Social Science & Medicine 148 (2016) 71–78

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

"You have to make a judgment call". — Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa

Alexandra Müller*, Stefanie Röhrs, Yonina Hoffman-Wanderer, Kelley Moult

Gender, Health and Justice Research Unit, University of Cape Town, South Africa

ARTICLE INFO

Article history:
Received 19 May 2015
Received in revised form
1 October 2015
Accepted 26 November 2015
Available online 30 November 2015

Keywords:
South Africa
Adolescents
Sexual and reproductive health
Street-level bureaucracy
Nurses
Legislative frameworks

ABSTRACT

South Africa's legal framework on sexual and reproductive health (SRH) care for teenagers is complex. On the one hand, the law protects their right to make decisions regarding reproduction — e.g. giving girls of any age the right to terminate a pregnancy, and allowing adolescents to consent to receive contraception from age 12. On the other hand, the Sexual Offences Act sets the age of consent to sex at 16 years, and requires mandatory reporting of anyone younger. These contradictory obligations mean that nurses, doctors and counsellors are expected to provide care, and counsel teenagers about their choices, but also report and enforce the law. They must therefore make judgments about inherently moral issues: should teenagers be having sex, and what services should they receive? Based on in-depth interviews at 28 healthcare facilities conducted in 2012, and data from workshops on the 'conflicting laws' held in 2014, the paper uses the theoretical framework of street-level bureaucracy to understand barriers to nurses providing SRH care for teenagers in South Africa, and the implication that this has for adolescents' SRH. The paper argues that nurses' adaptation of the law is a response to significant structural constraints, moral discomfort, and poor understanding of the law — all taken against an ethical framework that emphasizes quality, responsive patient care. The result is uneven implementation that undermines SRH information, access to services, and ultimately increases risks for teens.

1. Introduction

How are health policies implemented, and what role does discretion play in policy implementation? Policy and public administration theorists offer two main angles for considering these questions: top-down and bottom-up approaches. Good policy in a top-down model is built on clearly articulated rules, predictable procedures, equal treatment and minimal discretion to ensure that implementers do not develop their own 'coping devices' to simplify, and often distort the aims of policymakers (Elmore, 1982). Other scholars (Lipsky, 1980; Maynard-Moody and Musheno, 2003) argue that this view is limited, because it fails to give due regard to the normative, personal, organizational and political factors that weigh on individuals' decision-making, and ignores the complexity of front-line workers' everyday practice. Bottom-up theories have been applied particularly to understanding the routines and adaptations that emerge in the delivery of social services, for example healthcare, arguing that discretion is an essential element used by front-line workers to make decisions that respond effectively to variable client needs (Lipsky, 1980). Front-line providers like teachers, police, social workers and healthcare personnel have been described as 'street-level bureaucrats' (SLBs) who have a major impact on policy implementation because they develop their own day-to-day processes to manage and simplify their workloads, especially in under-resourced settings (Hudson and Lowe, 2004; Maynard-Moody and Musheno, 2003). How they make their implementation decisions is profoundly shaped by cultural context, organizational structure and social pressures (Gelsthorpe and Padfield, 2003). In being forced to straddle the divide between policy, rules and client needs, these bureaucrats pragmatically improvise to reconcile the schism between 'ungrounded' policy and 'front line' reality. Maynard-Moody and Musheno (2003) argue, therefore, that the practices of SLBs effectively become public policy.

This paper uses the theoretical framework of street-level

* Corresponding author. GHJRU, Room 1.01.5, Falmouth Building, Anzio Rd, Observatory 7925, South Africa.
E-mail address: alexandra.muller@uct.ac.za (A. Müller).

http://dx.doi.org/10.1016/j.socscimed.2015.11.048
0277-9536/

bureaucracy (SLB) (Maynard-Moody and Musheno, 2003) to examine how South African nurses make decisions about, and implement, sexual and reproductive health (SRH) care policy for adolescents. Few studies have examined the implementation of health policies from this theoretical perspective (Walker and Gilson, 2004). This paper seeks to explore the implementation of adolescent SRH care policies in South Africa, and investigate the dynamics influencing the implementation of these contested policies at the front-line.

South Africa's regulatory framework around adolescent SRH is complex and, at times, contradictory. The Constitution (1996) protects the right to make decisions regarding reproduction and the right to access healthcare services for both adults and children. Several laws action these constitutional rights and make them accessible to children. The Choice on Termination of Pregnancy Act (CTPA; Act 92 of 1996) allows that girls of any age can request an abortion up to 12 weeks, and the National Health Act (NHA; Act 61 of 2003) mandates that all information concerning a patient is confidential. The Children's Act (CA; Act 38 of 2005) states that children from the age of 12 may not be refused condoms and contraceptives, and that such provision must be kept confidential. All of these laws, as well as the Sexual Offences Act (SOA; Act 32 of 2007), which says that children may only freely consent to sex at 16 years of age, regulate aspects of teenagers' access to SRH care, and specify obligations and responsibilities of SRH care workers.

This framework is complicated further by mandatory reporting requirements imposed by two of these Acts: the SOA mandates that *any person* with knowledge of a sexual offence against a child report this act to the police, while the CA requires *certain professionals* to report reasonable belief of sexual abuse to a range of reporting agencies, among them social workers. McQuoid-Mason (2011) argues that the reporting requirements under the SOA are inconsistent with the purpose of the CA, which prioritizes the need to protect adolescents' health by making contraceptive services and condoms available from age 12. While these tensions may be resolved by affording healthcare workers discretion as to whether to report the child to the police, the current legal framework does not provide such discretion, and also does not differentiate between consensual and non-consensual sex amongst children under the age of 16 years.

The implementation challenges caused by the complexity of the legal framework are exacerbated by the nature of South Africa's health system, which is based on primary healthcare and experiences a shortage of physicians (Department of Health, n.d.): with 113,000 nurses and only 16,000 physicians at last count – a nurse-physician ratio of 7:1 – nurses provide the vast majority of SRH services, often in conditions of structural constraint and with the pressure of high patient loads. Primary healthcare policy has expanded the role of nurses to include "the promotion of health and family planning by teaching to and counselling with individuals and groups of persons" (Regulations Relating to the Scope of Practice of Persons Who are Registered or Enrolled under the Nursing Act, 1991). Thus, nurses are perceived as an important link to the community and increasingly find themselves with more community-oriented duties.

South African adolescents have access to a range of SRH services, including contraceptives, termination of pregnancies (TOPs), treatment for STIs including HIV, as well as information and counselling around healthy sexuality and safer sex (Department of Health (2011)). The need for access to comprehensive SRH services is highlighted by the high national rate of youth pregnancy, with 35% of women pregnant before the age of 20 (Panday et al., 2009); and by the fact that HIV/AIDS is now recognized as the primary reproductive health concern for teenagers: HIV prevalence among young women aged 15–24 years is currently 11.4% (Shisana et al., 2014). However, research has shown that negative attitudes of healthcare providers and lack of youth-friendly SRH services and information are crucial barriers for adolescents in general, and sexual and gender minority adolescents in particular (Kowen and Davis, 2006; Wood and Jewkes, 2006).

This is in part because teenage sex is still highly stigmatized. Asking for contraceptives is often seen as a 'public admission of sexual activity', frowned upon by nurses (Wood and Jewkes, 2006). Nurses tell teenage girls that they are too young to be sexually active and must 'stop going around with men' (Mfono, 1998), and some teenagers report being turned away at clinics without receiving contraception (Ehlers, 2003). Wood and Jewkes (2006) highlight the problematic relationship between teenagers and nurses: teenagers saw nurses as 'rude, short-tempered and arrogant' and complained that nurses asked 'funny questions' about why they wore mini-skirts. Furthermore, teenagers complained that nurses would not allow them to choose their method of contraception (Wood and Jewkes, 2006). Conversely, nurses reported that they felt uncomfortable providing contraception for fear of encouraging teenage sex, and 'repercussions' from parents (Wood and Jewkes, 2006). These findings emphasize that while nurses see themselves as necessarily involved in SRH education, their involvement is often dictated by personal values and beliefs (Wood and Jewkes, 2006).

The examples cited highlight precisely the kind of discretionary implementation that SLB theory tries to understand. While we know that law and policy is written with a view to shaping and regulating implementation, and that at least some decision-making follows such regulation, we also recognize that there is often deviation within service delivery that tries to be responsive to clients. In South Africa this is illustrated by the conflict between laws and policies on the one hand, and what nurses may think is the appropriate course of action, given the highly morally charged terrain, on the other. We were therefore interested to see whether, in resolving day-to-day conflicts between agency preferences, client claims and the practical (and personal) burdens of providing services in clinics, nurses would act in ways that SLB theory can account for. Previous work suggests that actual practices by nurses in South Africa 'on the ground' are often determined more by their attitudes and knowledge than by laws and policies. The importance of nurses as front-line implementers, and their use of discretion in respect of healthcare services, including SRH care and TOP, has already been established (Ehlers, 2003; Harries et al., 2009; Walker and Gilson, 2004; Wood and Jewkes, 2006). This article therefore extends the existing literature on nurses and SRH service provision by exploring the utility of using the framework of SLB to understand nurses' decision-making in the provision of adolescent SRH services (specifically) in light of their structural constraints, legal knowledge (of both law and policy) and personal moral values.

2. Methodology

2.1. Study design and sampling

This study utilized in-depth individual interviews and focus group discussions with SRH care nurses and associated stakeholders. Individual interviews, aimed at eliciting subjective experiences and decision-making processes, were conducted with 28 nurses providing SRH services in rural (n = 15) and urban (n = 13) health facilities in the Western Cape province of South Africa, between March and December 2012. The urban areas in this province have the best-developed health infrastructure in South Africa (Coovadia et al., 2009), but many rural health facilities struggle with the infrastructural and resource challenges common in the rest of the country. SRH services are divided between clinics (primary care