #EndAdolescentAIDS’ was launched as a global platform for action and collaboration for social change in February 2015 by global leaders and civil society partners. This global agenda provides opportunities for ensuring that existing and new strategies and programmes on HIV prevention, treatment and care are effectively implemented to benefit young people. These include the 2012 guidance on Pre-exposure Oral Prophylaxis (PrEP) for serodiscordant couples, men, and transgender women who have sex with men at high risk of HIV transmission, as well as the 2013 guidance for HCT and care for adolescents living with HIV and young key population policy briefs.

All In To #EndAdolescentAIDS works through four workstreams. As part of workstream 1, global partners have prioritised joint action to take stock of the current situation in countries with respect to Age of Consent for services including HIV prevention by carrying out a systematic desk review of Age of Consent laws and a mapping of the processes led and outcome of reforms undertaken by countries to address this barrier. Through the All In To #EndAdolescentAIDS, many agencies, and global partners including the United Nations Development Programmes (UNDP), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the PACT and AIDS Alliance have already initiated actions on data collection to inform their policy advocacy efforts globally and specifically within the 25 focus countries. This review will inform the development of a source or toolkit for learning on this theme and capacity building of experts and policymakers worldwide.

Why Age of Consent review?

Several global bodies, including UNICEF and WHO, are currently undertaking a number of initiatives to change the global guidelines with regard to adolescent access to a range of HIV prevention services, including Age of Consent and informed consent, confidentiality, availability, accessibility, and acceptability. Adherence and quality must inform these services.
The SRHR Africa Trust (SAT) in collaboration with UNICEF worked with participating local law firms, and a consultant to conduct the Age of Consent research. The three areas of the research included the following:

1. Age of Consent legal review
2. Ethical, Social, Cultural (ESC) desktop review
3. Youth attitudes survey

Therefore, the main goal of the project was to conduct research on “Age of Consent” laws, regulations, and policies, as well as ESC factors, in relation to adolescents. This entailed collecting country experiences to address Age of Consent laws / polices and ESC factors that serve as potential barriers to adolescents accessing SRH services, including HIV prevention, care and treatment. The research explored implications for expanding SRHR services and HTC in adolescents aged 10–19 years.

Methodology

The South Africa legal, ethical, cultural and social review was prepared by SAT and is based on legal review research conducted by Norton Rose Fulbright South Africa and the ethical, cultural, and social review by Jerome Amir Singh, Centre for the AIDS Programme of Research in South Africa (CAPRISA), Durban, South Africa, and Dalla Lana School of Public Health, University of Toronto, Toronto, Canada.

The ethical, cultural and social review focuses on the norms and practices around the Age of Consent in relation to the various aspects relating to SRHR. The legal review looks at all the relevant national laws (including nationally recognised customary or religious laws), regulations, and policies exploring the ages for girls and boys separately where relevant, including where contradictions exist in laws, policies, and regulations on these issues.

The review specifically looked at the following:

1. Age of Consent to sexual intercourse including the age for statutory rape
2. Age of Consent to access modern contraceptives, with and without parental consent
3. Age of access to emergency contraceptives, with and without parental consent
4. Policy framework and legislation enabling or disenabling access to Pre-exposure Prophylaxis (PrEP) including Age of Consent, with and without parental consent
5. Policy framework and legislation enabling or disenabling access to Post-exposure Prophylaxis (PEP) including Age of Consent, with and without parental consent
6. Policy framework and legislation enabling or disenabling access to safe abortions and postabortion care including Age of Consent, with and without parental consent
7. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC) including Age of Consent, with and without parental consent
8. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent, with and without parental consent
9. Age of Consent to access HIV testing without parental consent.

The ethical, cultural and social component of the study seeks to highlight social and cultural factors, and the ethical dimensions thereof, that impact on adolescent health in the following contexts:

1. Age of Consent for sex.
2. Homosexuality and transgender expression.
3. Access to Sexual and Reproductive Healthcare Services, including autonomous HIV counselling and testing [HCT] and contraception access.

South Africa’s analysis was conducted through a desk review of publically accessible sources, including works published by international agencies such as UNICEF, WHO, UNAIDS, UNFPA, and the World Bank, South African Government reports, and non-governmental research outputs.
Country overview

South Africa is Africa’s most heterogeneous country, with a multiracial, multiethnic population of approximately 55 million people, and 11 national languages. Vast intra-cultural variation occurs within South Africa. An estimated 44.23 million of the population is black (who are culturally and linguistically diverse, but primarily of Bantu descent), 4.83 million is mixed-race, 4.53 million is white (who are descendants of numerous European countries, but who today primarily identify as Afrikaans or English speaking), and 1.36 million is Asian (who are culturally diverse, but primarily of Indian, and secondarily, Chinese descent). Approximately 30.2% of South Africa’s population is under 15 years of age. Collectively, adolescents aged 10-19 years account for 20% of the country’s population, with adolescents aged 10-14 years of age constituting approximately 10% of the South African population, and adolescents aged 15-19 years comprising 10% of the population. Of the total adolescent population, male and females comprise approximately 50%, respectively.

Whilst approximately 86% of the country’s population identify as Christian, the country is home to significant religious minorities. Approximately 5% of South Africans follow ancestral, tribal, animist, or other traditional religions, 2.2% of the population is Muslim, approximately 1% is Hindu, 0.2% is Jewish, 0.3% follow other faiths, while 5.5% report not following any religion in particular. Significant regional variations occur amongst South Africa’s nine provinces in respect to religious and cultural beliefs. Individuals were most likely to be Christians in the Northern Cape (98%) and Free State (98%), and least likely to be so in Limpopo (77.8%), and KwaZulu-Natal (78.7%), where 7.2% and 11.1% of individuals, respectively, followed ancestral, tribal, animist or other traditional African religions. The largest number of individuals who profess to follow ‘nothing in particular’ are to be found in Limpopo (14.5%), Eastern Cape (8.7%), and Gauteng (7.7%). The highest concentrations of Muslims are to be found in the Western Cape (7.4%) and KwaZulu-Natal (2.6%), while the highest concentration of Hindus is to be found in KwaZulu-Natal (3.9%). These variations highlight that social and cultural factors that could impact on adolescents differ widely across South Africa.

Country context

- South Africa is classified as an upper middle income country with a nominal GDP of $350.1 billion.
- South Africa’s mid-year population estimate in 2015 was approximately 55 million.
- Females comprise approximately 51% of South Africa’s population.
- 18% of the global population of people living with HIV (PLWHIV) are South African and 25% of PLWHIV in Sub-Saharan Africa, are South African.
- Globally, South Africa accounts for 16% of new HIV infections annually and 23% of Sub-Saharan Africa’s new HIV infections.
- South Africa accounts for 17% of AIDS-related deaths in Sub-Saharan Africa and 13% of globally.
- The total number of PLWHIV in South Africa is estimated to be approximately 6.2 million (2015). This equates to approximately 11.2% of the country’s total population. Approximately one-fifth of South African women in their reproductive ages are HIV-infected.
Chapter Two: Age of Consent to sexual intercourse

Age of Consent for sex

According to South African law, ‘sexual penetration’ includes any act which causes penetration to any extent whatsoever by-

a. the genital organs of one person into or beyond the genital organs, anus, or mouth of another person;

b. any other part of the body of one person or, any object, including any part of the body of an animal, into or beyond the genital organs or anus of another person; or

c. the genital organs of an animal, into or beyond the mouth of another person, and ‘sexually penetrates’ has a corresponding meaning.13

Early sexual debut (<16 years of age), voluntary or coerced, continues to be a major risk factor for acquiring HIV infection in South Africa.14 It is thus important to consider the impact of social and cultural factors on Age of Consent for sex.

In South Africa, the legal Age of Consent for sex, regardless of sexual orientation, is 16 years of age,15 although sexual acts between two children, where both are between 12 and 16 years of age or where one is under 16 years of age and the other is less than two years older, are not criminal.16 Data from nationally representative cross-sectional surveys conducted in South Africa indicate that the median age of sexual debut in SA is approximately 16 years for males and 17 years for females.17 South Africa's Birth to Twenty Plus study, which is unique in that it is the largest and longest running study of child and adolescent health and development in Africa,18 reports a median age of sexual debut of 16 years for females and 15 for males.19 From some samples of MSM in South Africa, the majority report their age of sexual debut to be earlier than 16 years of age.20

All major religions practiced in South Africa consider pre-marital sex morally repugnant. As noted earlier, approximately 86% of South Africans identify as Christians.21 Christian morality prohibits premarital sex, restricting it solely to the confines of marriage. Similarly, African culture dictates that women should remain chaste until marriage.22 In African culture, adolescent girls are rarely recognized as sexual beings and the preservation of virginity on the part of a female is synonymous with preserving her honor.23 According to African traditional religions, the virginity of a young girl is symbolic of purity. Virginity is tantamount to good social standing and brings honor to the virgin’s family.24 Likewise, Islam places a high premium on preserving virginity until marriage and premarital sex is deemed unacceptable.25 Hinduism does not consider premarital sex to be a religious taboo.26 However, such interactions are discouraged for cultural and caste reasons.27 Judaism is ambivalent towards premarital sex. Jewish holy scripture does not overtly mention premarital sex, but there is no strict prohibition against it either.28

In terms of traditional African customs, puberty is regarded as the minimum requirement for marriage as the ultimate goal of a marriage was regarded as procreation.29 According to traditional Islam, once puberty is reached, marriage can occur.30 Similarly in traditional Hinduism, fathers are encouraged to arrange their daughter’s marriage soon after she reaches puberty31 and marriage is permissible if both parties have reached puberty.32 Similarly, Jewish tradition encourages marriage once puberty is reached.33 These traditional beliefs and practices align with South African Roman-Dutch common law, which holds that a child cannot get married below the age of puberty, i.e. under 12 years of age for girls and under 14 years of age for boys.

Only three types of marriages enjoy legal recognition in the country: (i) statutory civil marriages, (ii) African customary marriages, and (iii) civil unions (enacted specifically to allow for same-sex unions).34 Cohabitation / domestic partnership, sometimes referred to ‘common law marriages’ (i.e., informal marriages, or marriages by habit and repute that have not been statutorily registered), do not enjoy legal recognition in South Africa. Similarly, marriages concluded solely in accordance with Hindu, Islamic, or other religious rites do not enjoy legal recognition in South Africa. However, if the marrying parties go through a civil marriage ceremony or are married by a Muslim or Hindu priest who is a marriage officer, the law will recognize their marriage. The parties then cannot marry any other person by civil law, and the marrying parties, must, in addition, statutorily register their marriage for their union to enjoy legal recognition.
Thus, while from an historical perspective in South Africa, it was considered culturally and legally permissible for adolescents to marry and to subsequently have sexual intercourse from the onset of puberty in furtherance of conjugal duties and/or procreation, in terms of contemporary South African statutory law, individuals may autonomously marry from 18 years of age, unless certain conditions are met (see Box 1). Furthermore, a child below the minimum age set by law for a valid marriage may not be given out in marriage or engagement; and above that minimum age may not be given out in marriage or engagement without his or her consent.

Box 1

Age at which a child may enter into marriage in terms of civil law in South Africa

18 – without parental consent.

Girls: 15 to 17 – with consent of the girl and her parents.
Girls: 12 to 14 – with the consent of the girl, her parents AND the Minister of Home Affairs.
Boys: 14 to 17 – with the consent of the boy, his parents AND the Minister of Home Affairs.


Age at which a child may enter into marriage in terms of African customary law in South Africa

18 - without parental consent

Boys aged 14 to 17: With the consent of the boy, the parents AND the permission of the Minister of Home Affairs or an officer in the public service authorised by the minister to give permission for the marriage.
Girls aged 12 to 17: With the consent of the girl, the parents AND the permission of the Minister of Home Affairs or an officer in the public service authorised by the minister to give permission for the marriage.


Marriages involving adolescents under 18 years of age remains relatively uncommon in South Africa. In 2013, of the 158,642 civil marriages registered in the country that year, the marriages of only 14 bridegrooms and 172 brides aged less than 18 years of age were registered. African traditional practices such as ukuthwala (discussed below, page 14, paragraph 2) allow for early-age marriages.
Legislation and policy framework

South African law provides for differing ages of consent depending on the age of the respective parties.

CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT 32 OF 2007

Definitions and interpretation of Act

1. Children under the age of 12 are deemed “incapable in law of appreciating the nature of the sexual act” and are therefore unable to give consent to a sexual act. Engaging in a sexual act with a child under the age of 12 years is therefore an offence under the appropriate section of the Act (the nature of the offence and the section which applies depends on the nature of the sexual act) “child” means a person under the age of 18 years and “children” has a corresponding meaning; “sexual penetration” includes any act which causes penetration to any extent whatsoever by -

2. Where both parties are 12 years or older, but younger than 16 years of age, consensual sex between the parties may legally take place.
   a. the genital organs of one person into or beyond the genital organs, anus, or mouth of another person;
   b. any other part of the body of one person or, any object, including any part of the body of an animal, into or beyond the genital organs or anus of another person; or

3. Where one party (A) is 16 or 17 years old and the age difference between A and other party (B) is not more than two years, consensual sex between the parties may legally take place. (i.e a 14-year-old may legally have consensual intercourse with another party who is no older than 16; a 15-year-old may legally have consensual intercourse with another party who is no older than 17).

For the purposes of sections 3, 4, 5(1), 6, 7, 8(1), 8(2), 8(3), 9, 10, 12, 17(1), 17(2), 17(3)(a), 19, 20(1), 21(1), 21(2), 21(3) and 22, “consent” means voluntary or uncoerced agreement.

4. In all other cases, both parties must be 16 years or older in order for consensual intercourse to take place legally. (3) Circumstances in subsection (2) in respect of which a person (“B”) (the complainant) does not voluntarily or without coercion agree to an act of sexual penetration, as contemplated in sections 3 and 4, or an act of sexual violation as contemplated in sections 5(1), 6 and 7 or any other act as contemplated in sections 8(1), 8(2), 8(3), 9, 10, 12, 17(1), 17(2), 17(3)(a), 19,20(1), 21(1), 21(2), 21(3) and 22 include, but are not limited to, the following:

The above provisions apply equally to males and females.

d. where B is incapable in law of appreciating the nature of the sexual act, including where B is, at the time of the commission of such sexual act –
   i. asleep;
   ii. unconscious;
   iii. in an altered state of consciousness, including under the influence of any medicine, drug, alcohol or other substance, to the extent that B’s consciousness or judgement is adversely affected;
   iv. a child under the age of 12 years; or
   v. a person who is mentally disabled.

(the underlining is ours)
15. Acts of consensual sexual penetration with certain children (statutory rape)

1. A person (‘A’) who commits an act of sexual penetration with a child (‘B’) who is 12 years of age or older but under the age of 16 years is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual penetration with a child, unless A, at the time of the alleged commission of such an act, was-
   a. 12 years of age or older but under the age of 16 years; or
   b. either 16 or 17 years of age and the age difference between A and B was not more than two years.

2. a. The institution of a prosecution for an offence referred to in subsection (1) must be authorised in writing by the Director of Public Prosecutions if A was either 16 or 17 years of age at the time of the alleged commission of the offence and the age difference between A and B was more than two years
   b. The Director of Public Prosecutions concerned may delegate his or her power to decide whether a prosecution in terms of this section should be instituted or not.
   c. The genital organs of an animal, into or beyond the mouth of another person, and “sexually penetrates” has a corresponding meaning;

Definition of statutory rape

Statutory rape is not a defined term in South African legislation. However, Section 15 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 32 of 2007 (the Sexual Offences Act) is headed “Acts of consensual sexual penetration with certain children (statutory rape)".

Legislation and policy framework

Section 15 of the CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT 32 OF 2007, above

16. Acts of consensual sexual violation with certain children (statutory sexual assault)

Section 15 states that a person who has sex with a child who is 12 to 15 years of age is ‘guilty of the offence of having committed an act of consensual sexual penetration with a child’ unless the circumstances fall within those set out in the answer to section above. Therefore, although the term is not expressly defined, this section sets out the definition of statutory rape.

1. A person (‘A’) who commits an act of sexual violation with a child (‘B’) who is 12 years of age or older but under the age of 16 years is, despite the consent of B to the commission of such an act, guilty of the offence of having committed an act of consensual sexual violation with a child, unless A, at the time of the alleged commission of such an act, was-
   a. 12 years of age or older but under the age of 16 years; or
   b. Section 16 of the Sexual Offences Act deals with statutory sexual assault. This section makes it an offence to commit a consensual act of sexual violation with children in the same age brackets as those set out in s15 (b) either 16 or 17 years of age and the age difference between A and B was not more than two years.

“sexual violation” includes any act which causes -

a. direct or indirect contact between the -

The definitions in the act (quoted in question 1 above) provide that a child under the age of 12 is deemed incapable of giving consent to a sexual act. Therefore, committing a sexual act with a child under the age of 12 is an offence under the section of the Act which deals with the particular sexual act in question.
i. genital organs or anus of one person or, in the case of a female, her breasts, and any part of the body of another person or an animal, or any object, including any object resembling or representing the genital organs or anus of a person or an animal;

Eg. Section 5(1) of the Sexual Offences Act provides that “A person (“A”) who

ii. mouth of one person and - unlawfully and intentionally sexually violates a complainant (“B”), without the consent

aa. the genital organs or anus of another person or, in the case of a female, her breasts; of B, is guilty of the offence of sexual assault.” Therefore, any person who intentionally

bb. the mouth of another person; sexually violates a child under the age of 12 is guilty of sexual assault as the child cannot consent to the violation.

cc. any other part of the body of another person, other than the genital organs or anus of that person or, in the case of a female, her breasts, which could -

aaa. be used in an act of sexual penetration;

The effect of the above is as follows:

bbb. cause sexual arousal or stimulation; or

● A person younger than 12 years cannot consent to sexual acts - sex with such a person is therefore statutory rape

ccc. be sexually aroused or stimulated thereby; or

● 12 year olds and 13 years olds may legally consent to sex with other persons who are not older than 15 years of age. If a person who is 16 years or older engages in a sexual act with a person who is 13 years or younger, it would constitute an offence.

dd. any object resembling the genital organs or anus of a person, and in the case of a female, her breasts, or an animal; or

● 14 year olds may consent to sexual acts with other persons who are not older than 16 years of age. If a person who is 17 years or older engages in a sexual act with a person who is 14 years or younger, it would constitute an offence.

iii. mouth of the complainant and the genital organs or anus of an animal;

● 15 years olds may consent to sexual acts with other persons who are not older than 17 years of age. If a person who is 18 years or older engages in a sexual act with a person younger who is 15 years or younger, it would constitute an offence.

b. the masturbation of one person by another person; or

● 16 year olds may consent to sexual intercourse with any person who is older than they are. Consensual sexual intercourse with a person who is 16 years or older would therefore not constitute an offence.

c. the insertion of any object resembling or representing the genital organs of a person or animal, into or beyond the mouth of another person, but does not include an act of sexual penetration, and “sexually violates” has a corresponding meaning
Ethical implications and recommendations

The country’s liberal legislative stance in treating alike the Age of Consent for sex in respect to heterosexuals and homosexuals, is to be applauded. While major religions in South Africa have historically facilitated adolescent sexual activity through the performance of religious ceremonies involving adolescents, contemporary social mores and the country’s legislative environment have ensured that relatively few adolescents under the legal Age of Consent for sex have been parties in civil marriages. This indicates that marriage has an insignificant impact on adolescent sexual debut in contemporary South Africa.

Gendered role beliefs about the appropriateness of refusing sex has been shown to play a significant role in encouraging multiple sexual partnerships. Such cultural norms may play a role in adolescent sexual debut and/or sexual activity, irrespective of legal Age of Consent for sex, or marriage norms. Multiple sexual partners are significantly more common in South Africa among those who have early sexual debut. Authorities and other stakeholders should engage with communities, especially adolescents, to change social norms about the apparent perceived inappropriateness to refuse sex. Moreover, adolescents should be encouraged to delay sexual debut and discouraged from engaging in multiple concurrent sexual relationships.

Homosexuality and transgender expression

South Africa boasts one of the world’s most liberal legislative environments in respect to sexual orientation. The country became the first in the world to prohibit discrimination on the grounds of sex, gender, and sexual orientation in its Constitution. Sodomy was explicitly decriminalized in 1998 and the country permits same-sex couples to contract civil unions, which the parties could refer to as a marriage or civil partnership. Despite South Africa’s liberal constitutional and legislative stance in respect of sexual orientation, societal values in regard to homosexuality in South Africa tend to be conservative. Homosexuality is considered sinful and offensive to Christian morality. From a traditional African perspective, homosexuality is regarded as counter to cultural traditions and beliefs. Accordingly, many African traditionalists consider homosexuality to be a western construct and alien to Africa, despite the prevalence of homoerotic elements in South African history, including reports of inter-femoral sex amongst men in African society, and claims of Shaka Zulu and his warriors engaging in homosexual activities. Similarly, the cultural practices of other ethnic and religious groups in South Africa also consider homosexuality taboo. For instance, all three monotheistic faiths condemn homosexuality in their respective scriptures. The Rigveda, one of Hinduism’s four canonical sacred texts is believed to recognize both homosexuality and transsexuality.

In light of the above, the majority of traditional cultural beliefs across different ethnic and cultural groups in South Africa, as well as religious mores, serve as barriers to adolescents expressing their homosexuality freely. From a social perspective, homosexuality is considered socially unacceptable amongst South African youth. Discrimination, bullying and abuse of homosexual students is rife in South African schools. However, a study conducted in a private secondary school among Grade 11 learners in an affluent area of Johannesburg, revealed that although students may feel uncomfortable around homosexual students, this discomfort does not necessitate violence. Some students expressed ambivalence towards the sexual orientation of their peers, whilst others had no issue with homosexual classmates. In fact, some believed that homosexuality is acceptable. Consequently, since transsexuals are usually misconstrued as homosexuals, they too are socially and culturally misunderstood and condemned by South African society. Likewise, transsexual adolescents suffer the same abuse, stigma and discrimination as homosexual adolescents do.

Exceptions for gay sex

There are no exceptions in law for gay sex in South Africa. The provisions of Section 15 and 16 of the Sexual Offences Act are widely defined and encompass virtually all sexual acts.
Ethical implications and recommendations

Evidence has shown that: “there is no basis for the view that homosexuality is ‘un-African’ either in the sense of being a ‘colonial import’, or on the basis that prevalence of people with same-sex or bisexual orientations is any different in African countries, compared to countries on any other continent.”58,59,60

Government, the media, corporate sector, civil society, and society at large, including academics, scientists, and religious leaders, should work towards challenging misconceptions about the history and prevalence of homosexuality in Africa. Moreover, these role-players have an ethical duty to foster an ethos of acceptance towards homosexuals and transgender adolescents in South Africa, in line with the country’s constitution and universal human rights norms.

Country experiences in addressing the barriers

Despite the vast legal gains South Africa has made in regards to sexual orientation, homophobic attacks continue to plague the country’s lesbian, gay, bisexual and transsexual (LGBT) youth.61 Increasingly violent hate crimes effected against the LGBT community, including corrective rape and murder62 has pervaded South Africa. In acknowledgment of the dire need to protect South Africa’s LGBT community, in March 2016 the country’s Department of Justice and Constitutional Development (DOJ&CD) and the South African Human Rights Commission (SAHRC), hosted a summit to foster deliberations on how to address discrimination predicated on the sexual orientation and gender identity of individuals.63 There is hope that the declaration stemming from this summit will urge other Governments to follow suit.64 In 2011, a national action plan on crimes against the lesbian, gay, bisexual, transsexual and intersex (LGBTI) community was mandated by DOJ&CD.65 The minister of the DOJ&CD mandated the formation of a National Task Team (NTT) to establish a national intervention strategy to address violent attacks based on sexual orientation and gender identity affecting the LGBTI community.66 Moreover, in an attempt to dissipate the baseless notion that homosexuality is un-African67, the Academy of Sciences of SA (ASSAF) convened a multi-disciplinary expert scientific panel to consider homosexuality in the African context. Entitled ‘Diversity in Human Sexuality, Implications for Policy in South Africa’,68 the report dispels the perception that homosexuality is a “lifestyle choice” as opposed to an inherent characteristic that one is born with and has no control over.
Chapter Three: Access to contraception services and commodities

Access to sexual and reproductive health services [SRHS], including autonomous HIV counselling and testing [HCT] and contraception access

Condoms are freely accessible in South Africa from a wide ranges of places, including clinics, public toilets, and telephone booths. Condoms can also be bought from pharmacies and shops. However, alternative contraception, including injectables and pills, require consultations with medical professionals or medical providers. This hinders access as adolescents are often met with judgmental attitudes. Adolescents express concerns about attending SRHS consultations as they fear that staff will breach their confidentiality to their parents. Some adolescents express negative perceptions regarding contraception. For instance, they believe contraception stunts fertility. This can be a major deterrent to contraceptive use as child-bearing is considered a pivotal role in traditional African culture. Male adolescents have negative attitudes towards use of female contraceptives. They believe that it could render adolescent girls sterile. Moreover, they believe that it makes their female peers promiscuous. Significantly, male adolescents believe that it prevents them from controlling their partner. Adolescent girls shy away from contraception because they are afraid that it could result in their relationships being terminated by their boyfriends. Parents, teachers and church leader’s attitudes towards sexuality and contraception erects moral and religious barriers. There is a lack of communication with adolescents concerning these matters as it is viewed as culturally immoral, inappropriate, and embarrassing to discuss. Communication between parents and adolescents about contraception is viewed as encouraging or condoning promiscuity. Catholicism prohibits artificial methods of family planning. Therefore, contraception use is prohibited by the Church. Conversely, mainstream Protestantism has no restriction on contraceptive use, and neither does Islam nor Hinduism. African traditional religions place emphasis on high fertility, equating reproductive failure with sin. Thus, contraceptive use is not encouraged. Contraceptive prevalence in South Africa is estimated to be 65%. Contraception services are freely and widely accessible from the majority of public health facilities, as these services are funded by the Government’s health budget. Condoms are not yet freely accessible in schools. However, the Department of Basic Education (DBE) is working towards making SRHS, including the provision of male and female condoms, accessible to all students in public schools.

Numerous cultural norms and social practices impact on adolescents’ access to SRHS. The focus in this section will be on four such factors: (a) potentially harmful traditional practices; (b) stigma and discrimination; (c) institutionalized male dominance; and (d) sexual partnering norms.

The Children’s Act 38 of 2005 (the Children’s Act) provides that no person may refuse to sell condoms to a child over the age of 12 or provide a child over the age of 12 with condoms on request where such condoms are provided free of charge. It also provides that contraceptives other than condoms may be provided to a child on request and without the consent of a parent or care-giver if:

i. the child is at least 12 years of age;
ii. proper medical advice is given to the child; and
iii. a medical examination is carried out to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child.

Legislation and policy framework

Children’s Act 38 OF 2005

1. Interpretation
   1. In this Act, unless the context indicates otherwise -

   “child” means a person under the age of 18 years;

134. Access to contraceptives
1. No person may refuse -
   a. to sell condoms to a child over the age of 12 years; or
   b. to provide a child over the age of 12 years with condoms on request where such
      condoms are provided or distributed free of charge.

2. Contraceptives other than condoms may be provided to a child on request by the child and without
   the consent of the parent or care-giver of the child if –
   a. the child is at least 12 years of age;
   b. proper medical advice is given to the child; and
   c. a medical examination is carried out on the child to determine whether there are any medical
      reasons why a specific contraceptive should not be provided to the child.

Access to emergency contraceptives

The Children’s Act does not distinguish between ordinary contraceptive services and emergency
contraception. The same age limits therefore apply as set out in the answer to question 4, above.

Legislation and policy framework

See s134 of the Children’s Act, above

a. Potentially harmful traditional practices

Traditional male circumcision is practiced by some communities in South Africa, including the Xhosa,
Jewish, and Islamic communities. While circumcision is usually performed on neonates or toddlers amongst
members of the Islamic and Jewish communities, amongst the Xhosa, traditional male circumcision is
regarded as a sacred and indispensable cultural rite intended to prepare initiates for the responsibilities of
adulthood. There is pressure on Xhosa boys to get circumcised as soon as they reach a particular age,
as not doing so risks the boy being classified as inferior. In recent times, mortality and morbidity related
to traditional circumcision has reached alarming proportions. Between 1995-2005 – in just the Eastern
Cape alone – 5,813 hospital admissions, 281 penile amputations, and 342 deaths were associated with
traditional male circumcisions. Such alarming statistics raises serious ethical concerns. Many traditional
male circumcisions constitute only partial circumcisions, which negates any potential HIV prevention effect
successful circumcision may confer. In one study, among those who self-reported having been circumcised,
86% were unwilling to undergo MMC if they learnt that their circumcision had been incomplete. In
such instances, it can be argued that the performance of traditional circumcisions serves as barrier to
the performance of safe MMC. Moreover, the unsafe performance of traditional circumcisions, and the
incomplete performance of such circumcisions, are not in the best interests of the boys undergoing the
procedure.

Ethical implications and recommendations

While the right to participate in cultural practices should be respected, the respect and protection of
cultural practices does not, and should not, extend to activities that cause serious and avoidable harms.
Notwithstanding respect for cultural practices, it is an ethical imperative that the South African Government
demonstrates greater political will to speak out against unsafe traditional circumcision practices, implements
effective monitoring, prosecution, and punishment of offenders. Moreover, Government and civil society
need to do more to engage with and encourage communities that practice traditional circumcisions, to opt
for MMC, or, at minimum, for medical supervision of traditional circumcisions, notwithstanding culture and
tradition. It would be unethical to allow harmful cultural practices to trump the best interests of a child.

Country experiences in addressing the barriers

While ukuthwala is recognized as a traditional cultural practice, it is still subject to South Africa’s
Constitution. Given the trauma, abuse and sexual violence that often accompanies the contemporary
practice, ukuthwala is inconsistent with the provisions of South Africa’s Bill of Rights. Moreover, section 28
of the country’s Constitution states the child’s best interests will always remain paramount in all matters concerning the child. This cultural practice is not in the child’s best interest. The country’s Recognition of Customary Marriages Act also specifies that the marital parties must both consent to the union and be of 18 years of age. If one of the parties is below the legal age either parental consent is required, or in its absence, permission from a High Court Judge or the Minister of Home Affairs is required. Ukuthwala satisfies the requirements for rape under section 15 of the Sexual Offenses Amendment Act of 2007. Section 17 further prohibits parents and others from sexually exploiting the children. If parents or relatives of the child collude with the perpetrators of the practice, they could be charged under section 48 of the Prevention and Combatting of Trafficking in persons Act, 7 of 2013. The Government does not seem to have any guidelines in place on how to address the issue of ukuthwala. This is probably because child marriage is not a significant issue in South Africa.

93 Still, it is a reality for some adolescent girls in parts of South Africa and should receive Government attention and intervention. The DOJ&CD has stated that police arrest suspects of ukuthwala in accordance with the Sexual Offenses Amendment Act. 94 Furthermore, social workers and teachers must investigate and report any suspected cases of abuse, including cases of ukuthwala. 95 Lastly, the State must prosecute all cases of ukuthwala accordingly, and the Department of Home Affairs must assist victims in securing proper documentation to access social services. 96

The Girl’s Education Movement (GEM) was launched by the National Department of Education with the support of UNICEF in 2003. The Government acknowledged the high levels of gender-based violence in the country which compounds the HIV infection rates amongst young girls. It further recognizes that young girls are not always safe at schools and may fall victim to sexual abuse and exploitation by male peers and teachers. 97 GEM was enacted to address these specific issues.

Likewise, South Africa’s well-known Thuthuzela Care Centres which have dedicated their time to fighting against sexual violence against women and child, focusing particularly on rape and HIV infection. 98 The centre’s objective to to reduce secondary trauma of victims, improve conviction rates and assist in finalizing cases more efficiently. 99

b. Stigma and discrimination

Stigma and discrimination remains a daily struggle for people living with HIV/AIDS (PLWHA). HIV is erroneously linked with promiscuity, shame, ‘deviant behavior’ such as homosexuality, and drug abuse. 100,101 However, stigma is not confined to PLWHIV. 102 Attendance at a clinic providing SRHS could spark suspicion amongst a community. A survey conducted in the Eastern Cape on school-going adolescents found that adolescents expressed concerns about attending consultations as they were afraid of having their privacy breached by staff. 103 Another conducted in six secondary schools in Cape Town revealed that adolescents girls did not want to be seen utilizing SRHS because they did not want to be labeled as promiscuous. Boys did not want to be seen by female peers at such clinics because they did not want female peers to think they were HIV-positive. 104 Students also expressed that they would prefer counsellors that were not judgmental, preferably younger in age, and well trained so they would be familiar with contemporary youth culture. 105 Moreover, MSM are known to avoid public health services out of fear that they will be subjected to stigma and discrimination from healthcare providers. 106 A study conducted in rural KZN on the experiences of homosexual patients accessing primary healthcare services, showed patients were stigmatized and faced persistent prejudice from healthcare providers. 107

Ethical implications and recommendations

South Africa’s growing HIV prevalence rate in young people and rising teenage pregnancy rate, 108 indicates a dire need for adolescent-friendly health services. Additionally, there remains significant social and cultural barriers to adolescents accessing vital SRHS. These include stigma, discrimination, poor education, poverty, and staff with judgmental attitudes. 109 In 2006, the Department of Health took over the management of the National Adolescent Friendly Clinic Initiative (NAFCI) from the non-governmental organisation (NGO), LoveLife. Operating under the banner of the Youth-friendly Services (YFS) programme, YFS is aimed at improving the quality of primary-care health services for adolescents. The initiative also aims to reinforce the way in which the public health sector responds to adolescent health needs. 110 The initiative intends doing so by “making health services more accessible and acceptable to young people, establishing national standards and criteria for adolescent healthcare in clinics throughout the country, and building
the capacity of healthcare workers to provide quality services.” However, research has shown that YFS does not necessarily deliver a more beneficial experience to adolescents as compared to health facilities that do not provide YFS. As the experience usually depended on the subjective attitudes and behaviors of the healthcare provider, adolescents expressed the need to prioritize the altering of provider attitudes as opposed to structural issues. This indicates that regular sensitization training and monitoring could enable healthcare workers to address young people’s needs. South Africa should also consider establishing school-based SRHS programmes. Research indicates that school-going adolescents would prefer accessing important SRHS, such as HTC, in schools, and that such services should be provided by youth-friendly and competent staff who did not have judgmental attitudes. Aside from South Africa being a secular democracy, health authorities have an ethical duty to facilitate SRHS access to adolescents, regardless of prevailing social, cultural, or religious norms and values. Authorities should continue to facilitate HCT, contraception, and MMC access available in places where adolescents and young persons will feel free and comfortable to access such services. Staff must be trained to provide services in a non-judgmental and child-friendly manner.

c. Institutionalised male dominance

Patriarchy in African culture and traditions is systemic. Women are deemed inferior and subservient to men. Males impose their masculinity through sexual violence, incidentally increasing vulnerability to HIV infection. Gender-based violence is pervasive in South Africa and often underpins a number of cultural and traditional beliefs practice. Sexual gender-based violence and aggression is rife in poor communities lacking social support and social capital, such as townships and rural areas. Traditional systems in such environments are patriarchal in nature and encouraging of males to prove their masculinity, and assert their social and economic dominance. Often, masculinity and dominance is asserted through sexual violence. Sexual relationships are often the avenue through which power imbalances between genders are expressed. In such contexts, males dictate whether or not safe-sex will be practiced, if conception will occur and how intercourse will take place. In South Africa, patriarchal norms have ensured that male dominance is usually established and enforced through sexual violence. According to the South African Police Services, cases of rapes were reported nationally in 2014/15. While this figure does not take into account unreported cases, it still translates to an alarming 147 cases daily. It is estimated that one in three South African women will be raped in her lifetime. Further, one in four will be a victim to domestic abuse. Moreover, it had been reported that 1.6% of a sample of over 11,000 women were raped prior to turning 15. Sexual violence is also prevalent amongst youth in schools where young girls are targeted by older male students and teachers. It is not uncommon for adolescent girls to be coerced into sex by their boyfriends. Adolescent girls residing in townships, in particular, live in constant fear of rape and violence. Rates of childhood sexual abuse are high in South Africa, with high levels of penetrative sexual abuse before age 12, especially among girls. There is evidence that girls experiencing sexual abuse are more likely to engage in riskier sexual behaviours, including early sexual debut, than their peers.

In some parts of South Africa, traditional practices have been used to justify violence against young females. An example of such a practice is ukuthwala. Contemporary practice of traditional ukuthwala is linked to the abduction and rape of adolescent girls, prior to forced marriage. Ukuthwala is practiced amongst some members of the Xhosa and Zulu communities in South Africa. Initially ukuthwala did not involve abduction or raped. It was usually consensual amongst the marital parties and considered away to unite families. However, ukuthwala has become increasingly more violent. This could be due to lack of economic resource. In order to marry, the bridegroom is required to pay the family of the bride a ‘bride price’ or lobola. Lobola is sometimes on-going if the families are friends and ‘payment’ is higher for virgins. Since ukuthwala occurs prior to marriage, the man can reduce payment, as once the victim has been raped, the price of lobola will significantly decrease.

In urban settings, especially black townships, multi-perpetrator rape is prevalent. MPR has been referred to by several colloquialisms such as ‘istimela’, ‘jackrolling’, and ‘streamlining’. Perpetrators regard the practice as form of entertainment and a means of imposing control over women. Istimela is used as a form of punishment for those who do not comply with patriarchal constructs of female sexuality. Women who are perceived as promiscuous or are inebriated are usually prime victims of this form of sexual violence. So too are women who reject sexual advances. Streamlining is also used as a source of entertainment for perpetrators wishing to humiliate ex-girlfriends.
Ethical implications and recommendations

Social and cultural norms that reinforce male dominance, and female subordination and powerlessness, serve as a major barrier to female adolescents accessing SRHS in South Africa. The prevalence of institutionalized male dominance may reduce the opportunity of adolescent girls accessing SRHS before their sexual debut, either because they may be denied access to such services by controlling sexual partners, or may fear the repercussions of doing so autonomously. Authorities must take tangible steps to address gender inequality, and must empower adolescent females to access SRHS, a report episodes of abuse and sexual violence to relevant authorities. School-based SRHS may mitigate the chances of out-of-school male partners deterring school-going adolescent females from accessing SRHS. Such measures may encourage adolescents to access SRHS, including contraceptives, HCT and PrEP. Further measures may be needed to understand and reverse poor adherence amongst adolescent females regarding PrEP.

d. Sexual partnering norms: age-differential relationships and multiple concurrent sexual partnering

It is estimated that adolescent girls and young women within the 15-24 years age range account for 113,000 new cases of HIV infection annually in South Africa. This equates to roughly quadruple the incidence of their male peers. These staggering incidence rates are a result of age-sex disparity in acquiring HIV, particularly amongst adolescent girls within the 15-19 years age range, who acquire the virus five to seven years prior to acquisition by their male counterparts.

In some South African communities, polygamy is considered socially and culturally acceptable. Age-disparate relationships have also historically been the model for marriage throughout southern Africa, and is thus considered culturally familiar and socially acceptable. Norms and values rooted in these social arrangements persist in contemporary society. Today, multiple concurrent sexual partnering is legitimized through supportive “cultural scripting” - i.e. men’s sexuality is unrestrainable and infidelity is to be expected; on the other hand, the women’s duty is not to question, but to tolerate and forgive men for infidelity. Such social and cultural constructs have legitimized and facilitated the growth of age-disparate multiple concurrent sexual partnerships in South Africa. Predictors of multiple sexual partners (MSP) across both gender are race, having a history of a sexually transmitted infection, being in a short relationships (<1 year) and suspecting the current partner of infidelity. Blacks are more likely to engage in multiple concurrent sexual partnerships than other race groups in South Africa. MSP among men enjoyed greater community acceptance and was mainly done for social status. Furthermore, men reporting MSP were mostly younger (15–24 years old). Among women, determinants of MSP included economic vulnerability, younger age at sexual debut and living in formal urban rather than formal rural areas. Age-disparate or intergenerational relationships are often based transactional sex arrangements. In such instances, young girls engage in sex with multiple and concurrent sexual partners in return for cash, material goods (such as cell phone vouchers) or services (such as transport). Whereas early research emphasized poverty as the driver of girls seeking or accepting older employed men for sexual partnering, ethnographic research indicates that mutual exploitation is at play. In urban areas material gain was found to be a leading factor luring young women to have sex with older men. Entertainment and fun emerged as the primary drivers of such unions, with fun tied to glamour and enjoyment of material goods and lifestyle consistent with urban life. Transactional sex is rarely met with condom use.

Because of patriarchal norms which dictate that males are unaccountable to women and the traditional subordinate status of women in South Africa, adolescent girls in South Africa generally lack the social status to question their male partner’s HIV status, or to negotiate condom use. Furthermore, risk perception in such partnering tends to be low. Males in South Africa are generally under the impression that young females are less likely to be HIV-infected. Similarly, young women view older men as ‘safe’ partners because they appear to be less risk-taking, more stable and more responsible. The misguided perceptions may deter adolescent girls from accessing SRHS in South Africa.

Ethical implications and recommendations

Predictors of MSP common across gender were race, having a history of STI, being in a short relationship (<1 year) and suspecting the current partner of infidelity. MSP among men enjoyed greater community
acceptance and was mainly done for social status. Furthermore, men reporting MSP were mostly younger (15–24 years old) and use condom at last sex. Among women, determinants of MSP included economic vulnerability, younger age at sexual debut and living in formal urban rather than formal rural areas. There is an urgent need to increase the risk perception of young women and older men regarding intergenerational, age-disparate, and multiple-concurrent relationships. Health authorities, civil society, and other role players should encourage older female peers who have successfully resisted mixed-age affairs to play a key role in encouraging, mentoring and supporting adolescent females to resist sex with older men, and to regularly access SRHS, especially HCT. Similarly, role-players need to focus on changing social norms in respect to male behavior patterns. To this end, adult men must be discouraged from engaging in intergenerational and age-disparate relationships with adolescent girls. Social messaging should remind men that sexual liaisons with young women are an abuse of power and status, and could have legal consequences. Condom use and MMC should be encouraged.

In regard to adolescent MSM, it has been noted that “young MSM are generally not catered for within prevention programming for adolescents, as most safer-sex education is strictly heterosexual.” Because of their age, young MSM may also not be targeted by adult MSM programming. Accordingly, despite their vulnerability, adolescent MSM are being excluded from both adolescent and MSM-specific SRHS programming, “leaving them entirely unprepared to protect themselves against the HIV epidemic”. This gap speaks to the need for health authorities to devise SRHS messaging and services for adolescent MSM.

Country experiences in addressing the barriers

Campaigns such as the ‘Graduate Alive!’ Programme conducted on university campuses across South Africa, seeks to curb HIV/AIDS-related stigma and discrimination and raise awareness of the dangers of intergenerational sex. Similarly, a youth movement entitled the ‘Vintage Gang’, raises awareness of the country’s “sugar daddy” trend, seeking to use fashion to empower young girls to be independent. Similarly, the ‘Sugar Daddy Campaign’, spearheaded by the provincial minister of health in KwaZulu-Natal, has erected approximately 90 billboards around the province, the goal of which is to promote healthy lifestyles for young women between the ages of 14-25 years by stigmatizing intergenerational sex. The campaign ultimately seeks to deter and prevent young girls from falling victim to the perils of intergenerational relationships. Additionally, the ‘First Things First Campaign’ led by the Higher Education and Training HIV/AIDS Programme (HEAIDS), partnered with the Innovative Medicines South Africa (IMSIA) supported by United States Agency for International Development (USAID), President’s Emergency Plan for AIDS Relief (PEPFAR) and South African National AIDS Council (SANAC) prioritizes HCT in young people. It promotes HIV-Testing and pre- and post-test counselling among students, encouraging them to be responsible and take charge of their health and well-being.
Chapter Four: Age of Consent and HIV testing

Section 130 of the Children’s Act in South Africa makes specific provisions for consent of a child to HIV testing. It provides that, a child can consent to an HIV test if they are:

i. 12 years old or older; or
ii. Under the age of 12 years and has sufficient maturity to understand the benefits, risks and social implications of the test (“the implications”).

If a child is under the age of 12 years and does not have sufficient maturity to understand the implications, the following people can consent:

i. Parent or care-giver;
ii. Provincial head of social development; or
iii. A designated child protection organisation arranging the placement of the child.

The superintendent or person in charge of a hospital can give consent on behalf of the child if:

i. The child is under the age of 12 years and does not have sufficient maturity to understand the implications; and
ii. There is no parent or care-giver and there is no designated child protection organisation arranging the placement of the child.

A children’s court can give consent if:

i. Consent by the persons listed in 12.1 or 12.2 is unreasonably withheld; or
ii. The child or the parent or care-giver of the child is incapable of giving consent.

Legislation and policy framework

Children’s Act

130. HIV-Testing

1. Subject to section 132, no child may be tested for HIV except when –

a. it is in the best interests of the child and consent has been given in terms of subsection (2); or
b. the test is necessary in order to establish whether –

i. a health worker may have contracted HIV due to contact in the course of a medical procedure involving contact with any substance from the child’s body that may transmit HIV; or
ii. any other person may have contracted HIV due to contact with any substance from the child’s body that may transmit HIV, provided the test has been authorised by a court.

2. Consent for a HIV-test on a child may be given by –

a. the child, if the child is –

i. 12 years of age or older; or
ii. under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a test;

b. the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;

c. the provincial head of social development, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;
d. a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test;

e. the superintendent or person in charge of a hospital, if –

   i. the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a test; and

   ii. the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or

f. a children’s court, if –

   i. consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld; or

   ii. the child or the parent or care-giver of the child is incapable of giving consent.

Age of Consent to report the HIV status direct to adolescents

The HIV status will be directly reported to children who consented to the HIV test on their own behalf. In other cases the test results will be reported to the persons who consented to the HIV test for the child.

In terms of section 133 of the Children’s Act a person may not disclose the fact that a child is HIV-positive to a third party without consent being given by the same persons allowed to give consent to the testing of the child (as per paragraph 12 above).

The exceptions are that it may be disclosed:

i. Within a person’s powers and duties in terms of the Children's Act, 38 of 2005 or any other law;

ii. Where necessary for purposes of carrying out the provisions of the Children's Act, 38 of 2005;

iii. For the purpose of legal proceedings;

iv. In terms of a court order.

Legislation and policy framework

The HIV status will be directly reported to children who consented to the HIV test on their own behalf. In other cases the test results will be reported to the persons who consented to the HIV test for the child.

In terms of section 133 of the Children’s Act a person may not disclose the fact that a child is HIV-positive to a third party without consent being given by the same persons allowed to give consent to the testing of the child (as per paragraph 12 above).

The exceptions are that it may be disclosed:

i. Within a person’s powers and duties in terms of the Children’s Act, 38 of 2005 or any other law;

ii. Where necessary for purposes of carrying out the provisions of the Children’s Act, 38 of 2005;

iii. For the purpose of legal proceedings;

iv. In terms of a court order.
Legislation and policy frameworks

Children’s Act

133. Confidentiality of information on HIV/AIDS status of children

1. No person may disclose the fact that a child is HIV-positive without consent given in terms of subsection (2), except –

   a. within the scope of that person’s powers and duties in terms of this Act or any other law;
   b. when necessary for the purpose of carrying out the provisions of this Act;
   c. for the purpose of legal proceedings; or
   d. in terms of an order of a court.

2. Consent to disclose the fact that a child is HIV-positive may be given by -

   a. the child, if the child is -
      
      i. 12 years of age or older; or
      ii. under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;

   b. the parent or care-giver, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;

   c. a designated child protection organisation arranging the placement of the child, if the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure;

   d. the superintendent or person in charge of a hospital, if –
      
      i. the child is under the age of 12 years and is not of sufficient maturity to understand the benefits, risks and social implications of such a disclosure; and
      ii. the child has no parent or care-giver and there is no designated child protection organisation arranging the placement of the child; or

   e. a children’s court, if –
      
      i. consent in terms of paragraph (a), (b), (c) or (d) is unreasonably withheld and disclosure is in the best interests of the child; or
      ii. the child or the parent or care-giver of the child is incapable of giving consent.
Chapter Five: Age of Consent on Anti-retroviral Therapy (ART)

On 17 November 2003, South African Parliament approved the Operational Plan for Comprehensive HIV/AIDS Care, Management and Treatment (the Operational Plan). The plan provides the framework in terms of which the South African Antiretroviral Therapy programme is implemented. As at 1 December 2015, South Africa had the largest ART programme in the world, treating approximately 3 million people.

The Operational Plan provides guidelines for the administration of ART to persons (including persons under the age of 6 years old). However, it does not regulate the giving of consent in relation to ART. Consent is regulated by the general provisions of the Children’s Act (s129), discussed in the answer to question 8 below.

Legislation and policy framework

The Operational Plan provides guidelines for the administration of ART to persons (including persons under the age of 6 years old). However, it does not regulate the giving of consent in relation to ART. Consent is regulated by the general provisions of the Children’s Act (s129), discussed in the answer to question 8 below.
Chapter Six: Age of Consent and access to Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP)

The South African Government’s National Strategic Plan on HIV, STIs and TB (2012 – 2016) establishes as a strategic objective “preparing for the potential implementation of innovative biomedical prevention strategies such as microbicides, Pre-Exposure Prophylaxis (PrEP) and treatment as prevention.

In terms of the Medicines and Related Substances Act, 101 of 1965 a medication must be approved for use by the Medicines Control Council and registered with the Registrar of Medicines before it can legally be sold, distributed or possessed in South Africa. On 28 November 2015, the South African Medicines Control Council (MCC) approved a fixed-dose combination of tenofovir disoproxyl fumarate and emtricitabine (known better by its trade name “Truvada”) for use as a PrEP in South Africa. Following the approval of the MCC, an individual may elect to use Truvada. However, this medication is not currently dispensed by the State as a public health measure.

Prohibition on HIV Pre-exposure Prophylaxis (PrEP), including Age of Consent with and without parental consent. There is no prohibition on Pre-exposure Prophylaxis (PrEP), young people are able to access PrEP in accordance with Section 129 of the Children’s Act.

The provisions of Section 129 of the Children’s Act regulates the age at which a child may consent to medical treatment (which includes PrEP). It provides that a child may consent to his or her own medical treatment if they are over the age of 12 years and have sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of the treatment. Failing which the consent of a parent, guardian or care giver is required.

South Africa does not have any prohibition on PEP in South Africa. Since the legislation dealing with PEP does not specify an Age of Consent, one must look elsewhere. The provisions of Section 129 of the Children’s Act regulates the age at which a child (i.e a person younger than 18 years) may consent to medical treatment (which includes PEP for HIV). In summary it provides that child may consent to his or her own medical treatment if they are over the age of 12 years and have sufficient maturity and mental capacity to understand the benefits, risks, social and other implications of the treatment. Failing which the consent of a parent, guardian or care giver is required.
Legislative and policy framework

**Children’s Act**

129. **Consent to medical treatment and surgical operation**

1. Subject to section 5(2) of the Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996), a child may be subjected to medical treatment or a surgical operation only if consent for such treatment or operation has been given in terms of either subsection (2), (3), (4), (5), (6) or (7).

2. A child may consent to his or her own medical treatment or to the medical treatment of his or her child if –

   a. the child is over the age of 12 years; and
   b. the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the treatment.

3. A child may consent to the performance of a surgical operation on him or her or his or her child if –

   a. the child is over the age of 12 years; and
   b. the child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and
   c. the child is duly assisted by his or her parent or guardian.

4. The parent, guardian or care-giver of a child may, subject to section 31, consent to the medical treatment of the child if the child is –

   a. under the age of 12 years; or
   b. over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the treatment.

5. The parent or guardian of a child may, subject to section 31, consent to a surgical operation on the child if the child is –

   a. under the age of 12 years; or
   b. over that age but is of insufficient maturity or is unable to understand the benefits, risks and social implications of the operation.

6. The superintendent of a hospital or the person in charge of the hospital in the absence of the superintendent may consent to the medical treatment of or a surgical operation on a child if –

   a. the treatment or operation is necessary to preserve the life of the child or to save the child from serious or lasting physical injury or disability; and
   b. the need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required.

7. The Minister may consent to the medical treatment of or surgical operation on a child if the parent or guardian of the child –

   a. unreasonably refuses to give consent or to assist the child in giving consent;
   b. is incapable of giving consent or of assisting the child in giving consent;
   c. cannot readily be traced; or
   d. is deceased.

8. The Minister may consent to the medical treatment of or surgical operation on a child if the child unreasonably refuses to give consent

9. A High Court or children’s court may consent to the medical treatment of or a surgical operation on a child in all instances where another person that may give consent in terms of this section refuses or is unable to give such consent
10. No parent, guardian or care-giver of a child may refuse to assist a child in terms of subsection (3) or withhold consent in terms of subsections (4) and (5) by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.

PEP

In terms of section 28 of the Sexual Offences Act a victim who has been exposed to the risk of being infected with HIV as a result of a sexual offence having been committed against them, may receive PEP for HIV infection, at a public health establishment provided that they:

i. lay a charge with the South African Police Service (SAPS) in respect of the alleged sexual offence; or

ii. report the incident in respect of the alleged sexual offence at a designated health establishment within 72 hours after the alleged sexual offence taking place.

A victim who complies with the reporting obligations above, is also entitled to receive free medical advice regarding the administering of PEP prior to the treatment.

The Sexual Offences Act requires the SAPS or the medical practitioner to whom the sexual offence is reported to inform the victim of:

i. the importance of obtaining PEP for HIV infection within 72hrs of the alleged offence;

ii. the need to obtain medical advice and assistance regarding other possible STI’s; and

iii. the fact that they are entitled to receive PEP for HIV infection and free medical advice in accordance with Section 28 of the Sexual Offences Act. Therefore, the Sexual Offences Act does not restrict access to PEP on the basis of age.

Eligibility to start PEP:

• Any exposure classified as risk in the last 72 hours
• Survivor of violence tests HIV negative on initial testing
• Survivor of violence consents to treatment

PEP shall never be refused on moral judgment about the kind of exposure (accident, negligence, rape, ‘burst condom’). PEP is safe in pregnancy and breastfeeding. Severe anaemia (<8g/dl) is contraindication for AZT/3TC (used as standard PEP regimen for patients weighing under 35kg). Severe renal failure is contraindication for TDF/3TC (used as standard PEP regimen for patients weighing 35kg and above). New HIV test from the source person is mandatory to confirm negative HIV status but this shall not delay starting PEP if HIV testing and counselling is not immediately available (no test kits, night, etc.).

Legislation and policy framework

CRIMINAL LAW (SEXUAL OFFENCES AND RELATED MATTERS) AMENDMENT ACT 32 OF 2007

28. Services for victims relating to Post-exposure Prophylaxis and compulsory HIV testing of alleged sex offenders

1. If a victim has been exposed to the risk of being infected with HIV as the result of a sexual offence having been committed against him or her, he or she may –

   a. subject to subsection (2) -

      i. receive PEP for HIV infection, at a public health establishment designated from time to time by the cabinet member responsible for health by notice in the Gazette for that purpose under Section 29, at State expense and in accordance with the State’s prevailing treatment norms and protocols;

      ii. be given free medical advice surrounding the administering of PEP prior to the administering thereof; and
iii. be supplied with a prescribed list, containing the names, addresses and contact particulars of accessible public health establishments contemplated in section 29(1)(a); and

b. subject to Section 30, apply to a magistrate for an order that the alleged offender be tested for HIV, at State expense.

2. Only a victim who –

a. lays a charge with the South African Police Service in respect of an alleged sexual offence; or

b. reports an incident in respect of an alleged sexual offence in the prescribed manner at a designated health establishment contemplated in subsection (1)(a)(i), Within 72 hours after the alleged sexual offence took place, may receive the services contemplated in subsection (1)(a).

3. A victim contemplated in subsection (1) or an interested person must –

a. when or immediately after laying a charge with the South African Police Service or making a report in respect of the alleged sexual offence, in the prescribed manner, be informed by the police official to whom the charge is made or by a medical practitioner or a nurse to whom the incident is reported, as the case may be, of the -

i. importance of obtaining PEP for HIV infection within 72 hours after the alleged sexual offence took place;

ii. need to obtain medical advice and assistance regarding the possibility of other sexually transmitted infections; and

iii. services referred to in subsection (1);
Chapter Seven: Age of Consent and access to safe abortions and/or post-abortion care

The Choice on Termination of Pregnancy Act, 92 of 1992, (the Choice Act) is the primary legislation which regulates the carrying out of abortions in South Africa.

The Choice Act stipulates the time periods and circumstances in which a pregnancy can be terminated. The Choice Act also provides that counselling is to be made available to persons before and after the termination of pregnancies.

In order to promote safer terminations, the Choice Act prescribes requirements which facilities and practitioners must comply with in order to be entitled to legally perform abortions. Failure to comply with these requirements is an offence punishable by a fine or a term of imprisonment.

Regulations published under the Choice Act list information which must be provided to a woman seeking to have a pregnancy terminated including:

i. That only her consent is necessary for the termination (provided she meets the requirements of the Act in relation to the time of termination);
ii. Private and confidential counselling must be made available to her.
iii. The counselling must be sufficient for her to make informed decisions about the pregnancy.
iv. The counselling must include information about available alternatives, the termination procedure and its associated risks, and contraceptive options that can be used in future; and
v. The location of the nearest facility for the termination of the pregnancy.

The Regulations also provide a Management Protocol for the Termination of Pregnancy (the Protocol). The Protocol provides for the plans and procedures that must be put in place in order to provide pre- and post-abortion care to women.

The Protocol outlines the process to be followed when terminating a pregnancy. It emphasises the importance of the preparation and assessment of the woman, both before and after the termination. It also provides guidelines for the level of care to be provided before and after the termination, in order to ensure consistent standards of care are applied. The Protocol indicates the importance of applied pharmacology and appropriate pain control for women at all stages of the termination (include after termination). The Protocol contains a specific post termination procedure to be applied.

The Choice Act provides that the informed consent of the woman terminating the pregnancy is required. It further provides that a minor (i.e. a woman under the age of 18) may consent to the termination of a pregnancy without consulting or obtaining the consent of her parents, guardian or caregiver.

The Choice Act obliges the medical practitioner, registered midwife or registered nurse to advise the minor to consult with her parents, guardian or care-giver – but the termination may not be refused if the minor declines to consult with them. Parental consent is therefore not required for the termination of a pregnancy. The Choice Act makes provision for consent in circumstances where a woman does not have the mental capacity to give informed consent.

Legislation and policy framework

**CHOICE ON Termination of Pregnancy Act 92 OF 1996**

2. **Circumstances in which and conditions under which pregnancy may be terminated**

1. A pregnancy may be terminated -
   a. upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;
   b. from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that –
i. the continued pregnancy would pose a risk of injury to the woman’s physical or mental health; or
ii. there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
iii. the pregnancy resulted from rape or incest; or
iv. the continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy

i. would endanger the woman’s life;
ii. would result in a severe malformation of the fetus; or
iii. would pose a risk of injury to the fetus.

2. The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may also be carried out by a registered midwife or registered nurse who has completed the prescribed training course.

3. Place where termination of pregnancy may take place

1. Termination of a pregnancy may take place only at a facility which –
   a. gives access to medical and nursing staff;
   b. gives access to an operating theatre;
   c. has appropriate surgical equipment;
   d. supplies drugs for intravenous and intramuscular injection;
   e. has emergency resuscitation equipment and access to an emergency referral centre or facility;
   f. gives access to appropriate transport should the need arise for emergency transfer;
   g. has facilities and equipment for clinical observation and access to in-patient facilities;
   h. has appropriate infection control measures;
   i. gives access to safe waste disposal infrastructure;
   j. has telephonic means of communication; and
   k. has been approved by the Member of the Executive Council by notice in the Gazette.

4. Counselling

The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy.

5. Consent

1. Subject to the provisions of subsections (4) and (5), the termination of a pregnancy may only take place with the informed consent of the pregnant woman.
2. Notwithstanding any other law or the common law, but subject to the provisions of subsections (4) and (5), no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.
3. In the case of a pregnant minor, a medical practitioner or a registered midwife or registered nurse, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.
4. Subject to the provisions of subsection (5), in the case where a woman is –
   a. severely mentally disabled to such an extent that she is completely incapable of
understanding and appreciating the nature or consequences of a termination of her pregnancy; or

b. in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy in terms of section 2, her pregnancy may be terminated during the first 12 weeks of the gestation period, or from the 13th up to and including the 20th week of the gestation period on the grounds set out in section 2 (1) (b) –

i. upon the request of and with the consent of her natural guardian, spouse or legal guardian, as the case may be; or

ii. if such persons cannot be found, upon the request and with the consent of her curator personae:

Provided that such pregnancy may not be terminated unless two medical practitioners or a medical practitioner and a registered midwife or registered nurse who has completed the prescribed training course consent thereto.

5. Where two medical practitioners or a medical practitioner and a registered midwife or registered nurse who has completed the prescribed training course, are of the opinion that –

a. during the period up to and including the 20th week of the gestation period of a pregnant woman referred to in subsection (4) (a) or (b) –

i. the continued pregnancy would pose a risk of injury to the woman’s physical or mental health; or

ii. there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or

b. after the 20th week of the gestation period of a pregnant woman referred to in subsection (4) (a) or (b), the continued pregnancy -

i. would endanger the woman’s life;

ii. would result in a severe malformation of the fetus; or

ii. would pose a risk of injury to the fetus,

they may consent to the termination of the pregnancy of such woman after consulting her natural guardian, spouse, legal guardian or curator personae, as the case may be: Provided that the termination of the pregnancy shall not be denied if the natural guardian, spouse, legal guardian or curator personae, as the case may be, refuses to consent thereto.

6. Information concerning termination of pregnancy

A woman who in terms of Section 2 (1) requests a termination of pregnancy from a medical practitioner or a registered midwife or registered nurse, as the case may be, shall be informed of her rights under this Act by the person concerned.

REGULATIONS UNDER THE CHOICE ON Termination of Pregnancy Act, 1996 (ACT NO. 92 OF 1996)

7. Consent by woman to terminate pregnancy

a. A woman requesting the termination of her pregnancy and the medical practitioner or registered midwife performing the termination of the pregnancy of that woman shall complete a standard consent form.

b. The consent of a woman to the procedure to terminate her pregnancy shall include consent to other surgical procedures which may be necessary as a result of complications associated with the termination of her pregnancy.
8. **Counselling**
   
a. Counselling in terms of Section 4 of the Act shall at the least include sufficient information to assist a woman to make an informed choice regarding the termination of her pregnancy.

b. A woman requesting the termination of her pregnancy shall be informed during counselling with regard to-
   
i. the available alternatives to the termination of her pregnancy;

   ii. the procedure and the associated risks of the termination of her pregnancy; and

   iii. contraceptive measures which can be taken in the future.

   
c. A woman requesting the termination of her pregnancy shall also be informed that counselling is private and confidential, unless she chooses to disclose the nature or content of such counselling.

9. **Training course**

   1. The training course for a registered midwife regarding the termination of a pregnancy shall include the following-

   a. counselling and communication skills;

   b. clinical competence in assessment and technique;

   c. anaesthesia and analgesia;

   d. knowledge of contraception;

   e. post-abortion care; and

   f. management of reproductive system infections.

   
   2. A registered midwife who has completed the training course and who terminates a pregnancy at a public facility shall follow the clinical guidelines that are provided by the Department of Health, as amended from time to time, for the termination of a pregnancy under the Act.

10. **Information concerning the termination of a pregnancy**

A woman requesting the termination of her pregnancy shall be informed-

a. that she is entitled to the termination of her pregnancy upon request during the first 12 weeks of the gestation period;

b. that, under the circumstances determined by Section 2 (1) (b) of the Act, her pregnancy may be terminated from the 13th up to and including the 20th week of the gestation period;

   
c. that only her consent is required for the termination of her pregnancy;

   
d. that counselling contemplated in Section 4 of the Act shall be available; and

   
e. of the locality of facilities for the termination of pregnancies.
Chapter Eight: Age of Consent and access to Antenatal Care (ANC)

In South Africa the **National Health Act** states that ‘Subject to any condition prescribed by the Minister, the State and clinics and community health centres funded by the State must provide pregnant and lactating women and children under the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services.’

This section has been implemented as far as possible throughout South Africa but, due to inconsistent access to resources, the quality of treatment varies from treatment centre to treatment centre. An objective of the **National Development Plan 2030** (an SA Government policy document published in 2012) is to ‘Reduce maternal, infant and child mortality’ (Chapter 10: Promoting Health).

Further to this, South Africa’s **National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA)** (a policy document proposing goals to fulfil the requirements set out in the African Union CARMMA programme which was launched in 2009) outlines the need to improve Antenatal Care and attendance at Antenatal Care sessions. It is unclear how much progress has been made in line with these objectives.

The Department of Health has also issued the **National Guidelines for Maternity Care in South Africa** (the **guidelines**). The latest version of the guidelines, the fourth edition, was published in July 2015 and aims to be used in all clinics, community health centres and district hospitals where specialist services are not usually available.

The guidelines are endorsed by the **Department of Health** though the implementation of these guidelines depends on the resources available at each respective healthcare institution. There is no legislative structure that enforces the guidelines nor regulations which outline the processes involved in the enforcement of these policies. Health institutions are therefore not compelled to follow these guidelines.

The guidelines outline the process for diagnosis and management of common but serious pregnancy problems as well as outlining the roles of specific healthcare institutions (such as clinics, community centres, hospitals etc…). With regard to antenatal health specifically, the guidelines deal comprehensively with screening for pregnancy problems, assessing pregnancy risks, treating problems that may arise during the antenatal period, giving medications that may improve pregnancy outcomes, providing information to pregnant women regarding the risks and treatments involved and providing assistance with the physical and psychological preparation for childbirth and parenthood.

There is no legislation or regulations which deal specifically with the Age of Consent to receive Antenatal Care. The legislative provisions which deal generally with consent to medical treatment (Section 129 of the Children’s Act) apply. As mentioned above these allow a child over the age of 12 years to consent to medical treatment themselves (provided they are mature enough to understand the benefits, risks and further implications of the treatment). Children younger than 12 years require the consent of their parent, guardian or care-giver.
Legislation and policy framework

Section 129 of the Children's Act - see response to chapter on Post-exposure Prophylaxis above.

**National Health Act, 61 of 2003**

4. **Eligibility for free health services in public health establishments**

1. The Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed.

2. In prescribing any condition contemplated in subsection (1), the Minister must have regard to-

   a. the range of free health services currently available;
   b. the categories of persons already receiving free health services;
   c. the impact of any such condition on access to health services; and
   d. the needs of vulnerable groups such as women, children, older persons and persons with disabilities.

3. Subject to any condition prescribed by the Minister, the State and clinics and community health centres funded by the State must provide-

   a. pregnant and lactating women and children under the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services;
   b. all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary healthcare services; and
   c. women, subject to the Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996), free termination of pregnancy services.

**National Development Plan: Vision for 2030**

(Chapter 10: Promoting Health).

**National Strategic Plan for a Campaign on Accelerated Reduction of Maternal and Child Mortality in Africa (CARMMA)**

**National Guidelines for Maternity Care in South Africa**
Chapter Nine: Age of Consent and access to HPV vaccine and cervical cancer screening and treatment

South Africa does not have any legislation or regulations on the requirements for Human Papillomavirus vaccination or screening for HPV.

In line with the National Development Plan 2030’s goals to improve maternal health; the UN’s Millennium Development Goals’ aim to reduce child mortality and to combat serious diseases and the World Health Organisation’s recommendation that all countries start HPV vaccination programmes to prevent cervical cancer, the Department of Health announced in 2014 that it would rollout a national free HPV vaccination campaign to girls aged 9 to 10 years in schools throughout the country.

This campaign is not founded on a formal policy document and is not legislated or regulated. The campaign is undertaken by groups of medical specialists appointed by the Department of Health that travel from school to school screening for the virus and vaccinating children. It also includes an advertising campaign to educate people about the risks of HPV and cervical cancer and the necessity for vaccination.

As there is no legislation dealing specifically with the Age of Consent for HPV vaccinations, the Age of Consent is governed by legislation relating to medical procedures generally (i.e. s129 of the Children’s Act). The Children’s Act allows a child over the age of 12 years to consent to medical treatment themselves (provided they are mature enough to understand the benefits, risks and further implications of the treatment). Children younger than 12 years require the consent of their parent, guardian or care-giver.

The campaign does not target all schools in South Africa and is only aimed at vaccinating young girls therefore leaving most boys as potential carriers of the virus. Because of the legislation regarding consent, there is the possibility that many children exposed to the campaign might remain unvaccinated due to a lack of parental consent (usually because of a lack of education/ understanding of the risks of HPV and vaccination in general).

Legislation and policy framework

Section 129 of the Children’s Act

Chapter Ten: Conclusion

Authorities must engage with communities on social and cultural factors that facilitate early sexual debut. This should include focused campaigns in communities where early sexual debut and multiple concurrent sexual partnerships is deemed socially acceptable, with the aim being to change such norms and values. Authorities, civil society actors, and community leaders must actively work towards increasing awareness amongst adolescents to the dangers posed by intergenerational / age-disparate sexual partnerships. Furthermore, authorities must take tangible measures to reduce gender equality and encourage adolescents to seek SRHS. To this end, South Africa’s legal Age of Consent for sex (16 years of age, unless both adolescents are between 12 and 16 years, or where one is under 16 years and the other is less than two years older), appears to be incongruent with the country’s laws in relation to contraception access (>12 years of age) and termination of pregnancy (any age). Ongoing engagement with adolescents through various fora, such as social media and social marketing, will be necessary to encourage adolescents who may be deterred by the country’s legal Age of Consent (and the disclosure obligations such a law entails) to access SRHS.

A limitation of this work is that data sources were limited to publically-accessible documents, and not based on original qualitative or quantitative research. Relevant studies may have been missed if they were not included in the databases searched for this review.
## Chapter Eleven: Recommended intervention on legal and policy framework

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<td>Policy framework and legislation on access to Antiretroviral Therapy (ART)</td>
<td>L P</td>
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<tr>
<td>Policy and legislation on young people’s access to PEP</td>
<td>N/A</td>
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<td>Policy framework and on access to Antenatal Care (ANC)</td>
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<td>Policy framework &amp; legislation on access to HPV vaccine and cervical cancer screening and treatment</td>
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<td>Policy framework and/or legislation on access to safe abortions and/or post abortion care</td>
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<tr>
<td>Age of Consent to access HIV testing without parental consent</td>
<td>L</td>
<td>LR</td>
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<tr>
<td>Legal and policy framework on the Age of Consent HIV status will be reported directly to an adolescent</td>
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<td>LR</td>
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<tr>
<td>Address of various policy and legislation inconsistencies</td>
<td>N/A</td>
<td>N/A</td>
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References


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Annex 1

KEY QUESTIONS IN ESC REVIEW

i. Age of Consent for sexual intercourse: From an ESC perspective, what is considered to be the permissible Age of Consent for sexual intercourse / activities, and/or what are the permissible circumstances for adolescents to engage in sexual intercourse / activities? Indicate if different ages for heterosexual adolescents (males and females), and if applicable, homosexual adolescents males and females.

ii. Adolescent homosexuality and transgender expression: From an ESC perspective, how is (i) adolescent homosexuality, and (ii) transgender expression, viewed in the local context? Specify if different for males and females.

iii. Contraception access and use: From an ESC perspective, how is contraception access / use amongst adolescents viewed in the local context? Specify if different for males and females.

iv. Access to sexual and reproductive health services: What are the potential ESC factors that hinder or facilitate adolescents accessing sexual and reproductive health services? Specify if different for heterosexual adolescents (males and females), and/or homosexual adolescents (male and female).

v. Autonomous HIV testing: What are the potential ESC factors that hinder or facilitate adolescents accessing HIV testing without parental consent? Specify if different for male and female. In each country-specific case study, research will focus on:

vi. How ESC factors impact on adolescent health in the above contexts, regardless of the enactment of relevant national laws (including nationally recognized customary or religious laws), regulations, and policies in relation to the respective contexts.
Annex 2

KEY QUESTIONS FOR THE LEGAL REVIEW

1. At what age may sex between consenting individuals legally take place? (Age of Consent to sexual intercourse) Indicate if there are different ages for males and females?
2. Is there a definition of statutory rape? Please define.
3. Are there exceptions to question (1)? For example gay sex?
4. At what age may a young person access contraceptive services including contraceptive commodities? Please specify with and without parental consent if the answers are different.
5. May a young person access emergency contraceptives (e.g. the ‘Morning-after pill’)? At what age? Please specify if there are different ages with and without parental consent.
6. Policy framework and legislation enabling or disenabling access to Antiretroviral Therapy (ART), including Age of Consent, with and without parental consent.
7. Specify whether there is any prohibition on HIV Post-exposure Prophylaxis (PEP), including Age of Consent, with and without parental consent.
8. If there is no prohibition in question 7, would young people be legally able to access PEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
9. Is there any legislation or policy specifically enabling PEP use in the country? Please specify if it deals with Ages of Consent and give details.
10. Specify whether there is any prohibition on HIV Pre-exposure Prophylaxis (PrEP), including Age of Consent, with and without parental consent.
11. If there is no prohibition in question 10, would young people be legally able to access PrEP if it was offered? At what ages? Please specify if there are different ages with and without parental consent.
12. Is there any legislation or policy specifically enabling PrEP use in the country? Please specify if it deals with Ages of Consent and give details.
13. Please state whether there is policy framework and/or legislation enabling or disenabling access to safe abortions and/or postabortion care, including Age of Consent, with and without parental consent.
14. Policy framework and legislation enabling or disenabling access to Antenatal Care (ANC), including Age of Consent, with and without parental consent.
15. Policy framework and legislation enabling or disenabling access to HPV vaccines and cervical cancer screening and treatment, including Age of Consent, with and without parental consent.
16. What is the Age of Consent to access HIV testing without parental consent?
17. What is the Age of Consent at which the HIV status will be reported directly to an adolescent and legal/policy requirements to report the status to her/his parents?
18. Please explain any inconsistencies between the answers above.