

Reproductive health issues emanating from the Children's Act No. 38 of 2005 as amended in 2008: A pilot study of the rights of parents versus rights of children

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The study took as its point of departure the Children's Act No. 38 of 2005 implemented in 2010, which aims to promote the preservation and strengthening of families and to give effect to the rights of children as enshrined in the Constitution of the Republic of South Africa. When the Act was introduced certain segments of society applauded the government for its efforts to promote the rights of children, while others condemned the government's approach towards parents' rights in relation to reproductive health issues affecting their children. The primary aim of the research project was to explore the views of a group of parents in Johannesburg Metro Region 11 regarding reproductive health care as embedded in the Children's Act. A small-scale, descriptive, cross-sectional pilot research design was employed which involved individual interviews with 35 participants. The main findings that emerged from the study were that participants did not participate in the process leading up to the promulgation of the Act and consequently had little knowledge about the Act or its objectives. The fact that participants did not support certain clauses on reproductive health care and were of the opinion that their rights as parents were being violated has implications for amendment of the Act.

Following the advent of the new political dispensation in 1994, South Africa developed a constitution that has been widely recognised by the international community as progressive (Act 108 of 1996).¹ The Bill of Rights in the Constitution enshrines the rights of all people in South Africa and affirms the democratic values of human dignity, equality and freedom.

In a bid to fulfil its mandatory obligations in respect of children, the South African government made a commitment to have children's rights embodied in legislation. South Africa is also a signatory to other international conventions that seek to protect and promote the interests of children, such as the United Nations Convention on the Rights of the Child² and the African Charter on the Rights and Welfare of the Child.³ In addition to these conventions, and as a constitutional obligation of the state to provide mechanisms to protect children against all forms of abuse and neglect, the government has adopted a developmental approach towards the upbringing of children. This approach is reflected in the Children's Act (No. 38 of 2005) as amended in 2008^{4,5} and implemented in April 2010. In essence, the Act is aimed at protecting children from discrimination, exploitation and any other physical, emotional or moral harm or hazards in a bid to promote the preservation and strengthening of families. This goal is also encapsulated in the Constitution of the Republic of South Africa (Act 108 of 1996)¹ where these rights are related to the general right of children to social services. In addition, Dutschke⁴ indicates that this Act, together with other policy documents such as the Integrated Service Delivery Model in South Africa, is designed to enable a shift to the rights-based developmental social welfare approach.

When it was introduced, the Children's Act evoked mixed reactions with some human rights groups viewing it as a positive response by the government following many cases involving gross maltreatment of children in various forms, including child traffick-

ing, child labour, child pornography and an increase in sexual activity on the part of children. This kind of behaviour is believed to be associated with the spread of sexually transmitted infections, including HIV, as well as an increased rate of teenage pregnancies.⁶

In contrast, some reactions have been characterised by disapproval of the way government has endeavoured to deal with the reproductive health issues of children. For example, groups such as Women of the National Democratic Convention have expressed their disapproval of the Act. They are particularly opposed to those clauses in the Act that make provision for children as young as 12 years to have access to condoms and be able to undergo abortions without parental consent.⁷ Moreover, Schmid (p. 260⁸) asserts that 'the child's best interest standard and the child protection interpretation of children's rights, potentially pits children against their parents and relatives rather than acknowledging the integrated nature of children and family group needs'.

Some have also taken the view that there is an internal contradiction in the legislation regarding children's sexualisation. This contradiction was highlighted by Ashley Theron, Executive Director of Johannesburg Child Welfare, when he stated: 'The Children's Act contradicts present law whereby a child can only consent to sexual relations once they are 16 years and older.'⁷ Moreover, despite the fact that people were afforded the opportunity to participate in the consultative process leading up to the promulgation of the Act, these anecdotal statements suggest a degree of dissatisfaction with the Act.

The researchers were therefore motivated to translate these anecdotal findings into scientific research by conducting a research survey of the views of a broader group of parents regarding the reproductive health issues incorporated within certain clauses of the Children's Act. It was envisaged that the study would address the

manner in which parents were informed about the developments in legislation governing their children and what implications they felt the new law had for parental control. A study of this nature seemed to be both timely and relevant given the high prevalence of HIV/AIDS, child sexual abuse, teenage pregnancy and school drop-out rates in this country.⁹ The research also appeared to have particular salience for social workers who are mandated to implement the provisions of the Children's Act, and it was anticipated that there might be policy implications if participants recommended amendments to the Act.

Literature review

Discourses on Sexuality and the Children's Act No. 38 of 2005⁹

The earlier Child Care Act No. 74 of 1983¹⁰ indicated that children could only consent to sexual relations if they were aged 16 years and older. However, the current Children's Act 38 of 2005⁴ makes provision for sexual activity of children from the age of 12 years. For example, the Children's Act sub-section 1 of section 134 states that '*... no person may refuse to sell condoms to a child over the age of 12 years or to provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge ...*' (p. 95¹⁰). According to Theron (*Mail & Guardian*, July 2007⁷), the assumption underpinning this clause is that children from the age of 12 years can be expected to be sexually active. This change of focus suggests that over the past two decades there has been a change in how children view and understand sexual activities. Holgate *et al.*¹¹ argue that implicit in the earlier legislation was a conceptualisation of children as sexually innocent, which contradicts the increasing early sexualisation of young people as alluded to in the new Children's Act. From this statement one can deduce that sexual activities were not originally intended for children, with a developmental distinction made between childhood (an asexual period) and adolescence, which is characterised by heightened sexuality. However, Buga *et al.*¹² found that age of menarche was decreasing for both urban and rural females in Transkei. Furthermore, one can infer from the data on teenage pregnancies that many children in South Africa are engaging in sexual activities before the age of 16.

The Children's Act No. 38 of 2005⁴ further regulates on the consent to medical treatment and surgical operations involving children. Subsection (2) of section 129 of the Act states that '*... a child may consent to his or her own medical treatment or to the medical treatment of his or her child if the child is over the age of 12 years and the child is of sufficient maturity and has a mental capacity to understand the benefits, risks, social and other implications of the surgical operation*' (p. 91⁴).

The Act further makes provision for appropriate assistance from a parent or guardian. In relation to surgical intervention, the earlier Child Care Act No. 74 of 1983¹⁰ afforded certain powers to parents or guardians over their children. However, in the present Act, the terminology has been changed from 'parental powers' to 'parental responsibilities'.¹³ According to the South African Law Commission,¹³ the term 'parental powers' implied that parents or guardians had absolute control over their children, including decisions on activities that appear to be too personal for children. With regard to the term 'parental responsibility', members of the Commission favoured a definition which they viewed as enumerat-

ing the components of parental responsibility in a non-exhaustive manner.¹³

Parental responsibilities, parenting and the Children's Act of 2005

According to the South African Law Commission,¹³ *parental responsibilities* include *care*, which encompasses the responsibility of a parent to create a suitable residence for the child and living conditions that promote the child's health, welfare and development in order to safeguard and promote the well-being of the child. The intention is for the child to be protected from ill treatment, abuse, neglect, exposure, discrimination and any form of physical and moral harm. Furthermore, parental responsibilities entail safeguarding the child's scholastic, religious and cultural education and upbringing in a manner appropriate to the stage of development of the child.¹³ Although this description could be viewed as encompassing a broad range of responsibilities on the part of parents and guardians, there appears to be an overlap with the rights of children. This overlap would appear to have the potential to create conflict between children wanting to exercise their rights and parents seeking to exercise their responsibilities. This conflict could potentially be a source of threat to conventional family roles. Conflicts could also be related to the stages of psychosocial development of the child or adolescent.

Stages of psychosocial human development in relation to the Children's Act

The Children's Act No. 38 of 2005,⁴ section 13, states that every child has the right to have access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction. However, in considering children's rights, one also needs to take into consideration their stage of development and their ability to understand certain concepts and make decisions regarding sexuality and reproductive issues. In his life cycle theory, Erikson (cited by Lesser and Pope¹⁴) maintains that the socialisation process consists of eight phases where each stage is characterised by a psychosocial crisis which arises and demands resolution before the next stage can be satisfactorily negotiated. He further notes that satisfactory learning and resolution of each crisis is necessary if the child is to manage the next and subsequent ones satisfactorily.¹⁴ Hence, certain clauses in the Children's Act No. 38 of 2005 need to be considered in relation to Erikson's theory of psychosocial human development. For example, Clause 134 of the Act states that '*No person may refuse to sell condoms to a child over the age of 12 years or to provide a child of the same age with condoms on request where such condoms are provided or distributed free of charge*'.⁴

Erikson states that the first stage of development is characterised by learning of trust versus mistrust, which is said to happen during the period of *infancy* (1 - 2 years).¹⁵ At this stage, the child needs maximum comfort with minimal uncertainty to develop self-trust and to trust others and the environment. As children at this stage of the life cycle would appear to be asexual and cannot distinguish between different genders or sexual differences, the clause regarding condoms would therefore appear to be irrelevant to this age group. According to Erikson, the second developmental stage is that of *toddlerhood*, which occurs between the ages of 1 and 2 years and is characterised by autonomy versus shame and doubt. At this stage the child works to master the physical environ-

ment while maintaining self-esteem and avoiding causing shame to him/herself.¹⁶

This stage is superseded by the *preschool* stage between 2 and 6 years of age, which is characterised by 'initiative versus guilt'. At this stage the child begins to initiate independent activities and to take the initiative as opposed to imitating others. Furthermore, the child develops a conscience and a sexual identity. It is essential at this stage for adults to affirm the child's initiatives as the child might develop a sense of guilt as a result of being denied a chance to initiate activities.¹⁶ At this stage, sexual identity refers to different roles associated with either males or females with the exclusion of sexual activities.¹⁴

According to Erikson,¹⁶ children in this stage are characterised by conflict when issues of industry and inferiority take centre stage in their lives. Furthermore, at this stage children are learning to see the relationship between perseverance and the pleasure of a job completed.¹⁶ The most important event for children at this level of psychosocial development is attendance at school. They also need to be productive and successful in their academic work, as it is assumed that they are both physically and mentally ready for this kind of engagement. If children at this stage have schooling and academic success as the main priorities in life, the question arises whether they have the capacity to engage in sexual activities and at the same time achieve success at school. In addition, does the child have the cognitive ability to make decisions regarding medical treatment at this stage of development?

The next stage as described by Erikson¹⁴ is the *adolescent stage*, which ranges from 12 to 18 years. This stage is relevant to the discussion in view of the fact that the Children's Act defines a child as anyone below the age of 18 years. A child aged 12 in this stage is said to be an adolescent in search of identity that will lead him/her to adulthood.¹⁴ This stage of adolescence is characterised by conflict revolving around identity versus role confusion. This is the stage referred to in the Children's Act No. 38 of 2005⁴ when children are expected to be able to make decisions regarding the use of condoms and termination of pregnancy. Erikson notes that if conflicts emanating from previous stages were not adequately dealt with, the child may be unable to deal with challenges of the next stage and for that reason may face serious challenges in his/her life. However, the Act does not seem to make any provision for children who by virtue of their age fall chronologically within the adolescent stage but have remained in previous stages as a result of not having successfully resolved that stage. Instead, the Act provides such a child with an absolute right to take full responsibility for decisions about engaging in sexual activities and decisions about an unborn child.⁴ It is therefore of interest to note that, according to Erikson, if a child at this stage cannot make deliberate decisions and choices, especially about vocation, sexual orientation and life in general, role confusion may occur.

Subsequent stages of development described by Erikson¹⁴ include *young adulthood*, *middle adulthood* and *old age*. However, because these stages fall outside the ambit of the Children's Act, they are not included in the present discussion.

Moreover, the developmental stages delineated by Erikson also need to be viewed together with development of moral reasoning in order to ascertain whether children at different developmental stages have the capacity for moral understanding of what is expected of them. This assertion can be backed by Pemba's¹⁷

research, which indicated that in spite of extensive awareness campaigns by governmental and non-governmental organisations regarding HIV/AIDS, there is still a relatively high prevalence of teenage pregnancies. One possible explanation might be young people's lack of understanding of the information that is being imparted to them due to their mental incapacity to process it. Pemba¹⁷ further argues that according to Piaget's 1965 theory, the risk-taking behaviours of teenagers are linked to the underdevelopment of their 'operational/formal thinking', which also defines the state of their moral development or development of moral reasoning. Kohlberg *et al.*¹⁸ emphasise that moral reasoning is the basis for ethical or moral behaviour. If this particular aspect of Kohlberg *et al.*'s theory of moral development is correct, it is possible that the concerns regarding these rights enshrined in the Act may have a strong moral basis.

Kohlberg *et al.*¹⁸ further note that children in their early teens are characterised by conventional thinking. At this level of thinking persons who reason in a conventional way judge the morality of actions by comparing them to societal views and expectations. If according to societal standards it is expected of adolescents to use condoms, one could infer that society condones sexual activities by adolescents. For this reason adolescents can be expected to view the act of engaging in sex by adolescents as morally right. As indicated previously, Erikson notes that at this stage of adolescence (12 - 18 years) the child is in search of an identity that will lead him or her to adulthood.¹⁴ It is possible that this is the point at which one can begin to understand the logic behind these particular rights embedded in the Children's Act No. 38 of 2005.⁴ Among the activities that adults engage in are sexual activities; hence the right to access condoms could possibly be construed as assisting adolescents towards finding their identity as adults.

Sexually-based cultural practices, human rights and the Children's Act

Historically in the African context, culture has been perceived as an anchor of humanity, providing standards of morality.¹⁹ Ross²⁰ further notes that culture plays an integral part in how people define themselves and is intrinsic to the construction of human identity. However, with the advent of colonisation and with many African countries subscribing to the Western notion of being civilised, the notion of culture has been put under immense scrutiny with some deeming it to be a decelerating force in terms of human progress.⁶ This stance has been attributed to the fact that some aspects of the African culture have been seen as violating certain human rights.²¹ For example, Bonani Yamani, a young man from the Eastern Cape, lodged a successful constitutional challenge against his parents on their decision to have him forcefully circumcised.²² In the Xhosa tradition, traditional circumcision is a cultural initiation that marks the boy's passage from *ubukhwenkwe* (boyhood) to *ubudoda* (manhood).²² In this case, the young man viewed this practice as being against his personal rights and religious beliefs. Moreover, under the Children's Act of 2005⁴ it is illegal for any circumcision to be performed on a boy over the age of 16 without his written consent.

A second example of the intersection of cultural practices and human rights is in relation to virginity testing. On the one hand, African cultures such as the Zulu, Xhosa and Venda view virginity as a virtue. Ramsden²³ notes that in recent years virginity testing has been revived and has gained popularity, particularly in rural areas

such as KwaZulu-Natal. The practice is often supported by local *amakhosi* and even by some church leaders. South Africa is not unique in virginity testing; for example, Gundani (cited by Barry⁶) acknowledges the practice as a strategy to curb HIV and AIDS in Zimbabwe. However, some have argued that this very practice exposes the persons concerned to discrimination and infection with HIV, which could be detrimental to their well-being.²⁴

This practice might seem like a plausible strategy to revive culture as a project to rebuild human morality. However, it has met with serious criticisms from many scholars and human rights groups. Subsection 5 of section 12 on social, cultural and religious practices in the Children's Act No. 38 of 2005 states: 'Virginity testing of children under the age of 16 is prohibited. *Virginity testing of children over the age of 16 may be performed if the child has given consent to testing in the prescribed manner*'.⁴ Ramsden²³ criticises virginity testing by acknowledging that although it has the justified objective of encouraging sexual abstinence of young people, the practice is unjust because it is not accurate. She further argues that justice is a basic human right, and virginity testing is a violation of this right because it is not possible for anyone to tell whether a girl is a virgin by an external examination – and often not even from an internal examination by a doctor. This argument in terms of human rights is based on the Constitution of South Africa.¹

According to the South African Human Rights Commission, as cited by Ross,²⁰ virginity testing as an African traditional practice poses more harm than good to girls regardless of whether they pass or fail the test. They further note that this practice is likely to strip the girl of her dignity, cause emotional distress, and represent an invasion of bodily privacy. Above all, although the practice is meant to be voluntary, Ross²⁰ notes that some parents may place undue pressure on their daughters to undergo the examination to comply with cultural norms and to avoid being stigmatised. In this way parental rights may be pitted against the rights of their children.

Provisions within the Children's Act designed to combat sexually transmitted illnesses

A further rationale for the Children's Act is that if adolescents are already sexually active, the best strategy is to provide them with a way of engaging in safe sexual practices. Sub-section 2 of section 134 of the Act stipulates that '*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 that child is at least 12 years of age and proper medical advice is given to the child*' (p. 95⁴). The reason for bypassing parents and caregivers is that many teenagers are reluctant to inform their parents or caregivers that they are engaging in sexual activities as they expect that such activities would not be approved of by their elders. However, the malfunctioning or misuse of the contraceptives by the targeted group is most likely to result in what Bopape²⁵ terms the 'unintended consequences' of such acts. These could include unplanned adolescent pregnancies, which the Act intends to minimise or eradicate, given the significant number of adolescents in South Africa reported to have been pregnant or to have had a child in their teens.²⁵ Hence the Act makes provision for proper advice being given before issuing such devices to children.

Methodology

Research question

What are the views of adults residing in Johannesburg Metro Region 11 regarding reproductive health issues addressed in the Children's Act No. 38 of 2005?

Aim and objectives

Flowing from this research question, the primary aim of the study was to investigate the views of a group of adults living in Johannesburg Metro (Region 11) regarding reproductive health issues highlighted in the Children's Act No. 38 of 2005.⁴ The secondary objectives generated from the primary aim sought to elicit parents' views on clauses in the Children's Act No. 38 of 2005 that allow minor children the right to surgical procedures, virginity testing, access to contraceptives and termination of pregnancy. The study further sought to explore parents' opinions about the consultative process that preceded the promulgation of the Act.

Research design

A small-scale, descriptive, cross-sectional pilot study research design was employed with cluster sampling used to recruit participants.

Sample

A sample of 35 adults from different areas of Johannesburg Metro Region 11 was interviewed. Region 11 includes Orange Farm, Ennerdale, Finetown, Lenasia, Eldorado Park and Thembelihle. Orange Farm has predominantly black residents, Eldorado Park is home to mainly coloured persons, and Lenasia has a largely Indian population. The area as a whole could be described as working class with a relatively low socio-economic status. However, there are pockets of affluence in Lenasia, while Thembelihle is a sprawling informal settlement. The reason for targeting this area was that it is a heterogeneous region with inhabitants drawn from most of South Africa's cultural groupings. It was anticipated that the nature of this region would enable the researcher to draw a fairly representative sample in terms of different backgrounds, with the exception of the white group.

The researchers employed cluster sampling, which enabled them to draw a sample based on different sections of the geographical area. Using an area map of Johannesburg Region 11, the researchers placed the names of all the clusters into a container and randomly chose seven clusters. Thereafter houses were selected from the area map with a minimum of 5 houses per cluster to ensure a sample size of 35 participants. The participant selection criteria required that participants be adults aged 18 years and older and residents of Region 11 of Johannesburg Metro.

Research instrumentation

An interview schedule was constructed by the researchers and pre-tested by the first author before administration. The pre-test was conducted on one male and one female who were parents and were excluded from participation in the final study. They recommended minor adjustments to the wording of the schedule. Section A included items on the socio-demographic background of participants, while section B included reproductive health issues selected from clauses in the Children's Act. It was anticipated that some of the participants might not have had any prior knowledge

about the Act. For this reason, the relevant clauses from the Act were read to them so that they could comment on them.

Data collection

Interview schedules were administered to participants on an individual, face-to-face basis and in the interviewees' homes. Different official South African languages were accommodated depending on the preference of interviewees and the competency of the first author in the preferred languages. In order to enhance reliability of data collection, all interviews were conducted by the same researcher.

Data analysis

Closed-ended questions were analysed using descriptive statistics, while open-ended items were analysed using thematic content analysis. Thematic content analysis entails identifying dominant issues or themes that keep recurring during data collection.²⁶

Ethical considerations

Efforts were made to ensure adherence to the ethical principles of voluntary participation, informed consent, non-maleficence, confidentiality, and avoidance of deception and perverse incentives. The study was reviewed and received ethics clearance from the Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand.

Results and discussion

Demographic profile of participants

A total of 35 persons participated in the study, of whom 25 were females and 10 were males. Their ages ranged from 19 to 43 years and older, with the age category 43 year and older having the largest proportion of participants and categories 19 - 22, 23 - 27 and 28 - 32 having the least. Within the total number of participants, 10 were of mixed descent and were Afrikaans speakers. Of the 25 remaining participants, who were all black, 12 were from Zulu ethnic group, 5 were Xhosa, 4 were Sotho and 4 were Tswana. IsiZulu was the dominant language and seSotho the least common. The participants were also from different religious groupings, as follows: Christian 20 adherents, African traditional religions 6, and Jewish 1; 8 persons stated that they were non-believers. While there were no white persons in the sample and it was not necessarily representative of the broader South African population, the demographic patterns of the participants had a somewhat diverse spread that provided a broad range of opinions.

Knowledge of the Children's Act No. 38 of 2005

Although 20 of the participants (57%) indicated that they had some knowledge about the new Children's Act, their knowledge seemed very limited. It is possible that some of these participants provided socially desirable responses and claimed to have knowledge of the Act because they did not wish to appear ignorant. Fifteen participants (43%) stated that they had no knowledge at all about the Act or its objectives, but this did not preclude them from participating as they answered the questions on the basis of the clauses read to them before each question.

Participants' views regarding medical treatment and surgical operations on 12-year-old children

While the majority (27) of the participants totally disagreed with children from the age of twelve years having the right to consent to surgical operations, a minority (8) felt that children had the right to make such decisions. Table I illustrates how participants responded to this clause in relation to variables such as gender, age, race, language and religion.

Table I indicates that more females than males were opposed to children's right to consent to medical procedures to be carried out on them as stipulated in the Children's Act of 2005. In terms of the age variable, more participants aged 35 years and older were opposed to the clause, which could indicate that those generations have different value systems from those espoused by the Act. More participants from the Zulu language group opposed the clause compared with other language groups, which could possibly be attributed to the fact that overall there were more Zulus than other groups in the sample. With regard to religion, more Chris-

Table I. Quantitative distribution of participants opposed to versus those in favour of children's rights to consent to medical procedures (N=35)

Variable	Sub-category	Opposed (N=27) (No.)	In favour (N=8) (No.)
Gender	Males	7	3
	Females	20	5
Race	Black	20	5
	Mixed descent	7	3
Age (yrs)	19 - 22	2	2
	23 - 27	1	3
	28 - 32	2	3
	33 - 37	3	-
	38 - 42	6	-
Language	43 and older	7	-
	IsiZulu	10	2
	Afrikaans	7	3
	IsiXhosa	4	1
	SeTswana	3	1
Religion	SeSotho	3	1
	Christians	20	4
	African traditionalists	6	-
	Jews	1	-
	Non-believers	8	4

tians opposed this clause, again possibly because they were in the majority compared with the other religious groups that participated in the study.

The participants who opposed this clause were concerned that a child aged 12 was unlikely to have the mental or emotional maturity to make decisions on matters with serious ramifications such as surgical operations. One participant commented: *'My child can never do that, I cannot agree to that because in most cases there are complications that can permanently affect one's life especially when there is lack of parental care.'*

A seSotho-speaking female Christian participant in the age category 33 - 37 pointed out that the nature of children's rights raises different concerns depending on the prevailing circumstances. She explained that such a right would be problematic if the child had conservative parents, whereas other more tolerant parents might not have a problem with children being afforded such rights. She reluctantly indicated that she would be at ease only if the age of consent to surgery could be raised to 16 years. A contrasting viewpoint was expressed by another Christian female believer in the category 38 - 42, who commented: *'I must be given a right to look after my child so that she can grow with the right manners. If she wants to do as she pleases, then let her leave my house. That is how I was brought up.'*

In contrast, 8 participants were in favour of the clause, with female participants outnumbering their male counterparts. An equal number of non-believers opposed and were in favour of this clause. One female participant in the age category 23 - 27 and who indicated that she was a non-believer said: *'Children should be given the opportunity to choose what they want; I guess it's OK that they have this right.'* Another female participant (19 - 22 years, also a non-believer) commented: *'It is fine because we are living in a democratic society.'* These responses would seem to reflect the ideals of a democratic society as stated in a Convention on the Rights of the Child.² This document states that children have the right to be respected and to participate fully in all aspects of their social lives.

Parents' perceptions of virginity testing

Analysis of responses on views of parents on virginity testing revealed three main themes. Two female participants, in age categories 28 - 32 and 33 - 37 years respectively, indicated that they were indifferent regarding this particular matter as they had never thought about the practice as being either good or bad for children. One of them was a Christian while the other was a non-believer.

Twenty-five participants were in agreement with the practice of virginity testing. One female participant in age category of 43 years and older and from an African traditional religious group commented: *'Virginity testing has always been done in our tradition and children have always participated happily. I would love to see the majority of our children taking part in this tradition as it saves a lot of good than harm to both the children and the community.'* Others viewed virginity testing as a social ritual that brought positive outcomes to the children and to the broader community in as far as good moral values are concerned. However, these responses seemed to focus on the children who passed the examination and had no regard for those who might have lost their virginity, either intentionally or unwillingly. Those who supported this clause included Christians and members of African traditional religions, and 22 of them were over the age of 33 years, suggesting that religion and age also inform people's thinking and that

their views are likely to be influenced by the values prevalent when they were born and raised.¹⁴

Eight participants (3 males and 5 females), of whom 4 were Christians, 3 non-believers and 1 a member of the Jewish faith, opposed the practice of virginity testing. One female participant stated: *'I don't think virginity testing is good no matter what the age of the child is because of the emotional abuse it has on children resulting from pressure on them from their parents.'*

Other participants who opposed virginity testing elaborated by pointing out that unless one is a specialised doctor it is not possible to tell whether a child is a virgin or not by simply looking at the external genitalia. Moreover, they indicated that some parents would want to appear good parents to their communities if their children were examined and passed the examination. They further argued that the practice usually becomes a publicity exercise for parents, who would disregard the best interests of their children. Some participants suggested that the practice has little impact on shaping behaviour, and that it should be discontinued for that reason. The following responses encapsulated this theme: *'What is the purpose of testing whether a girl is still a virgin or not? You cannot change the situation. Privacy is essential. Emphasis needs to be placed on sexual abstinence for physical, emotional and spiritual reasons.'* Another participant reflected: *'Virginity testing is a big no. What happened to privacy? We are living in a Western society. Stop this as it sometimes brings in more damage than good.'*

Yet others focused on double standards, arguing that communities and leaders who advocate virginity testing discriminate against females in the sense that they expect females to be sexually pure whereas their male counterparts are not subject to the same expectations. For example, a male participant in the age category 23 - 27 stated: *'If a male counterpart can prove his masculinity by engaging in sexual activities with as many partners as they please, why should a female in the same position be discriminated against?'* However, with regard to the issue of gender inequality, Holomisa²⁷ explains that if a girl loses her virginity, the boy who was responsible does not escape censure. *'He too is ostracized and prohibited from socialising with his peers for a period. He has brought shame to them as well. If he was due for initiation into manhood, he forfeits his right to do so that particular season'* (p. 154²⁷).

Participants' views on the age stipulation for virginity testing

Results revealed two main themes. Ten participants were of the view that 16 (as stipulated in the Act) would be the appropriate age for virginity testing. One of the participants commented that a girl aged 16 could be expected to be the right chronological age to engage with issues regarding her sexual life. This viewpoint would seem consistent with Erikson's adolescent stage of development, which is characterised by identity versus role confusion with the emphasis on sexual identity and sexual role.¹⁴ A seTswana male participant indicated: *'Nowadays children look younger than their ages, so I think at the age of 16 they would be more mature to understand the purpose of the practice.'*

Of the 25 participants who agreed with the clause on virginity testing, 15 were of the view that 16 years of age would be too late for parents to take preventive measures or teach a child to abstain from sexual activity. For example, an isiZulu-speaking male participant commented: *'I think age 16 would be too late. Instead 13 years of age would be appropriate for a child to start virginity test-*

ing as children start at that age to be sexually active. In that way, early pregnancies and illnesses would be avoided.'

From a different perspective, one could argue that this view presupposes that virginity testing is a deterrent to sexual engagement, which is contrary to the findings reported by Whitty.²⁴ She indicated that young girls were opting rather to engage in anal sex in order to keep their status as virgins intact, which in itself poses greater risks for the spread of HIV.

Participants' views regarding the use of contraceptives and termination of pregnancy (TOP) by their children

Eighteen of the 35 participants disagreed with the fact that the Act allowed children as young as 12 years of age to use contraceptives and to make decisions regarding the termination of pregnancy, as they felt that these choices involved adult issues. Twelve persons concurred with the Act, citing reasons why it was justified, and 5 agreed with this clause subject to certain conditions. Of the 12 participants who were in favour of this clause, 6 were Christians, 4 were non-believers and 2 were from African traditional religions; 7 were female and 5 were male. These participants were in favour of the clause on the use of contraceptives and termination of pregnancy by their children. For example, one female participant in the age category 38 - 42 years of age explained: *'My child would rather prevent than coming home to find that she is pregnant and also has a virus. However, I must ensure that I advise him/her on the decisions that they make.'*

A further argument in favour of the use of contraceptives and TOP by one male participant aged between 19 and 22 years was encapsulated in the following quote: *'Since children do not tell their parents how they plan to behave, particularly when it is sexually related, they would rather be taught about contraceptives to prevent being a burden to their parents once they have contracted terminal illnesses or fallen pregnant.'*

Ironically, 9 of the participants who supported access to contraceptives by children (7 of whom were females and 2 males) indicated that termination of pregnancy would go against their moral values, especially if their children were to have a pregnancy terminated. Six of the 9 participants were Christians, 1 was a non-believer and the remaining 2 were from the African traditional religions. Instead, they felt that children should be allowed free and easy access to contraceptives by both their parents and the law: *'It's better for my child to prevent pregnancy through contraceptives than terminating pregnancy or having a child born in poverty to suffer.'*

Eighteen participants, 15 of who were above the age of 33 years, held views opposing the clause of the Children's Act on the use of contraceptives and termination of pregnancy by their children. One female Christian participant aged between 33 and 37 years indicated: *'Contraceptives should be given to married couples and single mothers as they can use them for family planning.'* Another female participant in the same age group commented: *'Condoms are made for grooms not children; if they were made for children they could have been stated that they are for children as well.'*

The same participant commented that condoms are elastic and designed for adults. He therefore queried whether the government would manufacture condoms for children that would be the appropriate size in respect of their genitals and if not, would the current form of condoms serve the preventive purpose they were

meant to serve? According to Erikson's theory,¹⁴ one can deduce that a 12-year-old child would be less likely to rationalise the act of sexual engagement and be able to critically process information regarding the impact of certain contraceptives because of their stage of psychological development. For such reasons, whatever decisions they make would need parental guidance.

The Termination of Pregnancy Act 92 of 1996²⁸ states: *'... pregnancy may be terminated upon request of a woman during the first 12 weeks of the gestation period of her pregnancy ...'*. On the other hand, section 11 of Chapter 2 in the South African Constitution states: *'Everyone has the right to life.'* In this regard two participants, one a male non-believer aged between 23 and 27 years and a female aged between 28 and 32 years affiliated to the Christian religion, argued that the law shows a selective preference regarding who has a right to life as it chooses not to accord a legal persona to an unborn child, thereby depriving such child of the rights that are accorded a born child. A Tswana-speaking female participant aged between 38 and 42 years who also subscribed to Christian values believed that there was no difference between termination of pregnancy and murder, and that the only distinction lay in the fact that the former was condoned by law in South Africa while the latter was viewed as a criminal offence. Similarly, all Christian participants and the one Jewish participant expressed sentiments rejecting the clause.

Five other participants were indifferent in terms of their views on the termination of pregnancy. They explained that the decision was an individual's choice based on her circumstances. One of these 5 participants indicated that both the child and her parents needed to make a decision on whether to terminate the pregnancy or not. This comment was consistent with the objective of the Children's Act to protect and empower children to make decisions affecting their well-being.

Fig. 1 shows the views of participants on the termination of pregnancy clause in relation to religion. More Christians in the sample than participants from other religious groupings were opposed to the clause on termination of pregnancy, which may have been related to the fact that there were more participants from the Christian faith than from any of the other religions.

The extent to which interviewees participated in the build-up to the promulgation of the Act

According to Dutschke⁵, article 18 of the Convention on the Rights of the Child states: *'Parties shall use their best efforts to ensure*

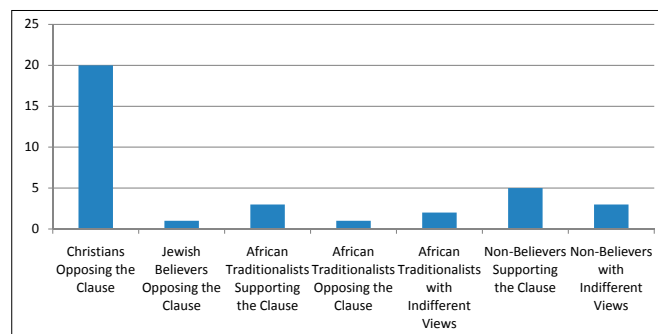


Fig. 1. Views of participants on termination of pregnancy clause in relation to religion (N=35).

recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.'

This article makes provision for parents or guardians to be conscientised about their responsibilities in respect of their children. Participants were therefore asked about the extent to which they participated in the build-up to the promulgation of the Act. Twenty participants claimed to have some knowledge about the Children's Act No. 38 of 2005.⁴ However, only 3 of them indicated that they had participated in the public hearings before the promulgation of the Act. In contrast, 22 participants indicated that they had not participated in these discussions because they were not aware of the existence of such a process. They further indicated that the little information they had about the Act was derived from other people they knew but mainly from the media in the form of radio, print media and television.

Conclusions

The study revealed that participants had limited general knowledge about the Children's Act No. 38 of 2005⁴ and its objectives, despite the government's claims that there was adequate consultation before the promulgation of this Act. It also emerged that participants did not participate in the build-up process to the Act despite the fact that this is a legislative mandate of the government that is reflective of the strength of any democracy. The government adopted a developmental approach that sought to empower children and emancipate them from any form of exploitation, which was in keeping with the Constitution of the country¹ and the United Nation's Convention on the Rights of the child.² In this regard, the research revealed that participants were generally happy with the government's attempts to protect children. However, they wanted to see parents being given more control or responsibility for decisions affecting their children. Even though it was anticipated that the Children's Act with its emphasis on the rights of children would be perceived as a vehicle for empowerment, the responses of participants indicated that the Act was perceived to empower children while disempowering their parents and guardians.

Recommendations

It is recommended that the Department of Health and Social Development engage in a series of educational public forums about the Act to afford the public the opportunity to ask pertinent questions that would enhance their understanding of the various clauses. Based on the concerns and suggestions regarding the age for children to consent to surgical procedures and to access contraceptives, it is recommended that the age be raised from 12 years to 16 years. It is further recommended that parents' rights be respected and that they be afforded greater responsibility for decisions affecting the health, well-being and moral socialisation of their children.

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