



**HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA**

**GUIDELINES FOR GOOD PRACTICE  
IN THE HEALTHCARE PROFESSIONS**

**GENERAL ETHICAL GUIDELINES FOR  
REPRODUCTIVE HEALTH**

**BOOKLET 8**

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## THE SPIRIT OF PROFESSIONAL GUIDELINES

Practising as a healthcare professional is based upon a relationship of mutual trust between patients and healthcare practitioners. The term "profession" means "a dedication, promise or commitment publicly made".<sup>1</sup> To be a good healthcare professional requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one's fellow human beings and society. In essence, practising as a healthcare professional is a moral enterprise. In this spirit the Health Professions Council of South Africa presents the following ethical guidelines.

[Note: The term "healthcare practitioner" in these guidelines refers to persons registered with the HPCSA].

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<sup>1</sup> Pellegrino, ED. Medical professionalism: Can it, should it survive? *J Am Board Fam Pract* 2000; 13(2):147-149 (quotation on p. 148).

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## 1. PREAMBLE

The concept of reproductive health will play a crucial role in improving women's health and rights in the country. While reproductive health is an important component of health for both women and men, it is more critical, however, for women. A major burden of disease in females is related to their reproductive function and reproductive potential, and the way in which society treats or mistreats women because of their gender. The concept of reproductive health offers a comprehensive and integrated approach to health needs related to reproduction. It puts women at the centre of the process, and recognizes respects and responds to the needs of women<sup>1</sup>. Women have a unique vulnerability because of their reproductive function and role. Social discrimination and abuse based on gendered undervaluing of women may further compromise women's health. Concern for family welfare may take precedence over individual health and also increase their health risk. However, whatever the social norms, these should not be allowed to impact negatively on women's health.

The concept of reproductive health received great attention and was endorsed at the United Nations International Conference on Population and Development held in Cairo in 1994. The definition of reproductive health adopted at the conference reads as follows:

"Reproductive health is 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 healthcare service that will enable women to go safely through pregnancy and childbirth.."<sup>2</sup> This would serve to provide women with the best chance of having a healthy infant.

In the delivery of healthcare to women, justice requires that all women are treated with equal consideration, irrespective of their socioeconomic status<sup>3</sup>. Allocation must therefore be based on clinical needs and be in line with the Bill of Rights of the Constitution. Moreover, women's rights to bodily integrity must always be respected and the unequal power relationship between men and women must be taken into account when facilitating women in making their own choices.

1. Cook RJ, Dickens BM, Fathalla MF eds. Reproductive Health and Human Rights. Oxford University Press. 2003.
2. UN Department of Public Information, Platform For Action and Beijing Declaration. Fourth World Conference on Women, Beijing, China, 4-15 September 1995. (New York: UN, 1995), Para94.
3. November 2003. Recommendations on Ethical Issues in Obstetrics and Gynaecology by the FIGO Committee on the Ethical Aspects on Human Reproduction and Women's Health. <http://www.figo.org>. These guidelines have in the main been drawn from the FIGO recommendations.

## **2. THE ROLE OF THE HEALTH PRACTITIONERS AS ADVOCATES FOR WOMEN'S HEALTH**

As advocates for women's health:

- 2.1 Health practitioners have an ethical duty to be advocates for women's healthcare. The HPCSA places an obligation on health practitioners to advocate for improvements in the health and social status of women. This is because the knowledge base and social standing of practitioners places them in a position with potential to influence policies regarding women's health.
- 2.2 Health practitioners are obliged individually and as a profession to monitor and publicise indices of reproductive health and provide data to sensitise the public to health issues and rights of women. The informative function should not be limited to quantifying the problem, but they should also identify social and cultural causes in order to develop appropriate strategies for improvement.
- 2.3 Failure to advocate policies that will improve women's health care and advance women's rights broadly will deleteriously influence the health care of the individual patients.
- 2.4 Practitioners should inform the community about problems of sexual and reproductive health and promote a wide debate in order to influence health practices and legislation. The debate should include a broad spectrum of society such as healthcare practitioner associations, women's organizations, legislators and educators. Health professionals are also obliged to organize themselves and other professional groups to ensure that essential health services are available for disadvantaged, impoverished and underprivileged women.

## **3. INTIMATE EXAMINATIONS<sup>2</sup>**

Complaints of sexual impropriety against health care practitioners are escalating. Professionalism in the practitioner-patient relationship and the role-based trust in health care do not allow crossing of sexual boundaries. Communication with patients is key to prevent erroneous allegations of sexual misconduct. The intimate examination is difficult to define. A chaperone present during an intimate examination protects the patient and practitioner and should be considered a risk reduction strategy in practice.

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<sup>2</sup> This section is based on extracts from Ames Dhai, Jillian Gardner, Yolande Guidozzi, Graham Howarth, Merryl Vorster "Professionalism and the intimate examination – are chaperones the answer?" *S Afr Med J* 2011;110:814-816.

- 3.1 Sexual misconduct may be categorised as “sexual impropriety” 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 doctor and a patient, whether or not it was consensual and/or Initiated by the patient.
- 3.2 The Healthcare practitioner Protection Society (MPS) defines intimate examinations as including, but not limited to, examination of the breasts, genitalia and rectum, and any examination where it is necessary to touch the patient in close proximity, and cautions practitioners to be vigilant in situations of 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.
- 3.3 Sexual involvement with a patient could affect the practitioner’s healthcare practitioner judgment and thereby harm the patient. Sexual relationships between patients and practitioners are considered unethical and a form of professional misconduct by the HPCSA. Because of the unequal power relationship and the dependence of the patient on the practitioner, even a consenting sexual relationship does not relieve the practitioner of the HPCSA’s ethical prohibition.
- 3.4 The following framework for the conduct of intimate examinations is recommended:
  - i. Ensure the intimate examination is necessary and will assist in the patient’s care.
  - ii. Explain to the patient that an intimate examination needs to be done and why.
  - iii. Explain what the examination will involve.
  - iv. 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 authorisation.
  - v. Offer all patients who are to undergo intimate examination a chaperone, irrespective of the gender of the practitioner.
  - vi. Should the patient wish to have a chaperone, the presence of the chaperone and the chaperone’s identity should be noted at the time.
  - vii. Should the patient decline a chaperone, this should be noted at the time.

- viii. Should the patient decline the offer of a chaperone and the practitioner prefers to have one present, this should be communicated to the patient. If the patient still declines the offer of a chaperone, the practitioner should probably not perform the examination.
- ix. Give the patient privacy to undress and dress.
- x. Adequate and appropriate draping should be used when the patient is undressed.
- xi. Keep the discussion relevant and avoid unnecessary personal comments.
- xii. Encourage questions and discussion.

#### **4. VIOLENCE AGAINST WOMEN**

Violence against women is a reflection of the unequal power relationship of men and women in societies. The HPCSA condemns violence against women, whether it occurs in a societal setting (such as virginity testing) or a domestic setting (such as spousal abuse). It is not a private or family matter. Violence against women is not acceptable whatever the setting and therefore practitioners treating women are ethically obligated to:

4.1 Inform themselves about the manifestations of violence and recognize cases. Documentation must take into account the need for confidentiality to avoid potential harmful consequences for the woman, and this may need separate, non-identifiable compilation of data.

- i. Treat the physical and psychological results of the violence.
- ii. Affirm to their patients that violent acts towards them are not acceptable.
- iii. Advocate for social infrastructures to provide women the choice of seeking secure refuge and ongoing counselling.

4.2 The physical, financial and social vulnerabilities of women are fundamentally harmful to the future of a society. Not redressing them fails to prevent harm to subsequent generations and contributes to the cycle of violence. Practitioners treating women therefore have an obligation to:

- i. Affirm women's rights to be free of physical and psychological violence, particularly sexual violence including sexual intercourse without consent within marriage.
- ii. Advocate for non-violent resolutions in relationships by Enlisting the aid of social workers and other health care workers where appropriate.
- iii. Make themselves and others, in particular men, aware of the



harmful effects of the embedded discrimination against women in social systems.

4.3 There is a need for wider awareness of the magnitude of the problem of violence against women. Practitioners are uniquely placed to assist in this. Only if a problem is recognized can it be addressed. There is therefore a duty for professional societies and practitioners to publicize information about the frequency of types of violence against women.

## **5. DOMESTIC VIOLENCE<sup>3</sup>**

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” , while 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, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life”. Domestic Violence is a form of Gender-based violence or interpersonal violence and does not preclude men and children as victims.

5.2 According to the United Nations “Gender-based violence” is 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 survivors of gender-based violence, especially sexual violence.

5.3 Health care professionals must be responsive to domestic violence by the following actions:

- I. Screening: Ask gently about violent and/or controlling behavior and believe response.
- ii. 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.
- iii. Supportive care: Provide supportive bio-psycho-social care.
- iv. Document: Document any evidence of abuse on a Domestic Violence examination form.
- v. 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

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<sup>3</sup> Based on the Domestic Violence Screening Protocol Prepared by the Professional Board for Emergency Care.

violence, including the risk of HIV and in the case of a sexual offence their right to get free HIV treatment under the Sexual Offences Act.

- vi. Refer responsibly: Refer clients to appropriate resources and identify their support system.

5.4 When conducting a risk assessment in situations where the patient is uncertain about reporting continued dangerous domestic violence to the police, health care professionals should establish the following in order to develop a safety plan:

- i. Has the violence increased?
- ii. Does the perpetrator use alcohol and drugs?
- iii. Has the perpetrator threatened to kill the patient?
- iv. Does the perpetrator have access to weapons?
- v. Is the patient afraid to go home?
- vi. Has the patient or perpetrator thought about killing themselves?

## **6. CONTRACEPTION**

Women have the right to make a choice on whether or not to reproduce and should therefore 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 satisfies the ideal of safety, effectiveness, reversibility, ease and religious acceptance. Contraceptive counseling and the rendering of contraceptive care are clear examples of healthcare practitioner care requested for other than the treatment of disease.

- 6.1 The principle of beneficence requires that contraceptive methods must be safe, effective, and acceptable to women.
- 6.2 In introducing contraceptive methods, healthcare practitioner practitioners 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: healthcare practitioner quality requirements and the need to take into account the woman's express wishes. Healthcare practitioner quality requirements include that 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 personnel must be respectful and take into account women's inputs and opinions.
- 6.5 Nobody may refuse to sell condoms to a child over the age of 12 years, or provide a child over the age of 12 years with condoms on request where condoms are provided or distributed free of charge (Children's Act, 2005 section 134(1)) .
- 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 care-giver 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 (Children's Act, 2005 section 134(2)).
- 6.7 A child who is legally competent to obtain condoms, contraceptives or contraceptive advice entitled to confidentiality in this respect (Children's Act, 2005 section 134(3)).

## **7. ETHICAL CONSIDERATIONS IN STERILIZATION**

Decisions about sterilization involve personal values and therefore may be subject to inappropriate practitioner bias. Ethical considerations evolve from these unique and controversial aspects of fertility control.

Sterilization differs from other contraceptive methods because in theory it eliminates any further option to procreate. The intention of permanency underscores the need for patients and practitioners to consider a special set of ethical issues and the well-documented possibility of later regret by the patient

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

### **7.1 Specific ethical considerations in sterilization**

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

- 7.1.2 The withholding of other healthcare practitioner care by linking it to the patient's agreement to undergo sterilization is coercive and unacceptable.
- 7.1.3 The physician's personal values or sense of societal objectives should never be a basis for urging sterilization. Ethnic, racial or socioeconomic factors should never be grounds for limiting a patient's choices about sterilization.
- 7.1.4 The physician's personal values should not limit counseling, services or referral.
- 7.1.5 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 decision because of mental incapacity or mental retardation, nevertheless they must be involved in the decision-making process to the fullest extent their capacity allows, and their best interests must be taken into account.
- 7.1.6 Hysterectomy solely for the purpose of sterilization is inappropriate because of the disproportionate risks and costs.
- 7.1.7 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 failure rate with any sterilization procedure.
- 7.1.8 No minimum or maximum number of children may be used as a criteria for access to sterilisation.
- 7.1.9 At a public policy level, the profession 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 practitioner care.
- 7.1.10 Practitioners may also encounter situations in which, according to their best judgement, sterilization would not be appropriate. It is the right of these practitioners to abstain from the performance of the sterilizing procedures.

**(See the Sterilization Act No 44 of 1998)**

- 7.1.11 In terms of the Constitution practitioners may refuse to participate in a sterilization procedure because of their conscience or religious beliefs

(Constitution of the Republic of South Africa, 1996 section 15) provided it is not an emergency situation.

## **8. TERMINATION OF PREGNANCY FOR NON-MEDICAL REASONS**

- 8.1 Abortion is very 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 abortion for other social reasons remains very controversial because of the ethical dilemmas it presents to both women and the healthcare team. Women frequently agonise over their difficult choice, making what they regard in the circumstances to be the least worst decision. Health care providers wrestle with the moral values of preserving life, of providing care to women and of avoiding unsafe abortions.
- 8.3 Every effort must be made to improve women's rights, status and health and to prevent unintended pregnancies by education, counseling, making available reliable information and services on family planning. Abortion should never be promoted as a method of family planning.
- 8.4 Providing the process of a properly informed consent has been carried out a woman's right to autonomy coupled with the need to prevent unsafe abortion, justifies the provision of safe abortion.
- 8.5 Where practitioners feel that abortion for non-healthcare practitioner reasons is not permissible whatever the circumstances, respect for their autonomy means that they should not be expected to advise or perform abortions against their personal convictions. Their careers should not be prejudiced as a result. Such practitioners are obliged to refer the woman to a colleague who is not in principle opposed to the abortion.
- 8.6 Practitioners do not have the right to impose their religious or cultural convictions regarding abortion on those whose attitudes are different. Counseling should include objective information. Post abortion counseling on fertility control should always be provided.
- 8.7 After appropriate counseling, a woman has the right to have access to healthcare practitioner or surgically induced abortion, and the health care service has an obligation to provide such services as safely as possible.
- 8.8 A female child of any age is legally competent to consent to a termination of pregnancy (Choice on Termination of Pregnancy Act, 1996 (Act No. 92 of 1996)) provided she has the necessary mental capacity to give an informed consent by understanding and

appreciating the benefits, risks, social and other implications of the termination of pregnancy.

- 8.9 Practitioners are urged to facilitate access by female children seeking a termination of pregnancy to appropriate non-directive education, counseling and family planning services.

## **9. SEX SELECTION**

Deeply-rooted discrimination based on gender and sex is still prevalent in many societies. Selective abortion of a fetus based on gender (e.g female fetus) is another manifestation of this social injustice.

- 9.1 The ethical principles of protection of the vulnerable and justice are violated by sex selection abortion (whether male or female). No fetus should be sacrificed because of its sex alone.
- 9.2 The use of preconceptional sex selection to avoid sex-linked genetic disorders is completely justifiable on healthcare practitioner grounds.
- 9.3 Preconceptional sex selection should never be used as a tool for sex discrimination against either sex, especially female.

## **10. SURROGATE MOTHERHOOD**

- 10.1 Surrogacy can be applied only in cases of very limited special indications.
- 10.2 Special attention has to be made to the ethical principle of protection of the surrogate mother who can be exploited because of her socioeconomic status.
- 10.3 The autonomy of the surrogate mother should be respected and the surrogate arrangement should not be commercialized.
- 10.4 Surrogacy should be practiced strictly under healthcare practitioner supervision, taking into consideration full regard of ethics and the law. Participants should be fully informed of the legal position.
- 10.5 All surrogacy agreements must be approved by the High Court (Children's Act No. 38 of 2005, section 292) and practitioners should ensure that this has been done before engaging in surrogacy procedures.
- 10.6 In terms of the Constitution practitioners may refuse to participate in a surrogacy procedure because of their conscience or religious beliefs (Constitution of the Republic of South Africa, 1996 section 15) provided it is not an emergency situation.

## **11. PREVENTING IATROGENIC MULTIPLE PREGNANCY**

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.

- 11.1 Multiple pregnancy has very serious implications for the mother and her offspring, for the family and the community, and for health service resources.
- 11.2 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.
- 11.3 Assisted reproductive technologies whether by the induction of ovulation, transfer of gametes, pre-embryos or embryos should only be performed by those practitioners qualified to do so and should aim to achieve singleton pregnancies. Under optimal conditions, not more than two pre-embryos or embryos should be transferred.
- 11.4 Centers offering assisted reproductive technologies should be accredited to ensure a uniformly high standard.
- 11.5 The risks for both mother and her resulting children with triplets and higher order pregnancies are sufficiently great to justify consideration by the couple and their healthcare practitioner advisors of the use of fetal reduction.
- 11.6 Couples seeking treatment for infertility must be fully informed of the risks of multiple pregnancy both to the woman and to their potential progeny.

## **12. ETHICAL GUIDELINES REGARDING THE PROCEDURE OF COLLECTION OF CORD BLOOD**

The discovery that umbilical cord-blood provided 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 need to be recognized and protected. Any advertising and marketing of cord blood storage must be done responsibly and must not exploit parents' vulnerabilities.

- 12.1 It is ethically necessary for the mother to give informed consent (before delivery) for the collection of cord-blood for banking where indicated.
- 12.2 The information that blood in the placenta is no longer of use to the baby and this "waste blood" may help to save another person's life is incomplete and does not permit informed consent.
- 12.3 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. The taking of 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.
- 12.4 Early clamping of the umbilical cord following vaginal delivery is likely to deprive the newborn infant of at least a third of its normal circulating blood volume, and it will also cause a haemodynamic disturbance. These factors may result in serious morbidity.
- 12.5 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.
- 12.6 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.
- 12.7 Any payment to the health care practitioner by the company for cord blood collection is viewed by the HPCSA as a "finder's fee" and therefore unethical.
- 12.8 There should be no alteration on the usual management of the third stage of labour
- 12.9 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***
- Booklet 2: Ethical and professional rules of the health professions council of South Africa as promulgated in government gazette R717/2006***
- 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 patients with HIV infection or AIDS***
- 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 Telemedicine***
- 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: Professional self-development***