Mandatory Reporting of Sexual Offences in the Tertiary Education Healthcare Environment

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Abstract

Sexual offences at higher education institutions have reached alarming levels. In a bid to address this concern the legislature, through *Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act* 13 of 2021, has extended the definition of "vulnerable person" to females under 25 who are enrolled in post-school education. The *Criminal Law (Sexual Offences and Related Matters) Amendment Act* 32 of 2007 further provides for mandatory reporting obligations concerning victims who resort within the "vulnerable person" categories. As a result, any person who is aware or has a reasonable suspicion that a vulnerable person has been the victim of a sexual offence is required to report such knowledge or suspicion to the South African Police Service. Considering this legislative development, healthcare providers and institutions, specifically those engaged with tertiary students, are effectively required to breach the well-established and constitutionally based healthcare principles of autonomy, confidentiality and privacy, *in lieu* of facing potential criminal liability. This contribution analyses the importance of the said healthcare principles and contends that the amendment to the definition of a vulnerable person, to the extent that it includes a very narrow category of adult persons free from diminished capacity, is neither desirable nor justifiable in a democratic society. It further cautions of the potential indirect limitations to the rights to access to health care services, dignity and physical and psychological integrity it may cause.

Keywords

Mandatory reporting; sexual offences; higher education; health care user rights; vulnerable persons.

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1 Introduction

Concerns regarding the prevalence of sexual offences perpetrated against students in the South African higher education environment have been widespread during the last two decades.[1] Although this is indeed of universal concern,[2] South African statistics have shown a steady increase in reported cases of sexual offences at, or against students of, higher education institutions.[3] Between 2011 and 2014, 247 cases of rape and sexual assault were recorded across fifteen South African universities.[4] In 2017 a parliamentary report by the then Minister of Higher Education and Training, the Honourable Naledi Pandor, indicated an annual report of 47 reported incidents of rape and/or sexual assault occurring on campuses throughout South Africa.[5] By 2022 the National Higher Education Statistics showed a massive increase in the number of cases reported from institutions of higher learning, accounting for approximately ten per cent of all sexual offences recorded in South Africa.[6]

In order to address the scourge of the commission of sexual offences at, or against students of, higher education institutions, the Ministry of Higher Education and Training in 2020 initiated several initiatives aimed at a multifaceted approach to curbing the commission of sexual offences in the sector.[7] This included a call on all institutions to adopt Gender Based Violence (GBV) policies,[8] to ensure available supportive services for victims of GBV and sexual offences,[9] and to implement educational preventative programmes to address the root causes of GBV and sexual offences, for instance.[10] In addition thereto, the Minister of Justice and Correctional Services, the Honourable Ronald Lamola, in August 2020 introduced a Bill

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1 Orth, Van Wyk and Andipatin 2020 *SAJHE* 192.

2 Fedina, Holmes and Backes 2018 *TVA* 77; Steele *et al* 2024 *Journal of Interpersonal Violence* 1927; Heywood *et al* 2022 https://universitiesaustralia.edu.au/wp-content/uploads/2022/03/2021-NSSS-National-Report.pdf 2; Krahé, Schuster and Tomaszewska 2021 *Archives of Sexual Behavior* 2110; Bullens 2023 https://www.france24.com/en/france/20231125-gender-based-violence-in-french-universities-i-decided-something-had-to-change.

3 Boonzaier, Carr and Matutu 2019 *African Safety Promotion* 17.

4 National Assembly NW1173E Question 1020 of 22 August 2014.

5 Commission for Gender Equality *Research Report on Sexual Harassment* 6.

6 Bhengu 2022 https://www.news24.com/news24/southafrica/news/10-of-rape-cases-reported-nationally-stem-from-higher-education-institutions-nzimande-20220823.

7 DHET *Policy Framework to Address GBV* 7.

8 DHET *Policy Framework to Address GBV* 6.

9 DHET *Policy Framework to Address GBV* 14.

10 DHET *Policy Framework to Address GBV* 27.

to the National Assembly[11] aimed at amending the *Criminal Law (Sexual Offences and Related Matters) Amendment Act* 32 of 2007[12] (*SORMA*) by broadening the definition of vulnerable persons by extending it to female students at higher education institutions, who are younger than 25.[13] After an extensive public participation process the Bill was signed into law[14] and came into effect on 31 July 2022.[15]

The focussed nature of this legislation has a particular impact on health care and mental health care services rendered to the female student population across South Africa. It also affects the health services offered at tertiary institutions, campuses and surrounding student hubs.[16]

This contribution commences by providing an analysis of the amendments mentioned above before delving into health care user rights, in order to assess the impact the said amendments might have on those seeking health care-related services or intervention as a result of being subjected to sexual offences. It further seeks to determine whether the limitation of health care user rights, through mandatory reporting, can be considered justifiable in order to address the scourge of the commission of sexual offences in the higher education environment.

2 *SORMA* amendments affecting the higher education environment

Statutory provisions requiring the mandatory reporting of sexual offences are not new to the South African law.[17] The *Children's Act*,[18] the *Older Persons Act*[19] and *SORMA*,[20] for example, contain mandatory reporting provisions, each within a specific and focussed framework. Such mandatory reporting provisions aim to protect vulnerable members of society from abuse, neglect and other forms of physical and sexual violence.[21]

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11 *Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Bill* [B16-2020].

12 *Criminal Law (Sexual Offences and Related Matters) Amendment Act* 32 of 2007 (*SORMA*).

13 Section 5(c) of the *Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Bill* [B16-2020].

14 25 January 2022.

15 Proc R79 in GG 47105 of 29 July 2022.

16 Campus and institution-based health and mental health care services are offered across tertiary and post-schooling education institutions, with more than 420 sites included in the Higher-Health network. Higher Health 2024 https://higherhealth.ac.za/; SAACHS 2024 https://saachs.org.za/; SAACDHE 2024 https://www.saacdhe.co.za/.

17 Strode and Badul 2023 *SAJBL* 4.

18 Section 110 of the *Children's Act* 38 of 2005.

19 Section 25 of the *Older Persons Act* 13 of 2006.

20 Section 54(1) and (2) of *SORMA* (prior to 2021 amendment).

21 Holness 2021 *SACQ* 5.

The *Criminal Law (Sexual Offences and Related Matters) Amendment Act Amendment Act* 13 of 2021 (*Amendment Act* 13 of 2021), however, deviated from the focussed and separate approach to mandatory reporting provisions, which entails a singular approach to mandatory reporting in relation to all "vulnerable persons". *SORMA*, after the amendment, defines a "person who is vulnerable" as follows:

> (a) child or a person with a mental disability;
>
> (b) female under the age of 25 years who—
>
> (i) receives tuition at a higher education college, higher education institution or university college as defined in section 1 of the Higher Education Act, 1997 (Act 101 of 1997);
>
> (ii) receives vocational training at any training institute, other than the institutions referred to in subparagraph (i), or as part of their employment; or
>
> (iii) lives in a building, structure or facility used primarily as a residence for any of the persons referred to in subparagraphs (i) and (ii);
>
> (c) person who is being cared for or sheltered in a facility that provides services to victims of crime;
>
> (d) person with a physical, intellectual or sensory disability and who—
>
> (i) receives community-based care and support services, other than from a family member for;
>
> (ii) lives in a building, structure or facility used primarily as a residence for; or
>
> (iii) is cared for in a facility providing 24-hour care to, persons with physical, intellectual or sensory disabilities; or
>
> (e) person who is 60 years of age or older and who—
>
> (i) receives community-based care and support services, other than from a family member for;
>
> (ii) lives in a building, structure or facility used primarily as a residence for; or
>
> (iii) is cared for in a facility providing 24-hour care to,
>
> such persons.[22]

The vastness of the category of "vulnerable person[s]" is glaringly obvious from the above definition, with an array of categories of persons included therein. In this discussion the focus in subsection (*b*) on the tertiary education environment is of particular importance.[23] This section outlines the category of individuals enrolled in higher education who are deemed to be at specific risk of sexual offences as entailing female students enrolled

22 Section 40 of *SORMA* (as amended).
23 Section 40 of *SORMA* (as amended).

in higher education institutions and programmes.[24] Additionally, it includes female students who are taking part in vocational training programmes and females who reside in facilities or residences associated with institutions of higher learning or vocational programmes.[25] The age requirement in relation to all the criteria mentioned above is that the female student be below the age of 25.[26] A contextual interpretation of the section suggests that Parliament deem an adult female student in need of additional protection beyond the protections already extended to any adult person.

The parliamentary consultative record[27] shows that the criteria are based on the statistical prevalence of the exposure of members of the cohort identified to sexual offences and GBV.[28] In considering the criteria applied in subsection (*b*), it is appropriate to consider the composition of the category of persons included therein, i.e. female students or trainees younger than 25 years of age. According to available statistics, as of 2022,[29] female students account for 62.1 per cent of all students and trainees, which number approximately 1,277,505 individuals of both genders.[30] Of these enrolments, an estimated 56 per cent of all female students are younger than 25 years of age, with approximately 12.4 per cent of Community Education and Training College (CET) female enrolments being younger than 18 years of age.[31] Whilst the latter may very well resort under the mandatory reporting provisions pertaining to children,[32] the remaining female cohort between ages 18 to 24 makes up the vast percentage of the active post-schooling students. However, when compared to the national population statistics, this cohort accounts for less than 20 per cent of all females in the same age category and less than 2 per cent of the national population.[33]

Considering the above, the contention by the Department of Higher Education and Training (DHET)[34] that 10 per cent of all cases of reported

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24 For purposes of clarity, section 40 of *SORMA* refers to the relevant definition assigned to such individuals, stemming from s 1 of the *Higher Education Act* 101 of 1997.

25 Section 40 of *SORMA*.

26 Section 40 of *SORMA*.

27 DHET *Policy Framework to Address GBV* 18; Commission for Gender Equality *Research Report on Sexual Harassment* 3.

28 Ajayi, Mudefi and Owolabi 2021 *BMC Women's Health* 2; Orth, Van Wyk and Andipatin 2020 *SAJHE* 191.

29 DHET *Statistics on PSET*.

30 DHET *Statistics on PSET* 10.

31 DHET *Statistics on PSET* 63.

32 Subsection (a) of the definition of "person who is vulnerable" as contained in section 40 of *SORMA*.

33 Statista 2022 https://www.statista.com/statistics/1330839/population-of-south-africa-by-age-group-and-gender/.

34 Bhengu 2022 https://www.news24.com/news24/southafrica/news/10-of-rape-cases-reported-nationally-stem-from-higher-education-institutions-nzimande-20220823.

sexual offences and gender-based violence stem from the higher education environment or affect victims who are engaged in higher education is either remarkably alarming or alternatively vastly exaggerated. If the DHET statistics were to be accurate, this would imply that more than five thousand sexual offences are committed against the higher education population annually.

3 Health care statutory rights, obligations and ethics

There are several fundamental and universal premises for rendering health care services. These include, amongst others, the respect for health care users' autonomy, the principle of informed consent, and the assurance of confidentiality and privacy. These principles promote the realisation of a healthcare user's self-determination, and create an open and honest health care practitioner-user relationship, which in turn advances the best interest of the user and the user's right to access to health care services.[35] These doctrines are no longer mere ethical principles, but are statutory obligations aimed at respecting, fulfilling and realising the constitutionally protected rights of health care users.[36]

3.1 Autonomy, self-determination and informed consent

The principles of autonomy, self-determination and informed consent are interrelated and share the same fundamental rights basis.[37] Based on the rights to physical and psychological integrity,[38] as well as the right to human dignity,[39] they aim to place the user[40] at the centre of the health care system and in control of decisions that affect his or her health, as opposed to the paternalistic "the doctor knows best"[41] approach of the past.[42] These principles are encapsulated in several statutory instruments, regulations and health care statutory body ethical guidelines, emphasising the importance thereof.

35 Rule 5.1 of HPCSA *Booklet* 1.

36 Oosthuizen and Verschoor 2008 *SAFP* 36; Burke *et al* 2007 *South African Journal of Psychology* 114.

37 McQuoid-Mason 2008 *SAJBL* 7.

38 Pearmain and Carstens *Foundational Principles of South African Medical Law* 249.

39 Section 12(2) of the *Constitution of the Republic of South Africa*, 1996 (the *Constitution*).

40 *Beukes v Smith* 2020 4 SA 51 (SCA) para 25; *Stoffberg v Elliot* 1923 CPD 148 para 150.

41 Section 10 of the *Constitution*.

42 Swart and Carstens 2024 *SALJ* 52; Kling 2012 *Current Allergy & Clinical Immunology* 34; Beauchamp and Childress *Principles of Biomedical Ethics* 231.

The *Patients' Rights Charter*,[43] passed in terms of section 234 of the *Constitution*,[44] places the rights of autonomy, self-determination and informed consent at the heart of health care services.[45] The *National Health Act* 61 of 2003 (*NHA*) provides for encompassing legal obligations on the part of health care practitioners to fulfil these rights.[46] Section 6 of the *NHA* provides for users' right to all information applicable to their health or the relevant health care services,[47] while section 7 explicitly prohibits the rendering of health care services to a user unless the user has granted informed consent.[48] Informed consent is not merely the agreement by the patient to be subjected to unknown or nondescript services, but requires "full knowledge" and understanding of all aspects of the health care services,[49] and a subsequent voluntary and uncoerced consent thereto.[50] In respecting the right of users not to be subjected to any services, processes and treatments without their informed consent, respect for the bodily and psychological autonomy of health care users is achieved.[51] This ensures the user's control over his or her body,[52] respect for the user's self-determination,[53] and ultimately the dignity of a patient.[54]

From a regulatory perspective, statutory healthcare bodies such as the Health Professions Council of South Africa (HPCSA),[55] the South African Nursing Council (SANC)[56] and the South African Pharmacy Council

43 DoH 1999 https://www.justice.gov.za/VC/docs/policy/Patient%20Rights%20Charter.pdf (*National Patients' Rights Charter*).

44 Section 234 of the *Constitution*.

45 Section 234 of the *Constitution*: "Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements."

46 Chapter 2 of the *National Health Act* 61 of 2003 (*NHA*).

47 Section 6 of the *NHA*.

48 Section 7(1) of the *NHA*: "Subject to section 8, a health service may not be provided to a user without the user's informed consent, unless …".

49 Section 7(1) of the *NHA* read with the provisions of s 6(1) and (2) of the *NHA*. See also Swart and Carstens 2024 *SALJ* 56; Njotini 2018 *PELJ* 7.

50 Wethmar 2017 *Obstetrics and Gynaecology Forum* 11. Rule 6 of HPCSA *Booklet 4*.

51 Section 12(2) of the *Constitution*.

52 Section 12(2)(b) of the *Constitution*.

53 Chima *Investigation of Informed Consent* 108, Swart and Carstens 2024 *SALJ* 58.

54 Section 10 of the *Constitution*.

55 The HPCSA is the governing statutory body for most health care professions in South Africa and was established in terms of the *Health Professions Act* 56 of 1974. It regulates "control over the education, training and registration for and practising of health professions registered under this Act".

56 SANC constitutes the statutory body that governs the nursing profession in South Africa, in terms of the *Nursing Act* 33 of 2005. The SANC was established in terms of the *Nursing Act* 50 of 1978, which was repealed with the promulgation of the *Nursing Act* 33 of 2005.

(SAPC)[57] prescribe and enforce these principles as professional and ethical imperatives. The HPCSA defines autonomy as the ethical obligation of health care practitioners to respect the "right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences".[58] The SANC describes it as respect for "healthcare users to make their own decisions and choices in matters affecting their health".[59] The principle of autonomy, which results in respect for self-determination and respect for the right to informed decision-making, is not merely superficial in its application but forms a cornerstone of ethical healthcare practice in all facets of service provision, the practitioner-user relationship and the protection of fundamental rights.[60] It is a continuous process, constantly revisited[61] and reasserted so as to ensure that maximum control is lodged in the hands of healthcare users.

From a healthcare perspective, autonomy and self-determination are holistic concepts extending beyond mere healthcare.[62] The full control afforded to health care users extends to all aspects of the user's life, regardless of the direct relevance thereof to the health care status or reason for accessing health care services.[63]

When the needs of a health care user extend beyond health care services or beyond the scope of practice of a health care provider, logistical or procedural advice, or a referral to relevant services might be required. In doing so, health education or psychoeducation, to that end, may fall within the obligation, protocol or ability of such a practitioner.[64] This is particularly relevant in criminal matters, where victims receive both health care services and procedural education as part of the professional interaction with health

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57 Pharmacists and related professionals are regulated by the SAPC, the statutory regulating authority of the pharmacy profession, established in terms of the *Pharmacy Act* 53 of 1973.

58 Rule 2.3.5 of HPCSA *Booklet* 1.

59 SANC *Code of Ethics for Nursing Practitioners* 5.

60 Dhai 2008 *SAJBL* 29; Kling 2016 *Current Allergy & Clinical Immunology* 177; *Castell v De Greef* 1994 4 SA 408 (C) 409: "The formulation laid down in Australia in *Rogers v Whitaker* (*supra* at 52), being in accord with the fundamental right of individual autonomy and self-determination to which South African law is moving, as well as with developments in common law countries and judicial views in continental Europe, ought to be adopted here, suitably adapted to the needs of South African jurisprudence."

61 Chima 2013 *BMC Medical Ethics* 2.

62 Chapter 2 of the *National Policy Framework on Management of Sexual Offences* as published in GN 649 in GG 36804 of 6 September 2013; Milmalter, Gous and Heyns 2014 *AJPHERD* 377; Cathy 2017 *Mental Health Matters* 42.

63 Rule 3.1 of HPCSA *Booklet 4*; SANC *Code of Ethics for Nursing Practitioners* 7. Also see Oosthuizen and Verschoor 2008 *SAFP* 38 regarding the extent of constitutional and statutory protection afforded. Also see Moyakhe 2011 *SAJBL* 11; Rule 5.1 of HPCSA *Booklet* 1.

64 Chapter 2 of the *National Policy Framework on Management of Sexual Offences* as published in GN 649 in GG 36804 of 6 September 2013.

care professionals.[65] While this might be a common occurrence and considered the legal obligation of health care practitioners,[66] the applicable legal and ethical guidelines clearly dictate respect for health care users' autonomy and self-determination. This requires decision-making, by the user, based on the procedural information provided by health care services, and must be based on the user's wishes, preferences and beliefs. Inversely, it forbids coercion or any form of pressure in the decision-making process.[67] Therefore, a healthcare user who seeks healthcare services in response to, for example, assault, domestic violence, or sexual offences, may only be educated as to the available options or services, i.e. healthcare services, psychosocial support services, the reporting routes with relevant law enforcement services, rape crisis centres or the accessing of legal assistance.[68] The focus and limits of non-healthcare procedural or logistical information are strictly the education and empowerment of the user – and not the active participation in the resulting process.[69] At most, mere facilitation of processes, based on the will and informed consent of the user, may be undertaken.[70]

Mandatory reporting, in any form, however, negates the principles of autonomy, self-determination and informed consent. Ignoring the health care user's choice and will, automatically exclude the control the individual has pertaining to their autonomy, self-determination and, ultimately, their rights to physical integrity, psychological integrity and dignity.[71] Conversely, the practitioner also becomes an active participant in the process, distorting professional boundaries and potentially alienating the health care user.[72]

Regardless of whether a practitioner affords full knowledge and explanation to a user before enacting the mandatory reporting, as is required in ethics, any repudiation of reporting on the user's part could negatively influence the professional relationship.[73] A practitioner-user dynamic of this nature has the potential to cause distrust in health care services, even beyond the specific practitioner-user interaction.

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65 WHO *Guidelines for Medico-legal Care* 20.

66 DoH *National Sexual Assault Policy* 4.

67 Swart and Carstens 2024 *SALJ* 54.

68 Rule 27A of HPCSA *Booklet 2;* Parker 2020 *Acta Juridica* 300.

69 McQuoid-Mason 2009 *SAMJ* 703.

70 Section 6 of the SAPS *National Instruction 3 of 2008* (SAPS 2008 https://www.saps.gov.za/resource_centre/sexual_offences/downloads/2026/NI3of2008SexualOffencesV3.pdf).

71 Section 12 of the *Constitution*. Also see *Barkhuizen v Napier* 2007 5 SA 323 (CC) para 57: "Self-autonomy, or the ability to regulate one's own affairs, even to one's own detriment, is the very essence of freedom and a vital part of dignity."

72 Rule 21 of Annexure 12 of HPCSA *Booklet 2.* See also the principle of "continuity of care" in the *National Patients' Rights Charter.*

73 Masege *Managed Healthcare* 36.

3.1.1 Limitation of autonomy and related rights

The health care user's rights to autonomy and self-determination, like bodily and psychological integrity, are not without possible limitations. Whilst the limitation clause contained in the *Constitution* governs the limitation of fundamental rights,[74] legislation and ethical provisions explicitly deal with exceptions to autonomy and informed consent.[75] The language utilised in so doing, is relatively consistent across the legal instruments, in that both the autonomy and informed consent requirements may be limited in instances where, (i) the user lacks the necessary legal capacity to make health care decisions by virtue of age, immaturity,[76] prolonged or temporary mental incapacity,[77] (ii) in cases where legislation or a court order defers the decision-making capacity to another person,[78] or (iii) any law or court directs health care services to be rendered, without the informed consent of the health care user concerned.[79] It should be noted that even in extraordinary circumstances, as outlined above, the statutory and ethical provisions ultimately require a full reinstatement of autonomy, shared decision-making and informed consent, at the soonest, once the circumstances have been remedied, even in respect of minors with limited decision-making capacity.[80] It is, therefore, evident from the relevant legislative and regulatory provisions that the limitation of these principles should be considered on a case-to-case basis, treated as exceptions rather than general practice.

In addition to the express limitations provided for in legislation, statutory provisions also permit indirect limitations of autonomy, shared decision-making and informed consent through the discretionary application of exclusionary considerations. The most pertinent, in the current context, is section 6 of the *NHA*, which permits withholding relevant information from a health care user, where providers are of the opinion that "substantial evidence" exists, that disclosure of information would be "contrary to the best interests of the user".[81] Although not a direct limitation, the resulting inability of a user to obtain "full information" in order to make decisions regarding their care, or provide unimpeded informed consent, diminishes the user's rights to autonomy, shared decision-making, and ultimately informed consent. While this inclusion reflects internationally recognised

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74 Section 36 of the *Constitution*; Pearmain and Carstens *Foundational Principles of South African Medical Law* 881.

75 *NHA*; *Mental Health Care Act* 17 of 2002 (*MHCA*).

76 Section 129(4)-(10) of the *Children's Act* 38 of 2005.

77 Section 7(1)(b)-(e) of the *NHA*; s 9(1)(c) of the *MHCA*.

78 Section 7(1)(b) of the *NHA*.

79 Section 7(1)(c) of the *NHA*; s 9(1)(b) of the *MHCA*; s 129(9) of the *Children's Act* 38 of 2005.

80 Section 8(3) of the *NHA*; s 8(3) of the *MHCA*; Rule 14 of HPCSA *Booklet* 7.

81 Section 6(1)(a) of the *NHA*.

methodologies,[82] generally referred to as "therapeutic privilege",[83] its application requires the same amount of caution than that of the statutory limitations, as the resulting effects could correspond.

3.2 Confidentiality and privacy

Confidentiality and privacy are independent but mutually supportive concepts that aim to ensure a trusting relationship between the practitioner and the health care user.[84] Based on the expectation that all health care-related information shared between the practitioner and user will remain in confidence, it creates an environment for openness and honesty during the consultative, evaluative and treatment processes.[85] Confidentiality is generally described as a subcomponent of privacy, more focused on the realm of professional relationships, with privacy entailing an encompassing fundamental right to the protection of all sensitive and personal aspects of a person's existence.[86]

In the health care environment, the overlap between privacy and confidentiality is common, especially considering the sensitive nature of communication between users and practitioners, the physical and emotional disclosure during evaluation and treatment, and the resulting capturing of personal information.[87] The *Patients' Rights Charter* draws a valuable link between the broad fundamental right to privacy, as protected in the Bill of Rights,[88] and the statutory right to confidentiality.[89] Although the *Constitution* does not make direct mention of privacy in the health care

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82 Rule 2.1.3 of AMA *Principles of Medical Ethics*; *Reibl v Hughes* (1980) 2 SCR 880: "[A] particular patient may, because of emotional factors, be unable to cope with facts relevant to recommended surgery or treatment and the doctor may, in such a case, be justified in withholding or generalizing information as to which he would otherwise be required to be more specific". *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* 1985 AC 871: "To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise of professional skill and judgment as any other part of the doctor's comprehensive duty of care to the individual patient, and expert medical evidence on this matter should be treated in just the same way."

83 Steyn *Law of Malpractice Liability* 98; Pearmain and Carstens *Foundational Principles of South African Medical Law* 910.

84 Knapp Van Bogaert and Ogunbanjo 2009 *SAFP* 194; Benatar 2003 *CME* 11.

85 Van Rugge 2017 *Medical Chronicle* 18; Osman 2006 *SA Pharmacist's Assistant* 1; Steyn 2006 *JJS* 135.

86 Chima "Patient Confidentiality Rules in South Africa" 164; Nell *Aspects of Confidentiality in Medical Law* 19.

87 Pearmain and Carstens *Foundational Principles of South African Medical Law* 32.

88 Section 14 of the *Constitution*.

89 *National Patients' Rights Charter*: "Confidentiality and privacy - Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court."

setting, the reference to privacy of communication,[90] read together with the right to physical and psychological integrity,[91] control over one's body,[92] and the right to human dignity,[93] supports the holistic protection of one's most sensitive and intimate being. When interpreted alongside the "reasonable expectation of privacy" requirement,[94] the differentiation between privacy, as a right, and confidentiality as the obligations of practitioners, are easily bridged. Jointly, privacy and confidentiality ensure that all aspects of a health care user's service experience are protected.

The *NHA*, through section 14, further solidifies this approach by holding that "all information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment, is confidential".[95] Similarly, the *Mental Health Care Act* 17 of 2002 (*MHCA*), provides that "a person or health establishment may not disclose any information which a mental health care user is entitled to keep confidential in terms of any other law".[96]

Additionally, the *Protection of Personal Information Act* 4 of 2013 (*POPIA*) also affords protection to the health care user's identifying information, health care records and all forms of data collected from patients, with a broad and encompassing definition of "personal information" contained in section 1 of the Act.[97]

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90 Section 14(d) of the *Constitution*.

91 Section 12(2) of the *Constitution*.

92 Section 12(2)(*a*) of the *Constitution*.

93 Section 10 of the *Constitution*.

94 *Bernstein v Bester* 1996 2 SA 751 (CC) para 74.

95 Section 14(1) of the *NHA*.

96 Section 13(1) of the *MHCA*.

97 Section 1, definition of "personal information" in the *Protection of Personal Information Act* 4 of 2013 (*POPIA*): "'personal information' means information relating to an identifiable, living, natural person, and where it is applicable, an identifiable, existing juristic person, including, but not limited to—
(a) information relating to the race, gender, sex, pregnancy, marital status, national, ethnic or social origin, colour, sexual orientation, age, physical or mental health, well-being, disability, religion, conscience, belief, culture, language and birth of the person;
(b) information relating to the education or the medical, financial, criminal or employment history of the person;
(c) any identifying number, symbol, e-mail address, physical address, telephone number, location information, online identifier or other particular assignment to the person;
(d) the biometric information of the person;
(e) the personal opinions, views or preferences of the person;
(f) correspondence sent by the person that is implicitly or explicitly of a private or confidential nature or further correspondence that would reveal the contents of the original correspondence;
(g) the views or opinions of another individual about the person; and

In accordance with professional ethics, confidentiality and privacy are viewed as non-negotiables, with only limited, and then even highly restricted, exceptions.[98] The ethical standards impose a duty on all health care practitioners to implement the statutory and ethical standards to the extent that providers may not even confirm nor deny the rendering of services, professional interaction with a particular health care user, or any health care related information.[99] The protection of information further extends to any non-health care related information a health care user might want to keep private, superseding the plain health care confidentiality scope of protection provided.[100] From a practical perspective, this entails that all information of a personal nature, health-related or otherwise, alongside all physical, emotional, occupational, familial or relationship-related information be included in the ambit of protection.

The importance and *quasi*-sacredness of health care confidentiality are two-fold. Whilst respect for the private affairs of an individual is firstly easily discernible, the further need to protect health care users from exploitation or coercion,[101] based on health concerns or a predicament they find themselves in, is vital. Where insufficient protection exposes the health care user to external pressure or manipulation, an inherent threat to autonomy and self-determination exists.[102] Confidentiality and privacy should therefore enhance autonomy and self-determination, not hinder it.[103]

Self-disclosure by a user following a traumatic incident such as a sexual offence perpetrated against him or her carries the potential for secondary victimisation or subsequent trauma.[104] Confidentiality is just one of the essential factors that enables a victim the control and autonomy to brace

(h) the name of the person if it appears with other personal information relating to the person or if the disclosure of the name itself would reveal information about the person."

98 SANC *Code of Ethics for Nursing Practitioners* 5; Rules 2.3.8, 4.6.2 and 5.2.1 of HPCSA *Booklet* 1; HPCSA *Booklet* 5; Rule 1.3 of the SAPC *Good Pharmacy Practice.*

99 Rule 5.1 of HPCSA *Booklet* 5.

100 *National Patients' Rights* Charter; section 1 of *POPIA*.

101 Williams *et al* 2008 *Soc Sci Med* 443.

102 Chima 2013 *BMC Medical Ethics* 14.

103 Van der Reyden 2008 *SAJOT* 31. This is further supported by the informed consent requirements in relation to the divulging of information, placing autonomy at the heart of privacy and confidentiality. Section 14(2)(a) of the *NHA*. Also see rule 11, read with rule 13, of HPCSA *Booklet* 2.

104 Egenasi *et al* 2024 *Health SA Gesondheid* 1; Sepeng, Makhado and Sehlaro 2019 *AJNM* 17; Adefuye, Egenasi and Benedict 2024 *SAFP* 1. Lorge and Gerrand 2021 *Southern African Journal of Social Work and Social Development* 2: "'Secondary victimisation' refers to victimisation that occurs, not as a direct result of the criminal act, but through the response of officials, service providers, the community, and other individuals." Also see *S v Zulu* 2023 1 SACR 343 (MM) 355, *AK v Minister of Police* 2023 1 SACR 113 (CC) para 149.

against outside interference and victimisation in an attempt to maintain or regain self-determination. It underscores the pivotal role that informed consent and informed choice play in the disclosure of private or confidential information, placing the health care user in control of potentially far-reaching decisions.[105]

3.2.1 Limitation of confidentiality

The rights to privacy and confidentiality do not afford absolute protection.[106] It would be neither desirable nor practical to assume that a health care user's condition will never necessitate the disclosure of information pertinent to his or her health and well-being.[107]

For this reason the *NHA* provides exceptions to confidentiality in the health care environment by providing:

> [No] person may disclose any information contemplated in subsection (1) unless—
>
> (a) the user consents to that disclosure in writing;
>
> (b) a court order or any law requires that disclosure; or
>
> (c) non-disclosure of the information represents a serious threat to public health.[108]

Although phrased broadly and somewhat obliquely, it does provide the basis for other regulatory instruments and legislation to regulate the health care user's right to confidentiality and privacy. The consent requirement, as contained in section 14(2)(*a*), should not be interpreted in its most basic form but should reflect the "informed consent" approach as required by section 7(3) of the *NHA*.[109] Consent for the disclosure of private and confidential information thus requires a well-informed understanding[110] on the part of the user regarding the rationale that informs the predilection for disclosure,[111] alongside the possible adverse consequences of the disclosure.[112] Additionally, it allows for shared decision-making regarding the scope, limits and manner of the disclosure in accordance with the preferences of the user.[113]

The remaining exceptions contained in section 14(2)(*b*)-(*c*), however, reflect forms of the mandatory divulging of information, where so ordered by a

105 Steyn and Steyn 2008 *Acta Criminologica* 45-46; Knapp Van Bogaert and Ogunbanjo 2009 *SAFP* 195.
106 Van der Reyden 2008 *SAJOT* 30.
107 Moyakhe 2011 *SAJBL* 11.
108 Section 14(2) of the *NHA*.
109 Section 7(3) of the *NHA*.
110 Rules 8.2.1 and 8.2.2.3 of HPCSA *Booklet* 5.
111 Rule 8.2. of HPCSA *Booklet 5.*
112 Rules 8.2.2.2 8.2.2.5 of HPCSA *Booklet* 5.
113 Rule 8.2.2.3 of HPCSA *Booklet* 5.

court, where required by prescripts in law[114] such as law of general application,[115] or in instances where non-disclosure could have public health ramifications, especially concerning communicable or reportable diseases.[116] The *MHCA* follows a similar but mental health care-focussed approach, by also permitting the disclosure of confidential information if non-disclosure might be prejudicial to the health or mental health of the health care user, others or the public.[117]

3.3 Beneficence and non-malfeasance

The ethical concepts of beneficence and non-malfeasance are well recognised as entailing the endeavour to "promote good" and to "refrain from doing harm" respectively.[118] Originating during the paternalistic periods in health care development, its application was centred on the well-educated doctor making the necessary decisions for the less-educated patient.[119] The contemporary interpretation of beneficence and non-malfeasance, as components of the "best interest of the user"-principle, subscribe to respect for user autonomy, self-determination and informed consent.[120] This approach, based on respect for fundamental rights,[121] provides universal guiding principles for actions and decision-making by health care practitioners.[122]

It is noteworthy that these principles are neither justification for the unconsented subjection of a patient to the will or decisions of a health care provider,[123] nor the absolute shield from a shared decision-making process, as they are sometimes claimed to be.[124] This principle is nonetheless of particular importance in instances where a health care user is incapacitated, either partially or in full,[125] and thusly incapable of the required decision-making capacity.[126] This is also not an unregulated affair, with specific

114 Section 14(2)(*b*) of the *NHA*.
115 Section 36 of the of the *Constitution*.
116 Section 14(2)(*c*) of the *NHA*.
117 Section 13(2) of the *MHCA*.
118 WHO *Guidelines for Medico-legal Care* 19; SANC *Code of Ethics for Nursing Practitioners* 4; Rules 2.3.2 and 2.3.3 of HPCSA *Booklet 1*; Rule 2.13.1.3(d) of the SAPC *Good Pharmacy Practice*; Moyakhe 2011 *SAJBL* 10.
119 Chervenak and McCullough 2017 *Best Practice & Research Clinical Obstetrics & Gynaecology* 4; Pellegrino and Thomasma 1987 *J Contemp Health L & Pol'y* 23.
120 Motloba and Makwakwa 2018 *SADJ* 460.
121 McQuoid-Mason 2008 *SAJBL* 7.
122 Masege *Managed Healthcare* 38.
123 Barit *Doctrine of Informed Consent* 55.
124 Warner 2022 *Current Allergy & Clinical Immunology* 139.
125 Rules 8.1-8.3 of HPCSA *Booklet 4*; Rule 7.1.3 of HPCSA *Booklet 7*; Rule 7.3 of HPCSA *Booklet 17.* The *MHCA* addresses temporary and long-term incapacity in terms of "assisted care, treatment and rehabilitation" and "involuntary care, treatment and rehabilitation". See ch 5 of the *MHCA*.
126 Section 7(1)(*e*) of the *NHA*; s 9(1)(*c*) of the *MHCA*.

statutory and ethical provisions guiding the provision of health care services in the said circumstances.[127]

As mentioned above, the principle of the best interest of the user is employable as a barometer for limiting the user's right to be fully informed.[128] A "kaleidoscope" approach, utilising both subjective perspectives and objective research-based components, of "best interest", may offer assistance in determining whether a limitation, of the user's right, is reasonable and justifiable.[129] Additionally it should be employed with due consideration of the effect the limitation may cause,[130] the importance of the right subject to limitation, and the furtherance of health care rights in general.

4 Potential pitfalls of mandatory reporting in higher education health care services

4.1 Deficiencies in statutory definitions and provisions

When considering the newly amended sections on mandatory reporting, several concerns, *lacunas* and deficiencies can be identified. This holds true both in relation to the effective implementation of the said provisions and the safeguarding of the victim.

4.1.1 Definition of a vulnerable person

Considering the constitutional democratic imperative of equal protection in law,[131] it is difficult to comprehend the legislature's lack of gender neutrality reflected by section 40 of *SORMA*. Although the prevalence of gender-based violence and sexual offences against female victims cannot be disputed,[132] this is by no means the only manifestation of gender- or sex-based violence. It could be argued that persons of LGBTQQIP2SAA gender classifications could be equally susceptible to gender or sex-based violence.[133] This definition also creates the potential for further perpetuating

127 Rule 5 of HPCSA *Booklet 1;* Rule 6 of HPCSA *Booklet 4;* SANC *Code of Ethics for Nursing Practitioners* 4.

128 Section 6(1)(*a*) of the *NHA*.

129 Motloba and Makwakwa 2018 *SADJ* 461; Steyn *Law of Malpractice Liability* 157; Warner 2022 *Current Allergy & Clinical Immunology* 139.

130 Section 36(1)(*c*) of the *Constitution*.

131 Section 9(1) of the *Constitution*.

132 SAPS 2023 https://iq-blue.com/site/files/crime_statistics/2022-2023-Annual-Crime-Statistics-Report.pdf; Jina *et al* 2020 *SAMJ* 926.

133 Van der Schyff 2018 *Global Media Journal* 37; Sithole 2016 *Journal for Transdisciplinary Research in Southern Africa* 197; Chabalala and Roelofse 2015 *Acta Criminologica* 52; Van Vollenhoven and Els 2013 *De Jure* 227. The acronym refers to "Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Pansexual, Two-Spirited and Asexual".

the already severe underreporting of sexual offences against male victims, possibly undermining efforts to change societal bias in this regard.[134]

The narrow ambit of section 40's definition can also be faulted for a failure to provide equal protection to the larger female population of equivalent age, who might find themselves in less protected environments than that of tertiary institutions, with access to less victim support.[135] Arguably, a female below the age of 25, for example, living in informal areas, relying on a minimum wage, is as if not more susceptible to sexual violence or other offences, with fewer preventative and reactive resources to support her or to prevent re-victimisation.[136] Yet such a hypothetical female is not included in the scope of what is defined as a vulnerable person.[137]

While purportedly based on statistical prevalence, the question can be asked whether section 40 would be able to withstand constitutional judicial scrutiny. The narrow classification and allocation of "protection" is neither valuable nor preferable in the chronic war on sexual offences, and contrary to the ideals of the South African democratic dispensation.[138]

4.1.2 Section 54 provisions

The provisions contained in section 54(1)-54(2)(*b*)[139] are nothing if not straightforward and plain. With no exceptions included in the provisions, it holds that all incidents of sexual offences perpetrated against a "vulnerable person" must be reported.[140] The scope of such sexual offences is not defined, thusly including all forms of sexual offences.[141] The provisions are further mute on whether a prescription period is applicable, or how mandatory reporting applies to sexual offences perpetrated in the distant past.[142] Similarly, no definition is provided regarding what "knowledge,

134 Jina *et al* 2020 *SAMJ* 926; Sittol and Lubinga 2020 *Communitas* 2; Singh 2004 *Acta Criminologica* 129.

135 Gevers and Abrahams 2017 *South African Journal of Psychiatry* 5.

136 Bougard, Booyens and Ehlers 2015 *Acta Criminologica* 61; Gopal and Daniel 2008 *Acta Criminologica* 47.

137 Section 40 of *SORMA*.

138 Van der Westhuizen 2004 *Acta Criminologica* 104.

139 Section 54 of *SORMA*.

140 Section 54(1) of *SORMA*.

141 Section 54(1) of *SORMA* doesn't differentiate between categories or forms of sexual offences, but refers only to an "offence [that] has been committed against a person who is vulnerable".

142 Considering the category of "vulnerable persons" in the context of this contribution, the relevance of such a prescription period is two-fold. The age group of 18-24-year olds would have recently progressed past the child classification, contained in the s 40 definition of a vulnerable person, and thusly the self-reporting of sexual offences committed against them during the age of minority might still be possible in terms of s 54(1) well beyond the age of majority. Likewise, sexual offences committed against a victim in the tertiary environment might be reportable well beyond the completion of studies, and beyond the 25-year-old requirement set out by the s 40 definition.

reasonable belief or suspicion" entails. Unlike the mandatory reporting provision of section 110 of the *Children's Act*,[143] the scope of the individuals bound by section 54 is not well-defined. Instead, it refers to "a person", effectively binding any person with such "knowledge, reasonable belief or suspicion", including all family, friends, acquaintances, university staff, fellow students and fellow residents (in the current context).[144]

From a health care perspective, this would also extend far beyond the tertiary education environment. Considering that the South African student populace is served by public, private and higher education-based health care practitioners, every female victim fitting the age criteria of section 40 that reports for health care or mental health care intervention as a result of a sexual offence, would have to be thoroughly screened to determine her higher education status. Bearing distance learning programmes and distance education institutions in mind,[145] this would extend far beyond the campus and campus/town environment. Where the "knowledge" or "suspicion" develops in a location removed from the area where the crime was perpetrated, it creates the potential for jurisdictional and reporting complications, not to mention a complex and protracted process.[146] Equally, where health care or psychosocial services are rendered *via* methods of telemedicine,[147] the difficulties in navigating the above complexities would be even greater.[148]

In essence, section 54 subjects the entirety of the victim's support system to this statutory obligation. It also applies to all forms of sexual offences

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143 Section 110 of the *Children's Act* 38 of 2005: "Any correctional official, dentist, homeopath, immigration official, labour inspector, legal practitioner, medical practitioner, midwife, minister of religion, nurse, occupational therapist, physiotherapist, psychologist, religious leader, social service professional, social worker, speech therapist, teacher, traditional health practitioner, traditional leader or member of staff or volunteer worker at a partial care facility, drop-in centre or child and youth care centre who on reasonable grounds concludes that a child has been abused in a manner causing physical injury, sexually abused or deliberately neglected, must report that conclusion in the prescribed form to a designated child protection organisation, the provincial department of social development or a police official."

144 Section 54(1) of *SORMA* imposes the duty on "a person" without any limitation included therein.

145 Distance learning programmes or institutions are aimed at providing non-contact tertiary education, by means of postal, electronic or online education. See in this regard GN 535 in GG 37811 of 7 July 2014.

146 Rule 3.1 of HPCSA *Booklet 10*: "Telehealth involves secure videoconferencing or similar forms of technology which enable healthcare practitioners to replicate, as far as practical, the interaction of traditional face-to-face consultations between healthcare practitioners and patients. In this regard, information is exchanged electronically either synchronous or asynchronous (that is on or off-line) formally, informally or as a need for support by from consulting practitioner remotely."

147 Rules 5.1-6 of HPCSA *Booklet 10.*

148 Section 54(2)(a) of *SORMA*.

perpetrated against such a victim, however trivial she might consider them to be, for an unspecified or unlimited period after the offences occurred, throughout the Republic of South Africa, for which non-adherence could be met with criminal prosecution.[149]

The appropriateness of such a broad and far-reaching provision should be questioned. Besides the state's inability to police such limitless provisions, the consequences to both the victim and the victim's support system create not only the potential for secondary victimisation, but in fact require it.[150] This cannot be said to be in line with the constitutional ideals,[151] subjecting the most vulnerable to additional sanctioned trauma.

4.2 Indirect limitation of access to health care services

The aim of the mandatory reporting provisions is undoubtedly to curb the sexual offences epidemic through intelligence-led policing.[152] As pointed out previously, making reporting mandatory as a tool in this endeavour is unfortunately not without its unintended consequences. The limitation of a citizen's constitutional and statutory rights, however permissible, has far-reaching effects for the victims of crime. In addition to several limitations to fundamental rights resulting from mandatory reporting,[153] broader encompassing rights such as the right to access to health care services may also be indirectly limited.[154]

Fundamental rights impose both positive and negative obligations on the State.[155] The positive obligations, to protect, promote and fulfil[156] fundamental rights, are reliant on the negative obligation, "respect", which is aimed at limiting actions or measures that interfere with the realisation of rights, in order that the said rights may be fully realised.[157] Within the scope of sections 27(1) and 27(3), the negative obligations should entail the intentional abstention from any legislative or executive measures that lessen or impede "access" to health care.[158]

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149 Section 54(2) of *SORMA*.

150 This is also in stark contrast to the objects of the Act as contained in section 2(*d*) of *SORMA.*

151 Chapter 2 of the *Constitution*.

152 Maboa and Horne 2024 *IJSSRR* 533.

153 See paras 3.1-3.3 above.

154 Indirect limitations can be described as limitations by means of indirect discrimination, or alternatively, conduct, legislative or executive measures that are not intended to impose the specific limitation, but that "proliferate[s] into indirect limitations of other rights", nonetheless. See *S v Mlungwana* 2019 1 SACR 429 (CC) para 71.

155 Iles 2004 *SAJHR* 459.

156 Section 7(2) of the *Constitution*.

157 De Vos *et al South African Constitutional Law* 786.

158 Pearmain and Carstens *Foundational Principles of South African Medical Law* 42; Chaskalson *et al Constitution Law of South Africa* 41-29.

The awareness, on the part of a victim of a sexual offence that health care practitioners are obliged to report such offences might very well inhibit the victim's willingness to divulge relevant information to a health care practitioner, or might move the victim to avoid seeking health care and mental health care services altogether.[159] If any of the aforementioned scenarios were to occur due to the existence of the mandatory reporting requirements, the right to access to health care services would have been limited, albeit indirectly. In addition thereto, the limitation to access to health care services might also manifest in a limitation of the rights to dignity, physical integrity and psychological integrity, and potentially even the right to life.[160] In a wider sense, this unintended limitation of rights might also undermine the trust in health care services, practitioners and institutions in general.

From a limitation perspective,[161] it becomes a precarious balancing act when considering the "nature of the right(s)"[162] that might potentially be limited, compared to the "importance and purpose of the limitation".[163] The section now exceeds the mere limitation of autonomy, confidentiality and privacy, as discussed previously,[164] by creating additional factual harm to a victim of crime, beyond what has already been incurred.[165] As a result, the "nature and extent of the limitation"[166] becomes so vast, far-reaching and potentially devastating to the victim, that the limitation might outweigh the purpose thereof.

The limitation of access to health care services, in the context of physical and emotional harm that has befallen a victim, whether the limitation be direct or indirect in nature, should never be considered justifiable. Sections 27(1) and 27(3) aim to protect the most vulnerable in society by promoting and protecting the dignity, lives, physical and psychological integrity of those in need.[167] Undermining the aim of protecting the "vulnerable" under the auspices of protecting the "vulnerable" is counterintuitive and contrary to rationality.[168] Creating compounded harm merely to address and not necessarily to correct the initial harm cannot be justified in an open and

159 Steele *et al* 2019 *PLoS One* 12; Olchowska-Kotala, Strządała and Barański 2023 *Bioethical Inquiry* 410.
160 Sections 10, 11 and 12 of the *Constitution*.
161 Section 36 of the *Constitution*.
162 Section 36(1)(*a*) of the *Constitution*.
163 Section 36(1)(*b*) of the *Constitution*.
164 See paras 3.1-3.2 above.
165 Randa *et al* 2023 *Curationis* 2.
166 Section 36(1)(*c*) of the *Constitution*.
167 Davis 2004 *ESR Review* 7.
168 Iles points out that, a higher standard of protection is afforded to those who are most vulnerable in society, especially in relation to socio-economic rights. Iles 2004 *SAJHR* 460.

democratic society.[169] Although limitations are to be considered and challenged on a case-to-case basis, a blanket implementation without well-defined boundaries may have devastating results until it receives judicial consideration.

4.3 Lack of ethical and professional guidance

At present none of the statutory health care bodies, such as the HPCSA, the SANC, the South African Council for Social Service Professions or the SAPC[170] has provided ethical guidance to its registered health care practitioners in this matter. Similarly, the DHET and its sub-department, Higher Health, have provided little tangible guidance regarding the implementation of the amended provisions in the higher education environment.[171]

The lack of guidance at professional and ethical level specifically leaves health care users and health care practitioners in limbo, requiring these parties to negotiate already trying times individually and without the necessary direction. It is therefore of the utmost importance that the relevant governing bodies provide clear guidance and procedural support to the relevant professionals tasked with implementing the mandatory reporting provisions. Failing such guidance, the implementation of the provisions might very well become a chaotic and harmful affair.

5 Concluding remarks

The need for decisive action in curbing sexual offences and gender-based violence cannot be denied. Offences of this nature stem from larger societal root causes, often disproportionately affecting the most vulnerable. Nevertheless, it is difficult to justify potential secondary victimisation of a victim and secondary traumatisation, of a victim's support system under the auspices of fighting crime.

This contribution has considered the potential effects that the mandatory reporting of sexual offences committed against victims enrolled in higher education might have for the victims, as well as for the provision of health care services to such victims. It is clear from the above discussion that the *Amendment Act* 13 of 2021 establishes and necessitates a severe

169 "Compounded harm" refers to additional harm done to an individual, or a group of individuals, who has already suffered some form of harm, thereby exacerbating the physical and psychological effects of the initial harm. Lawless 2024 https://www.medicalindependent.ie/comment/medico-legal/compounded-harm-why-we-should-take-it-seriously/.

170 Para 3.1 above. It should be noted that none of the statutory bodies mentioned has updated their ethical guidelines to address the matter.

171 Beyond online training opportunities, no written guiding instruments have been published.

departure from well-established health care ethics and standards. These standards are not limited to professional or ethical practice, but are rooted in human and fundamental rights in furtherance of socio-economic rights.

When considering the principle of health care user autonomy coupled with the principles of informed consent and self-determination, the right to confidentiality, and its relation to the rights to human dignity, physical and psychological integrity, and privacy, the vast impact of the mandatory reporting of sexual offences committed against adult persons who are considered to be of age and to possess the ability to regulate their own lives without interference becomes unfathomable. Yet that is precisely what the provisions of the *Amendment Act* 13 of 2021 require.

The conflicting legal requirements place both the victim and health care providers in a precarious position. The victim has either to accept and submit to health care services, knowing that s/he will have no control over the ensuing process, or alternatively refrain from receiving possibly much-needed health and mental health care. Conversely, health care practitioners, will be required to act contrary to the multiple legal and ethical standards to which health care services aspire, where knowledge or suspicion of a sexual offence is encountered.

This contribution argues, from a health care law perspective, that these mandatory reporting provisions are neither desirable nor justifiable in their current form. The purpose of limiting the right to control over one's body, especially where control has been undermined by means of sexual violence, does not entirely outweigh the rights being infringed upon. Instead of prioritising the individual rights and best interest of the victim of a sexual offence, the provisions prioritise the State's ability to police such offences, and might exacerbate the distrust of victims in the criminal justice system and the health care sector alike.

Undermining trust in the health care system and health care providers is tantamount to indirectly limiting access to health care services. Hindering or constructively discouraging victims from accessing health and mental health care services might have not only a detrimental effect on victims of sexual offences but also on broader society by increasing the number of unwanted pregnancies, exposing victims and their partners, or future partners, to untreated sexually transmitted diseases, and exacerbating the existing mental health crisis and the associated socio-economic effects thereof.

Whilst it could be argued that the mandatory reporting provisions are aimed at protecting the vulnerable adult in the higher education environment, it could equally be held that these provisions might further aggravate vulnerability, not at the hands of criminal offenders, but by means of health

care services and other support systems that are supposed to promote, protect, fulfil and realise the best interest of the victim.

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List of Abbreviations

AJNM	Africa Journal of Nursing and Midwifery
AJPHERD	African Journal for Physical Health Education, Recreation and Dance
AMA	American Medical Association
CET	Community Education and Training College
DHET	Department of Higher Education and Training
DoH	Department of Health
GBV	Gender Based Violence
HPCSA	Health Professions Council of South Africa
IJSSRR	International Journal of Social Science Research and Review
J Contemp Health L & Pol'y	Journal of Contemporary Health Law & Policy
JJS	Journal for Juridical Science
LGBTQQIP2SAA	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Pansexual, Two-Spirited and Asexual
MHCA	Mental Health Care Act 17 of 2002
NHA	National Health Act 61 of 2003
PELJ	Potchefstroom Electronic Law Journal
POPIA	Protection of Personal Information Act 4 of 2013
PSET	Post-Schooling Education and Training
SAACDHE	Southern African Association for Counselling and Development in Higher Education
SAACHS	South African Association of Campus Health Services
SACQ	South African Crime Quarterly
SADJ	South African Dental Journal
SAFP	South African Family Practice
SAJBL	South African Journal on Bioethics and Law
SAJHE	South African Journal on Higher Education
SAJHR	South African Journal on Human Rights
SAJOT	South African Journal of Occupational Therapy

SALJ	South African Law Journal
SAMJ	South African Medical Journal
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
SAPS	South African Police Service
SORMA	Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007
Soc Sci Med	Social Science & Medicine
TVA	Trauma, Violence, & Abuse
WHO	World Health Organisation