ORIGINAL RESEARCH ARTICLE

Healthcare workers' knowledge and perceptions on the prescripts of the criminal law (sexual offences and related matters) Amendment Act 5 of 2015 in East London, South Africa

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Abstract

In 2015, South Africa amended the Criminal Law (Sexual Offences and Related Matters) Amendment Act 5 of 2015 to address several disparities surrounding the issue of consensual sex among minors. The amendment Act and its prescripts were met with mixed reactions from the stakeholders, healthcare workers and community. This affected its implementation as some supported the amendment while others opposed it based on their perceptions of the prescripts. The study was conducted in clinics in East London to explore the perception of healthcare workers (HCWs) regarding the prescripts of this Act and their implications to adolescent sexual and reproductive health services. The qualitative research approach and a combination of descriptive and exploratory research design were used to conduct the study. Data were collected through key-informant interviews, in-depth interviews and focus group discussions and analysed using thematic method. There were positive and negative perceptions that influenced the HCWs' attitudes and performance of their adolescent sexual and reproductive health duties towards minors. Those with positive perceptions regarded the Act as an enabler in the provision of adolescent sexual and reproductive health services that maintains adolescents' privacy and confidentiality as minors do not need parental consent to access these services. Those that had negative perceptions viewed the Act as taking away parental responsibilities, overloading health workers with parental duties and encouraging minors to be sexually active. The study recommended increased awareness about the Act to all members of society including minors, schools, parents and HCWs to ensure successful implementation of the Act. *(Afr J Reprod Health 2022; 26[12s]: 98-109).*

Keywords: Consensual sex, healthcare professionals, minors, sexual offences, sexual and reproductive health services

Résumé

En 2015, l'Afrique du Sud a amendé la loi n° 5 de 2015 portant modification du droit pénal (délits sexuels et affaires connexes) pour remédier à plusieurs disparités entourant la question des relations sexuelles consensuelles chez les mineurs. La loi d'amendement et ses prescriptions ont suscité des réactions mitigées de la part des parties prenantes, des travailleurs de la santé et de la communauté. Cela a affecté sa mise en œuvre car certains ont soutenu l'amendement tandis que d'autres s'y sont opposés en raison de leur perception des prescriptions. L'étude a été menée dans des cliniques de l'est de Londres pour explorer la perception des travailleurs de la santé (HCW) concernant les prescriptions de cette loi et leurs implications pour les services de santé sexuelle et reproductive des adolescents. L'approche de recherche qualitative et une combinaison de conception de recherche descriptive et exploratoire ont été utilisées pour mener l'étude. Les données ont été recueillies par le biais d'entretiens avec des informateurs clés, d'entretiens approfondis et de discussions de groupe et analysées à l'aide de la méthode thématique. Il y avait des perceptions positives et négatives qui ont influencé les attitudes des agents de santé et la performance de leurs devoirs de santé sexuelle et reproductive des adolescents envers les mineurs. Ceux qui avaient des perceptions positives considéraient la loi comme un catalyseur dans la fourniture de services de santé sexuelle et reproductive aux adolescents qui préservent la vie privée et la confidentialité des adolescents, car les mineurs n'ont pas besoin du consentement parental pour accéder à ces services. Ceux qui avaient des perceptions négatives considéraient que la loi supprimait les responsabilités parentales, surchargeait les agents de santé de devoirs parentaux et encourageait les mineurs à être sexuellement actifs. L'étude a recommandé une sensibilisation accrue à la loi auprès de tous les membres de la société, y compris les mineurs, les écoles, les parents et les travailleurs de la santé, afin d'assurer une mise en œuvre réussie de la loi. *(Afr J Reprod Health 2022; 26[12s]: 98-109).*

Mots-clés: Relations sexuelles consensuelles, professionnels de santé, mineurs, infractions sexuelles, services de santé sexuelle et reproductive

Introduction

Many countries worldwide including South Africa have passed laws that govern and protect minors and adults from gender-based violence, sexual offences and consensual sex issues. These laws however did not adequately protect survivors of sexual violence, but protects the perpetrators[1-3]. The laws also discriminated against women, children, persons with disabilities and lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI) people[1]. Many of these laws were later amended to protect these vulnerable groups and specifically, to protect minors from predatory sex with adults; and prevent punitive measures for consensual sex among minors of the same age group and within the legal age limits prescribed by the laws[2].

South Africa passed the Criminal Law (Sexual Offences and Related Matters) Amendment Act 5 of 2015 on the 5th of June 2015, as a revision of the Sexual Offences Act to protect vulnerable groups and to address the issue of imprisonment as punishment for consensual sex among minors[4-5]. For the purpose of this article, the Criminal Law (Sexual Offences and Related Matters) Amendment Act 5 of 2015 will be referred to as the Act.

The Act also referred to as Consensual Law was passed to guide the responsible authorities in dealing with minors who were imprisoned or awaiting trial for consensual sex with other minors. Consensual sex in this context refers to sexual intercourse where the persons engaging in sexual activity have consented prior to and during sexual activity[4]. Thus, this Act decriminalised consensual sexual activity by minors between the ages of 12 and 15 years and with age difference of not more than 2 years. It seeks to ensure that persons engaged in the sexual activity are age appropriate and must have agreed to engage in the sexual activities. It further prescribes conditions that minors should ascertain before and during sexual activity with their age appropriate partners[4,5]. The conditions are as follows: the consenting participant should not be under the influence of alcohol or drugs or mentally ill or under the age of 12 years[4]; minors between 12 and 15 years of age can only have a sexual partner who is under 16 years and the age gap between the two partners must not be more than 2 years[5]. This means that a 12-year-old minor cannot have consensual sex with a 15-year-old minor as a consensual sexual partner or vice versa; minors aged 16 and 17 should only participate in consensual sexual intercourse with partners of the same age group. If the conditions in which sexual intercourse happen are contrary to those mentioned above the sexual activities amounts to rape and is punishable by law[4,5].

This law also defines sexual offenses and rape in clear terms that enables stakeholders including HCWs understand them. Under the law, instances of rape include cases where one of the partners involved in the sexual activity is against it or has not consented, or feels forced or coerced or indicates during the process that the partner stop but the assailant refuses to do so. It is also rape if one partner is asleep, under the influence of substances, mentally disabled or under the age of 12. Other instances include cases where a person above the age of 16 engages in sexual activity with a minor under 16 and if adults have sexual intercourse with minors[4]. In a nutshell, the purpose of this amendment is to ensure that children of certain ages are not liable for sexual activity with one another if it is consensual. The law allows the presiding officers to exercise discretion on a case-by-case basis to determine whether sexual offenders who are minors should be included in the National Registry of Sex Offenders[4]. It also specifies conditions for application for the removal of the particulars of children convicted for having engaged in consensual sexual acts with each other from the National Register for Sex Offenders[2].

There is lack of consensus on perception and level of acceptability of the Act based on multiple factors. There are studies that show misconceptions about the Act among health professionals, social welfare teachers and the general public. These misconceptions continue to exist despite consultations and awareness-raising initiatives that have been undertaken throughout the country[7]. These misconceptions cause unnecessary confusion and ethical dilemmas among HCWs in relation to reporting sexual activity among minors and provision of sexual and reproductive services including antenatal care to adolescents[8]. This is based on the fact that the initial Act required minors that needed contraceptives to disclose their partners and HCWs had a clear obligation to report these cases to the police and to also seek parental consent. As a result of this, minors are often arrested for having consensual sex with minors of their age group.

With the amendment, it therefore becomes very important that HCWs who deal with rape cases and who are involved in completion of relevant police forms[8] are well informed of the relevant laws and understand the implications of the amendment as it relates to consensual sex and rape. This will ensure that HCWs are able to apply the laws appropriately to ensure that adolescence have access to accurate information about their sexual and reproductive health (SRH); and their SRH rights (SRHR). It is important that HCWs are able to distinguish between rape and consensual sexual activities permissible within the limits of the law. Rape is a criminal offence and the appropriate form needs to be completed and submitted to the police for further investigation[7]. In other words, HCWs must have knowledge and understanding of the Amended Act to be able to educate and guide adolescents, parents and communities on its prescripts as they relate to ascertaining the age of the person with whom a minor has had, or plans to have, consensual sex. HCWs must also take steps to ascertain that partners of minors seeking SRH services are within the age brackets prescribed by the Amendment Act 5 of 2015[7-10]. It is against this background that this study assesses knowledge, perceptions and level of implementation of the Act by HCWs in the provision of adolescents' SRH services in three clinics in East London.

Methods

This was qualitative research study that used exploratory and descriptive research design. The exploratory and descriptive research design allowed the researcher to assess, explore and describe the knowledge and perception of healthcare professionals regarding the amendments to the Consensual Laws in South Africa. This study was conducted in the clinics of East London, Buffalo City Municipality of the Eastern Cape Province[11]. There are a total of 31 clinics offering SRH care to adolescents in East London. Three clinics were purposively selected, because they provide primary healthcare services to urban, rural and informal settlement in East London and surrounding rural areas. They were selected, because they offer SRH care to adolescents from the nearby schools, university and communities. Their 2018 statistics indicated that approximately 75% of their clients were categorised as youths in annual reports.

Population and sampling

The population of this study consisted of different categories of HCWs, namely clinic managers, professional nurses and adolescent healthcare practitioners responsible for adolescent SRH in the three participating clinics. Adolescents' healthcare practitioners is a general term that refers to caregivers, health educators, health promoters and counsellors responsible for adolescent SRH in the three participating clinics. These HCWs were targeted, because they were working within the adolescent SRH services and therefore expected to be aware of legislations and policies related to youth and adolescents.

Purposive sampling technique was used to select the participants[11]using the following criteria: the participant should be a clinic manager responsible for the management of healthcare services in the clinic; a professional nurse responsible for maternal and child health or family planning services; an adolescent healthcare practitioner in the clinic. A total of three clinics, three clinic managers, nine professional nurses and thirteen adolescent healthcare practitioners were selected based on the set criteria.

Data collection and analysis

Data collection methods used included key-informant interviews (KIIs) with the clinic managers, in-depth interviews with the professional nurses and focus group discussions (FGDs) with the adolescent healthcare practitioner responsible for adolescent SRH. This allowed for the triangulation of methods and data, which increased the credibility and validity of the results. Appointment dates for the interviews and FGDs were set with the participants. Venues with minimal distractions were identified and used for the collection of data[11]. The study and purpose of the interview were explained and issues of confidentiality addressed. The participants were then given time to read information sheet to read and sign the consent for participation and for the use of a digital voice recorder if they chose to participate. The consent forms were collected and stored in an envelope and sealed before the interviews or discussions started. The KII, in-depth interview and FGD guides were used to collect data. The guides had demographic sections that were completed by the participants and the other sections consisted of questions and

probes. Data collection with the managers and professional nurses were conducted in English, because it is their work language, but participants were allowed to answer in any language they were comfortable with. The FGD with adolescent healthcare practitioners were conducted in IsiXhosa to allow the participants to express themselves fully. The information was recorded using a digital voice recorder during KII, in-depth interviews and FGD.

The collected data were transcribed verbatim into text. The transcribed data that needed translation were translated from IsiXhosa to English by a professional translator. The main method used for data analysis in this research was thematic analysis, except for analysing the demographic characteristics of the participants which was quantitative. Thematic analysis enabled the issues pertaining to the study to be well-structured into different themes that allowed the researcher to understand the findings[11]. Table 1 indicates the themes, sub-themes and categorises that were developed from the collected data. There were both positive and negative perceptions that were developed from different subthemes and categories of the participants' responses. The themes are discussed in details in the results section.

Results

The demographic details of the participants were analysed using quantitative methods and are presented in Table 1. Qualitative data were analysed and developed the following themes: Inadequate knowledge among HCWs on the prescripts of Amendment Act No.5 of 2015; The Act prescripts enables HCWs provide sexual and reproductive health services to adolescents; The Act prescripts encourages sexual activities among adolescents; The Act overloads HCWs by taking away the sexuality education responsibility from parents, resulting in conflict between the HCWs and parents.

Demographic characteristics of the participants

A total of twenty-four (24) participants, three (3) clinic managers, nine (9) professional nurses and twelve (12) adolescent sexual and reproductive practitioners participated in the study. About 14 of the participants were females and 10 were males. The participants' ages ranged from 21 to 60 years with three quarter (18) of them aged between 31 and 50 years. The majority, 21(88%) of the participants had more than 8 years' work experience with only one professional nurse who had between 4 and 5years experience working with adolescents.

Inadequate knowledge among HCWs on the prescripts of Amendment Act No.5 of 2015

Although all the participants were aware of the existence of the Act, about a third of them (8) conceded that they had limited knowledge of it. They were also aware of the gaps in their own understanding and knowledge of the prescripts of the Act. This is evident in the way they describe the prescripts.

"It is an amendment or revision Act that accommodates twelve-year olds and above in consensual sex".

"Legislative framework concerned with teenagers/adolescent/12-year olds".

"Is one of the legal structures that governs HCWs on how to conduct themselves when concerned with sexual and reproduction health to 12-year olds and above".

"The act decriminalises sexual intercourse among teenagers"

"It is an Act that allows 12-year-old children to engage in sexual activities"

One of the participants in one of the FGDs indicated that although she attended in-service education about the Amendment Act No.5 of 2015, she is not confident that she has enough knowledge to apply it accurately or teach young people about it.

"I feel that I still do not know the specifics of this Act. I always believe the people who come here to support us also have no clear idea of what this law is about".

There was a view among some of the participants that the training they received introduced them to the Act, but they were not confident that they have the required knowledge to apply the prescripts appropriately. In their view good support and on-

Table 1: Demographic characteristics of the participants relevant to this study

Variables	**Participant groupings**		
	Clinic Managers	**Professional nurses**	**Adolescent sexual and reproductive practitioners**
Gender			
Male	1	4	5
Female	2	5	7
Total	**3**	**9**	**12**
Age Group			
20 years & below		-	-
21-30 years		2	2
31-40 years	1	3	4
41-50 years	2	3	5
51-60 years		1	1
Total	**3**	**9**	**12**
Years of Experience			
0-3 years	-	-	-
4-8 years		1	2
More than 8 years	3	8	10
Total	**3**	**9**	**12**

going in-service could improve their knowledge and proper implementation of the Act.

"*Nurses need on-going in-service trainings on the prescripts of the amendment."* (Focus Group Participant)

The HCWs' description of their understanding of the Act was dominated by two interpretations of Amendment Act prescripts, which could have influenced their perceptions (positive and negative perceptions) of the Act. Some HCWs were of the view that the Act encourages, allows and supports 12-year-old children to engage in consensual sex. '*This Act allows certain age groups to have consensual intercourse'*. They view consensual sex prescripts as permission given to adolescents to engage in sexual activities. They were concerned about the consequences related to early sexual activities among adolescents which include engaging in risky sexual behaviours, sexually transmitted diseases, transmission of HIV and teenage pregnancies.

Another worrying concern was that HCW were of the view that the parents and communities were not aware of the Amended Act causing conflicts between HCWs and families; between adolescents and their families; and between communities and families. There were no awareness programmes that were conducted about the Amendment Act in the community. The adolescent sexual health practitioners indicated that their training programmes for parents and communities are based on the initial Act.

The Act prescripts enables HCWs to provide sexual and reproductive health services to adolescents

The HCWs acknowledged that the amendment Act enabled them to provide sexual health education, ANC, HIV testing and counselling, and abortion services in a safe environment that maintain adolescent patients' privacy and confidentiality. It also provides a safe environment that allows for transparency and trust between the HCWs and adolescents to discuss sexual health issues. Some of these HCWs also commented on minors consenting to HIV testing and other services without the need for parental consent as a positive development in healthcare which is directly linked to the amendment Act.

"*It enabled everyone to be transparent about their sexual health and it is easier for healthcare professionals to provide assistance when it is needed. It allows 12 year & older to sign and do abortion without their parent knowing about it"* (FGD participants).

"The Act maintains patients' privacy and confidentiality" (4).

"*This Act allows us to provide HIV counselling to everyone, regardless of their age. When we are providing sexual education to them, we even tell them about ANCs because we know that they will fall pregnant. We only do not get into detail about ANC because they have not reached that stage yet. Overall, this Act is important because it opens the doors for ANC for everyone"* (Clinic Manager).

"The Act allows the healthcare workers to provide ANC services to everyone, even the young ones" (Professional nurse).

However, some felt that offering ANC to minors needs people with experience in dealing with adolescents as they need a different approach as their needs are different from those of adults. A professional nurse described providing antenatal care to minors to be a serious challenge if not well prepared.

There was a view among some participants that the Amendment Act has improved access to Adolescent sexual and reproductive health (ASRH) education that has led to the decrease in adolescents' pregnancies and unsafe abortions in the community. Some participants even argued that the Act has had direct effect in reducing the numbers of unsafe abortions.

"*There has been a positive effect experienced since the introduction of the Act. The number of street abortions has fallen compared to the times prior to the introduction of this amendment. Adolescent pregnancies have also fallen because the children are now allowed to go for family planning*" (Clinic Manager).

The information provided by the clinic manager above was echoed by other participating HCWs in the different participating clinics.

"*The implication of the amendment Act has allowed young adolescents to be able to come to clinic and search for more information and get contraception as early as they can, which can reduce teenage pregnancy at the same time. It also helps them to access HIV information, testing and counselling early and this can reduce the spread of HIV*" (Professional Nurse).

In other cases, the Amendment Act No.5 of 2015 has led to the fostering of a positive contraception culture among the adolescents, particularly those in high school. In one of the clinics that participated in this study, there was a 'Youth friendly health services initiative' established to assist adolescents with sexual and reproductive health education.

"*I was an engineer for Youth Friendly Program during the time the Act was amended. Awareness on consensual sex, reproduction health and sex education programs were conducted to the high school learners on a monthly basis. We would use the netball fields there and they would be full of young adolescents. During school days, after school, we would see learners flocking to our clinic because they knew that they will get a lot of assistance in this clinic*" (Clinic Manager).

The participants who viewed the Amendment Act No.5 of 2015 positively also linked it to the maintenance of privacy and confidentiality of minors' SRH information and access to reproductive health services. Some participants indicated that the Act changed their attitudes towards adolescents that are sexually active.

"The Act on consensual sex has taught me to be less judgemental towards the children who come for sexual health information …" (Professional Nurse).

Some participants made a comparison of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 5 of 2015 and the initial Act. The participants were of the view that the amendment Act is more flexible than the previous one. Minors' clinical information is more protected than in the past and the privacy and confidentiality of their patients, especially minors is well protected by the amendment Act. Also, minors feel free to access sexual health information and the healthcare providers feel comfortable to talk to minors about their sexual health needs and questions. One of the clinical managers indicated:

"The amendment Act has made the healthcare workers to become comfortable in conducting their duties. We can now tell them everything about consensual sex and reproduction health and they are free to ask for relevant services. Initially, we were obliged to call their parents or the guardians that so and so is here to ask for family planning and ask for their consent. But now we are no longer doing that because of this Act" (Clinic Manager).

A number of participants indicated that, because the Act incorporates people from different age groups, minors benefit from discussions with other women who share their experiences during antenatal care classes and SRH education in waiting rooms. While some negative implications have also been noted. Instances of older women who were sometimes judgemental or who purposely tried to scare young girls in the waiting rooms were noted. The available factual SRH information that pregnant adolescents receive during ANC classes, empower these pregnant girls to challenge some unfriendly utterances meant to humiliate pregnant adolescents in waiting rooms. Sometimes these situations

become teaching moments for us about the Criminal Law (Sexual Offences and Related Matters) Amendment Act 5 of 2015. Some participants indicated that after teaching about it they have observed some improvement in relationships between the adolescents and older women in the waiting rooms. One of the participants indicated:

"The fact that this Act enables young teenagers, most of whom are sexually active, to access sex-related education and to give consent to sex has a positive impact on the way in which SRHR are disseminated and I think it also help some of the older women in teaching their own children".

This is a positive development within the healthcare industry with regard to the privacy and confidentiality of minors. It only needs HCWs to gain enough knowledge to implement it properly and ensure that adolescents, parents and communities are aware of the Act and its prescripts.

The Act prescripts encourages sexual activities among adolescents

Some of the HCWs who participated in the in-depth interviews and FGD of the study were of the view that this amendment Act is inappropriate, because it encourages minors and protect them to engage in sexual intercourse before they mature. Parents are unable to intervene as they know that there is law which protects their children. Some of them associated it with immorality indicating that has opened doors for children to engage in sexual activities.

"*I think to a certain extent the Act is wrong because it encourages children, at a younger age, to engage in sexual intercourse. At 12 years of age these children are still too young to indulge in sexual intercourse"* (Professional Nurse).

"Main challenges are parents who feel like their children are being destroyed, because of the Amendment Act No.5 of 2015 and they have to deal with the consequences thereof without the government who in the first place gave their children such rights" (Clinic Manager, adolescent healthcare practitioner, responsible for Adolescent Sexual and Reproductive Health).

These views were further supported by a number of HCWs who indicated during focus group discussions that:

"The amendment Act No.5 of 2015 encourages and allows children at the age of 12 years to have sex. This is inappropriate as children in that age are still immature, and unwilling and not ready to face consequences of sexual intercourse. These children are not mature enough to understand the implications of engaging in sexual intercourse and they can be easily manipulated" (Adolescent healthcare practitioner).

These negative perceptions about the Act could be related to the limited understanding of the Act and inadequate knowledge about the prescripts of the Act. Another view that the HCWs expressed, which is related to inadequate understanding and knowledge is that the amendment Act overloads HCWs by taking away the sexuality education responsibility from parents, resulting in conflict between the healthcare services and parents.

The Act overloads HCWs by taking away the sexuality education responsibility from parents, resulting in conflict between the HCWs and parents

Some participants were of the view that, since the introduction of the amendment Act, there has been an increase in the number of adolescents coming to the clinics to access information and contraceptives. The increased number of adolescents increased their workload as they have to spend more time with them explaining about sexual and reproductive health issues, which sometimes were too much for them to comprehend or deal with their questions effectively because of lack of time. Furthermore, adolescents' access to sexual and reproductive health information often resulted in conflict situations between the healthcare services and parents, because the parents felt that HCWs gave their children information that they, as parents, did not want them to access.

"We have encountered several adverse outcomes of the introduction of this Act. One of the parents, a mother, came to the clinic complaining that her daughter came home with some information about their right to partake in sexual

intercourse as early as 12-years. It had to be explained to the mother that it was not a way to encourage her child to have sex but to educate her about consensual sex. This will assist her make informed decisions about sexual activities and the boundaries set by the law" (Professional Nurse).

Discussion

Demographic characteristics of the participants

The study participants were female dominated reflecting the gender demographics of HCWs in clinics and SRH services. In South Africa, the provision of healthcare in clinics is mainly by female HCWs and the users are also mainly females, particularly in rural and low economic income communities. There is female dominance among HCWs in many of HCW except among doctors where males still dominate the profession[12]. The age distribution of participants described above reflects the ageing nursing population in South Africa described by Schütz[13] who argues that South Africa has an ageing nursing population. In 2020, almost half (47%) of registered nurses and midwives were aged 50years and above with only 6% aged between 20 and 29 years. Gender and ages of the HCWs could have implications on the provision of ASRH services by giving much attention to the SRH needs of girls and less focus on boys and their unique needs, because of the high numbers of female HCWs in most of these programmes including the clinics where this study was conducted. Some of the HCW are not confident and even shy to discuss SRH with male adolescents in particular[14,15]. The reasons for targeting girls and young women particularly in rural areas and low-income communities could be the fact that they are considered vulnerable and at a high risk of contracting and transmitting sexually transmitted diseases (STDs), including HIV/AIDS[14-16]. Another reason could be the fact that for many years, ASRH programmes were guided by feminist research and models and mainly protecting the sexual and reproductive rights (SRHR)[18-19]. Johnson, *et al*[17] argue that the vulnerability of girls and women to STIs, HIV/AIDS, teenage pregnancy, increased single parenthood, increased maternal and child morbidity and mortality, female cancers, increased abortion, increased violence against women and children and increased depression among girls and women influenced the HCWs, programmes developers, researchers, funders and SRH services to focus on females more than males.

Perceptions related to the knowledge of HCWs on the prescripts of Amendment Act No.5 of 2015

Although all the participants were aware of the Act, about a third of them conceded that they had limited knowledge of it. Some of the participants were positive about this Act, while others shared more pessimistic views about it. The HCWs described the Act as the law that decriminalises sexual intercourse among adolescents from 12 years and among teenagers within the prescribed age groups, describes consensual sex, legislative framework that governs HCWs on how to conduct themselves when dealing with sexual and reproduction health rights of 12-year olds and above, and guides the practices of HCW when dealing with adolescent sexual and reproductive health services. According to Bhamjee *et al*[4] the Amendment Act 5 of 2015 decriminalises consensual sexual activities among minors between the ages of 12 and 15 years who are 2 years or less between them. This is similar to decriminalisation of sexual intercourse as described by HCWs. However, some participants described it as a law of consent that gives children aged 12 years to consent to having sex with their partners. The Act gives a clear definition of consensual sex defining it as sexual activity where all parties involved in the sexual activity have consented prior and throughout the sexual activity-. This legislation amended in 2015 specifies that when two adolescents participate in sexual activity without mutual consent it is rape. The teenager who is the enforcer should be legally prosecuted. Adolescent consensual sexual activities within the prescribed age brackets is no longer treated as a criminal offense and therefore the adolescents must have access to SRH services and counselling as needed[18,19].

The HCWs' understanding and perceptions of the Act were dominated by their interpretations of, concerns related to the Amendment Act prescripts and impact of early sexual activities. According to *Johnson, et al*[17] early sexual initiation has harmful effects which include sexually transmitted infections, unplanned pregnancies, increased abortion, early marriage and cancer of the

cervix. The amendment Act covers all the recommendations made by UNFPA in relation SRH laws and policies. These include among others policies that protect SRHR of adolescents and young people, prevention of stigmatisation, prejudice and denial of health services to adolescents with disabilities or those who are HIV-positive, who engage in sex work, who are out of school, who inject drugs, who belong to the LGBTI community or are associated with other sexual minority groups[14,19]. In 2018 the WHO also developed recommendations on adolescent sexual and reproductive health and rights that take into consideration consensual sex laws that were enacted by many countries including South Africa, to address the issue of consensual sex among minors and to deal with the many minors who are jailed as a result of consensual sex with other minors[9].

The inadequate knowledge, understanding and interpretation of the Act among HCW interfere with adolescent SRH services provision in healthcare facilities. Evidence shows that some HCWs still have negative attitudes towards adolescents using contraceptives. Stigma and discrimination have also been reported as HCWs feel that it is not right time for the adolescent to access contraceptives. These negative attitudes can create role conflict in health HCWs, which can further lead to unprofessional and hostile behaviours towards adolescents. These behaviours prevent adolescents in developing countries from accessing SRH services due to stigma and discrimination by HCWs[9,20] .

Implications of HCWs perceptions to healthcare provision

Healthcare workers that perceived the prescripts positively viewed the Amendment law as a law that has enabled everyone to be transparent about their sexual health and made it easier for healthcare professionals to provide assistance when it is needed. It allows 12 year olds and older minors to sign and do abortion without their parents knowing which maintains patients' privacy and confidentiality. Those who were supportive suggested that they found the Amendment Act 5 of 2015 to be appropriate and had an impact on enhancing sexual education. The training that they received in relation to this law assists them to recognise gender based violence issues among their clients. The participants indicated that the prescripts of the Act enable HCWs to provide sexual health education, ANC, HIV testing and counselling and abortion services that maintains patients' privacy and confidentiality. It allows sexual health education for adolescents in the clinics and school and reduce teenage pregnancy at the same time. It also prevents HCW from judging minors, reduced judgemental attitudes and verbal abuse from HCW in healthcare facilities when minors seek sexual and reproductive health assistance. According to Chilinda *et al*[21] untrained HCWs are not aware that ASRH is a public health issue. Some of the healthcare providers are not receptive to adolescence which often result in stigmatisation and discrimination of adolescent seeking SRH services.

The participants who showed positive attitudes towards the Amendment Act were pleased by its positive effects in the reduction of the number of teen pregnancies and street abortions in their communities. They also found that the children and young adults who were introduced to this amendment law to have made more regular use of health facilities than before. These HCW also claimed that access to sexual health education for adolescents has led to a decrease in the number of adolescents' pregnancies and street abortion in their community. This is similar to the findings by Mokomane *et al*[22] indicating that facilities that offer sexual health education that enhances patients' privacy and confidentiality are more desirable to adolescents than health facilities with Adolescent and Youth Friendly Service (AYFS) that do not exercise patients' privacy and confidentiality practices. These facilities are major contributors to preventing teenage pregnancies as well preventing risky sexual behaviours among adolescents[19].

Those that had negative perceptions about the Act also displayed negative attitude when attending to adolescent's RH needs has also adversely affected the adolescents' access to SRHS. Most of the negative participants were primarily worried about that the Act allow minors to be sexually active and making available and to make use of the facility, as opposed to the former law forcing parents to give their permission. The HCWs' negative attitudes toward adolescents are evident in the way the treat adolescents. The adolescents are often shouted, told to go fetch their parents when they need SRH services and use judgemental approach toward them. Evidence in a

number of studies show that adolescents indicated that poor attitude of HCWs have been barrier for them from accessing SRH education and abortion services. These judgemental attitudes often drive adolescence away from healthcare facilities and end up seeking assistance from unlawful unsafe abortion services[19,20]. Hence, there is a need to train health care providers to provide integrated youth-friendly SRHS and ensure that Acts related to consensual sex are also included.

Furthermore, these participants were of the view that the Act encourages the risky sexual behaviours and consequences of early sexual debut among adolescents which are responsible for increase teenage pregnancy and HIV among young girls in the community. Sexual risk behaviours among adolescents include early sexual debuts, multiple sexual partners, unprotected sexual intercourse and sexual intercourse while under the influence of alcohol or drugs. Early sexual intercourse and its consequences are already a challenge in South Africa[21].

Some of the negative implications identified in this study, namely that disciplinary issues arose as a result of the decriminalisation of sexual activity among minors, also raised concerns about the debate on sexual debut. Early initiation of sexual intercourse, whether voluntary or pressured, increases exposure to high-risk sexual behaviour among adolescents, which may lead to unplanned adolescent pregnancy and STIs, including HIV[22-24]. Findings from South African studies note peer education to be effective in increasing condom usage and postponing sexual debut, contributing to delaying sexual debut, improving knowledge of HIV and AIDS prevention and improving HIV knowledge and attitudes among young people and therefore reduce youth risky sexual behaviours[21-25].

Although the amendment of the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2015, was to ensure that minors of certain ages are not held criminally liable for engaging in consensual sexual activities[2]. According to Doyle *et al*[6] the Amendment Act was introduced to ensure that minors of certain ages are not held criminally liable for engaging in consensual sexual acts with each other; to give presiding officers discretion to decide, in individual cases, whether the particulars of children should be included in the National Register for Sex Offenders or not; to provide a procedure in terms of which certain persons may apply for the removal of their particulars from the National Register for Sex Offenders[6]. The World Health Organization recommendations on adolescent sexual and reproductive health and rights describe adolescents as a heterogeneous group with different and evolving needs that are based on their individual development stages and circumstances in their lives. Therefore, ASRH services in these communities must educate, empower and support both girls and boys to make independent decisions and protect themselves from harm[9,18]. Adolescent services must deal with adolescents health needs, rights and provide counselling services that can contribute to helping them stay well, and to get back to good health when they are ill or injured[18,19,25]. More studies need to be conducted to determine knowledge of adolescence boys and girls regarding the Criminal Law (Sexual Offences and Related Matters) Amendment Act, 2015 and accessibility of ASRH services to adolescent males.

Ethical considerations

This research factored the various ethical concerns found by the Ethics Committee of the University of Fort Hare under the Govan Mbeki Research Development Centre (GMRDC). The researcher applied for ethical clearance and the UFH Ethical Clearance Certificate was obtained upon fulfilment of all the requisite for ethical considerations. Permission to conduct the study in clinics was granted by the Eastern Cape Department of Health and the Buffalo City Metro Health District. The study paid special attention to ethical issues related to the respect of participants, maintaining confidentiality, privacy and philosophy of beneficence, informed consent and the principle of justice throughout the study.

Conclusions

Despite the continual claims by the participants that they had not received adequate training about the prescripts and uses of this Act, the majority of participants showed valuable knowledge that improved their attitudes towards adolescents' sexual health. In terms of the implications of the act, the study established different perceptions of the implications of the Act by healthcare practitioners. Some of the participants were optimistic about the

Act, while others shared their negative sentiments. Those who were supportive suggested that the amendment to Act 5 of 2015 was appropriate and enhanced sexual education among users. They recommended that there should be programmes that create awareness about the Act in the community and healthcare facilities. Healthcare workers working with adolescents must be trained in order to disseminate accurate information about the Act among adolescents. In their view the negative perceptions and attitude towards the law is mainly due to inadequate knowledge and misinterpretation of the prescripts. Therefore, training of HCW will be able to deal with that. The trained clinic managers must run programmes for their clinics staff and improve the HCWs' knowledge, attitude and behaviour towards adolescents seeking sexual and reproductive health services. This will ensure that HCWs create a suitable ASRH platform that will not be judgemental but treat adolescents with respect and maintain privacy and confidentiality at all times.

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