HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA

GUIDELINES FOR GOOD PRACTICE IN HEALTH PROFESSIONS

GENERAL ETHICAL GUIDELINES FOR REPRODUCTIVE HEALTH

BOOKLET 8

PRETORIA

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THE SPIRIT OF PROFESSIONAL GUIDELINES

High quality clinical outcomes are only achievable when, amongst other things, patients and health practitioners trust each other explicitly. Practice in the healthcare profession is therefore a moral enterprise and demands of health practitioners to have a life-long commitment to sound, ethical professional practice and an unstinting dedication to the interests and wellbeing of society and their fellow human beings.

It is in this spirit that the HPCSA formulates these ethical guidelines to guide and direct the practice of health practitioners. They apply to all persons registered with the HPCSA and are the standard against which professional conduct should be evaluated.

[Note: The term “health practitioner” and “health professional” may be used in these guidelines referring to persons registered with the HPCSA].

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1. INTRODUCTION

1.1. Reproductive health plays a crucial role in improving health for both women and men, moreover so, for women. While women carry a significantly high burden of reproductive health-related diseases, they often are at the receiving end gender-based ill-treatment and abuse in society. Women have a unique vulnerability because of their reproductive function and role. Social discrimination and abuse based on gender and undervaluing of women compromise women's health and mental status. Concern for family welfare may take precedence over individual health and also increase health risk. However, whatever the social norms, these issues shall not be allowed to impact negatively on overall women's health.

1.2. Reproductive health offers a comprehensive and integrated approach to health needs related to reproduction. It seeks to put women at the centre of care, and recognises, respects and also respond to the needs of women.

1.3. The concept of reproductive health receives great attention and was endorsed at the United Nations International Conference on Population and Development held in Cairo in 1994. The conference defined reproductive health as: as:

> [a] state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care service that will enable women top go safely through pregnancy and childbirth. This would serve to provide women with the best chance of having a healthy infant.

1.4. In the delivery of healthcare, justice requires that all genders are treated with equal consideration, irrespective of their socioeconomic status.

1.5. Allocation of resources must therefore be based on clinical needs of patients and be in line with the Constitution of the Republic of South Africa, 1996. Moreover, rights to bodily integrity must always be respected and the unequal power relationship between men and women must be taken into account when gender-based choices have to be made.

1.6. At a professional conduct inquiry, the relevant committee shall be guided by the ethical rules, ethical rulings or these guidelines and policy statements which the board concerned, or the HPCSA makes from time to time.

2. THE ROLE OF A HEALTH PRACTITIONER AS ADVOCATES FOR REPRODUCTIVE HEALTH

2.1 A health practitioner has an ethical duty to be advocates for reproductive health care. The HPCSA places an obligation on a health practitioner to advocate for improvements in the health and social status, especially for women. This is because the knowledge base and social standing of a health practitioner place them in a position with potential to influence policies that may impact reproductive health

2.2 A health practitioner is obliged as an individual, and as a professional, to monitor and publicise indices of reproductive health and provide data to sensitize the public on health issues and rights of women, thereto. The information generated should not be limited to quantifying the problem but should also assist identify relevant social and cultural determinants underpinning reproductive health so that appropriate strategies for improvement may be developed.

2.3 Failure to advocate for policies that will improve reproductive healthcare and advance rights, broadly deleteriously undermine the healthcare of the individual patients.

2.4 A health practitioner should liaise with the community regarding the problems of sexual and reproductive health and promote a wide debate in order to influence health practices, policies and legislations. The recipients of such information should include a broad spectrum of society such as health practitioner associations, women's organisations, legislators, educators etc. A health practitioner is also obliged to organise with other professional interest groups to ensure that essential health services are available for disadvantaged, impoverished and underprivileged women.

3. INTIMATE EXAMINATIONS

3.1 Complaints of sexual impropriety against a health practitioner are escalating. Professionalism in the health practitioner-patient relationship and the role-based trust in healthcare does not allow for crossing of sexual boundaries. Communication with patients is key to preventing erroneous allegations of sexual misconduct, especially during intimate examinations.

3.2 Intimate examinations include, but are not limited to, examination of the breasts, genitalia and rectum, and any examination where it is necessary to touch the patient in close proximity. Cautions to a health practitioner to remain vigilant in situations of patient's vulnerability, e.g. when listening to the chest, taking blood pressure using a cuff and palpating the apex beat, as these could involve touching the breast area or any examination of any sensitive arears.

3.3 In instances where intimate examinations may give rise to discomfort on either a health practitioner and/or patient, the presence of a chaperone should be considered as a potential risk reduction strategy.

3.4 Sexual misconduct may be categorized as "sexual impropriety", which refers to behavior, gestures or expressions that are sexually suggestive, seductive or disrespectful of a patient's privacy or sexually demeaning to a patient, and "sexual violation" refers to physical sexual contact between a health practitioner and a patient, whether or not it was consensual and/or initiated by the patient.

3.5 Sexual involvement with a patient could affect the health practitioner's judgment and thereby harm the patient. Sexual relationships between patients and a health practitioner is considered unethical and a form of professional misconduct by the HPCSA due to the unequal power relationship and the dependence of the patient on the health practitioner; even a consenting sexual relationship does not relieve a health practitioner from the HPCSA's ethical prohibition.

3.6 The following framework for the conduct of intimate examinations is recommended:

a) Ensure the intimate examination is necessary and will assist in the patient's care.
b) Explain to the patient that an intimate examination needs to be done and why it has to be done.

c) Explain what the examination will involve.

d) Obtain the patient's permission - verbal permission and the co-operation of the patient to adopt an appropriate state of undress and position may provide sufficient authorization. It is recommended that express consent be provided for intimate examinations, where practical.

e) Offer all patients who are to undergo intimate examination a chaperone, irrespective of the gender of the health practitioner or patient.

f) Should the patient wish to have a chaperone, the presence of the chaperone and the chaperone's identity should be noted at the time.

g) Should the patient decline a chaperone, this should also be noted at the time.

h) Should the patient decline the offer of a chaperone, and the health practitioner prefers to have one present, this should be communicated to the patient. If the patient still declines the offer of a chaperone, the health practitioner should probably not perform the examination and instead refer the patient to another health practitioner or facility where the required care can be obtained.

i) Give the patient privacy to undress and dress.

j) Adequate and appropriate draping should be used when the patient is undressed.

k) Keep the discussion relevant and avoid unnecessary personal comments.

l) Encourage questions and discussion.

4. GENDER BASED VIOLENCE

4.1 Violence is a reflection of the unequal power relationship in societies. The HPCSA condemns violence against anyone, whether it occurs in a societal (including cultural), group (including family) or bilateral (of individuals) setting. It is not a private or family matter, and health practitioners are ethically obligated to:

a) Educate themselves about the manifestations of violence and recognize cases.

b) Ensure documentation that takes into account the need for confidentiality to avoid potential harmful consequences, and this may need separate, non-identifiable compilation of data.
c) Treat the physical and psychological aspects of health resulting from violence.
d) Affirm to their patients that violent acts towards them is not acceptable.
e) Advocate for social infrastructures to provide victims with the choice of seeking secure refuge and ongoing counselling.

4.2 According to the United Nations Gender-Based Violence as any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females and is usually regarded as interchangeable with "violence against women." It highlights the relationship between the subordinate status of women in society and their increased vulnerability to violence. Men and boys may also be victims of Gender-Based Violence, especially sexual violence".

4.3 The physical, financial, mental and social vulnerabilities are fundamentally harmful to the future of society. Not addressing them will lead to failure to prevent harm to subsequent generations and also contribute to the cycle of violence. Health practitioners therefore have an obligation to:

a) Affirm patients' rights to be free of physical and psychological violence, particularly sexual violence including sexual intercourse without consent within a marriage.
b) Advocate for non-violent resolutions in relationships by enlisting the aid of relevant persons in a position to mitigate their circumstances, including social workers and other healthcare workers where appropriate.
c) Make themselves and others, in particular men, aware of the harmful effects of the embedded discrimination in social systems.

4.4 There is a need for wider awareness of the magnitude of the problem of violence against vulnerable persons. A health practitioner is uniquely placed to assist in this regard. Only if a problem is recognised can it be addressed. There is therefore a duty for professional interest groups and health practitioners to publicise information about violence, including the frequency and types of violence.

5. DOMESTIC VIOLENCE

5.1 Domestic violence is defined by the Domestic Violence Act as: “Any controlling, abusive, fear-inducing act that threatens to harm the health, well-being or safety of a person in a domestic relationship”. The United Nations defines it as: “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women [and men], including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life”.

5.2 Domestic Violence may be a form of gender-based violence or interpersonal violence and does not preclude men and children as victims.

5.3 A Health practitioner must be responsive to domestic violence by taking the following actions:

a) Screening: Ask gently about violent and/or controlling behavior and believe response.
b) Assess Risk: Conduct a risk assessment in all cases of domestic violence to identify imminent danger – especially where the patient still has contact with the perpetrator.
c) Supportive care: Provide supportive bio-psycho-social care.
d) Document: Document any evidence of abuse on a domestic violence examination form.
e) Inform: Inform patients of their rights, services and the legal remedies, including how to obtain a protection order under the Domestic Violence Act, and whether they want to report the case to the police. Explain the implications of domestic violence, including the risk of HIV and in the case of a sexual offence under the Sexual Offences Act, their right to get free treatment.
f) Refer responsibly: Refer clients to appropriate resources and facilities and identify their support system.

5.4 When conducting a risk assessment in situations where the patient is uncertain about reporting continued domestic violence to relevant entities, including law enforcement, a health practitioner should establish the following necessary for the development of a safety plan:

a) Does the perpetrator use alcohol and drugs?

b) Has the perpetrator threatened to kill?

c) Does the perpetrator have access to weapons?

d) Is the patient afraid to go home?

e) Has the patient or perpetrator thought about killing themselves?

6. CONTRACEPTION

Whether or not any person wishes to reproduce is a personal right that shall enable them to have access to legal, safe, effective and affordable methods of contraception. Responsible control of procreation enjoys wide social acceptance. However, none of the current methods of fertility control fully satisfy the ideal of safety, effectiveness, reversibility, ease and religious acceptance. Counselling a patient on matters relating to contraceptive and provision of contraceptive are clear examples of healthcare required in addition to the treatment of diseases.

6.1 The principle of beneficence requires that contraceptive methods must be safe, effective, and acceptable to women.

6.2 In introducing contraceptive methods, a health practitioner must be guided by respect for an individual's autonomy.

6.3 The same respect for autonomy requires that, standards especially relevant to the introduction of methods of fertility regulation should include both facilitating informed choice and delivering quality care.

6.4 There are 2 major aspects to delivering quality of care: the health practitioner's quality requirements and the need to take into account people's express wishes. Quality requirements include matters such as a range of appropriate contraceptive methods is offered, that appropriate support counseling services are available and that providers are technically competent. Interpersonal relations with healthcare professionals must be respectful and take into account women's inputs and opinions.

6.5 A child who is legally competent to obtain condoms, contraceptives or contraceptive advice is entitled to confidentiality in this respect (See Children's Act, 2005). Nobody may therefore refuse to provide contraceptives, including condoms, to a child over the age of 12 years in line with the applicable legislation.

6.6 Contraceptives, other than condoms, may be provided to a child on request by the child and without the consent of the parent or caregiver of the child if the child is at least 12 years of age, 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.

7. STERILIZATION

7.1 Decisions about sterilization involve personal values and therefore may not be subject to health practitioner's determination.

7.2 Sterilization in theory, eliminates any further option to procreate. The intention of permanency underscores the need for patients and a health practitioner to consider special set of ethical issues and the well-documented possibility of later regret by the patient.

7.3 The obvious relationship of sterilization to procreation, the potential irreversibility of the procedure, and its usually elective nature requires that certain ethical considerations receive special emphasis. Although these considerations involve matters of private and individual choice, they may also have societal implications as well.

7.4 Specific ethical considerations in sterilization

7.4.1 Because a patient's ability to procreate may significantly affect the lives of others, a health practitioner should encourage the patient to include other appropriate persons, such as a partner in the counseling process. However, the partner's consent must not be obligatory.

7.4.2 Withholding any healthcare by a health practitioner by linking it to the patient's agreement to undergo sterilization is unacceptable.

7.4.3 A health practitioner's personal values or sense of societal objectives should never be a basis for granting or denying sterilization. Ethnic, racial or socioeconomic factors should never be grounds for limiting a patient's choices about sterilization.

7.4.4 A health practitioner's personal values should not limit counseling, services or referral.

7.4.5 The rights of mentally handicapped and other vulnerable persons, whether institutionalized or not, should be carefully protected. Even if a person is unable to make their own decisions because of mental incapacity or mental retardation, they must, nevertheless, be involved in the decision-making process to the fullest extent their capacity allows, and their best interests must be taken into account.

7.4.6 Hysterectomy solely for the purpose of sterilization is inappropriate because of the disproportionate risks and costs.

7.4.7 Special informed consent considerations inherent in sterilization counselling include:

a) Sterilization is intended to be permanent.
b) Life circumstances may change.
c) The patient may later regret her sterility.
d) Male sterilization may be an appropriate alternative.
e) There is a measurable chance of failure with any sterilization procedure.

7.4.8 No minimum or maximum number of children may be used as a criterion for access to sterilization.

7.4.9 At a public policy level, a health practitioner has a duty to be a voice of reason and compassion, pointing out when legislative and regulatory measures interfere with personal choice and appropriate healthcare.

7.4.10 A health practitioner may also encounter situations in which, according to their best judgement, sterilization would not be appropriate. It is within the right of the morally conflicted health practitioner to abstain from the performance of the sterilizing procedures.

7.4.11 Given their rights to freedom of conscience, religion, thought, belief, and opinion, and except in emergency situations, a health practitioner may refuse to participate in a sterilisation procedure.

8. TERMINATION OF PREGNANCY FOR NON-MEDICAL REASONS

8.1 Termination of pregnancy (generally known as abortion) is widely considered to be ethically justified when undertaken for medical reasons to protect the life and health of the mother.

8.2 The use of termination of pregnancy for other social reasons remains very controversial because of the ethical dilemmas it presents to both women and the healthcare team. Women frequently agonize over their difficult choices, making what they regard in the circumstances to be the least-worse decision. A health practitioner usually wrestles with the moral value of preserving life, of providing care to women and of avoiding unsafe abortions.

8.3 Every effort must be made to improve reproductive rights, status and health and to prevent unintended pregnancies by providing education, counseling, and making reliable information and services available. Termination of pregnancy should never be promoted as a method of family planning.

8.4 Proper informed consent supports the premise of human right to autonomy which also improves safe reproductive interventions.

8.5 Where a health practitioner feels that termination of pregnancy for non-healthcare reasons is not permissible whatever the circumstances, respect for their autonomy means that they should not be expected to advise or to terminate pregnancy against their personal convictions. The career should not be prejudiced as a result. Such health practitioners are obliged to refer the woman elsewhere where such a service may be professionally provided.

8.6 A health practitioner does not have the right to impose their own religious or cultural convictions regarding the termination of pregnancy on those whose attitudes are different. Counseling should include objective information. Post termination of pregnancy counseling on fertility control should always be provided.

8.7 After appropriate counseling, a woman has the right to have access to a health practitioner or surgically induced termination of pregnancy and a health practitioner has an obligation to provide such services as safely as possible.

8.8 In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her

parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them (Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996), section 5(3). Also, a minor must be assessed to ensure that she has the necessary mental capacity to give informed consent by understanding and appreciating the benefits, risks, social and other implications of the termination of pregnancy.

8.9 A health practitioner is urged to facilitate access of minors seeking a termination of pregnancy to appropriate non-directive education, counseling and family planning services.

8.10 A health practitioner shall, when continuation of a pregnancy poses a serious danger to the life or health of the individual or the foetus, and regardless of gestational or the health practitioner's personal beliefs, carry out a termination of pregnancy when required to do so in accordance with the National Department of Health's National Guidelines (2019) on Implementation of the Choice Act 1996.

9. SURROGATE MOTHERHOOD

9.1 Surrogacy can be applied only in cases of very limited special indications.

9.2 Special attention must be made to the ethical principle of protection of the surrogate mother who can be exploited because of socioeconomic and mental status.

9.3 The autonomy of the surrogate mother shall be respected, and the surrogate arrangement should not be commercialized.

9.4 Surrogacy should be practiced strictly under the health practitioner's supervision, taking into consideration full regard for ethics and the law.

9.5 All surrogacy agreements must be confirmed by a High Court (Section 292 of the Children's Act) and a health practitioner shall ensure that this is done before engaging in surrogacy procedures.

9.6 Given their rights to freedom of conscience, religion, thought, belief, and opinion, and except in emergency situations, a health practitioner may

refuse to participate in a surrogacy procedure, and when such refusal is made, the patient shall be referred to an alternate facility or to another health practitioner to receive health services.

10. PREVENTING IATROGENIC MULTIPLE PREGNANCY

10.1 The use of ovulation inducing drugs and of multiple embryo transfer in the treatment of infertility has led to a dramatic increase in multiple pregnancies. The need for infertility treatment has also been rising sharply due to factors which include the trend towards pregnancy at later ages, and the impact of sexually transmitted diseases.

10.2 Multiple pregnancies may present very serious implications for the mother and her offspring(s), for the family and the community, and for health service resources.

10.3 The misuse of drugs for the induction of ovulation is responsible for a great deal of iatrogenic multiple pregnancies. Therefore, those prescribing these drugs should be appropriately trained and familiar with the indications for their use, their adverse side effects, and the methods of monitoring and preventing iatrogenic multiple pregnancy.

10.4 Assisted reproductive technologies whether by the induction of ovulation, transfer of gametes, pre-embryos or embryos shall only be performed by those health practitioners who are qualified to do so and shall aim to achieve singleton pregnancies. Under optimal conditions, not more than two pre-embryos or embryos should be transferred.

10.5 Centers offering assisted reproductive technologies shall be accredited to ensure a uniformly high standard.

10.6 The risks for both mother and higher order offsprings are sufficient great to justify consideration by prospective parents and their healthcare advisors to be fully informed on matters relating to fetal reduction.

10.7 Parents seeking treatment for infertility must be fully informed of the risks of multiple pregnancy both to the woman and to their potential progeny.

11. COLLECTION OF CORD BLOOD

11.1 The discovery that umbilical cord-blood provides a rich source of haemopoietic stem cells used in transplantation in diseases such as leukaemia, has led to the organised collection of blood from this source and its retention in cord-blood banks until required. Altruistic non directed donations for public cord blood storage is currently not practiced in South Africa. Directed donations can be for “at risk families or “low risk families”. No major controversy exists regarding directed donations in “at risk families”. However, with “low risk families” the chance of using personal cord blood before the age of 20 years is low with estimates varying between 1 in 2 700 and 1 in 20 000. Currently, it is very expensive to store umbilical cord blood in private banks. Hence, patients end up compromising themselves financially as the likelihood of them ever requiring the cells is very low. The vulnerability of parents at this emotional period in their lives needs to be recognized and protected. Any advertising and marketing of cord blood storage must be done responsibly and must not exploit parents’ vulnerabilities.

11.2 It is ethically necessary for the mother to give informed consent (before delivery) for the collection of cord-blood for banking where indicated.

11.3 The timing of informed consent from the mother is crucial in order to ensure an understanding and appreciation of the procedure. Moreover, she needs to be made aware of not only the benefits of the collection but also the associated risks which include the possibility of insufficient harvesting of the stem cells and the chance of using the blood before the age of 20 may be very low. Accordingly, consent should be taken early in the antenatal period. Obtaining informed consent during active labour and delivery does not lend itself to an ethically and legally valid and binding decision. Moreover, during this confusing and emotional period the ability of the woman to make a rational decision is highly unlikely.

11.4 For consent to be informed the harmful effects of early cord clamping should be disclosed and the mother assured that the collection of cord-blood will not involve early clamping.

11.5 Permission to collect blood from the cord for banking should not lead to clamping of the cord earlier than 20-30 seconds after delivery of the baby.

11.6 Any payment to a health practitioner by the company for cord blood collection is viewed by the HPCSA as a “finder’s fee” and therefore unethical.

11.7 The HPCSA advises that there is insufficient evidence to recommend directed cord blood collection and storage in “low risk families”. Hence, private cord blood banking cannot be recommended as a routine for everyone.

Ethical guidelines for good practice in the health care professions

The following Booklets are separately available:

Booklet 1: **General ethical guidelines for health care professions ethical guidelines for health care professions**

Booklet 2: **Ethical and professional rules of the health professions council of South Africa**

Booklet 3: **National Patients' Rights Charter.**

Booklet 4: **Seeking patients' informed consent: The ethical considerations.**

Booklet 5: **Confidentiality: Protecting and providing information.**

Booklet 6: **Guidelines for the management of chronic diseases**

Booklet 7: **Guidelines withholding and withdrawing treatment.**

Booklet 8: **Guidelines on Reproductive Health management.**

Booklet 9: **Guidelines on Patient Records.**

Booklet 10: **Guidelines for the practice of Telehealth.**

Booklet 11: **Guidelines on over servicing, perverse incentives, and related matters.**

Booklet 12: **Guidelines for the management of health care waste.**

Booklet 13: **General ethical guidelines for health researchers.**

Booklet 14: **Ethical Guidelines for Biotechnology Research in South Africa.**

Booklet 15: **Research, development and the use of the chemical, biological and nuclear weapons.**

Booklet 16: **Ethical Guidelines on social media.**

Booklet 17: **Ethical Guidelines on Palliative Care.**

Booklet 19: **Ethical Guidelines for matters relating to billing practices**