

An examination of people's reaction to the Children's Act 38 of 2005 Section 134 in Chesterville.

By

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DECLARATION-PLAGIARISM

I, Goodness Buhle Zondi, declare that,

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DEDICATION

To my late father Mr. Mandlenkosi Mkhwanazi, and my Spiritual father Mfundisi Bafana Hopewell Mahlobo.

ABSTRACT

The study examines people's reaction to the **Children's Act** (No. 38 of 2005), which emanated from the Bill of Rights enshrined in the Constitution of the Republic of South Africa (Act 108 of 1996). The primary aim of the research project was to explore and examine the views of parents in the Durban metro Region with specific reference to those residing in Chesterville Township regarding reproductive health care as embedded in the Children's Act of 2005 Section 134. This Act has as its primary 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. This includes the protection of children from maltreatment, neglect, abuse or degradation and the fact that the best interest of a child are of paramount importance in every matter concerning children.

The study used semi-structured interviews with parents, teachers/educators and the youth aged between 18 and 20 years. Focus group discussions were also used in order to maximize data sets to be used for interpretation. The results revealed that people hold different views regarding the Children's Act. These views are premised on a number of factors such as age, ethnicity and religious affiliation. As such, it is recommended that in assessing the impact of the Act on the ground, government needs to consider these and other factors in its assessment measures. Lastly, taking a cue from the results of this study, it is recommended that when formulating legislation government should consult widely before an Act of parliament is passed. This would ensure that the resultant Act is embraced by many South Africans across different spectra.

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ABBREVIATIONS/ACRONYMS

AIDS..... Acquired immunodeficiency syndrome

CBD.....Central Business District

CTOP.....The Choice of Termination of Pregnancy

CRC.....The Committee on the rights of the Child

DoE.....Department of Education

HIV..... Human Immunodeficiency Virus

MPMLP.....Measures for the Prevention and Management of Learner Pregnancy

SASA.....South African Schools Act

SOA.....Sexual Offences Act

STI.....Sexually Transmitted Infections

TOP.....Termination of Pregnancy

USA.....United State of America

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Background and outline of research problem:

South African political background that began in 1994 developed a Constitution that has been acknowledged by international community as progressive (Act 108 of 1996). Chapter Two of the Constitution contains the Bill of Rights which 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 government of the Republic of South Africa made a commitment to have children's rights embodied in legislation. The intention of our government through this Act was to serve the best interests of children wherever they are located. In a broader, the Act aims at protecting children from discrimination, exploitation and any other physical, emotional or moral harm or hazards to promote the preservation and strengthening of families. This goal is also summarized in the Constitution of the Republic of South Africa (Act 108 of 1996) where these rights are related to the general right of children to social services. In addition, these sentiments are further highlighted by Dutschke (2009) who indicates that this Act, together with other policy documents such as the Service Delivery Model in South Africa is designed to qualify a shift to the rights-based developmental social welfare approach. She further asserts that if this Act could be fully implemented, it has the potential to enhance the lifestyle of children and their families (Dutschke, 2009). The study will examine people's reactions towards the Act which will enlighten the researcher's mind and answer some questions which parents deal with in the field of practice.

1.2 Preliminary literature study and reasons for choosing topic

There is vast amount literature on research in general and on the theme addressed in this study in particular. Authors argue that gaining consent will require better understanding of the information parents will and will not have access to, and may result in complicated consent processes. As such, there is a view that researchers must keep the level of the law to establish when the age cut-offs for consent may change. Therefore, service providers and researchers acting lawfully in terms of the Children's Act by providing contraceptives to a sexually active 13-year-old will be acting unlawfully in terms of the Sexual Offences Act if they fail to report the child's engaging in a sexual offence to the police. For example, children can access sexual health services from age 12, whereas sex under the age of 16 is deemed illegal. Medical practitioners (and others) are under a statutory duty to report under-age sex. Buga, Amoko and Ncayiyana

(1996) found that the age of consent was decreasing for both urban and rural females in the Transkei. Thus, Parliament should justify its inconsistent approach in the setting of consent norms for children. In the present Act, the terminology has been changed from 'parental powers' to 'parental responsibilities' (South African Law Commission, 2001). The observation made in the literature is that in the future, there will generally be greater consistency, as parliament is lowering the age to 12 for consent for a range of medically related interventions. However, parliament has introduced a range of different obligations in many of these interventions that should be reconsidered and/or carefully defended. For example, the restrictions on male circumcision need further thought, given the rampant HIV epidemic. Also, lowering the age at which children may utilise services independently may increase their access to services; however, it is not clear whether the protections put in place will ensure that children are able to manage the implications of such services.

There are different views held by scholars about the Children's Act. Dutschke asserts that if this Act could be fully implemented, it has the potential to enhance the lifestyle of children and their families (Dutschke, 2009). Holgate, Evans and Yuen (2007) indicate that sexuality is a component of people's subjectivities that are a result of internalization, and the way in which it is experienced is also affected by multiple interrelated discourses. Some of these related discourses include adolescence and the construction of families. It is also likely that an understanding of the increase in teenage pregnancies can be gained through the lenses of sexuality and its centrality in people's lives. For example, Holgate et al. (2007) argue that sexuality is an important area of social life and is closely related to the most fundamental of social divisions, namely, that of gender, and to one of the most basic social institutions, namely, the family. The fact of being a parent is also likely to influence one's perceptions of sexuality and legislation. This could be attributed to the fact that parents have their own desires with regard to how they raise their children and some of these ideas may be based on their experiences of growing up and being socialized within their own families.

At a glance, it is clear that the age of consent varies a lot throughout the world. In some African countries (e.g. Tunisia) 20 is the age of consent. In several European countries like Germany, Austria, Italy and Portugal the age of consent is 14. Spain goes a year lower and sets the age of consent at 13. France, the Netherlands and a few other European countries set it at 15. In Britain and most US states the age of consent is 16, although the US states where the age of consent is 17 or 18 are generally the most populous ones. Ireland sets the age of consent at 17 and one or two European countries (e.g. New Zealand) set it at 18. China sets the age of consent at 14 (although Hong Kong sets it at 16) and Japanese federal law sets the

age of consent at 13, although from what I understand most Japanese prefectures (their equivalent of states) set up their own laws making the age of consent 18. India has an age of consent at 18, while most Central American countries have high ages of consent (15-18) and most South American countries have low ages of consent (like 14). Mexico City sets the age of consent at 12, but other Mexican states put their age of consent as high as 18. Some sources show that 12 is the age of consent in Vatican City, but it is not clear if this is true or just an anti-Catholic rumor making fun of the Catholic sex abuse scandals.

In dissimilarity other groups such as Women of National Democratic Convention have voiced their dissatisfaction with and disapproval of the Act. They are against and opposed the clauses in the Act that make condition for children as young as 12 years to have access to condoms and be able to perform abortions without the parents consent (Mail & Guardian, 2007). Schmid (2008, p.260) 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”. Women of the National Democratic Convention (NADECO) (Mail & Guardian, July 2007) state: “What makes this immoral Act unacceptable is the fact that contraception indirectly gives our children permission to engage in sexual activities at the age of 12”. Furthermore, they maintain that this Act holds the potential to cut short the life-expectancy rate of the younger generation, because some forms of contraception indirectly encourage unprotected sex, which opens a gateway to various kinds of sexually transmitted diseases, such as HIV/AIDS, which has plagued this country immeasurably and claimed many lives over the last decade.

There is also the view that there is an internal contradiction in the legislation regarding children’s sexualisation. This contradiction was highlighted by Ashley Theron, an Executive Director at Johannesburg Child Welfare when he said: “The Children's Act contradicts present law whereby a child can only consent to sexual relations once they are 16 years and older,” (Mail & Guardian, July 2007). Furthermore, although people were granted the opportunity to participate in the advice-giving process leading up to the dissemination of the Act, the statements by representatives from NADECO and Child Welfare, suggest a degree of disappointment with the Act. The complementary and challenging views are what caught the attention of the researcher as she comes across parents in her field of practice, who express concerns regarding the fact that the government could allow “minors” to engage in sexual activities and make termination of pregnancies available on demand. Although one can understand and support the intention of the government, there appeared to be a discrepancy between the purpose of the Act and the

objectives formulated to achieve that purpose. Moreover, there seemed to be a shortage of research conducted on specified clauses within the Children's Act. This is what triggered the projected study.

The researcher is therefore enthused to be able conduct a research in order to explore the perceptions of a broader group of parents regarding the reproductive health issues incorporated within certain clauses of the Children's Act. It is envisaged that the study would address a number of objectives that included an exploration of the manner in which parents were informed about the developments in legislation governing their children. To ascertain whether they were aware of any services rendered to children between 12 years and 18 years of age regarding reproductive health issues (such as contraception and termination of pregnancy) and what implications they felt the new law had for parental control. The 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 (Gallagher, 2004). The research appeared to have particular salience for social workers who are mandated to implement the provisions of the Children's Act. It further anticipated that sections of the Children's Act with its emphasis on the rights of children would empower them in relation to their protection and development in that particular context. Finally, it is anticipated that there might be policy implications if participants recommended amendments to the Act. The age at which young people can access contraceptives differs in different countries. The researcher is of an opinion that South African Government should reconsider the age concerning Section 134 of the Children's Act but that would be determined by the findings of the research.

1.2 Research problems and objectives: Key questions to be asked

In the Twenty first Century children as young as twelve can now access condoms and the birth control, and have an abortion, without their parents' consent. These are some of the implications of the Children's Act no 38 of 2005, which came into effect on 1 July 2007. The issue of abortion is regulated by the Termination of Pregnancy Act. While several studies have shown that children are becoming sexually mature and active at younger ages, questions remain about the psychological and physical effects of a full-term pregnancy on a very young girl, as well as the long-term effects of multiple abortions. In light of the above, the study aims, objectives and research questions can be listed as follows:

1.4 Objectives of the study

The primary aim of this study is to investigate how parents react to the Children's Act, 38 of 2005, especially Section 134. In particular, its objectives are:

- i) To establish parents' views regarding the use of contraceptives by their children;
- ii) To probe perceptions of parents in relation to children's rights to consent to medical treatment and surgical operations;
- iii) To determine parents' views on virginity testing and children's rights to termination of pregnancies; and
- iv) To establish the extent to which the public is involved in the formulation and implementation of government legislation

1.5 Research questions

This study has one key research question and three specific questions that it aims to answer:

Key question:

- What are parents' reactions to the specific provisions of the Children's Act 38 of 2005?

Sub-questions

- 1) What are parents' views on clauses in the Children's Act no 38 of 2005 regarding minor children's rights to surgical procedures, virginity testing, access to contraceptives and termination of pregnancy?
- 2) What are parents' perceptions regarding the objectives underpinning the Act?
- 3) How were parents informed by the government regarding provisions in the Act affecting their children?

1.6 Research problems and objectives: Broader issues to be investigated

The Children's Act sub-section 1 of section 134 states that:

...it is not allowed to refuse to sell condoms to a 12 year old child and older or to supply/issue condoms on request where condoms are provided or dispersed freely. (Children's Act 38 of 2005 pp.95).

The assumption underpinning this clause is that children from the age of 12 years can be expected to be sexually active (Theron, 2007). The issue becomes: what impact does this act have on the intended recipients (i.e. the children)? The broader issues to be addressed in this study as follows:

- Contradictions between policy formulation and policy implementation;
- The role of consultation when formulating legislation;
- The relationship between culture/custom and government legislation;
- Factors which shape people's opinion when engaging with government; and
- The role of the National Constitution in shaping societal behaviour.

1.7 Principal theories upon which the research project will be constructed

a) Public Participation Theory

The study will be constructed in part, using public participation theory which is a common means of consulting and involving members of the public in agenda-setting. Public participation includes decision making and policy-forming activities of local organizations or institutions responsible for policy development. The public plays a direct role in the policy processes-however in most democratic states policy decisions are highly taken by representative institution that empower specialised actors to determine the capacity and content of public policies. These institutions do not; provide mechanism through which the public can directly decide and participate in policymaking. Greighton (2005) argues that public participation is the process by which concerns, needs and values are incorporated into the governmental and corporate decision making. It is a two way communication and interaction with the overall goal of better decisions that are supported by the public.

b) Systems Theory

The study will also employ the systems theory to the systems design approach seeks to understand a situation as a system of interconnected, interdependent, and interacting problems. Likewise, the solutions it seeks to create emerge from a vision of the entity taken as a whole. Such an orientation permits the design of the future through an informed understanding of the dynamics that govern evolutionary systems.

It implies that we take responsibility for the creation of our future in co-evolutionary interdependence with our social and physical environment. This is based on the belief that we can shape our future on the one hand through the power of understanding the characteristics and requirements of the environment, and on the other through our aspirations and expectations.

Systems design is participatory by nature: significant social change can be brought about only if those who are most likely to be affected by it participate in soliciting it, and choose how it is to be implemented. Since in societal systems human beings are the critical factor, change must necessarily both emanate from and incorporate them. Systems design advocates *anticipatory* democracy, where people actively apply their skills to the analysis and design of socially and ecologically sustainable systems by becoming active participants in shaping their future.

Groups of people engaged in purposeful systems design form an evolutionary learning community, and such communities make for the emergence of a culture of evolutionary design. Science values objectivity, rationality, and neutrality. It has concern for the truth. The humanities value subjectivity, imagination, and commitment. They have a concern for justice. Design values practicality, ingenuity, creativity, and empathy. It has concerns for goodness of fit and for the impact of design on future generations (Banathy, 1996, pp. 34-35). These two theories were employed in this study because when policies are implemented it is vital to include those who are going to benefit from the Act, as well as the collect necessary views and opinions from the community, and relevant stakeholders. In this case parents and beneficiaries views were supposed to be taken into consideration as a guideline in implementing the Act. Systems theory assists in understanding how the system operates, that it advocates for people to apply their skills to become active participants in shaping their future.

1.8 Research methodology and methods

1.8.1 Research methodology

In the Social Sciences, research methodology employed is commonly categorised as being either quantitative or qualitative (Jayaratne and Stewart, 1991:85). While qualitative research seeks to gain in-depth knowledge about the contextual reality of research participants (Babbie and Mouton, 2001:270), quantitative research emphasises “gathering quantitative data by means of quantitative variables” with the aim of determining “the magnitude of variation” (Kumar, 1996:10). Qualitative methodology is particularly relevant to exploratory research which attempts to understand the impact of a new development e.g. technology and social processes (Robinson, 2002:271). This study will adopt a qualitative research approach; this is in the belief that a qualitative research approach is the only approach that will allow the researcher to analyse perceptions and meanings of participant’s world, their nature causes of individual behaviour. The motive of the researcher’s underpinning the decision to choose qualitative research is based on the fact that such an approach will provide greater richness, detail and diversification of the data, which would favour more positively ambiguity and contradiction.

This study will use primary and secondary data. Primary data in this research study will consist of data in a form of semi structured interviews with key informants and focus group discussions. Secondary sources in this study will involve identification of existing data such as that of books, scholarly journal articles, newspapers and electronic sources collected from relevant previous studies, which comprises of government documents, legislation and policies in order to understand implementation plan of the Children’s Act and the intended result.

1.8.2 Data collection process

According to Terre Blanche et al (2006) data come from observation, and can take the form of numbers or language.

1.8.3 Population Sampling.

This study will use purposive sampling. In purposive sampling, the researcher has a purpose in mind which guides the selection of the study sample. In this sampling method, “a sample is built up which enables the

researcher to satisfy her [his] specific needs in the project'' (Robinson, 2002:265). This sampling technique enables the researcher to select only those participants that have the requisite knowledge and were in position to answer the research questions.

This research study will also use quota sampling as selection method to select the participants. Quota sampling can be described as a method of gathering representative data from a group. In this kind of sampling method the researcher decides while designing the study how many people with which characteristics to include as participants (Babbie&Moun-ton, 2006, p.48). This sampling is relevant to this research study because during the design of the study the research had chosen how many participants to include, which characteristics they need to possess as this and their knowledge about the topic at hand.

1.8.4 In-depth interviews with key informants.

The main reason for choosing in-depth interviews as a data collecting technique is that it gives the researcher more flexibility to focus key themes, issues, and questions that the investigation aims at addressing. The questions will open-ended as this will allow respondents to include more information, including feelings, attitudes and understanding of the subject issue at hand. Using open ended questions also gives the researcher better access to the respondents true feelings and perspective on an issue. This entails in-depth interviews carried out in the focus group format.

Each region will host two types of focus groups, one for the youth and one for the adults. The youth focus group will comprise the youth who are positive minded towards the Act and supports it and those who are against. The age group which will be considered will be 18-25 as they are the beneficiaries of this Act and in consideration of reliability and validity. The community members comprises of Parents who are for and other group which is against the Section of the Act.

1. Community leaders from Chesterville
2. Representatives from the Department of Justice
3. Representatives of different stakeholders
 - a) Faith Based Organizations
 - b) Department of Education
 - c) Traditional Leaders

d) Parents

e) Department of Health

f) South African Police Service

4. Ward Councilor

1.8.5 Focus group discussions interviews

This research investigation shall employ focus group discussions as a method of data collection. The main reason for employing this data collection technique is that it allows the research to facilitate discussion around a set schedule of questions pertaining to the questions that the researcher wishes to address. It also gives the researcher the opportunity to stand back from the discussion watch participants share their similar or different experiences; this is where group dynamics also emerge. In focus group discussions the sizes of the group matters - focus groups work best with 6-10 people. A number of participants will be 10 females, and 10 male. It should be noted that males and females will engage in separate group and discussions as this will allow the participants to give a gendered perspective on challenges pertaining youth sexual activity at early age. This is done with the aim of exploring the different or similar challenges experienced by all the parties involved, parents, educators, community leaders and etc.

1.8.6 Data Analysis

Data will be analyzed by finding differences and similarities among male and female participants of this research. The analysis will also highlight perspectives from the government officials and their views on how the Children's Act can be amended or clarified for the community of Chesterville. In this study, the interviews, both individual and focus group discussions; will be recorded and transcribed. Individual responses and group discussion interviews will be compared and contrasted and interpreted to draw conclusions.

1.9 Ethics.

Ethical considerations for this research are important because data will be gathered through interviews with members and representatives of identified case study communities. Interviewees' request for anonymity will be accepted and identity protected. Since the study requires volunteers, a detailed explanation of the

aims and objectives of the study will be provided to the participants. The participants' voluntary participation in the study will be outlined from the outset, and they will be notified of the choice to leave the study whenever they feel uncomfortable. Undue pressure on interviewees to divulge information shall also be avoided. In order to agree to participate individuals will have to fill and sign an informed consent letter that states the above. The information gathered is to be used purely for academic purposes. Most importantly there shall be no financial or any other forms of compensatory benefits to be accumulated from participating in this study. For the purposes of this research, children will neither be interviewed nor surveyed during the data collection process. Participants in this research will be presented an ethical clearance form which will clearly stipulate the terms of their participation and how their identity will be protected. In other words participants' identity shall be protected through coded names, and they will be imparted that participation is in this particular voluntary and withdrawal from the study does not attract any adverse consequences. Most importantly there are no benefits to be accumulated from participating in this study.

1.10 Structure of dissertation

This dissertation has six chapters which are organized as follows:

Chapter 1 –Introduction and Background

This chapter provides a brief outline of the problem statement and background to the study. It also spells out the study objectives as well as the research questions the study planned to address. Lastly, this chapter presents the outline of the entire dissertation with the view to prepare the reader's mind-set.

Chapter 2 - Literature Review

Relevant books, articles and other publications on the topic will be reviewed and a summary of the past and current legislative framework dealing with Children's Act will be given in this chapter.

Chapter 3 - Research Design and Methodology.

In this chapter, an explanation relating to the research methods used to collect data will be discussed. This will include discussions on the data collecting instruments and data collection procedures.

Chapter 4 –Research Findings

This chapter will present the findings of the study from different data sets.

Chapter 5-Analysis and Discussion of findings

The findings presented in Chapter 4 will be analyzed and discussed in line with the research questions and objectives of the study.

Chapter 6 –Conclusion and Recommendations

This Chapter will pull the study together by emphasizing key points and findings and then make recommendations for future research on the theme of this study.

CHAPTER TWO LITERATURE REVIEW

2.1 Introduction

A literature Review according to Oaks is a planned, direct, and capable of being reproduced method for recognising, evaluating, and to compound the present body of the finished and recorded effort produced by researchers, scholars, and practitioners.”(Oaks, 2005). According to Hart (1998) a literature review is the effective evaluation of selected documents on a research topic. A literature review may shape an important part of the research process or may include a research project in itself. In the background of a research paper or thesis the literature review is a significant mixture of prior research done on the subject of the study. It is for this reason, therefore, that this chapter was included in this dissertation. Its aim is to review previous works that have been written on the theme of this study so that there can be no recurrence. As is predictable practice, all dissertations have to add to existing knowledge either through ground breaking research or an interpretation of pre-existing works.

There is no person who is in a better position to converse to South Africa’s spirit than Nelson Mandela. The journey of his life from the small village of Mvezo in Eastern Cape Province to the prison on Robben Island to the presidency of the Republic of South Africa allows us to offer him that merit even though appropriate treatment of children is an obvious moral mandate, Nelson Mandela clearly saw the importance of children’s rights to a successful society. Mandela advocated tirelessly the unity in South Africa, established that if the children of this country were not equally treated nor provided safety under the law, the society he aspired for could not be constructed in South Africa. Mandela served as president of South Africa from 1994 to 1999. The beginning of his presidency around urbanized in that country a growing association committed to children’s rights. The movement acknowledged that children are among the most susceptible members of South African society.

Throughout the untimely years of the Mandela presidency, the government of South Africa started to review the laws regarding the treatment of children in different contexts together with divorce, paternity and child protection. South Africa’s Children’s Act of 2005 is the culmination of this review. This complete piece of legislation, intended to protect children, transpired from the meeting of three separate currents in South African society. Although not at all times perceived in practice, the courts were at least communicating those principles in

their legal opinions. The third current was the force on South Africa of international conventions and declarations from transnational organizations. Throughout the Twentieth Century and into the Twenty-First, various international agreements came into existence whose main focus was to advance the cause of children. South Africa frequently signed on to those child-centred accords. As a result, South Africa created for itself a number of obligations that needed to be fulfilled domestically. (Walsh, 2009).

2.2 The Socio-Economic History of the children in South Africa

Socio-economic forces in South Africa had resulted in a desire by the people for greater protection of substantive rights. These socio-economic forces had been building since the first Europeans arrived on the Cape. International protocols and conventions, which were adopted by South Africa, encouraged and indeed mandated such protections on behalf of children. The legal system in South Africa as a whole had arrived at a place in its historical development wherein the best interest of the child was the guiding principle

The National Party came to power in 1948 on parliamentary elections in South Africa. The victory from elections signaled the dawn of a more noisy isolation policy. The right wing party that opposed South African involvement in World War two was the National Party on the side of the Allies. Instead they convinced South African soldiers to assist Germany. When they rose to power there was death in any future peaceful transition to majority rule. The laws approved by the National Party parliament promoted the approval of legislations that were in favour of the segregationist era and tightened...the administration of those laws. During a chain of prime ministers from 1948 until the early 1990's, the National Party government sustained a policy of legitimate domination and marginalization of black and coloured South Africans. This policy was known as apartheid and touched the lives of all South African in spite of race.

While such policies impacted all members of society, it invariably had the most negative impact on black and colored individuals and their children. Children were hit especially hard by apartheid. One commentator noted: If there is a group in South Africa which has consistently had their rights denied it is our children and in particular black children. From conception the black child's life is characterized by hunger and malnutrition, insecurity and

trauma, instability, family breakdown and dislocation of communities, a lack of primary health care and educational opportunities; and the absence of adequate housing, electricity, running water and sanitation. To understand the precarious position of black children during apartheid, it is helpful to look at four basic problem areas: mortality rates, poverty, quality of education and violence. Mortality rates among black children were more than five times higher than among whites. By the time apartheid ended, twenty-three out of every one thousand white children died in their first year of life. For black children the story was quite different. In the first year of life, 140 out of every one thousand black children died. (Mandela, N. 1995)

The years proceeding to independence had been complex on South African children of all races. Nelson Mandela believed that the soul of a society could be seen in the way it treats its children. The South African Children's Act allows the outside world to take a look at the soul of South Africa. The socio-economic currents that have been flowing in the part of the world that makes up South Africa brought the population to the point where it demanded broad protections for its children. The legal system sufficiently arrived at a point when it was already looking to protect the best interests of children. These factors combined with the desire of this country to fulfill international obligations it had undertaken as a member state of the United Nations and the African Union. In fact, South Africa's Constitution was "the first in the world to make an express commitment to children's socio-economic rights." It included not only the classic civil and political rights contained in the United States Bill of Rights, but also substantive economic and social rights. These rights include basic nutrition, shelter and basic health care services. (The Constitution of the Republic of South Africa).

South African government made a significant commitment to the welfare of children against this backdrop of abuse and neglect of South Africa's children by the apartheid government. The obligation to change this dislocation of children started with a constitution that contained a bill of rights particularly recognizing political and social rights for children. However Section 134 sub section 1-3 of Children's Act 34 of 2005 has caused some mixed reactions which reads thus: South Africa's 1996 Constitution, internationally acclaimed for its comprehensive and progressive Bill of Rights, protects the individual's right to make decisions regarding reproduction and the right to access health care services, including reproductive health care. These provisions, like all other rights in the Bill of Rights, also

apply to children. In addition, the Constitution stipulates that every child (i.e., person under the age of 18 years) has the right to basic health care services Children's Act (Act 38 of 2005). Furthermore, the Constitution requires that in *every matter* concerning a child, his or her best interests are paramount.

Since the enactment of the Constitution, several laws have been passed to breathe life into these constitutional protections, including the Children's Act (Act 38 of 2005), the Choice on Termination of Pregnancy Act (Act 92 of 1996), the National Health Act (Act 61 of 2003) and the Criminal Law (Sexual Offences and Related Matters) Amendment Act (Act 32 of 2007). All of these laws regulate or affect certain aspects of teenagers' sexual and reproductive rights. The following section provides a brief overview of relevant provisions of these laws and highlight potential areas of conflict between them.

2.3 The Children's Act

The Regulations and Children's Act, 2005, was finally promulgated in its total, in 2010. The Act sets out a structure for providing the social services necessary for the protection and care of children (i.e. persons under the age of 18 years), including protective measures relating to children's health. In particular, the Children's Act has systematically reformed the age of consent for medical procedures. Those who pass legislation acknowledged the need to toughen the independence of children in taking decisions that affect them and, therefore, to participate in such decisions, and the age of consent related to health issues was dropped to 12 years. The Children's Act further aims to protect children's sexual and reproductive health by regulating children's access to contraceptives.

When the Parliament established these rights it was based on recognition of the fact that children happen to be sexually active at a young age, Children's Act (Act 38 of 2005). The purpose of the legislature was, therefore, to shield sexually active children, especially teenagers, from exposed sex behaviours and sexually transmitted diseases including HIV. The Department of Social Welfare has also said that "access to contraceptives should go hand in hand with appropriate sexuality education" Children's Act (Act 38 of 2005). The legislation assumes that healthcare workers are trained adequately, to discover these needs

and to present the essential care and education. Section 134 of the Children's Act carries a strong public health message that it is in the best interests of children that condom to be supplied, and sets out strict penalties of a fine and/or imprisonment for up to ten years for anyone refusing to do so. The Act further mentions that contraceptives besides condoms need to be issued to a child request from the child without consent from the parent or guardian if the child is 12 years of age, this is on the conditions that the child received medical advice and a medical examination to ensure there are no medical reasons not to provide the contraceptives.

Besides the physical health safety measures there is no obligation that the child undergo any further counselling before being issued with the contraceptives. Children health status is confidential and it is protected by the Act and exclusively, with regard to accessing contraceptive services, the Act states: the child is entitled to confidentiality when in receipt of condoms, contraceptives or any advice regarding condoms. Section 110 of the Act forms a reporting obligation for certain professionals, including medical professionals, when they conclude on reasonable grounds or reasonably believe a child is a victim of abuse, and then confidentiality is limited. In such instances, a report must be prepared and be directed to either the provincial department of social development, a designated child protection organisation, or a police officer in order for the matter to be investigated and, where necessary, for the appropriate measures to be taken to protect the child from further harm. When one fails to report such it is considered as an offence under the Act and a person in contravention of this provision is liable to a fine and/or to imprisonment for a maximum of ten years.

It is therefore vital that professionals who are fraught with the reporting responsibility under section 110 (1) are clear of their duty in terms of reporting underage consensual activity. According to children's Act 'Abuse' is defined in the Children's Act as: includes: assault, bullying, exploitation, behaviour that may psychologically or emotionally harm the child and sexual abuse. The Children's Act is silent as to whether consensual sex between teenagers above the age of 12 years but under the age of 16 years – which is an offence under sections 15 and 16 of the SOA – constitutes sexual abuse. If, however, the term '*sexual abuse*' as used in the Children's Act is referring to or includes '*sexual offences*' as defined in the SOA, then the duty to report would include consensual sex between teenagers. Given that consensual sex

between teenagers above the age of 12 but under the age of 16 is considered a sexual offence under the SOA it seems that, when read in conjunction with the SOA, health care professionals have to provide contraceptives, including condoms, to children aged 12 years and older, but at the same time must report them to the authorities if those workers believe the children are having sex. There is a risk that the reporting requirement may lead to a decline in the numbers of teenagers accessing reproductive health services due to a fear their confidentiality may be breached, or worse, that they may face reprisals from authorities for their criminal behaviour, and this result would undermine the protective purpose of the Act in relation to children's sexual and reproductive health.

According to Section 9 of the Children's Act is clear that this standard must be applied in all matters concerning the care, protection and well being of a child. While needing to evaluate all the factors, considerations such as the nature of the relationship between the child and their parents or care-giver, the child's age, maturity and stage of development, gender, background and other relevant characteristics of the child, may be especially relevant to decisions related to the administration of reproductive health services to teenagers. Likewise, the child's physical and emotional security and his or her intellectual, emotional, social and cultural development may also be apposite. When balancing the reporting obligation introduced by the Children's Act with the constitutional principle of the 'best interest of the child' as expanded by the Children's Act, it is unlikely that health professionals would always consider reporting consensual sexual activity between children over the age of 12 and under the age of 16 as being in the best interest of the children in question. Rather, such action may result in significant disadvantage to the individual child by involving them in the stigma and consequences of the criminal justice system. The 'best interests' framework under the Children's Act allows discretion for health care workers to exercise their professional judgment in this regard.

2.4 Access to Contraceptives

The Children's Act states that no person may refuse to sell condoms to children over the age of 12 years, or refuse to provide condoms to children over the age of 12 years on request where such condoms are provided or distributed free of charge. This section applies to male and female condoms and would seem to be aimed at combating HIV infection among sexually active children. The section implies that condoms may be provided to children under the age of 12 years but that such requests can be refused. Contraceptives other than condoms may be provided to the child on his or her request and without the consent of the parent or caregiver of the child if: (i) the child is at least 12 years of age; (ii) proper medical advice is given to the child; and (iii) the child is medically examined to determine whether, on medical grounds, a specific contraceptive should not be provided to the child. Contraceptives other than condoms may therefore not be provided to children below 12 years of age without parental or caregiver consent. Children who obtain condoms, contraceptives or contraceptive advice in terms of the Act are entitled to confidentiality.

2.5 Section 134

Section 134 of the Children's Act carries a strong public health message that it is in the best interests of children that condoms are to be provided, and sets out stringent penalties of a fine and/or imprisonment for up to ten years for anyone refusing to do so. The Act further stipulates that Children are allowed to be provided by condoms and contraceptives without the parents consent if the child is at least 12 years of age, on the conditions that the child received medical advice and a medical examination to ensure there are no medical reasons not to provide the contraceptives. Aside from these physical health precautions there is no requirement that the child undergo any further counselling before being issued with the contraceptives.

The National Contraception Policy Guidelines issued by the Department of Health regards preventing pregnancy and the transmission of sexually infections (STIs) as a critical part of child protection. In accordance with this policy, the Children's Act facilitates children's access to contraceptives. The objective is to prevent sexually active children from contracting STIs (including HIV) or falling pregnant.

Section 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 over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge. A person who disregards these provisions is guilty of an offence and can be fined or imprisoned for 10 years or be given both a fine and a term of imprisonment.

Contraceptives other than condoms may be provided to a child on request from the child and without the consent of the parent or caregiver of the child if:

- The child is at least 12 years of age **and**
- Proper medical advice is given to the child **and**
- A medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child.

Finally, a child who obtains condoms, contraceptives or contraceptive advice in terms of this Act is entitled to confidentiality. However, this is subject to section 110(1) of the Act which obliges health professionals to report cases of physical or sexual abuse, or deliberate neglect of a child to the Department of Social Development, a designated child protection organisation or the police.

Obtaining consent will require a sound understanding of what information parents will and will not have access to, and may result in a complicated consent processes. The departments must also keep abreast of the law to establish when the age cut-off consent may change. Therefore, service providers acting lawfully in terms of the Children's Act by providing contraceptives to a sexually active 13-year-old will be acting unlawfully in terms of the Sexual Offences Act if they fail to report the child's engaging in a sexual offence to the police. For example, children can access sexual health services from age 12, whereas sex under age 16 is illegal. Medical practitioners (and others) are under a statutory duty to report under-age sex. Parliament should justify its inconsistent approach in the setting of consent norms for children. In the future, there will generally be greater consistency, as parliament is lowering the age to 12 for consent to a range of medically related interventions. However, parliament has introduced a range of different obligations in many of these interventions that should be reconsidered and/or carefully defended. For example, the restrictions on male circumcision need further thought, given the rampant HIV epidemic. Also, lowering the age

at which children may utilise services independently may increase their access to services; however, it is not clear whether the protections put in place will ensure that children are able to manage the implications of such services.

Families are the best place for children to develop and be nurtured to their full potential. However, many families struggle every day against poverty, unemployment, HIV/AIDS and violence. To assist such families, the state is firstly responsible for addressing the root causes of these stresses, such as providing medication to HIV-positive parents to stop them from dying; and addressing the high rate of unemployment so that parents can provide for their children's basic needs. Secondly, the state must assist families facing social stresses to care for, develop and protect their children by offering a range of social services tailored to the family's social needs. Ideally, parents are the first teachers of sexuality education. As young people move towards adulthood, they will explore new relationships, become involved in many activities outside the family and become increasingly independent. Nevertheless, their family remains an important element in their lives, and parents continue to be concerned for their children's happiness and welfare.

Discovering that their teenagers are having sex is generally not easy for most parents. That said, once they have thought about it, most would prefer that they are safe and make positive healthy decisions. To do that they need good quality sexuality and relationships education, access to sexual and reproductive health services and information, and to know they will not be treated in a judgmental or coercive way. Many young people do talk to their parents about their decision to become sexually active. For others it is not easy. Where young people are reluctant to talk to their parents, Family Planning encourages them to seek the support of a trusted adult. Boys and girls are reaching puberty at younger ages than previous generations in developed countries. This has been largely attributed to improved nutrition and general health.

2.6 What other Countries do in terms of age consent?

The age at which young people can access contraceptives is different in different countries. Ghana's policy is to provide contraceptives and reproductive health services to adolescents and to all couples engaging in sexual activity, regardless of age. In Zimbabwe, clinics are supposed to provide contraceptives to people over the age of 16. In South Africa children may have access to contraceptives from the age of 12; if they visit a clinic to request a prescription for contraceptives, they must also be given medical advice and a medical examination. The age of consent varies a lot throughout the world and it's rather fascinating. In some African country (Tunisia) 20 is the age of consent. In several European countries like Germany, Austria, Italy and Portugal the age of consent is 14, Spain goes a year lower and sets the age of consent at 13. France, the Netherlands and a few other European countries set it at 15. In Britain and most US states the age of consent is 16, although the US states where the age of consent is 17 or 18 are generally the most populous ones. Ireland sets the age of consent at 17 and one or two European countries (New Zealand) set it at 18.

China sets the age of consent at 14 (although Hong Kong sets it at 16) and Japanese federal law sets the age of consent at 13 there, although from what I understand most Japanese prefectures (their equivalent of states) set up their own laws making the age of consent 18. India has an age of consent at 18, most Central American countries have high ages of consent (15-18) and most South American countries have low ages of consent (like 14). Mexico City sets the age of consent at 12, but other Mexican states put their age of consent as high as 18. For a wide range of reasons, the average age of first sexual intercourse is earlier both in New Zealand and overseas; the age of marriage is later (29-30 years) and there appears to be a greater proportion of young people who are sexually active with more partners, although research findings are mixed on these complex issues. A number of pieces of New Zealand legislation provide for this. The Contraception, Sterilization and Abortion Act (1977) allows for young people under the age of 16 to be given contraceptive information, services and prescriptions.

The health provider is expected to encourage the child to talk to their parents but this unfortunately is not always a possibility. There is no statute or law restricting any health provider giving information or advice on the use of contraceptives or prescribing contraceptives to people of any age. In doing this the health professional must take into account the competence of the young person to make an informed decision. These provisions are based on the Gillick or Fraser Guidelines in the United Kingdom, on the basis that health professionals judge competence to make informed decisions on a daily basis, and that if young people cannot access confidential services they may not seek help at all. This rationale also fits in with the United Nations Convention on the Rights of the Child. In some families these issues, and issues of sexuality, are openly and easily discussed; in others this can lead to difficulties and misunderstanding. The Netherlands has developed successful policies for young people based on the three R's, Rights, Responsibility and Rapport.

These have contributed to very low unplanned pregnancy rates and a later age of first sexual experience than in the United States. In contrast, other groups such as Women of National Democratic Convention have expressed their dissatisfaction with and 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 (Mail & Guardian, 2007). Schmid (2008, p.260) 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". Women of the National Democratic Convention (NADECO) (Mail & Guardian, July 2007) state: "What makes this immoral Act unacceptable is the fact that contraception indirectly gives our children permission to engage in sexual activities at the age of 12". Furthermore, they maintain that this Act holds the potential to cut short the life-expectancy rate of the younger generation, because some forms of contraception indirectly encourage unprotected sex, which opens a gateway to various kinds of sexually transmitted diseases, such as HIV/AIDS, which has plagued this country immeasurably and claimed many lives over the last decade.

There is also the view that there is an internal contradiction in the legislation regarding children's sexualisation. This contradiction was highlighted by Ashley Theron, an Executive Director at Johannesburg Child Welfare when he said; "The Children's Act contradicts present law

whereby a child can only consent to sexual relations once they are 16 years and older," (Mail & Guardian, July 2007). Moreover, despite the fact that people were afforded the opportunity to participate in the consultative process leading up to the promulgation of the Act, the statements by representatives from NADECO and Child Welfare, suggest a degree of dissatisfaction with the Act. The contrasting and competing views are what caught the attention of the researcher as she comes across parents in her field of practice, who express concerns regarding the fact that the government could allow "minors" to engage in sexual activities and make termination of pregnancies available on demand. While one can understand and support the intentions of the government, there appeared to be a disparity between the purpose of the Act and the objectives formulated to achieve that purpose. Moreover, there seemed to be a dearth of research conducted on specified clauses within the Children's Act.

2.7 What do the relevant policies say?

South Africa has a relatively progressive legislative response to teenage pregnancy and motherhood, with some even suggesting it has a 'feminist influence' (Bhana and Clowes, 2008). The South African Constitution (1996) 'protects the right (of all citizens including children) to make decisions regarding reproduction and the right to access health care services, including reproductive health care' (Hoffman-Wanderrerr, 2013:4). Since 1996 a number of laws have been passed to actualise these rights, and some are discussed below, of particular relevance is: the Choice on Termination of Pregnancy Act, the South African Children's Act and the Sexual Offences Act (Hoffman-Wanderrerr, 2013).

The Choice on Termination of Pregnancy (CToP) Act (No. 92 of 1996) uses a rights-based framework to introduce the legalisation of termination of pregnancy. It allows that any pregnant women or girl can have a pregnancy terminated on request up to 12 weeks of gestation, provided by a certified midwife or doctor. And terminations can also be performed from 13-20 weeks in cases where the pregnancy poses a risk to the women's social, economic or psychological well-being. After 20 weeks terminations will only be performed to save the mother's life (Cooper et al., 2004 and Jewkes et al., 2005). Importantly this applies to 'any person of any age' and can be performed without parental consent, so long as the child is deemed able to provide informed consent. Children under 18 years are advised to seek counselling before doing so, but they are not obligated to do so (Hoffman-Wanderrerr, 2013:4). The Act allowed for surgical terminations to be performed by a doctor or trained midwife in designated facilities, whereas medical terminations can be performed anywhere.

In 2003 an Amendment was introduced in an attempt to broaden access to abortions, the critical change was to allow any health facility with a 24-hour maternity facility to offer abortions for the first trimester; and for any nurse who has completed the ToP training to undertake first trimester abortions, not only midwives (Cooper et al., 2004).

The South African Children's Act (2005) (as amended by the Children's Amendment Act, No. 41 of 2007) came into effect, with regulations, on 1 April 2010. It allows those over 12 years to 'access health care services, including HIV testing, contraceptives and termination of pregnancy (TOP) services, without parental consent'. The Act stipulates that: 'contraceptives other than condoms [and also including condoms] may be provided to a child on request by the child and without parental consent of the parent or care-giver of the child if the child is at least 12 years of age.' (Hoffman-Wanderr, 2013:7).

The Criminal Law (Sexual Offences and Related Matters) Amendment Act (Sexual Offences Act) (2007) protects children and adults from non-consensual sex, it states that children can only consent to sex once they are 16 years old. This means that even consensual sex between a child under 16 years and those over 16 would be considered non-consensual and statutory rape (Hoffman-Wanderer, 2013:9). It had also criminalised consensual sex between two children where both parties are between 12 – 15 years of age, this has been taken to court and on 14 January 2013 'Judge Pierre Rabie found that sections of the Sexual Offences Act, which made consensual sex between teenagers a crime, were unconstitutional' (Parker, 16 January 2013).

The introduction of *the Child Support Grant* has been critical to provide support to mothers of young children, children from 0 -18 years are now eligible for the grant, and the primary caregivers receive R280 per child per month, to be increased to R300 by October 2013.

In terms of schooling and teenagers' rights, *the South African Schools Act (SASA) (1996)*⁸ permits teenagers to stay in school while pregnant and to return to school after childbirth. In addition, *the Promotion of Equality and Prevention of Unfair Discrimination Act* (No. 4 of 2000) stipulates that school learners who become pregnant should not be unfairly discriminated against (Lince, 2011). Bhana and Clowes (2008) noted SASA appears to only apply to mothers, and not fathers, which further perpetuates gendered norms around women carrying the burden of childcare.

In 2007 the Department of Education (DoE) released *Measures for the Prevention and Management of Learner Pregnancy* (MPMLP). The intention was to address the issue of an ‘implementation vacuum for SASA’ through providing assistance around implementation with a dual focus on prevention of pregnancy and management of pregnancy where it does occur. However it has been heavily critiqued for having some conservative language such as: advocating on abstinence issue (Chohan, 2010) and for having some recommendations which do not seem to support girls

2.8 How effectively are policies being implemented?

Despite progressive policies supporting teenagers in their rights to, autonomous sexual choices; comprehensive sexuality knowledge; a range of contraceptive options from the public sector; access to terminations of pregnancies and educators that support them in their sexual choices, much of the literature spoke in detail of how teenagers are not able to realise these rights. This will be explored in detail further in the paper, suffice to say that policy is failing many teenagers, both girls and boys, and not enabling them to be in control of their sexuality.

While the policy arena is broadly supportive of enabling teenage girls to remain in school while pregnant and return as mothers, again implementation seems to remain a significant barrier, since as Morrell, Bhana and Shefer (2012:19) noted: The gender equality in schools is not driven by the legislative environment automatically. There are insufficient consequences for schools, principals and governing bodies if the policies are ignored. Within schools policies are interpreted and implemented by principals, governing bodies and teachers, often influenced by communities and families – and this allows ‘space’ for people to apply their own morals and values to implementation. Implementation is filtered through people’s own views on teenage sexuality, and beliefs about ‘appropriate girls and boys norms’ – and this has led to many violations of these policies (Chigona and Chetty, 2008; Morrell, Bhana and Shefer, 2012 and Panday et al., 2009). Panday et al. (2009:99) . Anecdotal reports through the media... indicate that girls continue to be expelled when they become pregnant.’ This was seen again with yet another case taken to the Constitutional Court in March 2013, the case is opposing two schools in the Free State that tried to keep pregnant teenagers and teenage mother’s way until the year after their babies are born (The Mercury, 6 March 2013).

The literature had numerous examples of teachers and principals violating the law extensively. Indeed in 2000 the Commission on Gender Equity received numerous complaints from teen mothers not allowed to return to school (Chigona and Chetty, 2008:265). Chigona and Chetty (2008) also noted many examples of teachers refusing to support girls who had missed classes because of childcare responsibilities.

Morrell, Bhana and Shefer (2012) noted that while some girls are still being expelled (illegally) this is decreasing. However discrimination, stigma and pressure to leave is still experienced by many girls. Shefer et al. (2012) also noted that girls experienced increased pressure to withdraw from school in the third trimester when the pregnancy was more visible.

Our interviews also reflected ignorance about the SASA policies, indeed, none of our respondents knew of the law enabling them to continue at school. However, Buhle, who was 16 years at the birth and returned to school one week after childbirth, was informed about it by her teacher, once pregnant. Both of the teenagers who left while pregnant reported that they left sexual activity among teenagers is ‘a common and normal bridge to adulthood’ (Senenyake and Faulkner, 2003; Flanagan et al, 2013: 19), and it should not be stigmatised nor condemned but rather, teenagers should be recognised as moving into a period of sexual discovery and be supported to ensure they are informed to be able to have healthy, safe and satisfying sex. Nonetheless one does need to be mindful of the different experiences of young teenagers (under 17) and those 17 and older because, as mentioned earlier, falling pregnant and becoming a mother have very different impacts for a young teenager as opposed to an 18 or 19 year old, and our responses need to take account of this nuanced reality.

Despite common assumptions that sexual debut in southern Africa is high, the highly acclaimed study by Pettifor et al. (2009) indicated that ‘age at first sex is fairly consistent worldwide; for most young women in Africa, sexual debut occurs at ages 17-20. The mean age at first sex among young men and women in South Africa ranges from 16-18 depending on the age and type of sample’ (Pettifor et al., 2009: 82). In terms of those having sex at a younger age, they found that ‘18% of young men and 8% of young women said they had sex for the first time at age 14 or younger’ (Pettifor et al., 2009: 83) They also noted that women’s first partners were generally 1-4 years older than them and most reported that their first sex was with a main partner. And while 7% of 15-19 year olds reported their first sex as coerced, when asked ‘whether they had been willing participants in their first sex’ only three

in five reported they had been willing. They also noted that most of young women who were involved sexually at an early stage reported that their first partner forced them to engage sexually with them, (Pettifor, 2009: 87). Jewkes, Morrell and Christofides (2009) reported that by 17, half of all teenagers were sexually active.

Furthermore, although most teenage pregnancies in South Africa are unplanned (DoH et al., 2007; Panday et al., 2009; Pettifor et al., 2005; Reddy et al., 2010; Flanagan et al, 2013), one must be cautious about seeing all pregnancies as unplanned. In Ehlers (2003) study she found 13.6% of the adolescent mothers had planned their pregnancies. Neloufar Khan reflecting on the Department of Social Development's current study on teenage pregnancy noted that when teenage mothers were asked about their reasons for falling pregnant some clearly had agency, and said that it was planned. Panday et al. (2009:56) also noted that in a 2006 survey 28% of young women reported that she fell pregnant because 'I wanted a baby'. Moving from a women's rights perspective it is important to recognise that not all teenage pregnancies are unplanned; their right to choose to become pregnant needs to be respected and balanced with a clear need to be reducing the number of unplanned pregnancies in the country.

Irrespective of whether a teen pregnancy is planned, it is important to recognise that teen pregnancies among young teenagers can be medically dangerous for the mother. Indeed, maternal mortality remains one of the biggest killers of teenage girls in Africa (World Population Foundation); girls in their teens are twice as likely as older women to die from pregnancy and childbirth-related causes (Save the Children, 2004), and further, young girls between the ages of 10 and 14 are five times more likely to die during delivery than mothers who are between 20 and 24 (Save the Children, 2004).

Ehlers (2003) went on to note that babies of teenage mothers had poorer neonatal outcomes and low birth weights. Ardington (2012:3) supported this noting that: nutrition status points that children produced by teens are underweight. They went on to note negative educational impacts children born to younger teenagers' shows poor outcomes than their peers. Children born to younger teenagers are most at risk – especially in rural areas. The younger the mother the higher the child's schooling deficit. Children born to older teenagers in urban areas are not lagging behind in grade attainment compared to peers born to older mothers' (Ardington, 2012:3). Much has been written about coping skills of teenage mothers, as it is specified that

they are not coping because they children themselves and they need supervision; however some of the literature highlighted young women embracing motherhood and being ‘good mothers’.

Mainstream literature, researchers and some South African leaders tend to highlight the issue as a hindrance for educational opportunities to teenage girls. Indeed, Jewkes, Morrell and Christofides (2009) and Clowes and D’Amant (2012) both noted judgemental attitudes from President Zuma towards teenage mothers, where Zuma suggested in the media that the ‘policy (on teenage pregnancy) has been too permissive, teenagers too indulged and that solutions require “tough love” (Jewkes, Morrell and Christofides, 2009:676). Zuma went further to say that: mothers should be separated from their children until they finish their education, because there is a huge increase in schools drop out after teenagers gave birth; (Clowes and D’Amant, 2012:35).

2.9 Conclusion

To summarize this chapter the views on literature is that South Africa is one of the countries who advocated strongly the rights of the children to be considered as paramount. In many respects the South African Children’s Act represents some of the very same values and principals embodied in the family codes of the several United States of America. It asserts a commitment to the best interests of the child in legal proceedings and to the protection of children who are victims of abuse or neglect. In other respects, however, the Children’s Act is a foreign piece of legislation that would not fit in with American jurisprudence. Yet in all respects it reveals the character of the South African people and reflects well on the soul of that nation, it has also discuss the age of consent from other countries, the Act speculations. Another aspect that was discussed is the life journey of President Nelson Mandela which inspired most of decisions he made concerning children’s rights. Throughout the untimely years of Mandela presidency, the government of South Africa started to review the laws regarding treatment of children in different context. The regulations and Children’s Act, 2005, was finally promulgated in its total in 2010. Section 134 was outlined which discuss access of contraceptives and condoms by children age 12 without the parents consent. This chapter also discusses what other countries do in terms of age consent, relevant policies and how effective policies are being implemented.

The next chapter (three) will discuss research methodology, sampling, data collection and other techniques used when one conducts a study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The previous chapter (Chapter two) focused on the theories which were used to guide the study. From a general perspective, a theoretical framework is the broader context within which the current research being undertaken is based. Its aim is to locate the study in a much broader context to ensure that it can be generalized or linked to other similar studies. While some theories transcend field boundaries, others are applicable to or generally used in specific academic fields. However, regardless of the academic field, the purpose of a theory remains the same.

Now that the theoretical framework which guided the study has been delineated, this chapter will explain the approach the researcher used to gather and analyse the data as well as the research methods used in this study. This includes a description of the study setting and related aspects thereof. Other significant aspects include an in-depth description of data collection methods and the rationale for conducting research using those research methods. There are also important factors such as the validity and reliability of the study, ethical consideration and some limitations of the study.

3.2 Study Setting

This study was conducted in a semi urban area called Chesterville, in Durban. Chesterville is an area right next to the famous Pavilion Mall. It has two High Schools and two Primary Schools, a Library, Community Hall, taxi rank, playground as well as the swimming pool. The community in Chesterville is modernized as evidenced in their lifestyle. However one has realized that there is diversity as well because there are foreigners who reside within this community because it is close to the Central Business District (CBD). In terms of religious orientation, in Chesterville there are people of different religious orientation. These include Christians, Traditionalists, and foreign religions such as Islam. This community faces challenges such as by teenage pregnancy, substance abuse, as well as high rate of school drop

outs. Since this study aims to examine people's reaction to the Children's Act 38 of 2005 section 134, this community was identified as an appropriate target area. A sample was selected from parents, educators, youth, community leaders and church leaders. These stakeholders were chosen because they play a major role in community functioning.

Since these participants play a major role in the community members' well-being their perceptions, feelings and attitudes towards the issue of children aged twelve receiving condoms and contraceptives without parents 'consent were very important. The main focus was to gain in-depth understanding on their reaction towards this section of the Children's Act, as well as to explore if these methods have any impact on the youth engaging in sexual activities at a younger stage.

3.3 Research Design

From a general perspective, a research design is a strategic framework for action that serves as a bridge between research questions and the execution or implementation of the research, a plan that defines the elements (e.g. variables, participants) their interrelationship, and methods (e.g. sampling, measurements) that constitutes the piece of research. It is also a fundamental plan that guides research throughout the process of conducting a study. Babbie and Mouton (2001: 74) define a research design as structured plan system of how a researcher is planning to conduct the study in order to interpret the complications. It refers to the main task of the researcher specifying and combining the key elements and methods to maximize validity, with the purpose of revealing the findings and reaching a conclusion. Based on the purpose of this study, which is to examine people's reaction to the Children's Act 38 of 2005, Section 134, the exploratory research design was used in this study because it was deemed appropriate by virtue of the nature of the study.

This type of research design is generally used when a researcher wants to expand knowledge in a particular area. It usually identifies the general terrain of a topic or problem area. The qualitative methods have been used in this study in order to examine people's reaction in an in-depth manner so that parents, teachers as well as the youth would be afforded an opportunity to discuss the issue openly and share their experiences. According to Babbie and Mouton (2001:75) qualitative research is naturalistic, holistic, and inductive; it assists the

researcher when conducting interviews to unfold situations, without manipulating or contaminating conversations.

Table 3.1 Themes of Qualitative Inquiry

1. NATURALISTIC	It is to study real world situations as they unfold naturally, non-manipulative, unobtrusive, and non-controlling, openness to whatever emerges-lack of predetermined constraints on outcomes.
2. HOLISTIC	The whole phenomenon under study is understood as a complex system that is more than the sum of its parts, focus on more complex interdependencies, not meaningfully reduced to a few discrete variables and linear, cause effect relationships.
3. INDUCTIVE	Immersion in the details and specifics of the data to discover important categories, dimensions, and interrelationships, begin by exploring genuinely open questions rather than testing theoretically derived hypotheses.

Source: Guest (2012).

3.4 Sampling strategy

From a general perspective, sampling is “the selection of research participants from an entire population, and involves decisions about which people, settings, events, behaviors, and/or social processes to observe” (Alston and Bowles, 2003: 120). The key questions answered through this research study are outlined in Section 1.5 under chapter one and they were addressed by drawing on the reactions of parents and stakeholders. Purposive sampling was adopted in this study because it is often used when looking for particular types of participants who are knowledgeable on the subject matter (Durrheim, 1999). This sampling method is also used to obtain a representative sample by identifying the key informants. The informants who were identified included the parents at each residence. Becker define a sample as another set of population selected to participate in a research (Becker and Bryman, 2004:405). The parents and the youth were targeted since they are the ones affected by this Act. The sample

consisted of 20 young people aged 18-30, 20 parents, 3 educators, 1 from the legislature, 1 from community leader, and 2 traditionalists. In total the sample consisted of 47 participants.

3.5 Participant selection process

As highlighted below, the main form of data collection was through focus groups. Focus groups allow for the interaction of participants (Stewart & Shamdasani, 1990) and provide a discursive forum suited to the aims of this study. Alston and Bowles (2003:81) also state that “non-probability sampling is the method that is generally used in exploratory research and by qualitative researchers.....it is very useful and justifiable when the researcher is seeking information on a new area and targets subjects or cases which typify the issue to be studied”. As a category of non-probability sampling, the purposive sampling strategy was used for the selection of research participants. The sample units were selected based on the purpose of the study and by the fact that participants were available, accessible, willing to participate and convenient.

Snowball Sampling was used because the selection was strategized. According to Bryman et al (2014) in purposive sampling it is important not to generalize participants to be selected strategically. Young people aged from 18-25 were targeted because they are the beneficiaries of this Act. Educators encounter teenage pregnancy in schools daily which affects the learners’ progress and performance in schools. Parents are also victims because they are expected to pick up the pieces when the child is sick or pregnant. And the Act states that access is without the parents’ consent as well as the community leaders who expect certain behaviour from the youth.

3.6 Data Collection Instrument

As part of this study, data was collected using the in-depth interviewing technique and focus group discussions. The former serves as a way of interaction between the researcher and participants. It also enables the researcher to gain in-depth knowledge from participants. According to Henning (2004:50), “research interviews assume that the individual’s perspective is an important part of the fabric of society and of our joint knowledge of social processes and of the human condition”. Interviews enable the researcher to get to know people better and to understand the meanings attached to certain actions. To collect data for

this study, *semi structured interviews* were conducted with the parents, stakeholders as well as youth to understand their perspectives towards section 134 of the Children's Act section one and two which states that children aged 12 can access contraceptives, and condoms without their parents' consent.

Semi structured interviews follow a set of topics which are the triggers for the main direction of the interview and allow the interviewer to explore additional information that the respondent has raised (Alston and Bowles, 2003: 116). The research interview schedule was developed in keeping with the research questions. As a norm, the schedule is in the form of an interview guide or questions that help the researcher to focus on relevant information or themes while maintaining the professional conversation. During the interviews main questions and probing was used to deeply explore participants' perceptions. All participants agreed to participate during the first contact since they were very interested in the study and appreciated the fact that someone was willing to listen to their views.

The interview sessions were conducted in the participants' place of choice within their households. The advantage of using participants' place of choice is that they seemed more comfortable and interested. During the initial contact the informed consent document was issued to the participants. The permission to use a tape recorder for transcription at a later stage was also obtained from the participants. Focus groups sessions took approximately 50-60 minutes which differed from individual interviews which took 30-45 minutes. Even though the structure of the interview was similar to an everyday conversation whereby people share their experiences, knowledge, meaning, views, perceptions, and so forth certain skills were used. These included professional conduct, unbiased questioning, probing and listening all in a non-judgmental or threatening manner. A rapport and a good relationship with the participants were established with the result that a rich source of information was obtained.

3.7 Dependability and Credibility (Reliability and Validity)

Qualitative research is open to multiple interpretations of situations; researchers often need to defend subjectivity in their work. Although some researchers refer to issues of reliability and validity, qualitative researchers are increasingly using the term dependability and credibility.

Reliability refers to the degree to which the research conclusions are sound. Data gathering through the in-depth interviews was conducted personally by the author who had developed, and was thus familiar with, the interviewing guide thus ensuring consistency in questioning and probing. Questions were clarified and repeated where necessary to prevent misinterpretation by the participants. In qualitative research, credibility focuses on confidence in the truth of the findings, including an accurate understanding of the context. As mentioned above, because qualitative data is subject to multiple interpretations, it is inevitably partial. Golafshani (2003) maintains that it is impossible to have absolute confidence regarding credibility mainly because research is influenced by the processes through which a researcher investigates and represents a particular topic and the findings. However, Golafshani (2003) and Ulin et al (2002) suggest that it should be ensured that the findings are consistent in terms of the explanations they support. In this study, the findings relate directly to the data gathered which was found to be rich, detailed and adequate to support the findings. Access to condoms and contraceptives by children as young as twelve years is a sensitive issue. An extensive reading on the topic and considerable engagement with experts in this area contributed to the credibility of the results.

3.8 Ethical Considerations

This study was approved and conducted in terms of the University of Kwazulu-Natal's Higher Degrees Committee and Ethics Committee stipulation which specifies certain procedures that should be followed by researchers when conducting research projects. As argued in the literature "Ethical issues in social research are both important and often ambiguous; most of the professional associations have created and published formal codes of conduct describing what is considered acceptable and unacceptable professional behaviour" (Babbie& Mouton, 2001: 528). Ethics guides, regulate, and maintain a professional relationship between the researcher and research participants and ensure that human dignity is

respected. Merriam (2009: 230) stressed that “the protection of subjects from harm, the right of privacy, the notion of informed consent and the issues of deception all need to be considered ahead of time, but once in the field issues have to be resolved as they arise”. The informed consent documents were administrated using the participants’ language which in this case was IsiZulu.

The ethical considerations relevant to this study were as follows:

- ***Informed consent***

Before the data collection process began, the participants were informed about their anonymity and the letter of consent and the consent forms were issued. Henning et al., (2004:73) emphasize that participants must be fully informed about the research in which they are participating and must give informed consent to participate. This process was done both verbally and in writing. Participants were informed about the purpose of the study, interview content procedures, utilization of collected data, as well as confidentiality assurance. Permission to use a tape recorder was also obtained from participants. All participants signed the consent from prior to the interview.

- ***Confidentiality and anonymity***

Participants were ensured that their confidentiality was guaranteed since data would be kept private and confidential at all times. According to Alston & Bowles (2003: 21) “confidentiality means that the information given to the researcher will not be divulged to others, except in reporting researcher as agreed, and also that information will not be used for any other purpose other than the research”. Participants were also informed that the author’s supervisor would have access to collected data; however their identity would be kept confidential. During research findings or discussions, pseudonyms were used to protect the identity of participants.

- ***Voluntary participation***

The research code of ethics emphasizes that it is significant that the researcher must obtain voluntary and written informed consent by participants, and also assure them that they may refuse to participate without any implied or actual deprivation or penalty. The informed

consent should include information about the nature, extent and duration of the participation (Marlow, 1998: 333). As a result, during initial contact, participants were informed that their participation was voluntary and that no monetary reward would be issued. They were also informed that they were free to withdraw from the study at anytime and/or to refuse to answer certain questions, and that no penalties would be charged. This process was done both verbally and in writing.

3.9 Potential limitations of the study

De Vos, Strydom, Fouche and Delport (2005) state that every study has its limitations and the researcher has to be cognisant of all these potential limitations and at the same time be mindful of and capitalize on all the strengths of the research project. During the study, the researcher encountered a number of challenges and limitations that threatened the reliability and validity of the research. However, attempts were made to keep these to a bare minimum.

Firstly, it was noted during the process of the data collection that some people were unwilling to share information or their views on the subject. This reluctance might have been due to the fact that some cultures treat sexually related topics as taboo. However, through the use of interviewing skills such as probing and questioning, the researcher managed to get interviewees to elaborate on the issues in question. Nonetheless, in certain instances, participants gave very brief answers and did not elaborate on their responses which can be construed as a limitation of the study. This factor could also possibly be attributed to the need to quickly complete the interviews or alternatively, they might have had little to say about the issues probed.

Secondly, ideally sampling should represent the entire population. However, the small scale sample in this project was another limitation as the size of the sample did not allow for adequate representation of the entire population of Chesterville. As such, the results of the study are not generalizable to the broader population of South African parents.

Thirdly, in view of the fact that there are high levels of crime in townships where the study was conducted, the researcher could not access entry into some homes due to mistrust of the dwellers regarding the researcher's credentials. For this reason, some in the township could

not be interviewed and valuable information may have been lost in this way. Consequently, the researcher only interviewed those persons who allowed her access into their homes and agreed to participate.

The fact that the researcher probed participants' views on children aged 12 given a right to access condoms and performing abortion without their parents' consent which is a challenging topic was another challenge because most of the parents do not discuss such issues with their children.

Despite the fact that the research tool was pre-tested, some questions remained unclear to the respondents and represented a further weakness of the study. However, as the method of data collection involved face-to-face interviews, the researcher managed to clarify those particular questions in relation to the context of the study.

3.9.1 CONCLUSION

This chapter has discussed research methodology which comprised study setting which elaborates on the location of the study and where it was conducted. The research design also shows the framework of the study, sampling strategy on how the participants were selected; as well as ethical consideration which is clearly outlined. This chapter also discussed the confidentiality issue which is a hindrance when one wants to respond as most of the participants likes to remain anonymous. The following chapter (four) will show the responses from the participants and other relevant stakeholders who took part in this study.

CHAPTER FOUR

RESEARCH FINDINGS

4.1 INTRODUCTION

Chapter four will show the reader all the discussion and responses composed during the interviews and focus groups with the participants. The findings and different stakeholders views who were the part of this study.

4.2 Responses from Educators in Chesterville High School

The researcher distributed questionnaires to educators in two High Schools in Chesterville. Educators complained about high rates of unprotected sexual activity and stated that pregnancy rates are particularly high in high school pupils in the areas of Chesterville. A large number of adolescents engage in sexual activities at a younger age and do not use contraceptives and Choice of Termination of Pregnancy Act services. This is despite the fact that these services are freely available throughout the country. Pregnancies among high school pupils are mostly unplanned, and many are terminated either legally or illegally. In part, this could be owing to ignorance, lack of knowledge and fear in the adolescents. This indicates a need to promote adolescent sexual reproductive health education. The researchers noticed high incidences of teenage pregnancy among high school pupils attending antenatal care at the local clinic in the Chesterville Township. This was the motivation for this study. One in three teenage adolescents who were interviewed informally were found to be pregnant or already had at least one child.

There were equally high incidences of STIs and HIV/AIDS in these pregnant high school pupils attending the clinics. Teenage pregnancies are associated with maternal, foetal and neonatal adverse outcomes, which include dropping out of school and lacking economic and social means with which to care for their children. The educators also stated their concerns that sexual activities are promoted at an early age by the media and social networks as well as these laws which give rights to children at age 12 to have access to contraceptives and TOP without parents' consent. The educators also discussed the issue of drop-outs and contracting HIV at an early stage, hence the legislation promoting access to condoms in schools has been

approved. The educators who are also parents raised their concerns and disbelief why our government promotes such Acts.

Educators who are also parents are concerned and worried about the Act and are against the Act as well as access of condoms to learners in High School. They believe that a child at school must be encouraged to focus on education and that the sexual activities should be discouraged at a young age. As a researcher I believe that educators encounter these issues daily and are expected to confront such issues on daily basis and encourage learners to focus on education yet the truth is that learners are engaging sexually at a young age.

4.3 Responses from Youth Focus Groups

Two focus groups were conducted comprising five males and five females from the age group 18-25 years. The first group was against the Act and the second group was in favour of this Act. The first group of ten young participants (five males and five females) stated that the Act is actually promoting sexual activities because they believe that a child at the age of 12 years is too young to be involved in any sexual activities. One of the participants who are a Christian stated that if abstinence can be preached in the youth of South Africa like how they advertise alcohol he believed change would be witnessed. He further mentioned that when our former President Dr Nelson Mandela passed away each and every channel was broadcasting and argues why the same is not done during the youth month.

One young lady stated that she believes that the Act was supposed to be discrete and be used when a child is raped and if the agreement is between parents and the Doctor or a Hospital. They also agreed that the age should be reconsidered maybe 18 years even though one still needs parents' advice until they are over 35 years old. They also referred to the Sexual Offense Act which states that it is criminal for a child who is between 12 and 16 years of age to engage in an act of consensual sexual penetration with another child between 12 and 16 years of age however, the new amendment has reversed this Act and allowed such children to engage in sexual activities as long as they have mutual agreement). The old Act further stated that it was to criminalize a child who is between 16 and 18 years of age engaging in an act of consensual sexual penetration with a child who is younger than 16 years and is 2 years or less younger than the former.

Some informants believed that this Act is contradicting itself; and requested government to reconsider it. The second group of the youth was in favour of the Act arguing that as children grow older and mature, they develop the capacity to be involved in making decisions regarding their own health care. They argued that teenage girls should be allowed to get birth control without a parents' permission, because for starters it reduces the number of teen pregnancies, teens have a safer home life. They argued that the Acts shows that teens are responsible. According to the youth informants aged 19 are less likely to use a condom properly, condom slippage and leakage is higher in younger users and only 38.9% will use a condom. This means that if girls were on Birth Control, they would be having safer sex by reducing the chance of getting pregnant. They further stated that as young people they are afraid of being disowned when parents find out that they are having sex. Most young people don't want their parents knowing that they are having sex; plus some parents will say no to having sex. Most teens are mature enough to take precaution towards having safer sex, they are smart enough to think ahead to get birth control. However they are scared to go to a parent and prefer getting it on their own.

The writer of 'Birth- control access risks conservatives' points out that Family planning groups say that notifying parents would rip away traditional confidentiality of the program. If someone is absolutely set on having sex, nothing is going to change that. They're going to do it no matter what. The problem with needing parental consent is that this is a very awkward and scary topic for young people to talk to their parents about. According to one participant aged 20 doing first year at DUT (Durban University of Technology) "they would probably rather have sex without birth control than have to talk to their parents about it". Letting children obtain birth control without parental consent allows for a greater chance of kids actually using it since they won't have to face and talk to their parents about it. She asked: 'what if their parents say no?' Surely, it's not going to stop them from having sex but they will not be as safe as they can. According to Article 12 of the CRC, 'Children have the right to express their view freely and to have it taken seriously in accordance with their age and maturity.'

Even children as young as 7 years old may be able to be involved in medical decision making. Infants and very young children lack the ability to make decisions; older children are developing decisional capacity, and teenagers generally have developed decisional capacity.

The challenge is that it may be difficult to judge the child's capacity to make a decision and there are no clear standards for judging competency.

One young male stated that children must be given full information in an understandable form so that they are able to participate in the decision-making process. Generally, children want to be informed as to what is going to happen to them, even if the information is distressing or painful. These young people also agreed that while it is appropriate to involve the child and respect his/her ability to make decisions, it is important to remember that the child belongs to a family and that the family should also be involved in the decision-making process. Young children who have no decisional capacity but who are able to understand should have the treatment explained to them. In pediatric research the term 'assent' has been used in the young child (from 7 years) who is able to understand but not make a fully informed decision, and this could be used in the clinical situation as well.

The general feeling among the youth was that it is difficult to force treatment on a child who strongly objects to it and is old enough to understand, especially if the treatment has marginal benefits and significant side-effects. One grade 11 learner stated that older children and mature minors should be given full information as well as the power to make a decision. The term 'emancipated minors' is used to denote young people who live separately from their parents, manage their own finances, are married or have children of their own, and these young people are regarded as fully autonomous. All this information they presented they believe that if children are emancipated at a young age are made aware of the negative consequences they will not engage sexually at a young age.

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

The issue about the use of contraceptives and TOP attracted contrasting views from the informants. Eighteen 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 informants concurred with the Act, citing reasons why it was justified. Five of them 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. Also, 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: She prefer that her child to prevent by using contraceptives rather than to contract virus and maybe fall pregnant, she further stated that as a parent she will monitor the procedure and advice the child on decision making concerning the child's life

A further argument in supporting the use of contraceptives and TOP by one male participant aged between 35 and 40 years was encapsulated in the following quote: Children do not want to discuss issues of sex with parents; they suggest that parents should teach their children on issues regarding termination of pregnancy and contraceptives.

Ironically, 9 of the participants who approved access to contraceptives by children (7 of whom were females and 2 males) mentioned that termination of pregnancy was against their beliefs and moral values. Six of the 9 participants were Christians, 1 was a non-believer and the remaining 2 were from the African traditional religions. Instead, they agreed that children should be allowed to access these services easily and that they should be free to obtain contraceptives by both the law and parents. One informant stated: she prefers prevention than having a child terminating pregnancy or bringing a child in a poverty stricken environment. Eighteen participants, 15 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 opined: Married couples should be given contraceptives as they are the ones allowed to use for family planning. Another female participant in the same age group commented: Condoms are not suitable for young boys; packaging and instructions suppose to state that they are only suitable for certain age.

The same participant commented that condoms are like rubber and strictly designed for adults. He therefore asked whether the government would in the future manufacture condoms for children that would be the fit properly in respect of their genitals and if not, would the current form of condoms serve the preventive purpose they were meant to serve? One can deduce that a 12-year-old child would be less likely to rationalize 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: any women may request termination of pregnancy during 12 weeks period of pregnancy.

However, section 11 of Chapter 2 of the South African Constitution states: '*Everyone has the right to life.*' In this regard two participants, one a male non-believer aged between 36 and 40 years and a female aged between 30 and 33 years from 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 female participant aged between 38 and 42 years who also subscribed to Christian values believed that there is 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 Muslim participant expressed sentiments rejecting the clause. Even though Christians had more participants than Muslims and traditionalist, they all agreed that Children Act section 134 is against their morals and values.

Five other participants were indifferent in terms of their views on the termination of pregnancy. They argued that the decision has to be made individually based on her circumstances. One of these 5 participants suggested 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. 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. According to Article 12 of the CRC acknowledge the principle that development of the child depends on the common responsibility of both parents. The best interest of the child should be their concern. This article (Article 12 of the CRC) 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. 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. The figure below shows the classification of the informants according to their nationality/ethnicity.

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

While the majority (14 participants) of the participants totally disagreed with the issue children from the age of twelve years having the right to consent to access of condoms and termination of pregnancy without their parents' consent, a minority (6) felt that children had the right to make such decisions. 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 stated by the Act. More participants from the Zulu language group (10) opposed the clause compared to 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 Christians (10) opposed this clause, again possibly because they were in the majority compared to 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 make sound decisions or emotional maturity to make decisions on matters with serious ramifications such as surgical operations.

A 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 as follows: As a parent I have a right to be involved in decision making when my child is under the age of 21, it a right that was given to parents by God, if my child wants to do as she/he pleases they can leave my house and conduct their life as they please elsewhere.

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 30 - 35 and who indicated that she was a non-believer said: A choice needs to be given to children so that they will be able to make decent choice concerning their lives, as Government made it clear that they have rights. Another female participant (33 - 35 years, also a non-believer) commented: Our country has democracy, so everyone has a right to choose how to conduct his/her life without other people's interference. These responses would seem to reflect the ideals of a democratic society as stated in the Convention on the Rights of the Child. This document states that children have the right to be respected and to participate fully in all aspects of their social lives.

The majority of parents who participated in this focus group was Christian and was against the Act and their children taking decisions without their consent. However eight parents stated that children can make their own decision regarding their lives. Other parents mentioned that they would be at ease if the age of consent was at least 16 years.

4.6 CONCLUSION

The participants voiced their concerns and to summarize the discussion it is clear that parents are concerned and have different views regarding Section 134 of Children's Act. The educators were concerned in terms of the large number of adolescents engaging in sexual activities at a younger age and do not use contraceptives and a need to promote adolescent sexual reproductive health education. The general feeling among the youth was that it is difficult to force treatment on a child who strongly objects to it and is old enough to understand, especially if the treatment has marginal benefits and significant side-effects. It is clear that while the majority of the participants totally disagreed with the issue children from the age of twelve years having the right to consent to access of condoms and termination of pregnancy without their parents' consent, a minority felt that children had the right to make such decisions. The contribution and responses from the informants towards this Act is diverse, unfortunately majority is disappointed. The next chapter (five) will analyse and discuss the findings.

CHAPTER FIVE

DATA ANALYSIS AND FINDINGS

5.1 INTRODUCTION

Data Analysis is the process of systematically applying statistical and/or logical techniques to describe illustrate, condense recap, and evaluate data. According to Shamoo and Resnik (2003) various analytic procedures “provide a way of drawing inductive inferences from data and distinguishing the signal (the phenomenon of interest) from the noise (statistical fluctuations) present in the data”. In line with this understanding, this chapter focuses on data analysis and findings of the study. Discussions, tables and graphs will be used where necessary to make the results clear to the reader and easy to understand.

5.2 Demographic Profile of Participants

A total of 48 persons participated in the study of whom 22 were females and 25 were males. The age groups of all 35 participants were distributed across 6 categories as reflected in Table 5.1. While the sample was not necessarily representative of the broader Chesterville population, the demographic patterns of the participants had a somewhat diverse spread that provided a broad range of opinions.

Table 5.1. Age group and gender distribution

AGE	18-25	25-30	30-35	35-40	40-45
MALE	10	5	7	2	1
FEMALE	10	1	9	1	2

Table 5.1 shows the age group of participants in the study who formed the part of focus groups conducted in the study and Table5.2 underneath will give ethnicity of the participants. Figure 5.1 than elaborate on the different stakeholder’s who also participated.

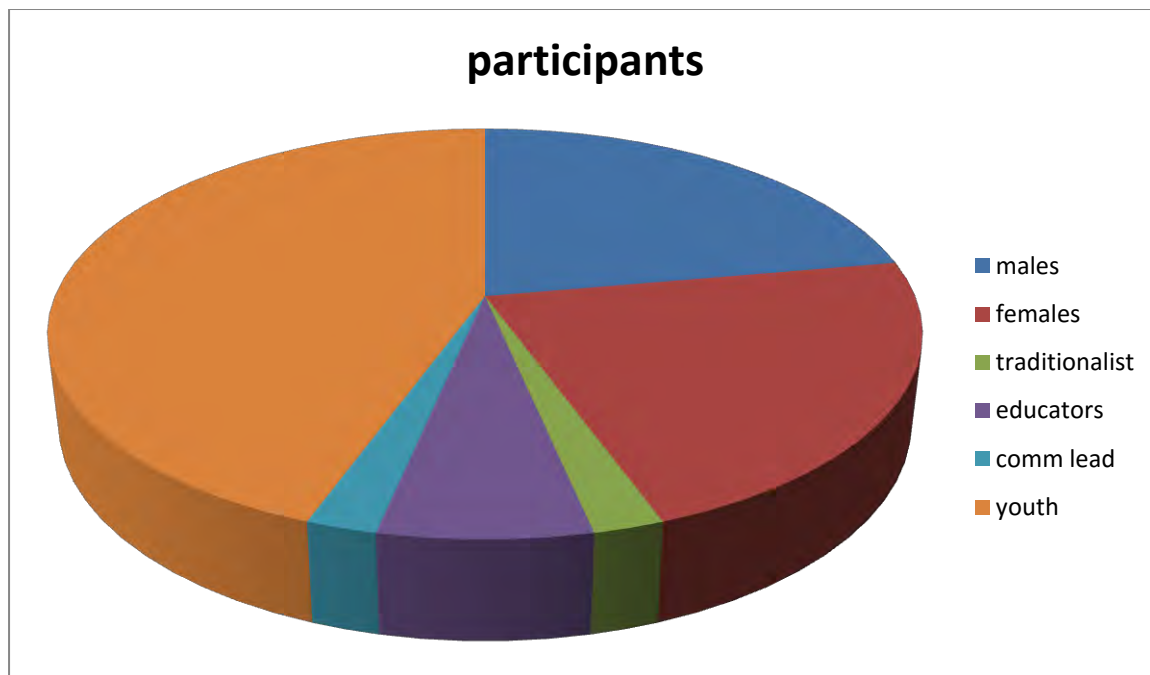
Table 5.2. Quantitative distribution of participants and their ethnicity.

GENDER	AGE	RACE
FEMALES/MALES	18-25	ZULU
FEMALES/MALES	18-25	ZULU

2FEMALE EDUCATORS/2MALE EDUCATORS	30-35 37-40	2ZULU 1XHOSA
MALE TRADITIONALIST	40-45	ZULU
COMMUNITY LEADER	40-45	ZULU
ATTORNEY	40-45	SOTHO
PARENTS	30-50	10ZULU/5ZIMBABWEAN/ 3XHOSA & 2 NIGERIANS

Source: Author's compilation

Fig. 5.1 Classification of the participants



Source: Author's compilation

5.2 Results and discussion

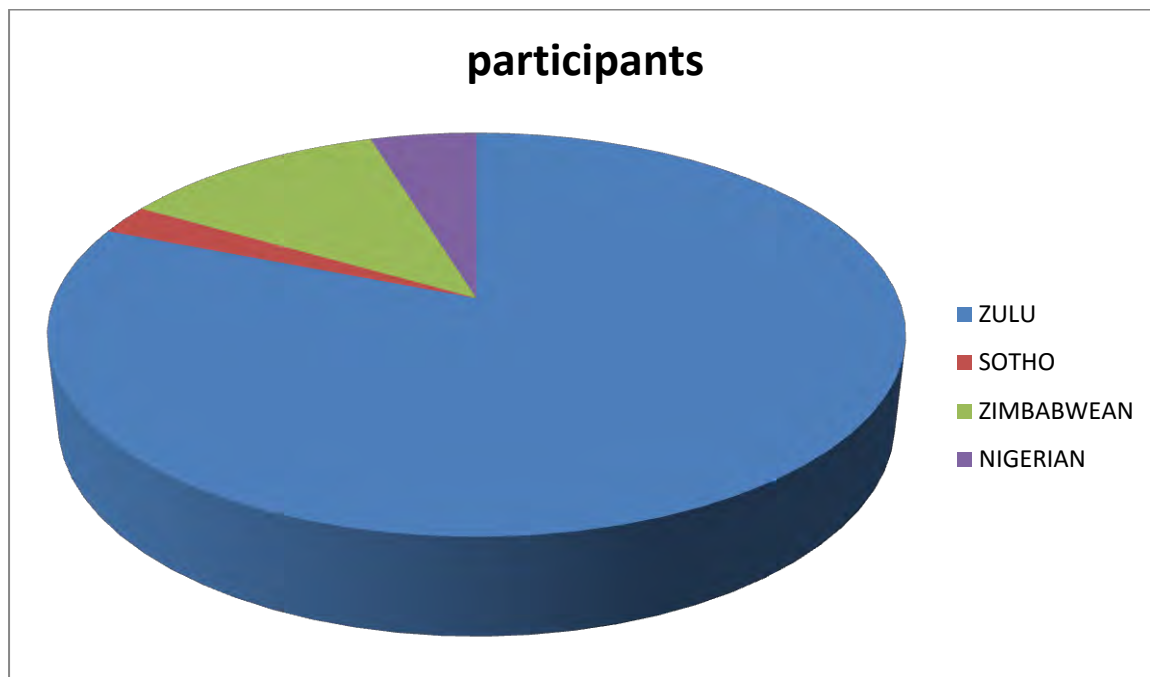
5.2.1 Knowledge of the Children's Act No. 38 of 2005

Although 25 of the participants stated that they had some knowledge about the new Children's Act, the knowledge they have was very limited. It is possible that most of the participants provided socially desirable responses and claimed that they have knowledge of the Act because they did not wish to appear ignorant. Fifteen participants stated that they had

no knowledge at all about the Act or its objectives. However, this did not exclude them from participating as they answered the questions on the basis of the clauses that were read to them before the questions session about the Act. For this reason, relevant clauses from the Children's Act were read to them so that they could comment on them.

Referring to the findings above the researcher concludes that public participation when government formulates and implements policies needs to be revisited. It is important to evaluate public participation instead of assuming that when it is broadcasted through television and newspapers that is enough. The theory in chapter three discussed that traditionally, the concept of public participation has been continuously debated in the development domain and political science literature. Although the concept was considered a decision-making adjunct, all schools of contemporary thought tend to view participation as a fundamental element of planning and decision-making (Carothers, 2005). This shift in understanding is said to have been prompted by mutually reinforcing processes of change over the last two decades. Despite an acknowledgment in the political science literature that democracy has spread as never before, there has also been a warning that the quality of democracy currently being practices is in crisis (Holmes and Scoones, 2000). In the developed countries of the global north, where democracy has matured, Gaventa (2007) refers to a large body of literature which focuses on the declining patterns of citizen participation in the processes of representative democracy.

Fig. 5.2 Classification of the informants by race/ethnicity



Source: Author's compilation

5.3. Conclusion

This chapter has presented the findings of the study as obtained from the different informants. As can be seen above, the informants held different views on each of the questions asked in the interviews and focus group discussions. Variables such as age, gender, race, etc. were considered when the study was conducted.

Referring to the findings above the researcher concludes that public participation when government formulates and implements policies needs to be revisited. It is important to evaluate public participation instead of assuming that when it is broadcasted through television and newspapers that is enough to spread the message. The chapter has outlined views from different participants, how they feel about the Children's Act. The educators discussed the experiences as well as challenges they encounter with the high rate of teenage pregnancy. Although parents had different views because of their belief systems, the researcher was able to understand how the community of Chesterville reacts towards section 134 of the Children's Act. The latter will allow the researcher to be able to draw conclusions and recommendations in the following chapter (Chapter six) which will provide clear and

better understanding of how the informants from the study area feel about the Act and what needs to be done as a way forward.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

The previous chapter discussed the findings of this study. In doing so, it considered the views of various informants divided according to gender, age, religion, nationality/ethnicity, etc. This concluding chapter will conclude and summarize the discussions from the previous chapters and pull the dissertation together. Once this goal has been achieved the researcher will propose some recommendations drawn from the content of the study as articulated by the participants. This will be followed by general recommendations as a way forward.

6.2 Conclusions of the study

This study was conducted in a semi urban area called Chesterville, in Durban. As stated in the introduction, geographically Chesterville is an area right next to the famous Pavilion Mall. It has two High Schools and two Primary Schools, a Library, Community Hall, taxi rank; Playground as well as the swimming pool. The qualitative research methods were used in this study in order to examine people's reaction to the 2005 Children's Act, Section 134. These informants included parents, teachers as well as the youth for whom the Act was promulgated. All these informants were afforded the opportunity to discuss the issue openly and share their experiences. According to Babbie and Mouton (2001:75) qualitative research is naturalistic, holistic, and inductive; it assists the researcher when conducting interviews to unfold situations, without manipulating or contaminating conversations. Participants were informed about the purpose of the study, interview content procedures, utilization of collected data, as well as confidentiality assurance. Permission to use a tape recorder was also obtained from participants. All participants signed the consent form prior to the interview.

The results of the study discussed in Chapter five showed a diversity of opinions among the informants. Although 20 of the participants 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 want to appear ignorant to the researcher. As many as fifteen participants stated that they had no knowledge at all about the Act or its objectives. However, this did not preclude them from participating in the study as they answered the questions on

the basis of the clauses read to them by the researcher before each question about the Act was asked. The study revealed that overall; participants had limited general knowledge about the Children's Act No. 38 of 2005 and its objectives. This was despite the government's claims that there was adequate consultation before the promulgation of this Act.

It also emerged from this study 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. Two focus groups comprising of the youth from ages 18-25 was a success and the researcher believes that those involved in implementing and drawing policies must involve the beneficiaries as well as guardians in order to understand how they feel and listen to their views. Eighteen 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 informants concurred with the Act, citing reasons why it was justified, and 5 agreed with this clause subject to certain conditions being adhered to. This leads to the conclusion that the informants hold different views as far as the Act is concerned. These views are predicated inter alia on the informants' cultural and religious orientation.

Pregnancy among high school pupils was singled out as one of the most concerning issues. These pregnancies are mostly unplanned, and many are terminated either legally or illegally. In part, this could be owing to ignorance, lack of knowledge and fear among the adolescents. This indicates a need to promote adolescent sexual reproductive health education –both at home and at school. 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 country and the United Nation's Convention on the Rights of the child. 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. It is understandable therefore that most parents were not happy about this Act.

6.3 Recommendations

6.3.1 Content 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 socialization of their children.

Young girls don't want to talk to their parents about sex or the idea of birth control because they will think that the parents suspect they're having sex. The findings show that 50 percent of the youth do not want their parents to know that they are engaging in sex at the young age of 16. But nonetheless they need protection so they should be able to obtain birth control without parental consent. The disturbing news when the parents are discussing the issue is that the world has accepted that sex is something everybody does— married or not. They argue that God instituted marriage that sex should be enjoyed by each other in marriage, as well as for producing children. Music, books, the internet and magazines all depict so much about sex and how to be sexy by what you wear, what you say, and how you can do it better. Parents further stated that sex is a 'gift' to give each other in marriage. It has become nothing more than just an activity to participate in. Given these views, it is recommended that children should be exposed to sex education so that they would know about these facts about sex. For example, they should be taught what sex means as well as when and why people engage in sexual activities.

One participant age 19 suggested that children need to have a trusting relationship with their parents, in order to be transparent and do not hide anything from them. The argument was that this would make it easier to ask for prenatal consent to get birth control and develop trust with parents and talk to them about having sex and about getting on the pill. It is therefore recommended that parents need to open up to their children before others teach them something else out there.

There is another recommendation to the Health authorities that a study must be conducted about the issuing of contraceptives to young children. Such a study should not only focus on the physiological aspects of children (important as that might be). On the contrary, cultural, religious and other concerns should also be considered.

6.3.2 General Recommendations

- It is recommended that government should consult widely before enacting any Act.
- Once an Act has been passed, studies should be conducted to establish its relevance.
- The impact of the Children's Act on society needs to be established.
- Given the high levels of teenage pregnancy, STIs and HIV/AIDS, the Act should be revisited.
- It is also recommended that similar but broader studies should be carried out to establish the national feelings about this Act.

REFERENCES

Alston, M. & Bowles, W (2003). ***Research for Social Workers: An Introduction to Methods (2nd Edition)***. New York: Routledge.

Ardington. Branson. Lam, D., Leibbrandt, M., Marteleto, L., Menendez, A., Mutevedzi, T. and Ranchold, V. (2012). *Revisiting the 'Crisis' in Teen Births: What is the impact of teen births on young mothers and their children?* A Southern African Labour and Development Research Unit Policy Brief. UCT.

Babbie, E. & Mouton, J. (2001). ***The Practice of Social Research***. Cape Town: Oxford University Press.

Banathy, B.H. (1993c). The cognitive mapping of societal systems: Implications for education,

Barry, D.H. (Ed). (2004). *Zimbabwe: The Past is the Future*. Harare: Weaver Press.

Baumrind, D. (1991). The influence of a parenting style on adolescent competence and substance abuse, *Journal of Early Adolescence*, 11 (1), 56-95.

BBC News (2005). *Uganda virgins offered university*. Retrieved January 12, 2008, from <http://newsvote.bbc.co.uk/mpapps/pagetools/print/news.bbc.co.uk/2/hi/africa/4700171>.

Becker, S. and Bryman, A. (2004). ***Understanding research for Social Policy and Practice: Themes, methods and approaches***. Policy: Bristol. Bhana, D and Shefer, T. (eds). (2012). *Books and Babies: Pregnancy and Young Parents in Schools*. Cape Town: HSRC Press, 49-62

Bhana, D. And Ngabaza, S. (2012) *Teacher responses to pregnancy and young parents in schools*.

Bhana, D., Clowes, L., Morrell, R and Shefer, T. (2008). *Pregnant Girls and Young Parents in South Africa*. Agenda, 78-90

Bhana, D., Morrell, R., Shefer, T and Ngabanza, S. (2010). *South Africa Teachers' Response to Teenage Pregnancy and Teenage Mothers in Schools*. Culture, Health & Sexuality, 18(8), 871-883

Bhana, D., Shefer, T. And Morrell, R. (2012) *Conclusion: Policy implications and issues for the future*. In Morrell, R., Bhana, D and Shefer, T. (Eds). (2012). *Books and Babies: Pregnancy and Young Parents in Schools*. Cape Town

Bopape, M.A. (2006). *Adolescents' Perceptions of Unplanned adolescent Pregnancies in the light of the Current High HIV/AIDS Rates in South Africa*. Masters Degree in Psychology. Johannesburg: University of Witwatersrand.

Braude, C. (1999). *Cultural Bloodstains: Towards Understanding the Legacy of Apartheid and the Perpetuation of Racial Stereotypes in the Contemporary South African*

Bryman et al (2014) ***Research Methodology Business and Management Context***: Cape Town: Oxford University Press Southern Africa.

Buga, G.A.B., Amoko, D.H.A., & Ncayiyana, D.J. (1996). Sexual behaviour contraceptive practice and reproductive health among school adolescents in rural Transkei. *South African Medical Journal*, 86, 523-527.

Chigona, A and Chetty, R. (2007). *Girls' Education in South Africa: Special Consideration to Teen Mothers as Learners*. Journal of Education for International Development, 3(1), 1-17

Chigona, A and Chetty, R. (2008). *Teen Mothers and Schooling: Lacunae and Challenges*. South African Journal of Education, 28, 261-281

Child Care Act No. 74 of 1983. Pretoria: Government Printer, 1983.

Children's Act No. 38 of 2005. Pretoria: Government Printer. Chalmers, B. (1990). *Pregnancy and Parenthood: Heaven or hell?* Pretoria: Juta & Company.

Children's Act No.38 of 2005, South Africa. <http://www.info.gov.za>

Clark, L. (2004). "Menstrual irregularity from hormonal contraception triggers significant reproductive health fears in adolescent girls", *Journal of Adolescent Health*, 34 (2), 123-124 DOI: [10.1016/j.jadohealth.2003.11.091](https://doi.org/10.1016/j.jadohealth.2003.11.091).

Clowes, L., D'Amant, T., Nkani, V. (2012) *School principles and their responses to the rights and needs of pregnant and parenting learners*. In Morrell, R., Bhana, D and Shefer, T. (Eds). (2012). *Books and Babies: Pregnancy and Young Parents in Schools*. Cape Town

Compton, B.R. (2005). *Social work processes*. Belmont, CA: Brooks/Cole.

Constitution of the Republic of South Africa Act No 108 of 1996. Pretoria: Government Printers.

Constitution of the Republic of South Africa Act No. 108 of 1996. Pretoria: Government Printer, 1996. Child Care Act No. 74 of 1983. Pretoria: Government Printer, 1983.

Cooper, D., Morroni, C., Orner, P., Moodley, J., Harries J., Cullingworth, L. And Hoffman M. (2004) *Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status*. Reproductive Health Matters. 12(24):70–85

De Vos, A.S.; Strydom, H.; Fouche, C.B. and Delport, C.S.L. 2002. ***Research at grass roots for the social sciences and human service professions. 2nd edition***. Pretoria: Van Schaik Publishers.

Department of Health (2012) *National Contraception and Fertility Planning Policy and Service Delivery Guidelines*. Pretoria. 1-104

Department of Health (2012) *Preventing Teenage Pregnancy*. Pretoria

Departments of Health and Basic Education (2012). *Integrated School Health Policy*. Pretoria.

Du Toit, L.D (2006). *The Darkest Africa*. Retrieved August 28, 2007, from <http://www.theothersideofkim.com/index.php/tos/index1/C7/>

- Durkheim, E. 1984 (1933). *The Division of Labour in Society*. New York: Free Press.
- Durrheim. (1999) ***Education Management and Research***. Arizona: University of Phoenix.
- Dutschke, M. (2009). Analysing the Paradigms: Developmental Social Welfare and Children's Right to Social Services in South Africa. *The Social Work Practitioner-Researcher*, 21 (2) 149-165.
- Ehlers, V.J. (2003). *Adolescent Mothers' Utilization of Contraceptive Services in South Africa*. International Council of Nurses, 50,229-241
- Flanagan, A., Lince, N., Durao de Menezes, I and Mdlopane, L. (25 February 2013). *Teen Pregnancy in South Africa: A Literature Review Examining Contributing Factors and Unique Interventions*. Ibis Reproductive Health.
- Gallagher C (2004). *Virginity testing in South Africa*. Sunday Times; 24 December, p. Media. South African Human Rights Commission.
- Gallagher, C. (2004, December 24). Virginity Testing in South Africa. *Sunday Times*.p.4.
- Golafshani, N. (2003) "Understanding Reliability and Validity in Qualitative Research". ***The Qualitative Report***, vol. 8(4): 597-607
- Grobman, J.H. (2004) *Diana Baumrind's Theory of Parenting Styles: Original Descriptions of the Styles*. London: University of Birmingham.Global Perspectives, Issues and Intervention London: Routledge, 2007.
- Guest, G; MacQueen, Namey (2012). *"Introduction to Thematic Analysis"*. *Applied Thematic Analysis*: Thousand Oaks, California.
- Henning, E; van Rensburg, W & Smit, B. (2004). ***Finding your way in qualitative research***. Pretoria: Van Schaik Publishers.
- Holgate H, Evans R, Yuen F, eds. Teenage Pregnancy and Parenthood: Holgate, H., Evans, R., & Yuen, F. (Eds). (2007) *Teenage Pregnancy and Parenthood: Global Perspectives, Issues and Intervention* London: Routledge.
- Holmes, T. & Scoones, I. (2000) ***Participatory environmental policy processes: Experiences from North and South***: Institute of Development Studies.
- Ife, J. (2001). *Human Rights and Social Work: Towards Rights-Based Practise*. Cambridge Oakleigh, VIC: David Philip.

Jewkes, R., Gumedde, T., Westaway, M., Dickson, K., Brown, H and Rees, H. (2005) *Why are women still aborting outside designated facilities in metropolitan South Africa?* BJOG: an International Journal of Obstetrics and Gynaecology. 112, 1236–1242

Jewkes, R., Morrell, R and Christofides, N. (2009). *Empowering Teenagers to Prevent Pregnancy: Lessons from South Africa*. Culture, Health & Sexuality.

Jewkes, R., Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A. and Duwury, N. (2008) *Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial*. British Medical Journal. 337:a506

Kohlberg, L., Charles L, & Alexandra H. (1983). *Moral stages: a current formulation and a response to critics*. Basel, NY: Karger.

Laszlo, E. and I. Masulli (eds.), *The evolution of cognitive maps: New paradigms for the twenty-first century*, New York: Gordon & Breach.

LeClerc-Madlala, S. (2001). Virginty Testing: Managing Sexuality in a Maturing HIV/AIDS Epidemic. *Medical Anthropology Quarterly*, 15 (4) 533-552. U.S.A: Pearson Education.

Lesser, J.G. & Pope, D.S. (2007). *Human Behavior and the Social Environment*. Boston, Messachusetts: Pearson Education.

Loffell J. Developmental Social Welfare and the Child Protection Challenge in South Africa. *British Association of Social Workers* 2008; 20:65-133.

Macleod, C. (2001). *Teenage Motherhood and the Regulation of Mothering in the Scientific Literature: The South African Example*. *Feminism & Psychology*, 11(4), 493-510 A Review of Teenage Pregnancy in South Africa, Partners in Sexual Health, 2013.

Mail & Guardian online. *Mixed reaction to Children's Act*. 2007. <http://www.mg.co.za/article/2007-07-03-mixed-reaction-to-childrens-act> (accessed in August 2009).

Mail&Guardian (2011) “Criminalizing sex is not the answer”. Accessed on 01 July 2014@ 15:00.

Mail&Guardian online (2007, July 3). *Mixed reaction to Children's Act*.<http://www.mg.co.za/article/2007-07-03-mixed-reaction-to-childrens-act>.

Marlow, C. (1998). *Research Methods for Generalists Social Work: 2nd Edition*. United States of America: Brooks/Cole Publishing Company. McCandles, R.B. (1967). *Children's Behavior and Development*. Florida: Emory University.

Merriam-Webster Collegiate Dictionary 10th edition (2009). Merriam-Webster, Incorporated, Springfield, Massachusetts, U.S.A. Morrell, R., Bhana, D and Shefer, T. (2012). *Pregnancy and Parenthood in South African Schools*.

Morrell, R and Devey, R. (2012) *Mothers, fathers and carers: Leaner involvement in care work*.

Ngabaza, S. (2011). *Positively Pregnant: Teenage Women's Experience of Negotiating Pregnancy with Their Families*. *Agenda*, 42-51

In Morrell, R., C.G. (2006). *Personality Theories*. Psychology Department: Shippensburg University.

Panday, S., Makiwane, M., Ranchod, C., & Letsoalo, T. (2009). *Teenage Pregnancy in South Africa – With A Specific Focus On School-Going Learners*. Child, Youth, Family and Social Development, Human Sciences Research Council. Pretoria: Department of Basic Education

Parker, Faranaaz, (16 January 2013). *Green Light for Sexual Offences Act development*, in Mail & Guardian, <http://mg.co.za/article/2013-01-16-green-light-for-healthy-sexual-development> (accessed 2 March 2013)

Pemba EN (1995). *Parental attitudes towards the use of contraceptives by adolescents*. M.Sc Report in the discipline of Child Health, University of the Witwatersrand, Johannesburg.

Pemba, E.N. (1995). *Parental Attitudes towards the Use of Contraceptives by Adolescents*. M.Sc Report in the discipline of Child Health. Johannesburg: University of Witwatersrand.

Pettifor, A., O'Brien, K., MacPhail, C., Miller, W. and Rees, H (2009) *Early Coital Debut and Associated HIV Risk Factors Among Young Women and Men in South Africa*.

International Perspectives on Sexual and Reproductive Health, 35(2), 82-90

Resnik, B. (2003) ***Responsible Conduct of Research***. Oxford: Oxford University Press.

Ross, E. (2008). The Intersection of Cultural Practices and Ethics in a Rights-Based Society: Implications for South African Social Workers. *International Social Work*, 51(3), 384-395.

Schmid J. Using Governmentality to develop an understanding of post-apartheid child welfare. *The Social Work Practitioner Researcher* 2008; 20:212-232.

Schmid, J. (2008). Using Governmentality to Develop an Understanding of Post Apartheid Child Welfare. *The Social Work Practitioner Researcher*, 20 (2), 212-232.

Seidman, S. (2004). *Contested Knowledge: Social Theory Today*. Victoria, Australia: Blackwell Publishing.

Shamoo, A.E., Resnik, B.R. (2003). ***Responsible Conduct of Research***. Oxford: Oxford University Press.

South African Law Commission. (2001). *South African Law Commission research paper*.

South African Law Commission. South African Law Commission research paper. Pretoria: South African Law Commission, 2001.

Statistics South Africa. (2008). *Statistical Release Community Survey 2007*, Pretoria: Statistics SA.

Termination of Pregnancy Act No. 92 of 1996. Cape Town: Government Printer, 1996.

TerreBlanche, M., Durrheim, K., & Painter, D. (Eds) (2006). *Research in Practice: Applied Methods for the Social Sciences*. Cape Town: University of Cape Town Press.

The Mercury, (6 March 2013), *School bodies have no right to exclude: Pupil pregnancy rules are illegal*. UNDP, (undated) *Republic of South Africa, Millennium Development Goals, Goal 2: Achieve Universal Primary Education*

Ulin, P. R., Robinson, E. T., & McNeill, E. T (2002). ***Qualitative methods: A field guide for applied research in sexual and reproductive health***. North Carolina, USA: Family Health International.

UNICEF. (1989) *Convention on the Rights of the Child*. New York: United Nations,

Van der Vyver, J.D. (1985). *Depriving Westminster of its Moral Constraints: A Survey Of Constitutional Development in South Africa*. Cambridge, Mass: Harvard University.

Webring (2007). *Erik Erikson's 8 Stages of Psychosocial Development*. Retrieved 08/03/08 from <http://www.geocities.com/SouthBeach/Shores/6052/newwebring.html/28/2008>