

The duty of the pharmacist to report child abuse: A gap in the Children's Act

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Keywords: abuse and neglect, Children's Act 32 of 2005, children's rights, duty of the pharmacist, mandatory reporting

Abstract

Owing to their frequent contact with children, pharmacists should have a duty to act in the best interests of the child. This premise echoes section 28(2) of the Constitution of the Republic of South Africa. Although it is mandatory for certain persons to report the abuse or neglect of a child according to the Children's Act 32 of 2005, pharmacists are omitted from the ambit of this act. However, the use of mandatory reporting to curb the abuse and neglect of children is controversial. Despite the challenges associated with mandatory reporting, it is argued that it is far more beneficial to include mandatory reporting in the state's extensive arsenal against child abuse and neglect than to omit it. It is recognised that mandatory reporting alone is not a panacea; it must work in tandem with other state interventions to improve the plight of children. The authors therefore call for an amendment to be made to the Children's Act, whereby pharmacists and other categories of pharmacy support staff are included in the list of persons mandated to report suspected child abuse.

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S Afr Pharm J 2017;84(4):52-56

Introduction

A recent national study has found that child abuse, including violence and neglect, is a prevalent problem in South African society.¹ More than a third of the children interviewed reported having experienced physical violence committed by a caregiver.¹ The study also determined that one in every three South African children has experienced some form of sexual abuse by the age of 17 years and that a fifth have suffered neglect by the same age.^{1,2} It is thus clear that the abuse and neglect of children is a critical issue in South Africa and one that must be taken seriously. The following extract describes an experience of one of the authors while working as a pharmacy student in a community-sector pharmacy, during which she was confronted with a situation of potential child abuse:

A woman phoned the pharmacy and I took the call. She mentioned that her daughter had recurring genital warts [owing] to a specific infection and she wanted to know if there were any non-prescription ways of treating the warts, as her daughter found the gynaecologist's freezing them to be too painful. She also said that she did not know how her daughter kept getting these infections. I had never heard of this infection before, and so I told the mother that I would investigate further and call her back. I asked her how old her daughter was. She said her daughter was nine years old.

I did some reading and found that the infection is a sexually transmitted one. I called the mother and told her about this.

Her response was: 'It's the bathrooms at school. They are not clean.' The more I told her that this was a sexually transmitted infection, the more she became in denial about what I was trying to convey: that her daughter could be experiencing sexual abuse. I told the mother that she had to take her daughter back to the gynaecologist for treatment. The mother thanked me and hung up.

I was in a state of shock: a child may have been abused. What should I do? We had not dealt with anything like this in class at university. I immediately told the responsible pharmacist, who was the owner of the pharmacy and under whose supervision I was working, about the conversation and asked him about contacting the police. His response: 'No, we can't do that. We don't know what's actually happening and then Social Services will take the child away from the mother.' I remember feeling very helpless.

What are the legal responsibilities of pharmacists and pharmacy support staff regarding actual or suspected child abuse? Do pharmacy schools adequately prepare students for these legal responsibilities? As we discuss in this case study, the Children's Act 32 of 2005 lists various individuals who are legally mandated to report child abuse, but excludes pharmacists from this list.

Research question

This case study seeks to address the following research question: Should the Children's Act 32 of 2005 be amended to include pharmacists and pharmacy support staff among those individuals

who are legally mandated to report suspected child abuse and neglect to the relevant authorities?

Problem statement

We argue in this case study that pharmacists and pharmacy support staff have frequent contact with children and may come across suspected child abuse in the course of performing their duties. Section 110(1) of the Children's Act 32 of 2005 does not include pharmacists and pharmacy support staff in the list of individuals who are mandated to report suspected child abuse. We thus call for an amendment to this section of the Children's Act.

Research goal

The goal of this research is to address what is deemed to be a gap in the Children's Act. This could potentially lead to an amendment of the Act, which may contribute to the increased detection of child abuse in South Africa.

Research objectives

To achieve the research goal and address the research question, the following research objectives form the basis of this paper:

- i. to identify the weaknesses in how the real-life scenario described earlier was addressed
- ii. to determine the ways in which community-sector pharmacists and pharmacy support staff interact with children in the course of their professional practice
- iii. to analyse the current legislation in South Africa in order to determine whether pharmacists and pharmacy support staff are legally obliged to report suspected child abuse
- iv. to investigate the advantages and disadvantages of mandatory reporting of child abuse.

Weaknesses in how the real-life scenario was addressed

The following weaknesses are identified in how the described scenario was addressed:

- i. The responsible pharmacist, who is legally in charge of the pharmacy and all service provision at the pharmacy, did not appear to have adequate knowledge of the legal and reporting mechanisms pertaining to suspected child abuse. Currently, such matters are regulated by the Children's Act 32 of 2005. A child in such a situation would not be automatically removed from the care of the mother. In terms of section 110(5)–(7) of the Children's Act, the provincial department of social development or a designated child protection organisation must perform an initial assessment of the child's situation before action is taken to remedy the situation; removal from the parent's care is not an automatic consequence. The responsible pharmacist also did not seem to regard it as his duty to notify the authorities of the possible child abuse. His perceived unwillingness to become involved could

have influenced how other staff members addressed such situations in future. If unsure about what to do, the responsible pharmacist could have contacted the gynaecologist who had treated the child to discuss the matter further. According to section 2.7.3.6 of the Good Pharmacy Practice (GPP) standards (also see (iii)), which deals with confidentiality, pharmacists can divulge patient information to someone who is authorised to have such information and who is acting within his/her lawful jurisdiction. This would include the gynaecologist who had treated the child in this situation.

- ii. Although the described situation is just one encounter between a pharmacy student and a responsible pharmacist, and another responsible pharmacist may have acted differently, it does reveal some potentially serious knowledge gaps in practically and legally addressing suspected or potential child abuse in the community pharmacy setting. This suggests a gap in the training curricula of pharmacists at university. In the Pharmacy Law module, which is part of the Pharmacy Practice course, students are introduced to legislation that will guide their practice, such as the Medicines and Related Substances Act 101 of 1965, the Pharmacy Act 53 of 1974 and the GPP standards (see (iii)).
- iii. The daily practice of pharmacists and pharmacist's assistants is guided by the GPP standards as published by the South African Pharmacy Council. These are minimum standards of practice with which pharmacists are expected to comply.
 - Section 2.13.1.3(d) of the GPP standards states that pharmacists must always act in the best interests of the patient. Any non-compliance with the GPP standards can be grounds for the Council instituting disciplinary action against the pharmacy, pharmacist(s) and pharmacy support personnel.
 - According to section 2.26.7.7(b) of the GPP standards, a pharmacist must report the physical harm, sexual abuse or sexual exploitation of a child under the age of 16 years to a local or provincial authority.

The responsible pharmacist's failure to report the matter in the described case suggests that he was either unaware of the specific GPP requirement or deliberately non-compliant. The former may well have been the case, as previous research conducted at the same pharmacy³ has shown that although all pharmacists expressed a philosophical commitment to the GPP standards, there was poor awareness of what exactly these standards entail. This may have contributed to that study's findings, which showed non-compliance with a number of GPP standards.³ It is possible that this may reflect a wider problem of inadequate awareness and understanding on the part of pharmacy staff with regard to their professional and statutory responsibilities.

Pharmacists' contact with children

Pharmacists have daily contact with children and adolescents. Section 18(3) of the Constitution of the Republic of South Africa

defines a child as 'a person under the age of 18 years'. Examples of such daily encounters, particularly in the community-sector pharmacy setting, include the following:

- i. When coming to the community pharmacy, caregivers often bring children along to ask the pharmacist to recommend over-the-counter medication for certain symptoms.
- ii. According to section 22A(4)(b) of the Medicines and Related Substances Act 101 of 1965, which has been reiterated in section 2.7.5(d) of the GPP standards, medication cannot be received by anyone younger than 14 years in the absence of an adult. This does not apply to a child with a valid prescription or a written order that mentions the purpose for which the medication is to be used and which is signed by someone known to the seller of the medication and who is over the age of 14 years (section 22A(4)(b) of the Medicines and Related Substances Act). Children who are 14 years or older may collect medication from the pharmacy themselves. This includes emergency contraception, which is available over the counter. Section 2.26.7.7 of the GPP standards deals with children and parents, and sub-section (a)(iii) of this provision specifically mentions the pharmacist's obligation to provide contraceptive and reproductive health services to minors. Section 2.26.7 of the GPP standards outlines the comprehensive counselling that community pharmacists need to provide when dispensing emergency contraception. For example, pharmacists need to counsel patients about the role of long-term contraception and the risk of sexually transmitted infections and pregnancy. Furthermore, in many pharmacies patients requesting emergency contraception are asked to complete a consent form, in which one of the standard questions is whether the patient has been a victim of sexual assault. It is possible that information related to sexual abuse may be disclosed to the pharmacist in the course of counselling or in the consent form completed by the patient.
- iii. Pharmacists may be counselling children or adolescents about nutrition. Section 2.16.3 of the GPP standards outlines the nutritional advice that pharmacists should provide to patients. Sub-section (c), for example, requires pharmacists to be aware of the signs and symptoms of anorexia. It is known that sexual abuse is one of the factors that may result in the development of eating disorders.³ This information may emerge in the interaction between the pharmacist and child.
- iv. Importantly, section 2.16.4(a) states that pharmacists and pharmacy support personnel need to know about childhood problems and the need for early referral, whilst section 2.16.4(d) requires pharmacists to keep up to date with the latest guidelines on child safety. Although the GPP standards do not specify which guidelines are referred to, this section highlights the need for pharmacists to be aware of child safety issues, presumably so that appropriate interventions can be undertaken if necessary.
- v. Pharmacists have the option of obtaining a Primary Care Drug Therapy qualification in order to prescribe certain essential

medicines up to the level of Schedule 4 in accordance with section 22A(15) of the Medicines and Related Substances Act and the Standard Treatment Guidelines. This means that these pharmacists may be in the position of diagnosing a limited range of primary health care conditions in children, in a similar way that a primary health care doctor or a professional nurse would.

- vi. Pharmacists may also interact with the perpetrators of child abuse and may find out about the abuse in this manner. Pharmacists may interact with perpetrators in both their professional capacity as pharmacists or in their personal standing as family members or members of the community.

It should be noted that whilst we have decided to focus on community-sector pharmacies, pharmacists working in other types of pharmacy, such as institutional pharmacies, could also be interacting with children. However, the nature and frequency of such contact are likely to be more limited compared with that experienced by the community-sector pharmacist, as community pharmacies are often open for longer and may be geographically closer to many caregivers. We also need to consider the role of pharmacy support personnel, in particular pharmacist's assistants and pharmacy technicians. According to the Pharmacy Act and its Regulations, which outline the scope of practice of pharmacy staff, pharmacist's assistants have to work under the direct personal supervision of a pharmacist. However, long queues, a shortage of pharmacists and poor awareness of the GPP standards and the appropriate scope of practice for pharmacy staff can result in pharmacist's assistants working without adequate supervision.⁴ Pharmacist's assistants often dispense over-the-counter medication and may thus also interact closely with children and caregivers. It is thus important that, in addressing the gap identified in the Children's Act, we do not mention only pharmacists, but also other categories of pharmacy staff.

Is a pharmacist in South Africa legally obliged to report the abuse or neglect of a child?

In terms of section 110(1) of the Children's Act, certain persons who, on reasonable grounds, conclude that a child has been abused in a manner causing physical or sexual harm or deliberate neglect, must report that conclusion in the prescribed form to a designated child protection organisation, the provincial department of social development or a police official. The provision clearly and intentionally defines the kind of abuse or neglect to be reported so as to ensure that reports are limited to those cases where intervention from the authorities is actually required.⁵ The provision is quite specific about which persons are listed and appears to target an extensive pool of persons, aimed at widening the net of reporters. As alluded to earlier, pharmacists are excluded from this list. Upon closer examination of the definitions section of the Children's Act (section 1), the pharmacist is not even listed under broader categories such as medical practitioners or social services professionals. Given that this is a closed list of persons, it is apparent that section 110(1) has omitted pharmacists from its

ambit. It seems unlikely that this was an intended omission, seeing that the legislature was quite careful about ensuring that the list included all those who interact with children on either a regular or ad hoc basis.

Not including pharmacists in section 110(1) has several disadvantages. Firstly, owing to the regular contact that pharmacists have with children, it would be important to equip pharmacists with such an obligation in order to safeguard the needs and best interests of the child. Secondly, owing to the omission in the provision, there is no legal requirement for pharmacists to be trained or equipped with knowledge on how to react in the case of suspected child abuse. The GPP standards, for example, do not include minimum standards for the reporting of suspected child abuse. Hence, as in the case described earlier, advice given to students or pharmacy support personnel may be uninformed and do more harm than good. Suspected abuse or neglect can therefore go unnoticed and may persist until one of the persons listed in section 110(1) is alerted to the situation. Thirdly, other statutory reporting obligations applicable to pharmacists do not carry the same might and weight. For example, section 110(2) of the Act states that any person who, on reasonable grounds, believes that a child is in need of care and protection may report that observation to the provincial department of social development, a designated child protection organisation or a police official. This provision applies to all persons and is known as 'community reporting'. When such a report is made in good faith, a person cannot be liable to civil action on the basis of the report (section 110(3) of the Children's Act). There is no prescribed form to be completed. It is notable that the reporting is not mandatory in such a case, nor is a criminal sanction applicable for a failure to report.

Is mandatory reporting the solution?

Mandatory reporting is skeptically perceived to be a reactive rather than a proactive response to child abuse.⁶ It has been argued that it results in 'legalistic "case-by-case" solutions', which do not do much to address the societal factors associated with the problem.⁶ Furthermore, South African medical practitioners are anecdotally reported to fear legal reprisals after reporting.⁷ It appears that these issues may be broadly related to certain misunderstandings about the operation of section 110. In terms of section 110(3)(b), a person who files a report in terms of the provision is not liable to civil action on the basis of the report. However, the machinery in place to deal with the child post reporting has limitations. For example, according to the South African Police Services, 495 540 cases of crimes against children were reported in the period 2012–2013.⁷ For the effective implementation of the Children's Act, 66 329 social workers are required, yet only 16 164 social workers are registered with the Council of Social Workers.⁸ The ratio of police officer to population is 1:336.⁷ These statistics indicate a shortage of resources available for dealing with child abuse and neglect. Aggravating this situation is the 'disturbing levels of complicity by families, the police and other services'.⁶ Despite there being strong

support for mandatory reporting in South Africa, some fear that the system can create fodder for the secondary abuse of a child, as the proper infrastructure is not in place.⁵

Takis⁹ summarises the various positions on mandatory reporting. She postulates that while the point of mandatory provisions is to remove the discretionary aspect of the obligation, it can simultaneously lead to unsubstantiated notifications and over-reporting owing to reporters being unable to exercise their judgement.⁹ However, mandatory reporting has the advantage of bringing more cases to the attention of authorities, most of which are substantiated.¹⁰ Furthermore, it increases the participation of professionals in the prevention of child abuse.⁹ Despite these advantages, appropriate infrastructure needs to be in place to ensure the system's effective implementation. Increased reports lead to resources being diverted to investigation rather than being put to use for the visibly more serious cases of abuse and neglect.¹¹ This drain on the system is worsened by multiple reports being submitted relating to the same case owing to poor feedback or a perceived lack of action taken on the part of government authorities.⁹

According to section 110(1) of the Children's Act, a high standard of proof is required before a report can be submitted. In terms of regulation 33, a report (to the provincial department of social development, a designated child protection organisation or a police official) must comply with form 22. The extensive information required in form 22 verifies this high threshold, as it requires the following: details of the informant and the child; information providing evidence of the alleged abuse or neglect; the possible perpetrator and his/her identifying details; any previous history of abuse known to the informant; any prior Children's Court interventions; details of the circumstances in which the present abuse or neglect occurred; details regarding medical interventions, and previous social work interventions or police actions taken in relation to the abuser. Whilst the obvious advantage of this high standard means that reports are filtered before reaching the applicable authorities, thus reducing the drain on resources, it may give rise to professionals being reluctant to report without proper substantiation.⁵ Another disadvantage stated by a South African child rights advocacy group is that unsubstantiated reports can create a worse situation for the child by making the child susceptible to retaliatory abuse.

It would seem that these factors could be argued in two ways. On the one hand, mandatory reporting may ensure the safety of the child by allowing the relevant state authorities to intervene in the matter. On the other, it may increase the risk for retaliatory abuse.¹² Despite compelling arguments, mandatory reporting does have an important role in protecting children from further abuse or neglect. A legislative provision compelling particular groups of professionals and others who may have direct and frequent contact with children makes it clear that the responsibility is on *society* to protect children, seeing that abuse or neglect is often shielded within the private sphere.¹³ It is important that the

legislation carefully identifies the reporters because this impacts on the training of such professionals.

In summary, mandatory reporting does not necessarily translate to an increase in the reporting of child abuse and in itself is not enough to improve the plight of abused or neglected children. Mandatory reporting is not a panacea, but should be part of a broader solution aimed at comprehensively addressing the issue. More resources need to be in place and proactive steps need to be taken to address the societal problems linked to child abuse and neglect. This will improve the plight of these children once substantiated reports have been investigated. Finally, it should be noted that if the Children's Act is amended to include community pharmacists and pharmacy support staff in the list of health care professionals mandated to report suspected child abuse, amendments may also need to be made to relevant legislation related to pharmacy education and practice. For example, the Good Pharmacy Education Standards, the Regulations Relating to Pharmacy Education and Training and the GPP standards would all need to be amended to take mandatory reporting into account.

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