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**University of Cape Town**  
**School of Advanced Legal Studies**  
**Dissertation for Masters in Social Justice (MPhil)**

**REPRODUCTIVE AUTONOMY AND CHOICE:  
A REALITY FOR WOMEN IN SOUTH AFRICA?**

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**Reproductive Autonomy and Choice: A Reality for Women in South Africa?**

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**DECLARATION**

Research dissertation/research paper presented for the approval of Senate in part fulfilment of the requirements for the Masters in Social Justice (MPhil) in approved courses and a minor dissertation/research paper. The other part of the requirement for this qualification was the completion of a programme of courses.

I hereby declare that I have read and understood the regulations governing the submission of Masters in Social Justice (MPhil) dissertations/research papers, including those relating to length and plagiarism, as contained in the rules of this University, and that this dissertation/research paper conforms to those regulations.

Signature \_\_\_\_\_

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**ABBREVIATIONS AND ACRONYMS**

AAI	AIDS Accountability International
ACHPR	African Commission on Human and Peoples' Rights
African Charter	African Charter on Human and Peoples' Rights
African Women's Protocol	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
AGI	Alan Guttmacher Institute
AI	Amnesty International
AIDS	Acquired immunodeficiency syndrome
AU	African Union
CCIHP	Centre for Creative Initiatives in Health and Population
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CHC	Community Health Centre
CLA	Christian Lawyers Association
CPD	UN Commission on Population and Development
CRR	Centre for Reproductive Rights
CTOP	Choice on Termination of Pregnancy Act
DoH	Department of Health
ECHR	European Court of Human Rights
FGM	Female Genital Mutilation
FIDA	International Federation of Women Lawyers
HIV	Human immunodeficiency virus
HRC	Human Rights Committee

ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MDG	Millennium Development Goal
MEC	Members of Executive Council
MMR	Maternal Mortality Ratio
MRC	Medical Research Council
NGO	Non-governmental organization
PAC	Post-Abortion Care
PoA	Programme of Action
SOAWR	Solidarity for African Women's Rights Coalition
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
TFR	Total Fertility Rate
TMBs	Treaty Monitoring Bodies
UN	United Nations
UN HRC	Human Rights Council
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

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## CHAPTER 1. INTRODUCTION

*“I do not wish them [women] to have power over men; but over themselves.”*

*Mary Wollstonecraft<sup>1</sup>*

### 1.1 RESEARCH QUESTION

Are women in South Africa autonomous decision-makers in their sexual and reproductive lives?

### 1.2 MOTIVATION FOR RESEARCH

The research investigates the extent to which social norms and beliefs in South Africa impact a woman’s autonomy and decision-making ability in respect of sexual and reproductive health. Despite the normative frameworks that address and promote sexual and reproductive health rights in South Africa, the realisation of rights in practice can become a distant reality for women. The increase in unsafe abortions and rates of maternal mortality in South Africa imply that barriers exist between individuals and health services. Barriers to access cause woman to opt for unsafe, ‘backstreet’ abortion services where privacy and confidentiality is maintained.

The research identifies and analyses how social norms act as barriers that hinder a woman’s choice and freedom to exercise her rights to access and services in terms of sexual and reproductive health.

In South Africa, there exists a conflict between reproductive freedom of the individual and social norms and beliefs that impede a woman’s liberty and decision-making abilities. This conflict is apparent in evidence that shows that while South Africa is one of three African countries to legalise abortion<sup>2</sup> and provide post-

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<sup>1</sup> Mary Wollstonecraft ‘*A Vindication of the Rights of Woman*’ (1792) ch 1.

<sup>2</sup> Cape Verde and Tunisia are the other African countries where abortion is provided without restriction as to a reason. See ‘*Facts on Abortion in Africa*’ (2010) Guttmacher Institute.

abortion care, rates of maternal mortality and the use of unsafe abortion services remain high.<sup>3</sup>

Alongside issues of access and available resources, women in South Africa also suffer from a history of inequality based on race, gender, culture and socio-economic status.<sup>4</sup> This discrimination is more apparent as it is situated within a traditionally male-dominant, patriarchal society. In this regard, historically and socially, women have had very little participation ability and decision-making power, particularly related to sex and gender-based issues.<sup>5</sup>

### 1.3 RESEARCH OBJECTIVES

- i. To analyse the current and historical social and cultural influences that impact a woman's decision to utilise unsafe and illegal abortion services.
- ii. To analyse how sexual and reproductive health rights are protected, promoted and fulfilled under international and regional human rights law.
- iii. To interpret behaviour and attitudes surrounding abortion and reproductive autonomy amongst health care providers in South Africa.
- iv. To understand the sexual and reproductive-related rights and freedoms of women under the South African Constitution and The Choice on Termination of Pregnancy Act (CTOP).
- v. To analyse if and how conscientious objection invoked by a health care provider serves as a barrier to access in South Africa.
- vi. To identify the shortcomings and gaps in the implementation of the CTOP Act.

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<sup>3</sup> Millennium Development Goal 5 aims to reduce maternal mortality by 75 per cent (roughly 38 per 100,000 live births). UNDP South Africa has stated that with a maternal mortality rate (MMR) of 625 in 2010 (an increase from 369 in 1994) that it is 'unlikely' that South Africa will meet MDG5. UN Millennium Declaration Resolution (2000), adapted by the 55<sup>th</sup> session, General Assembly. See [www.undp.org.za/millennium-development-goals/mdgs-in-south-africa](http://www.undp.org.za/millennium-development-goals/mdgs-in-south-africa) accessed on 2 January 2013.

<sup>4</sup> Hoosen Coovadia et al. 'The health and health system of South Africa: historical roots of current public health challenges' (2009) 374 *Lancet* 817 at 817.

<sup>5</sup> *Ibid.*

## **1.4 METHODOLOGY**

The dissertation analyses literature from secondary sources, including journals, reviews, books and articles. Case law and human rights frameworks (both international and regional) will be used as benchmarks to interpret national legislation and state responsibility. Additional sources will be utilised from relevant databases, journals and online sources.

Utilising secondary sources will allow the researcher to achieve the objectives highlighted above. The dissertation will incorporate organisation-based reports that provide insight into the experiences of women seeking services in South Africa. These organisations include: Centre for Reproductive Rights (CRR), Marie Stopes International, Amnesty International (AI), Women's Legal Centre (WLC), Human Rights Watch (HRW) and Action Aid International (AAI).

The literature will allow the researcher to analyse the various themes as written about in the publications and resources listed above. The themes involve specific investigation of sexual and reproductive health rights and the following sub-categories: autonomy, choice, social norms, stigma, Africa and human rights law. The analysis will allow the researcher to interpret how themes appear in literature and to detect thematic patterns and trends.

## **1.5 OVERVIEW OF CHAPTERS**

### **1.5.1 CHAPTER 2: INTERNATIONAL FRAMEWORKS**

This chapter investigates the development of sexual and reproductive health rights through the standards found in key United Nations (UN) international frameworks and in pivotal conference documents. It highlights how the right to abortion, though not explicitly stated in international human rights law, is implicit in nature through the realisation of other rights.

### **1.5.2 CHAPTER 3: AFRICAN NORMATIVE FRAMEWORKS**

This chapter investigates the human rights frameworks in Africa, specifically analysing the provisions of the African Charter on Human and Peoples' Rights<sup>6</sup> (African Charter) and the Protocol to the African Charter on Human and Peoples'

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<sup>6</sup> Organization of African Unity, African Charter on Human and Peoples' Rights CAB/LEG/67/3 (1982) [hereinafter the African Charter].

Rights on the Rights of Women in Africa<sup>7</sup> (Women's Protocol) pertaining to a woman's health and reproductive freedom.

The African Charter is the fundamental human rights framework of the African Union (AU). The Charter is distinctive in that it addresses the collective 'peoples' rights, yet has been criticised for its failure to holistically address women's rights.<sup>8</sup> To fill this gap, the Women's Protocol was adopted in 2003, becoming the first human rights instrument to explicitly address a woman's right to abortion.<sup>9</sup>

### 1.5.3 CHAPTER 4: SOUTH AFRICAN CASE STUDY

This chapter analyses South Africa as a case study looking at how laws pertaining to sexual and reproductive health are converted into reality. The reason for choosing South Africa as a case study is to illustrate how, since the end of Apartheid, the South African government has had the opportunity to create a new legal framework and pass instrumental sexual and reproductive health-related laws and policies that aim to give women complete control over their reproductive choices.

The chapter will point to statistics pertaining to maternal-related deaths and incomplete abortions and demonstrate how the implementation of South African laws remains unrealised for some women, particularly poor, non-white women.

### 1.5.4 CHAPTER 5: CONCLUSION & RECOMMENDATIONS

This chapter will pull together the findings of the research with the intent on highlighting how relevant and related abortion laws and policies look in practice and where gaps arise during implementation. It offers recommendations to how countries should enhance education and awareness efforts as well as evaluate gaps in the implementation process, so that social norms and perceptions shift in accordance with new legal frameworks. Lastly, the chapter will offer suggestions for future research based on gaps in the literature and current narratives.

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<sup>7</sup> African Union, Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa AHG/Res. 240 (XXXI) (2003) [hereinafter the Women's Protocol].

<sup>8</sup> Charles Ngwena 'Sexual Health and Human Rights in the African Region' (2011) Working Paper WHO, unpublished at 9 available at [www.ichrp.org/files/papers/185/140\\_Ngwena\\_Africa\\_2011.pdf](http://www.ichrp.org/files/papers/185/140_Ngwena_Africa_2011.pdf) accessed on 28 September 2012.

<sup>9</sup> Women's Protocol article 14.

## 1.6 BACKGROUND TO SEXUAL & REPRODUCTIVE HEALTH

It was not until the end of the twentieth century that women's rights became a predominant issue on the international human rights agenda. Historically, women have been under-represented in the development of policy, decision-making procedures and in issues most relevant to their lives i.e. their sexual and reproductive health.<sup>10</sup> The under-representation of women in the public domain rendered women voiceless on issues pertaining to their home and family lives.<sup>11</sup> Previously, state intervention was not permissible in the 'private sphere', despite it being the area where the majority of female oppression and subordination took place.<sup>12</sup> The combination of male dominance in the private sphere and limited female representation in the public domain disabled a woman's ability to exercise her sexual and reproductive health rights. The choice of if and when to have children and whether or not to use contraception or family planning measures has been ultimately dictated by men.<sup>13</sup>

Aside from inequitable gender relations, social, cultural and economic changes have had a direct influence on reproductive decisions of a family. Cook and Dickens highlight that in recent years, countries have shifted toward a smaller family size as employment opportunities for women have increased.<sup>14</sup> The attempt to control one's fertility caused an uptake in contraceptive use and family planning methods, increasing an individual's potential risk to contraceptive failure.<sup>15</sup>

## 1.7 SEXUAL AND REPRODUCTIVE HEALTH AS A HUMAN RIGHT

Over the last three decades, sexual and reproductive health has made significant advancement in international human rights law. This progression affirmed the view of Cook and Fathall who argue that '[w]omen's health is often

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<sup>10</sup> Hilary Charlesworth et al. 'Feminist Approaches to International Law' (1991) 85 *American Journal International Law* 613 at 622.

<sup>11</sup> Arvonne S Fraser 'The Origins and Development of Women's Human Rights' (1999) 21:4 *Human Rights Quarterly* 853 at 906.

<sup>12</sup> Ursula A O'Hare 'Realizing Human Rights for Women' (1999) 21 *Human Rights Quarterly* 364 at 368.

<sup>13</sup> Ibid.

<sup>14</sup> Rebecca J Cook and Bernard M Dickens 'Human Rights Dynamics of Abortion Law Reform' (2003) 25:1 *Human Rights Quarterly* 1 at 59.

<sup>15</sup> See Peter Kim Streatfield 'Role of Abortion in Fertility Control' (2001) 19:4 *Journal of Health, Population and Nutrition* 265 at 266.

compromised not by lack of medical knowledge, but by infringements on women's human rights'.<sup>16</sup> This argument highlights the shift that recognised sexual and reproductive health not just as a health issue, but as a human rights issue.

Zampas and Gher argue that 'it is the evolution of human rights interpretations and applications, stemmed by increased sophistication, women's empowerment and changing times, which have given force to women's human right to abortion'.<sup>17</sup>

Though not explicitly stated in international frameworks, the right to abortion is implicit in interpretation through various fundamental human rights, including the right to equality and non-discrimination, the right to life, the right to health and the right to reproductive freedom.

Stemming from the general frameworks, UN treaty monitoring bodies (TMBs) have addressed abortion and reproductive freedom in concluding observations, general recommendations and case decisions, encouraging states to decriminalise abortion, provide health services specific to women and enhance state reporting measures that demonstrate access and availability to safe services.<sup>18</sup>

Though sexual and reproductive health has gained stronger ground, Cook and Dickens conclude that the progressive realisation of the right to abortion has left women and health care providers to interpret abortion procedures on personal, moral and ethical beliefs.<sup>19</sup> Even when states decriminalise abortion, opposition and objection continues by individuals, communities and health practitioners, often on the basis of beliefs and social norms. For example, opposition to abortion services was prominent amongst the Roman Catholic Church. During the International Conference on Population and Development (ICPD)<sup>20</sup> in 1994, the Vatican Church

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<sup>16</sup> Rebecca J Cook and Mahmoud F Fathalla 'Advancing Reproductive Rights Beyond Cairo and Beijing' (1996) 3:22 *International Family Planning Perspectives* 115 at 115.

<sup>17</sup> Christina Zampas and Jamie M Gher 'Abortion as a Human Right – International and Regional Standards' (2008) 8 *Human Rights Law Review* 249 at 252.

<sup>18</sup> UN Population Fund (UNFPA) and Center for Reproductive Rights (CRR) 'Reproductive Rights: A Tool for Monitoring State Obligations' (2011) at 10-22.

<sup>19</sup> Cook and Dickens (2003) op cit note 14 at 15.

<sup>20</sup> Report of the International Conference on Population and Development (1994) U.N. Doc. A/Conf.171/13 [hereinafter the ICPD].

made a public statement to oppose abortion, making it one of the key focal points for international media following the ICPD.<sup>21</sup>

## 1.8 APPLYING A RIGHTS-BASED FRAMEWORK

In recent decades, literature has suggested that sexual and reproductive health be recognised under a rights-based framework: *the right to decide if and when to have a child has shifted from a health issue to a human rights issue*. Using international human rights law as a foundation enables a woman the right to equality and freedom of choice in sexual and reproductive decisions. The concept of a rights-based approach to reproductive health was first adopted at the ICPD and has been implemented by organisations ever since. A report produced by Eldis adds that a rights-based approach to sexual and reproductive health ‘exposes the social, cultural, political and economic influences and inequalities that are discriminatory and create barriers to access’.<sup>22</sup> Kols reaffirms the findings of the Eldis report and highlights that a rights-based approach identifies root causes and inequalities of inadequate access and care.<sup>23</sup>

On a policy level, the United Nations Population Fund (UNFPA) argues that utilising a rights-based approach adds clarity to the obligations of states to protect, promote and fulfil the rights of women.<sup>24</sup>

## 1.9 DEBATES ON ABORTION

Despite the progressive measures to acknowledge abortion under human rights law and amend current policies and laws, debates around abortion and the rights of the foetus versus the rights of mother have become more visible and have impacted the implementation of abortion-related laws for women.

<sup>21</sup> Axel I Mundigo ‘Determinants of unsafe induced abortion in developing countries’ in *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (2006) Guttmacher Institute 51 at 63.

<sup>22</sup> Realising Rights and Institute of Development Studies (IDS) ‘Universal access to sexual and reproductive health services’ available at [www.eldis.org/index.cfm?objectId=23544FED-9E56-8F30-993E6FD844D902FA](http://www.eldis.org/index.cfm?objectId=23544FED-9E56-8F30-993E6FD844D902FA) accessed on 14 December 2012 at 3.

<sup>23</sup> A Kols ‘A Rights-Based Approach to Reproductive Health’ (2003) 20:4 *Outlook* 1 at 2-3.

<sup>24</sup> UNFPA ‘The Human Rights-Based Approach’ available at [www.unfpa.org/rights/approaches.htm](http://www.unfpa.org/rights/approaches.htm) accessed on 17 November 2012.

A current approach to abortion reform by pro-life activists is known as the ‘woman-protective argument’ and is said to safeguard women’s health and their choices as mothers by prohibiting abortion.<sup>25</sup> Siegel uses the ‘woman-protective’ movement to highlight how anti-abortion claims have shifted from protecting the life of the foetus to ‘gender-based justifications’ to protest the termination of pregnancy.<sup>26</sup> The gender-based justification interprets the needs and wants of a woman through the lens of motherhood. Assumptions are made that pregnant women are in an irrational, emotional state and thus vulnerable to make termination decisions that they would regret.<sup>27</sup>

These assumptions negate a woman’s individual decision-making ability and reiterate the stereotype of a woman’s role in family and spousal domains. Siegel links the ‘woman-protective’ theory to countries that criminalise abortion, noting how these approaches illustrate how criminal sanctions are not solely based on the protection of the unborn, but also about judgments made toward women.<sup>28</sup> Cook and Dickens highlight that the argument insinuates that women need to be ‘protected’ through restrictive abortion laws, so to prevent a woman being coerced into having an abortion or by their own irrational decision to terminate a pregnancy.<sup>29</sup>

The woman-protective argument was illustrated in the 2007 case of *Gonzales v. Carhart*<sup>30</sup> where the US Supreme Court prohibited a form of abortion under the Partial-Birth Abortion Ban Act of 2003 (S. 3, 108th Congress). The case illustrated the stereotype of women’s ‘inability’ to make reproductive decisions when the judge banned a specific method of abortion because women, he claimed, may later regret their decision.<sup>31</sup> The Supreme Court noted:

*Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to*

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<sup>25</sup> Maya Manian ‘The Irrational Woman: Informed Consent and Abortion Decision-Making’ (2009) 16 *Duke Journal of Gender Law & Policy* 223 at 224.

<sup>26</sup> Reva B Siegel ‘The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions’ (2007) 119 *Public Law Working Paper* 991 at 999.

<sup>27</sup> *Ibid.*

<sup>28</sup> *Ibid.*

<sup>29</sup> Simone Cusack and Rebecca J Cook ‘Stereotyping Women in the Health Sector: Lessons from CEDAW’ (2009) 16 *Washington and Lee Journal of Civil Rights and Social Justice* 47 at 66.

<sup>30</sup> *Gonzales v. Carhart* 550 U.S. 124 (2007) at 159-160.

<sup>31</sup> Manian op cit note 25 at 224.

*abort the infant life they once created and sustained. Severe depression and loss of esteem can follow.*<sup>32</sup>

The view that women have limited personal agency to make reproductive decisions is exacerbated by male-dominated ideologies that place family and spousal decisions in the hands of a man.<sup>33</sup> The belief that women have a reproductive obligation, impedes the rights of women, including their right to equality and non-discrimination, the right to liberty and security and the right to reproductive freedom.

## **1.10 SYSTEMIC BARRIERS TO ABORTION**

Barriers that prevent women from accessing and utilising safe and legal abortion services are interdependent, interrelated and operate on all levels of society. Social ecological theories (as illustrated below) can be used to identify systemic barriers and the underlying root causes of poor service use. Gombachika et al. highlights that the social ecological framework as an analytical tool identifies barriers to access from the individual, interpersonal, community and societal levels. Price and Hawkins illustrate how individual and systemic conditions are interwoven, pointing to reproductive behaviour as an example and how it is entrenched in social relations and influenced by cultural and political contexts.<sup>34</sup>

### **1.10.1 ECOLOGICAL THEORY OF DEVELOPMENT**

The theory that strongly illustrates the relationship between the individual and the external influences is Bronfenbrenner's Ecological Theory of Development.<sup>35</sup> The model examines influences from a microsystem (direct contact with individual), mesosystem (two or more relations), exosystem (larger social system), macrosystem (attitudes and ideologies) and chronosystem (time and historical events).<sup>36</sup> The model is a useful tool to analyse interactions between a person and their environment, to improve relationships between subjects and to improve one's environment so to maximize individual potential.<sup>37</sup> The Center for

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<sup>32</sup> *Gonzales v Carhart* op cit note 30 at 159.

<sup>33</sup> Manian op cit note 25 at 225.

<sup>34</sup> Neil L Price and Kirstan Hawkins 'A Conceptual Framework for the Social Analysis of Reproductive Health' (2007) 25:1 *Journal of Health, Population and Nutrition* 24 at 24.

<sup>35</sup> Urie Bronfenbrenner *The ecology of human development: experiments by nature and design. Cambridge* (1979) at 330.

<sup>36</sup> *Ibid.*

<sup>37</sup> Price op cit note 34 at 24.

Creative Initiatives in Health and Population (CCIHP) used Bronfenbrenner's model to explore issues of gender and sexuality and the relationship at the individual, family, community and state level.<sup>38</sup> The CCIHP highlighted that at the macro-level of Bronfenbrenner's model, research must be conducted to understand perceptions of sexuality and gender and their roles in society.<sup>39</sup> The levels in Bronfenbrenner's framework are interrelated and subsequently influence one another. Stokols adds that an ecological model provides a holistic review of an individual's life and analyses the socio-economic, cultural, political, environmental, organisational, psychological and biological influences of behaviour.<sup>40</sup> The ecological model affirms that, despite individual choice and needs, factors at various layers ultimately influence an individual's behaviour and decisions.<sup>41</sup>

As will be shown in Chapter Four, the impact of social norms, attitudes and beliefs have had a severe impact on the accessibility of services for women in South Africa. South Africa would benefit from using Bronfenbrenner's framework as a way to both understand root causes and influences and to identify the barriers women face when deciding to pursue an abortion (see Appendix A on page 94).

#### 1.10.2 RESISTANCE BY HEALTH CARE PRACTITIONERS

Social norms and personal beliefs influence a health care provider's willingness to perform an abortion. At a structural level, conscientious objection invoked by health care providers to perform abortion services has become a significant barrier for women seeking and accessing safe and legal services. The New Dictionary of Medical Ethics defines conscientious objection as follows: 'to object in principle to a legally required or permitted practice'.<sup>42</sup>

A study cited in the *African Journal of Reproductive Health* illustrates the perceptions that providers have towards safe abortion procedures in Ethiopia. When respondents were asked about suggested solutions to reduce the incidence of unsafe, backstreet abortions, nearly 90 per cent suggested greater use and access to modern

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<sup>38</sup> Dai Hoc Hoa Sen 'A workshop: A Social Ecological Framework for Exploring Gender, Sexuality and Health' available at <http://gas.hoasen.edu.vn/en/gas-page/workshop-social-ecological-framework-exploring-gender-sexuality-and-health-0> accessed 18 November 2012.

<sup>39</sup> Ibid.

<sup>40</sup> Daniel Stokols 'Translating social ecological theory into guide- lines for community health promotion' (1996) 10:4 *American Journal of Health Promotion* 282 at 298.

<sup>41</sup> Price op cit note 34 at 31-32.

<sup>42</sup> KM Boyd, R Higgs and A.J. Pinching 'The New Dictionary of Medical Ethics' (1997) at 54-55.

contraceptives.<sup>43</sup> Less than 30 per cent of respondents suggested the increased use of safe and legal abortion services, while only 10 per cent stated the legalisation of abortion as a solution.<sup>44</sup> These statistics infer that while health care providers understand the consequences of unsafe abortion, very few consider performing safe and legal services as a viable option to eradicating the use of unsafe procedures.

### 1.10.3 ISSUES SURROUNDING CONSCIENTIOUS OBJECTION

Contention exists between the right to reproductive freedom by a woman and the right to freedom of conscience by a health care provider. This conflict creates a grey area to determine the obligations of a medical practitioner who is expected to assist a woman during an abortion.

The right to conscience is a fundamental right found in international human rights instruments. Under article 18 of the Universal Declaration of Human Rights<sup>45</sup> (UDHR), an individual has the right to freedom of thought, religion and conscience and the right ‘to manifest his religion or belief in teaching, practice, worship and observance’. The Human Rights Committee (HRC) addressed a similar provision through article 18 of the International Covenant on Civil and Political Rights (ICCPR)<sup>46</sup> and added that: ‘the terms ‘belief’ and ‘religion’ are to be broadly construed’.<sup>47</sup> Broadening the scope of conscience, belief and freedom warrants an individual the protection to exercise this right in various aspects of their life, without the association of a tradition or religion. Though medical personnel may be protected to object under grounds of conscience, there have been several instances in recent years where the practitioner’s objection has severely impacted the health and life of the mother.

In *P & S v. Poland*,<sup>48</sup> the European Court of Human Rights (ECHR) found that Poland violated its duty to protect a woman’s life after being denied an abortion

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<sup>43</sup> Jemila Abdi and Mulugeta B Gebremariam ‘Health Providers’ Perception towards Safe Abortion Service at Selected Health Facilities in Addis Ababa’ (2011) 15:1 *African Journal of Reproductive Health* 31 at 33.

<sup>44</sup> *Ibid.*

<sup>45</sup> Universal Declaration of Human Rights (1948) U.N. Doc. A/810 [hereinafter the UDHR].

<sup>46</sup> International Covenant on Civil and Political Rights (1966) U.N. Doc. A/6316 [hereinafter the ICCPR].

<sup>47</sup> ICCPR article 18.

<sup>48</sup> *P and S v. Poland* No. 57375/08 ECHR (2008).

following rape.<sup>49</sup> The 14-year-old girl had visited three different health care facilities and was denied, harassed and rejected by doctors who invoked conscientious objection and created false information regarding requirements for eligibility.<sup>50</sup> This case is an example of how maintaining restrictive abortion laws and denying women access to services (to the point of endangering a woman's life) is a fundamental violation of rights and freedoms embodied in international human rights frameworks.

In South Africa, health care providers working in public state-funded hospitals cannot turn away clients.<sup>51</sup> Under the South African Constitution,<sup>52</sup> doctors are legally obligated to render assistance in emergency cases.<sup>53</sup> By interpretation, in non-emergency situations, health care providers who invoke conscientious objection must provide access to information and a referral to another facility.<sup>54</sup> Additionally, section 4(3)(c) of the National Health Act mandates state-funded clinics and community health centres (CHCs) to provide women (subject to specified conditions) with free termination of pregnancy services. The legal obligations under the CTOP Act are in line with the Convention on the Elimination of All Forms of Discrimination (CEDAW)<sup>55</sup> Committee's General Recommendation 24, which highlighted its concern over conscientious objection and its discriminatory impact on a woman's reproductive freedom, and advises states to 'ensure that women are referred to alternative health care providers'.<sup>56</sup>

In South African law, the right to conscientious objection stems from the right to freedom of conscience, thought and belief<sup>57</sup> that is enshrined in the South African Bill of Rights.<sup>58</sup> The right to conscience elevates the autonomy and liberty of

<sup>49</sup> European Court of Human Rights 'Teenage girl who was raped should have been given unhindered access to abortion' (2012) available at [www.humanrightseurope.org/2012/10/court-teenage-girl-who-was-raped-should-have-been-given-unhindered-access-to-abortion/](http://www.humanrightseurope.org/2012/10/court-teenage-girl-who-was-raped-should-have-been-given-unhindered-access-to-abortion/) accessed 5 January 2013.

<sup>50</sup> Ibid.

<sup>51</sup> See section 1(25)(a) of the South African National Health Act, 2004 (No. 61 of 2003). Refer to section 25 (2) of the Act where 'health services' includes reproductive health care and emergency treatment, as stated in section 27(1)(a) of the South African Constitution.

<sup>52</sup> Constitution of the Republic of South Africa, 1996.

<sup>53</sup> Ibid section 27(3) and chapter 2 section 5 of the National Health Act.

<sup>54</sup> Detail provided by Nikki Naylor and Michelle O'Sullivan 'Conscientious Objection and the Implementation of the Choice on Termination of Pregnancy Act 92 of 1996 in South Africa' (2010) Women's Legal Centre and IPAS at 12.

<sup>55</sup> The Convention on the Elimination of All Forms of Discrimination Against Women (1979) U.N. Doc. A/34/36 [hereinafter CEDAW].

<sup>56</sup> CEDAW General Recommendation 24 (1999) A/54/38 para 11.

<sup>57</sup> David McQuoid-Mason 'State doctors, freedom of conscience and termination of pregnancy revisited' (2010) 3:2 *South African Journal of Bioethics and Law* 75 at 76.

<sup>58</sup> Section 15, chapter 2 of the Constitution of South Africa, 1996.

an individual and is applied without discrimination. As will be illustrated in Chapter Four, though a health care provider's objection to an abortion is protected under the South African Bill of Rights, obligations are set under the Choice on Termination of Pregnancy Act, 1996<sup>59</sup> (CTOP) that limits the extent to which a provider can exercise the objection. Under the provisions of the CTOP Act, section 10(1)(c) of CTOP reads that medical personnel may not obstruct access to an abortion facility or prevent a lawful termination.<sup>60</sup> 'Obstructing access' can be read as withholding information regarding the patient's rights under CTOP or a referral that enables the patient to seek an abortion elsewhere.

### 1.11 CONSEQUENCES OF BARRIERS TO SAFE AND LEGAL ABORTIONS

The barriers mentioned above influence a woman to seek illegal and unsafe, 'backstreet' abortions. Though women may be aware of the risks of these services, the procedure preserves a woman's privacy and poses no hurdles to access. Cook and Howard add that the phrase 'backstreet' does not solely indicate the unlawfulness of the abortion service, but is also a euphemism for the 'depressing measure of the costs of a woman's pursuit of autonomy and freedom of choice'.<sup>61</sup>

The World Health Organization (WHO) has come to define an unsafe abortion as 'a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both'.<sup>62</sup> In recent decades, the rates of unsafe and illegal abortion procedures have increased and efforts to support women and remove barriers of access have been inadequate. Statistics indicate that roughly 22 million unsafe abortions take place on an annual basis worldwide, with roughly 98 per cent of those procedures occurring in developing countries.<sup>63</sup>

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<sup>59</sup> Act No. 2 of 1996.

<sup>60</sup> Naylor op cit note 54 at 12.

<sup>61</sup> Rebecca Cook and Susannah Howard 'Accommodating Women's Differences Under the Women's Anti-Discrimination Convention' (2007) 56:4 *Emory Law Journal* 1040 at 1078.

<sup>62</sup> Statistic featured in David Grimes 'Reducing the complications of unsafe abortion: the role of medical technology' in *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (2006) Guttmacher Institute at 74.

<sup>63</sup> World Health Organization (WHO) 'Safe abortion: technical and policy guidance for health systems' (2012) at 17.

Africa has one of the highest rates of unsafe and illegal abortions.<sup>64</sup> According to the WHO, while Africa accounts for only 27 per cent of global annual births, 62 per cent of deaths caused by unsafe abortion took place in Africa in 2008.<sup>65</sup> Maternal morbidity as a result of unsafe abortion is increasing in Africa as women experience short and long-term health and maternal complications.<sup>66</sup>

Studies show that prevalent users of unsafe abortion procedures are young girls. As young girls reach childbearing age, they increase their chances of 'unsafe sexual activity, unwanted pregnancy, unsafe abortions, early childbearing and HIV infection'.<sup>67</sup> This is coupled with minimal knowledge and awareness of reproductive health services and a vulnerability to coerced sexual activity, as well as stigma from health care providers.<sup>68</sup> These factors place young woman as one of the most vulnerable age groups to face resistance and barriers to access for safe and legal abortion services.

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<sup>64</sup> Charlotte E Hord et al. 'Unsafe abortion in Africa: an overview and recommendations for action' in *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (2006) Guttmacher Institute at 115.

<sup>65</sup> WHO (2012) op cit note 63 at 20.

<sup>66</sup> Hord op cit note 64 at 115.

<sup>67</sup> Guttmacher Institute 'Into a new world. Young women's sexual and reproductive lives' (1998) cited in *Ibid*.

<sup>68</sup> A.A. Olukoya et al. 'Unsafe abortion in adolescents' (2001) 75 at *International Journal of Gynecology & Obstetrics* 137 at 143-144.

## CHAPTER 2. INTERNATIONAL FRAMEWORKS

### 2.1 INTRODUCTION

Sexual and reproductive health is a constituent of the right to health and is embodied in numerous international frameworks.<sup>69</sup> The right to health is traditionally clustered with social, economic and cultural rights, but has expanded through the promotion of other rights including the right to equality and non-discrimination, right to reproductive freedom, right to information, right to privacy and right to conscience. The expansion of rights illustrates how sexual and reproductive health is achieved not through a hierarchy of rights, but through the indivisibility of all human rights, including civil, political, cultural, social and economic.<sup>70</sup>

United Nations (UN) treaty monitoring bodies (TMBs) have articulated concern through concluding observations, comments and general recommendations over the violations of women's sexual and reproductive health rights.<sup>71</sup> Member states acknowledge and respond to guidelines set by these committees, though the process of developing and amending laws has been slow in implementation.<sup>72</sup> A report by Amnesty International (AI) argues that though there is a global consensus to improve public health issues, like maternal mortality, governments are reluctant to address issues, like abortion, that are culturally and politically sensitive.<sup>73</sup> However, published data and statistics relating to maternal mortality and unsafe abortion have helped advance abortion law and policy reform worldwide. As Cook and Dickens affirm, current abortion law has helped shift the view of abortion from one of criminal law to that of preventing unsafe abortion and protecting the general health and well-being of a woman.<sup>74</sup>

This chapter analyses how the right to abortion is implicitly and explicitly addressed in legally binding international law frameworks and also soft law

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<sup>69</sup> Dina Bogecho 'Putting it to Good Use: The International Covenant on Civil and Political Rights and Women's Right to Reproductive Health' (2004) 1 *Law, Social Justice & Global Development Journal* 1 at 6.

<sup>70</sup> *Ibid.*

<sup>71</sup> CRR 'Background Paper to Support the Development of a General Comment on the Right to Sexual and Reproductive Health by the CESCR Committee' (2010) at 2.

<sup>72</sup> *Ibid.*

<sup>73</sup> Amnesty International 'Realizing Sexual and Reproductive Rights: A Human Rights Framework' (2012) at 19.

<sup>74</sup> Cook and Dickens (2003) *op cit* note 14 at 12.

instruments. Though the right to abortion is not specifically addressed in human rights instruments (aside from the African Women's Protocol), it is implicitly recognised through the interpretation of other first-generation rights. The chapter will also look at state obligations to assess how the rights and needs of women are being fulfilled.

## 2.2 RIGHT TO EQUALITY AND NON-DISCRIMINATION

The right to equality and non-discrimination is enshrined in all UN human rights frameworks and is the fundamental starting point for the achievement of other human rights.<sup>75</sup> Mackinnon affirms that the right is both a means and an end goal, as it is an entitlement on its own and crucial to the realisation of other rights.<sup>76</sup> Combined, the right to equality and non-discrimination and the right to health strengthen a woman's access to sexual and reproductive health services and encourage autonomy in decision-making procedures.<sup>77</sup>

In the context of equality, marginalised groups are often most impacted by discriminatory access to services. The World Health Organization (WHO) notes in its guidelines that 'depending upon the context, unmarried women, adolescents, those living in extreme poverty, women from ethnic minorities, refugees...may be vulnerable to inequitable access to safe abortion services'.<sup>78</sup> The standards of the following human rights instruments enable individuals to hold abortion-service providers accountable to ensure they are being treated equally and free of discrimination.

### 2.2.1 UNIVERSAL DECLARATION OF HUMAN RIGHTS

The Universal Declaration of Human Rights (UDHR) recognises that though men and women are different, both have the right to equal protection before the law and the right to be free from discrimination.<sup>79</sup> While drafting the UDHR there was concern about utilising a male-specific term that could have led to the exclusion of

<sup>75</sup> Savitri Goonesekere 'A Rights-based Approach to Realizing Gender Equality' available at [www.un.org/womenwatch/daw/news/savitri.htm](http://www.un.org/womenwatch/daw/news/savitri.htm) accessed 7 September 2012.

<sup>76</sup> Catharine Mackinnon *Feminism Unmodified* (1987) at 34.

<sup>77</sup> CRR (2010) op cit note 71 at 4.

<sup>78</sup> WHO (2012) op cit note 63 at 78.

<sup>79</sup> UDHR article 7.

women.<sup>80</sup> The drafters settled on the gender-neutral term ‘everyone’, allowing the rights to be equally applicable to women. The inclusion of both sexes is most prevalent in article 2 of the UDHR, which forms the underlying principle of equality and non-discrimination and states that ‘everyone is entitled to all rights and freedom...without distinction of race, colour, sex...’<sup>81</sup>

Despite the inclusion of ‘everyone’ in the UDHR, there are only two direct mentions of women in the Declaration, namely in article 16 and the preamble. The preamble classifies men and women as ‘equal’, but the absence of women in all but one article reinforces stereotypes of women.<sup>82</sup> Article 16 looks at a man and woman’s right to marry and start a family free of discrimination, with article 16(1) noting that men and women are ‘...entitled to equal rights as to marriage and during marriage...’<sup>83</sup>

The UDHR is the cornerstone of international human rights law, though it has been criticised for acknowledging women solely in the stereotyped role of wife and caretaker (as evident through article 16).<sup>84</sup> Despite its weak inclusion of women, the UDHR’s principles of equality and non-discrimination serve as a foundation for other UN frameworks that address the rights of women.

### 2.2.2 INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

In 2000, the Committee on Economic, Social and Cultural Rights (CESCR) developed General Comment 14, which calls for a ‘gender-based’ approach to health.<sup>85</sup> This recommendation stems from an observation of historical human rights violations that resulted from gender stereotyping and discrimination. General Comment 14 is similar to text from the Convention on the Elimination of All Forms of Discrimination (CEDAW) Committee, which acknowledges gender-related aspects of descent-based discrimination, whereby factors like race, ethnicity and nationality (among others) increase an individual’s vulnerability to discrimination,

<sup>80</sup> Fraser op cit note 11 at 853-906.

<sup>81</sup> UDHR article 2.

<sup>82</sup> Hilary Charlesworth ‘The Mid-Life Crisis of the Universal Declaration of Human Rights’ (1998) 55 *Washington & Lee Law Review* 781 at 784

<sup>83</sup> UDHR article 16(1).

<sup>84</sup> Jennifer L Ulrich ‘Confronting Gender-Based Violence with International Instruments: Is a Solution to the Pandemic Within Reach?’ (2000) 7 *Indian Journal of Global Legal Studies* 629 at 639.

<sup>85</sup> Committee on Economic, Social and Cultural Rights (CESCR) General Comment 14: The Rights to the Highest Attainable Standard of Health (2000) E/C.12.2000/4.

including in the health sector.<sup>86</sup> In a 2008 report, the WHO noted that in order to address inequities in the health sector, one must address and evaluate the inequalities in society.<sup>87</sup> Braveman references the same WHO report and affirms that identifying inequities in the health sector gives room to protect and promote the rights of individuals, particularly those who have been historically disadvantaged.<sup>88</sup>

In light of descent-based discrimination, the CESCR Committee affirms that cumulative forms of discrimination hinder a woman's autonomy and decision-making ability.<sup>89</sup> Cusack and Cook add that 'the nature, frequency and immutability of obstacles' vary significantly and are influenced by factors such as age, sexual orientation, locality and religion.<sup>90</sup>

### 2.2.3 CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

The CEDAW framework goes beyond promoting equality and non-discrimination solely between men and women (like the UDHR), and addresses how women are discriminated against in all aspects of their lives. The CEDAW Committee elaborates on the meaning of equality in various articles and identifies the biological, social and cultural factors that differentiate women and men.<sup>91</sup> For example, article 5 of CEDAW urges states to modify or amend cultural and traditional practices that perceive women as inferior to men. Bunch adds that CEDAW's obligation on states to take positive measures to abolish discrimination (like in article 5) indicates how the 'Convention embodies more than an empty recitation of gender equality and instead mandates that states take definitive action in order bring about an end to discrimination against women'.<sup>92</sup>

### 2.2.4 SOFT LAW

The link between reproductive rights and gender equality was reinforced at key international conferences like the International Conference on Population and

<sup>86</sup> Alice Edwards 'UN High Commissioner for Refugees, Displacement, Statelessness and Questions of Gender Equality under CEDAW' (2009) PPLAS/2009/02 1 at 28.

<sup>87</sup> WHO 'Health and Freedom from Discrimination' (2001) 2 *Health and Human Rights Publication* at 12.

<sup>88</sup> Paula Braveman 'Social Conditions, Health Equity and Human Rights' (2010) 12:2 *Health and Human Rights* 31 at 34.

<sup>89</sup> *Ibid.*

<sup>90</sup> Cusack and Cook (2009) *op cit* note 29 at 49.

<sup>91</sup> Charlotte Bunch 'Women's Rights as Human Rights: Toward a Re-vision of Human Rights' (1990) 12 *Human Rights Quarterly* 486 at 490-91.

<sup>92</sup> *Ibid.*

Development (ICPD).<sup>93</sup> The linkage reinforced the notion that women suffer the most in the scope of sexual and reproductive health and that ‘many of these problems arise from persistent gender inequalities—including women’s relative lack of power and influence in both public and private life’.<sup>94</sup> The impact of gender inequalities influenced the WHO to urge policy makers to address the social, cultural, economic and political contexts that influence initiatives aimed to improve an individual’s sexual and reproductive health.<sup>95</sup>

## 2.3 RIGHT TO HEALTH AND HEALTH SERVICES

### 2.3.1 INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

The International Covenant on Economic, Social and Cultural Rights<sup>96</sup> (ICESCR) is the first UN human rights instrument to address the right to health. A woman’s right to sexual and reproductive health is featured in article 12, which speaks of the right to the highest attainable standard of physical and mental health.<sup>97</sup> The CESCR articulated in General Comment 14 that the right to health is considered both a freedom and an entitlement: ‘freedoms include the right to control one’s health and body, including sexual and reproductive freedom’, and ‘entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health’.<sup>98</sup>

The UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health highlights that the right to health is further realised through the availability, accessibility and quality of facilities, goods and services.<sup>99</sup> This idea is reiterated in the CESCR’s General Comment 14, where it notes:

*The realization of women’s right to health requires the removal of all barriers interfering with access to health services, education and*

<sup>93</sup> WHO ‘The WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes’ (2007) WHO/RHR/07.7 at 1.

<sup>94</sup> Ibid at 5.

<sup>95</sup> Ibid.

<sup>96</sup> The International Covenant on Economic, Social and Cultural Rights (1966) U.N. Doc A/ 6316 [hereinafter the ICESCR].

<sup>97</sup> ICESCR article 12.

<sup>98</sup> CESCR Comment 14 op cit note 85 at para 8.

<sup>99</sup> Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2007) U.N. Doc. A/HRC/4/28 para 68 and 71.

*information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.*<sup>100</sup>

General Comment 14 places an obligation on states to ensure that a woman's sexual and reproductive health is not impaired due to limited access to services and that the use of such services is attained free of coercion and discrimination.<sup>101</sup> Through General Comment 14, interpretation of article 12 infers that a woman's inability to exercise her sexual and reproductive rights constitutes a failure of the state to guarantee the right to health.

As highlighted by the CESCR, a gender-based approach to health helps surface the biological and socio-cultural factors that impede the accessibility of health services, particularly related to abortion.<sup>102</sup> The American Association for the Advancement of Science affirms that a 'gender-sensitive approach to health requires governments to take affirmative action to redress the barriers that systematically limit women's enjoyment of the right to health'.<sup>103</sup> One factor that directly impairs a woman's sexual and reproductive health rights is gender-based discrimination and female stereotyping. Cusack and Cook argue that stereotyping is most problematic when it ignores a woman's needs and characteristics, denies her rights and creates 'gender hierarchies by constructing women as inferior to men'.<sup>104</sup>

The CESCR Committee addresses other barriers to health services by acknowledging the risk women face due to restrictive and discriminatory abortion laws.<sup>105</sup> The CESCR's concluding observations for Chile, for example, recommends that in circumstances where pregnancy is as a result of rape or if the mother's life is in danger, states should legalise abortion and ensure that health services and post-abortion care (PAC) is readily available.<sup>106</sup> The availability of PAC for women has

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<sup>100</sup> CESCR Comment 14 op cit note 85 at para 21.

<sup>101</sup> Cook and Dickens (2003) op cit note 14 at 16.

<sup>102</sup> CESCR Comment 14 op cit note 85 at para 20.

<sup>103</sup> Judith Asher 'The Right to Health' at 58.

<sup>104</sup> Simone Cusack and Rebecca J Cook 'Combating Discrimination Based on Sex and Gender' in *International Protection of Human Rights: a textbook* (2009) Catarina Krause and Martin Scheinin at 59-68.

<sup>105</sup> See CESCR Concluding Observations on Azerbaijan (2004) U.N. Doc. E/C.12/1/Add.104 para 56 and Chile (2004) U.N. Doc. E/C.12/1/Add.105 para 25.

<sup>106</sup> Ibid.

become increasingly important, particularly to prevent maternal mortality or morbidity amongst women who pursue unsafe or self-induced abortions. A report published by AIDS Accountability International (AAI) discusses the economic implications of treating women with complications from unsafe abortions.<sup>107</sup> The report points to Malawi and calculates that it costs roughly \$45 USD to provide basic PAC for one individual (nearly \$1.06 million annually).<sup>108</sup> The AAI report was in response to Malawian document that was produced, and highlights that ‘if safe abortion services were made available to women, approximately \$435,000 would become available in public health care facilities each year to divert to other health care needs’.<sup>109</sup> The AAI and the Malawi report illustrate how restrictive abortion laws also have a substantial economic impact on health facilities that have to deal with the negative consequences of women pursuing unsafe and illegal abortions.

Addressing economic hurdles is most pertinent amongst lower-income communities where women may struggle to access and afford available health services. In order to reduce the economic impact on women seeking services, the CESCR encourages states to focus on marginalised groups, particularly adolescents and unmarried women, in lower-income areas.<sup>110</sup>

### 2.3.2 CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

Article 12 of CEDAW encourages states to take measures to eliminate discrimination within health care by ensuring that women have access to services. Cook adds that the denial of safe and legal abortion services is a component of sex-based discrimination as abortion services are specific to women.<sup>111</sup> As a result, signatory states have an obligation under CEDAW’s article 12 to disable hurdles to health care services that meet a woman’s family planning needs. Colombia is an example of a country that incorporated elements of article 12 into its national laws,

<sup>107</sup> Phillipa Tucker ‘Monitoring the Maputo Plan of Action’ (2012) AIDS Accountability International at 25.

<sup>108</sup> Ibid.

<sup>109</sup> IPAS and the Government of Malawi ‘Health System Costs of Providing Post Abortion Care in Malawi’ (2012) Think Africa Press available at <http://thinkafricapress.com/malawi/battle-legalise-abortion> accessed on 15 December 2012.

<sup>110</sup> CESCR Comment 14 op cit note 85 at para 18-19.

<sup>111</sup> Rebecca Cook ‘Abortion, human rights and the International Conference on Population and Development (ICPD)’ in *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (2006) Guttmacher Institute at 26.

reiterating CEDAW's obligation on states to address the social aspects of discrimination that contributes to the ill-health of women.<sup>112</sup>

In relation to countries that have addressed the social determinants of a woman's restricted access to health services, Chapter Four will discuss how South Africa's previous abortion law was a form of sex and race-based discrimination. The restrictions of South Africa's Abortion and Sterilisation Act<sup>113</sup> impacted black, lower class women who were unable to afford services or meet the stringent requirements needed for a safe and legal procedure.<sup>114</sup>

Cook and Dickens conclude that the evolution of South Africa's abortion laws exemplify how policies addressing women's sexual and reproductive health can be discriminatory not only between sexes, but against certain women. For example, barriers of access will not affect women who are economically stable; restrictive abortion laws are negatively biased to the 'choice, health, and very lives of powerless women who are poor, young, and marginal to the societies in which they live'.<sup>115</sup>

### 2.3.3 SOFT LAW

From the ICPD and Beijing Conference<sup>116</sup> grew a consensus to integrate a human rights approach into the public health sector. This was evident through the Programme of Action (PoA)<sup>117</sup>, the outcome document of the ICPD, as it reconceptualised reproductive health whereby health-related outcomes were linked to human rights.<sup>118</sup> Dr Shalev, former CEDAW expert member, adds that the ICPD affirmed that barriers to women's health was not solely based on access to services, but also to a woman's 'status in society and pervasive gender discrimination'.<sup>119</sup> Acknowledging the complexity of barriers to sexual and reproductive health influenced discussion at the ICPD. Member states agreed that the enhancement of

<sup>112</sup> Rebecca Cook 'Women's Health and Human Rights' Presented at the 1999 Adapting to Change Core Course at 4.

<sup>113</sup> Act No. 2 of 1975.

<sup>114</sup> Cook and Howard (2007) op cit note 61 at 1062.

<sup>115</sup> Cook and Dickens (2003) op cit note 14 at 160.

<sup>116</sup> Beijing Declaration and the Platform for Action (1995) A/CONF.177/20 [hereinafter Beijing Conference].

<sup>117</sup> UN Population and Development, Programme of Action (PoA) adopted at the ICPD (1994) Doc. ST/ESA/SER.A/149.

<sup>118</sup> Anna Glasier et al. 'Sexual and Reproductive health: a matter of life and death' (2006) 368 *Lancet* 1595 at 1595.

<sup>119</sup> Dr. Carmel Shalev 'Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women' (1998) presented at the International Conference on Reproductive Health.

reproductive health was made possible through the realization of reproductive autonomy and gender equality.<sup>120</sup>

The UN Commission on Population and Development (CPD)<sup>121</sup> conducted a 10-year review of the ICPD and analysed its achievements against the goals and objectives set forth in the PoA. Though the CPD commended the PoA for its efforts, the report did highlight its concern over the increase in maternal mortality rates, indicating a need to increase efforts in prevention and access to services.<sup>122</sup> The report also emphasised that the goals and objectives in the PoA would be further realised through the achievement of the Millennium Development Goals (MDGs).

Experts have critiqued the Millennium Declaration for failing to directly include sexual and reproductive health in the MDGs.<sup>123</sup> Offering an alternative view, the Guttmacher Policy Review highlights that many of the MDGs could not realistically be achieved without investing in sexual and reproductive health, particularly gender equality (MDG 3), reducing child mortality (MDG 4), improving maternal health (MDG 5) and combating HIV and AIDS (MDG 6).<sup>124</sup> Some goals, such as reducing maternal mortality and improving gender equality are *directly* [emphasis added] linked to sexual and reproductive health, as they are dependent on the accessibility and availability of safe and clean health services.<sup>125</sup>

At the World Summit Outcome in 2005, leaders declared that states must integrate sexual and reproductive health into national laws and policies in order to attain the MDGs.<sup>126</sup> The achievements and success of the MDGs are monitored through state reports, which document the efforts toward the realisation of goals. Aware that African nations will unlikely meet the MDGs pertaining to sexual and reproductive health, Ministers of Health in Africa created the Continental Policy

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<sup>120</sup> Glasier op cit note 118 at 1596.

<sup>121</sup> Developed in resolution 3 by the Economic and Social Council (1946), renamed in resolution 49/128 in 1994.

<sup>122</sup> Department of Economic and Social Affairs 'Review and appraisal of the progress made in achieving the goals and objectives of the Programme of Action of the ICPD' (2004) E/2004/25.

<sup>123</sup> Glasier op cit note 118 at 1597.

<sup>124</sup> Susan A Cohen 'Promoting Sexual and Reproductive Health Advances Maternal Health' (2009) 12:2 *Guttmacher Policy* 8 at 11.

<sup>125</sup> Stan Bernstein and Charlotte Juul Hansen 'Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals' (2006) *Millennium Project* at 21

<sup>126</sup> *Ibid* at preface.

Framework on Sexual and Reproductive Health and Rights in 2006.<sup>127</sup> Subsequently, the Maputo Plan of Action was developed for implementation.<sup>128</sup>

## 2.4 RIGHT TO LIFE

Although international human rights law protects an individual's right to life, key UN frameworks do not specifically state when exactly a life begins. In recent decades, anti-abortion activists have argued that the right to life begins at conception.<sup>129</sup> Some countries, like Guatemala and Chile, state in their constitutions that the right to life extends before birth.<sup>130</sup> Recent court cases argue otherwise and suggest that international frameworks infer that the right to life only begins at birth.<sup>131</sup> This argument was challenged in the *Christian Lawyers Association of SA v Minister of Health* where the applicant argued that the right to life extended to a foetus.<sup>132</sup> The Court's decision that the right to life of a foetus impedes on the rights and entitlements of the woman will be further analysed in Chapter Four.

The WHO has explicitly stated that restrictive and discriminatory abortion laws have a direct impact on a woman's right to life.<sup>133</sup> The Center for Reproductive Rights (CRR) further adds 'most maternal deaths are preventable, and therefore a systematic failure by governments to provide the services needed by women to survive childbirth constitutes a violation of the right to life'.<sup>134</sup>

### 2.4.1 UNIVERSAL DECLARATION OF HUMAN RIGHTS

Article 1 of the UDHR addresses the right to life as it states that 'all human beings are born free and equal' in rights. Analysts note that the drafters of the UDHR intentionally used the word 'born' in article 1 to eliminate any misconceptions on the application of the right to life. A proposal was rejected at the 1948 UN General

<sup>127</sup> Adopted by the Conference of African Ministers of Health in 2005.

<sup>128</sup> African Union (2006) Sp/MIN/CAMH/5(I).

<sup>129</sup> CRR '*Whose Right to Life?*' (n.d.) at introduction.

<sup>130</sup> See Constitution of the Republic of Guatemala (2002) cap. I article 3 and Constitution of the Republic of Chile (1980) article 19 para 1.

<sup>131</sup> Ibid.

<sup>132</sup> *Christian Lawyers Association of South Africa v The Minister of Health* 1998 (11) BCLR 1434 (T), (4) SA 1113 (T).

<sup>133</sup> WHO 'Unsafe Abortion: Global and Regional Estimates of Incidence of and Mortality Due to Unsafe Abortion with a Listing of Available Country Data' (1997) at 2.

<sup>134</sup> CRR 'Submission to the United Nations Office of the High Commissioner for Human Rights for the preparation of the thematic study on Maternal Mortality, Morbidity and Human Rights' (n.d.) at 1.

Assembly to remove ‘born’ from the text and a consensus was reached that rights that stem from the Declaration are ‘inherent from the moment of birth’.<sup>135</sup>

#### 2.4.2 INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS

Adding clarity to article 6 of the International Covenant on Civil and Political Rights’ (ICCPR), General Comment 6 of the Human Rights Committee (HRC) highlights that the right to life should not be interpreted restrictively and that states should take positive measures to ensure an individual’s right to life.<sup>136</sup> Positive measures include increasing access to information and family planning services in an effort to reduce rates of maternal mortality.

In 2005’s *K.L. v Peru* (Communication No. 1153/2003), the HRC considered whether denying K.L. an abortion breached Peru’s obligations under the ICCPR. In particular, the HRC found that denying access to a legal abortion violated a woman’s right to life.<sup>137</sup> The HRC’s conclusion was prominent for two reasons: it was the first time that abortion rights were examined by a UN TMB and second, the violations were challenged against provisions of the ICCPR and not Peruvian state law, which contains certain restrictions on abortion procedures.<sup>138</sup> In short, the HRC held Peru liable for failing to enable access and remove barriers to abortion services.

General Comment 28, which speaks about equality between men and women, urges states to report on current efforts to reduce unwanted pregnancies and prevent the use of unsafe, backstreet abortions.<sup>139</sup> Like CEDAW, the HRC has specifically addressed the relationship between a country’s restrictive abortion laws and a woman’s use of unsafe and illegal abortion services.<sup>140</sup> A WHO report points to evidence which shows that when abortion is granted with less restriction; when it is made legal on socio-economic grounds; and, when safe services are accessible; unsafe abortion and related mortality and morbidity decreases.<sup>141</sup> In response, the

<sup>135</sup> U.N. GAOR 3<sup>rd</sup> comm. 99<sup>th</sup> meeting (1948) U.N. Doc A/PV/99.

<sup>136</sup> Human Rights Committee (HRC) General Comment 6 (1982) 16<sup>th</sup> session at para 5.

<sup>137</sup> UN HRC, *K.L. v Peru* Final Decision (2003) CCPR/C/85/D/1153/2003 at 10-11.

<sup>138</sup> CRR ‘UN Human Rights Committee Makes Landmark Decision Establishing Women’s Right to Access to Legal Abortion’ available at <http://reproductiverights.org/en/press-room/un-human-rights-committee-makes-landmark-decision-establishing-womens-right-to-access-to-> accessed on 5 January 2013.

<sup>139</sup> See HRC Concluding Observations on Colombia (1997) CCPR/C/79/Add.76 at para 24.

<sup>140</sup> See HRC concluding observations on Bolivia (1997) CCPR/C/79/Add.74 para 22 and Cameroon (1999) CCPR/C/79/Add.116 para 13.

<sup>141</sup> See studies cited in WHO (2012) op cit note 63 at 100.

HRC notes that in order to address unsafe, clandestine abortions, states must increase access and remove barriers to services and information.<sup>142</sup>

#### 2.4.3 CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

CEDAW's General Comment 24 urges states to focus on the prevention of unintended pregnancies and amend legislation that 'remove[s] punitive provisions imposed on women who undergo abortion'.<sup>143</sup> While the CEDAW Committee has not explicitly acknowledged and promoted the use of safe and legal abortions, it has stated that restrictive abortion laws can be discriminatory on the basis of gender and sex.<sup>144</sup>

The case of *A.S. v. Hungary*<sup>145</sup> was brought to the CEDAW Committee and involved a Hungarian woman who was coercively sterilized in a public hospital. The Committee found that the Hungarian government violated A.S.'s sexual and reproductive health through the denial of information (article 10h), infringing her right to equality and non-discrimination in health care (article 12) and her right to reproductive freedom (article 16e).<sup>146</sup> The case was pivotal as it was the first time an international human rights monitoring body held a government accountable for failing to provide the necessary information that would enable an individual to give informed consent to a reproductive health procedure.<sup>147</sup>

In relation to the foetus' right to life, the CEDAW Committee has argued that the protection of the foetus is a form of gender-based discrimination and perpetuates a stereotyped role that all women want to become mothers.<sup>148</sup> As the principle of non-discrimination is a foundation for CEDAW, any protection warranted to the foetus may lead to the impairment of rights of women.<sup>149</sup>

<sup>142</sup> See Concluding Observations on Chile (1999) CCPR/C/79/Add.104 at para 15.

<sup>143</sup> CEDAW Recommendation 24 op cit note 56.

<sup>144</sup> Ibid.

<sup>145</sup> *A.S. v. Hungary* CEDAW/C/36/D/4/2004.

<sup>146</sup> Ibid at para 11.2 – 11.5.

<sup>147</sup> Dr. Dubravka Šimonovic 'Day of General Discussion on the Right to Sexual and Reproductive Health' (2010) at 10-11.

<sup>148</sup> CRR (n.d.) op cit note 129 at 6.

<sup>149</sup> See CEDAW op cit note 56.

## 2.5 RIGHT TO REPRODUCTIVE FREEDOM

### 2.5.1 UNIVERSAL DECLARATION OF HUMAN RIGHTS

While international legal instruments offer women protection in their reproductive lives, these protections are weakened when men are considered the primary decision-makers in the family. In addition to patriarchal influences, traditional and societal customs can often hinder equality in family and marriage-related rights. Article 16(3) of the UDHR acknowledges that ‘...the family is the natural and fundamental group unit of society and is entitled to protection by society and the state’. However, this specific article has been debated amongst the international community as it is within the family where women are most subjected to subordination and discrimination.<sup>150</sup> Affording protection to the family often conflicts with the individual rights of a woman.

In addition to article 16, the UDHR indirectly references women in article 25, whereby ‘motherhood and childhood are entitled to special care and assistance’.<sup>151</sup> Article 25 is the only provision that acknowledges the health and wellbeing of an individual and is extended to include special care and assistance for motherhood. Though the UDHR offers protection to all humans, the Declaration’s acknowledgment of women solely in relation to family life reiterates the traditional role of women as mothers and wives. Charlesworth states ‘the constant references to the family in the Universal Declaration reinforce the restricted image of women’.<sup>152</sup> Conversely, Cusack and Cook argue that stereotyping women as mothers is both descriptive and prescriptive.<sup>153</sup> Interpreting the stereotype as prescriptive causes society to view motherhood as something that all women ‘irrespective of their distinctive reproductive health capacity, their individual reproductive or other priorities...ought to desire and "do."’<sup>154</sup>

The traditional perception of women as mothers and child bearers has developed significantly since the drafting of the UDHR. This progression is heavily

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<sup>150</sup> O’Hare op cit note 12 at 367-368.

<sup>151</sup> UDHR article 25.

<sup>152</sup> Charlesworth (1998) op cit note 82 at 783.

<sup>153</sup> Cusack and Cook (2009) op cit note 29 at 57.

<sup>154</sup> Ibid.

influenced by the human rights instruments and documents that have defined and individualised gender and sex-related rights in recent decades.<sup>155</sup>

### 2.5.2 INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS

Though the ICCPR does not explicitly mention the right to health and reproductive freedom, experts in the public health sector utilise article 6(1), the inherent right to life, to make claims for protection in sexual and reproductive health and freedom.<sup>156</sup> In the context of sexual and reproductive health, an individual's right to life would entitle access to services and information that would prevent maternal mortality and increase life expectancy.<sup>157</sup>

Cook argues that the broad application of the 'inherent right to life' may contradict other rights in the ICCPR such as the right to family unity and equality in marriage.<sup>158</sup> General Comment 19 expands on article 23 of the ICCPR, which discusses the rights of men and women in family and marriage.<sup>159</sup> Specifically, General Comment 19 highlights that the right to found a family implies the right to procreate and share a life together.<sup>160</sup> Together, article 23 and General Comment 19 endorse the view that individuals have a right to reproductive freedom, which includes the decision of if and when to form a family.<sup>161</sup> The HRC has stated that the right to 'procreate and share a life together', by inference, includes the right to reproductive health care and safe and appropriate means of contraception.<sup>162</sup>

### 2.5.3 SOFT LAW

Emphasis on reproductive freedom was predominant in the ICPD and Beijing Conference's outcome documents, where delegates agreed that states must remove barriers to information and education that would support a woman's decision-making process.<sup>163</sup> The Beijing Conference was successful in that it recognised that women have the right to control their health, particularly their reproductive health.<sup>164</sup> Though

<sup>155</sup> Bunch op cit note 91 at 490.

<sup>156</sup> HRC Comment 6 op cit note 136 at ch 5.

<sup>157</sup> Vijayan K Pillai and GaungpZhen Wang 'Women's Reproductive Rights in Developing Countries' (1999) at 6-7.

<sup>158</sup> Cook and Fathalla op cit note 16 at 117-119.

<sup>159</sup> HRC General Comment No 19 (1990).

<sup>160</sup> Ibid.

<sup>161</sup> ICCPR article 23.

<sup>162</sup> UN Manual on Human Rights Reporting (1991) 120 HR/PUB/91/1 at 113.

<sup>163</sup> Beijing Conference op cit note 116.

<sup>164</sup> Margaret Plattner 'The Status of Women Under International Human Rights Law and the 1995 UN World Conference on Women' (1996) 84 *Kentucky Law Journal* 1249 at 1262-1263.

recommendations from the Beijing Conference are non-binding, they serve as guidelines for achieving gender equality and abolishing discrimination.

## 2.6 RIGHT TO PRIVACY

### 2.6.1 CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

Similar to provisions that address reproductive freedom, CEDAW has condemned laws and policies that require third-party authorisations for abortions. In its response to a country report from Turkey, the CEDAW Committee highlighted that Turkish law that forces women to seek authorisation from their husband prior to having an abortion was a violation of the right to privacy.<sup>165</sup>

A similar argument relating to the infringing of a woman's privacy was brought against the South African government when the Christian Lawyers Association challenged national policy that allowed minors to obtain abortions without the authorisation of a parent or guardian.<sup>166</sup> As will be highlighted in Chapter Four, the Court's decision was significant as it found that requiring an authorisation would breach the individual's right to privacy and reproductive freedom. In its policy and technical guidelines, the WHO adds that women, notably adolescents and unmarried women, are deterred by safe and legal abortion services due to the fear that abortion-care providers will breach a patient's confidentiality.<sup>167</sup> Similar to the judgment in the *Christian Lawyers Association* case, the WHO affirms that minors able to make informed decisions without parental consent are legally entitled to the right to privacy, which includes confidential treatment and care.<sup>168</sup>

In addition to authorisations, CEDAW has noted that a woman's right to privacy is denied when a health care provider breaches the patient's confidentiality by imposing personal beliefs on the patient's decisions. The CEDAW Committee addressed this issue in General Recommendation 24 and noted that breaches of patient confidentiality is most severe for women as doing so may impact a woman's decision to seek treatment for sexual and reproductive illnesses. A hesitancy to report

<sup>165</sup> See Turkey (1997) U.N. Doc. A/52/38/Rev.1 at para 196.

<sup>166</sup> See *Christian Lawyers Association v National Minister of Health and Others* [2004] JOL 12853 (T).

<sup>167</sup> WHO (2012) op cit note 63 at 78.

<sup>168</sup> Ibid at 79.

medical illnesses due to a lack of privacy and confidentiality is even more problematic if the situation arose from sexual or physical abuse or violence.<sup>169</sup>

## 2.7 RIGHT TO CONSCIENCE

A significant barrier to abortions is a provider's objection to perform services based on grounds of conscience, choice and belief. Case studies have shown that nurses and doctors who conscientiously object due to moral and ethical beliefs may impose judgment and shame on a patient. As Cook and Dickens illustrate, health care providers may criticize the woman for being 'ignorant' and 'irresponsible' for having an unplanned pregnancy.<sup>170</sup> In South African law, a provider is protected under law to object conscientiously, but is unable to obstruct a patient's access to an abortion service, which can be construed as withholding information or a referral to another provider willing to terminate the pregnancy.<sup>171</sup>

### 2.7.1 CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

CEDAW addressed the right to conscience in several reports and has specifically condemned countries that enable providers to impose conscientious objection to women seeking abortions within a legal time frame.<sup>172</sup> Many countries allow abortion procedures (without restrictions) for the first trimester of pregnancy.<sup>173</sup> Following the 12-week gestation period, many countries begin to impose restrictions and requirements for abortion. As a result, nurses may object conscientiously, aware that the referral process may delay the procedure past the 12-week mark, causing more administrative challenges for the patient.<sup>174</sup>

In a concluding report to Italy, the CEDAW Committee noted its concern over a woman's struggle to find a hospital willing to terminate a pregnancy.<sup>175</sup> Even if a hospital is qualified and trained to perform abortion procedures, conscientious

<sup>169</sup> CEDAW op cit note 56 at para 12(d).

<sup>170</sup> CEDAW report cited in Cook and Dickens (2003) op cit note 14 at 56.

<sup>171</sup> See section 10(1)(c) of the Choice on Termination of Pregnancy Act.

<sup>172</sup> CEDAW Report on Morocco (1997) A/52/38/Rev.1 para 353 and 360.

<sup>173</sup> Guidance from CRR 'The World's Abortion Laws' (2012) available at <http://worldabortionlaws.com/>.

<sup>174</sup> Jane Harries et al. 'Delays in seeking an abortion in the second trimester: a qualitative study in South Africa' (2007) 4:7 *Reproductive Health* 1 at 5-6.

<sup>175</sup> See CEDAW Concluding Comments on Italy (1997) A/52/38/Rev.1 para 353.

objection by staff that is unwilling to terminate pregnancies may cause a hospital to disable its available abortion services.<sup>176</sup>

### 2.7.2 INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS

The HRC addressed the right to conscience in multiple concluding observations, giving specific mention to the impact it has on a woman's access to abortion. Notably, the HRC's report to Poland addressed its concern regarding the limited accessibility to safe and legal abortion services, despite the fact that Polish law legalises abortion.<sup>177</sup> The report pointed to conscientious objection as a potential barrier, noting its impact on a woman's reproductive freedom. As a result, the HRC recommended that Poland educate its health care providers on how to interpret the conscientious objection clause in Polish law.<sup>178</sup>

## 2.8 CONCLUSION

The developments highlighted in the aforementioned frameworks and policy documents indicate the progression of the human rights community to acknowledge and address women's human rights issues. What first stemmed from the UDHR's assertion that 'all human beings are born free and equal in dignity and rights'<sup>179</sup> has now turned into directed policies, provisions and recommendations that focus on women-specific needs and the steps necessary to ensure the promotion, protection and fulfilment of rights for women, including the right to reproductive choice.<sup>180</sup>

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<sup>176</sup> WHO 'What health-care providers say on providing abortion care in Cape Town, South Africa: findings from a qualitative study' (2010) WHO/RHR/HRP/10.18 at 4.

<sup>177</sup> HRC Concluding Observations on Poland (2004) CCPR/CO/82/POL para 80.

<sup>178</sup> Ibid.

<sup>179</sup> UDHR preamble.

<sup>180</sup> O'Hare op cit note 12 at 365-366.

## CHAPTER 3. AFRICAN NORMATIVE FRAMEWORKS

### 3.1 INTRODUCTION

African human rights frameworks embody principles rooted in international human rights law, but are tailored to accommodate the diversity of people of the African continent. The African Charter on Human and Peoples' Rights (African Charter), and notably the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol), holds states accountable to address issues most heavily plaguing African individuals and provide further protection to women and girls.

Africa has some of the worst reproductive health statistics in the world with unprecedented rates of maternal mortality and unsafe and illegal abortions.<sup>181</sup> Studies show that Africa accounts for more than 25 per cent of the annual 20 million illegal (and frequently unsafe) abortion procedures.<sup>182</sup> Ngwena adds that Africa is also the region least positioned to meet the Millennium Development Goal (MDG) to reduce maternal mortality by 75 per cent by 2015.<sup>183</sup>

The figures above reflect the fact that Africa has some of the most restrictive abortion laws and policies in the world (see Appendix C on page 96).<sup>184</sup> By law, African Commonwealth countries allow legal abortions in the first trimester in the instance to save a woman's life.<sup>185</sup> Some countries contain less restrictive laws that allow abortion in instances of rape or to preserve the mother's health and well-being.<sup>186</sup> In recent decades, African nations have begun to amend abortion laws and reduce restrictions for women and health care practitioners. However, Ngwena adds that jurisprudence from UN treaty monitoring bodies (TMBs) highlight that decriminalising abortion does not always link to effective implementation efforts.<sup>187</sup>

<sup>181</sup> CRR 'Legal Grounds: Reproductive and Sexual Rights in African Commonwealth Courts' (2005) at 47.

<sup>182</sup> Gutmacher Institute 'Sharing Responsibility: Women, Society and Abortion Worldwide' (1995) at 35.

<sup>183</sup> Charles Ngwena 'Using human rights to combat abortion: What needs to be done?' available at [www.chr.up.ac.za/africlaw/charles\\_ngwenya.pdf](http://www.chr.up.ac.za/africlaw/charles_ngwenya.pdf) accessed on 12 November 2012.

<sup>184</sup> See annex on page 91.

<sup>185</sup> WHO (2012) op cit note 64 at 25.

<sup>186</sup> Ibid at 25.

<sup>187</sup> Ngwena (2011) op cit note 8 at 3.

As statistics and cases suggest, abortion rights in Africa are commonly seen as ‘paper rights’.<sup>188</sup>

The African Charter and the Women’s Protocol places pressure on states to create and amend national laws that promotes, protects and fulfils the sexual and reproductive rights of women. Notably, article 14 of the Women’s Protocol is significant in that it enables women the right to control their fertility and choose any method of contraception.<sup>189</sup> The Protocol, as a whole, is a powerful tool to address the alarming rates of maternal-related deaths that occur from unsafe abortions.

This chapter will critically analyse the provisions of the African Charter and Women’s Protocol that address sexual and reproductive rights. The chapter will look at how abortion and reproductive freedom is realised and promoted in African human rights frameworks. It will highlight the gaps that arise as provisions attempt to both advocate for the rights of women and simultaneously preserve African tradition and norms. Finally, the chapter will provide examples of how signatory states are interpreting relevant provisions and fulfilling their duties to protect, promote and fulfil the sexual and reproductive health rights of African women.

## **3.2 AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS**

### **3.2.1 RIGHT TO HEALTH**

Though the African Charter does not specifically address the sexual and reproductive health rights of women, its broad-ranging provisions are applicable through interpretation. For example, sexual and reproductive health can derive from article 16 of the Charter, which highlights the right to ‘enjoy the best attainable state of physical and mental health’. In *Purohit and Another v The Gambia*,<sup>190</sup> the African Commission on Human and Peoples' Rights (ACHPR) referenced article 16 to state that the right to health must be applied without discrimination.<sup>191</sup> This broad statement infers that the right to health, which includes reproductive health, must be enabled and fulfilled without interferences. Put into context, a scenario where a health care provider obstructs a woman’s access to an abortion can be construed as a violation of article 16, particularly if the continuation of the pregnancy places the

<sup>188</sup> Ngwena (2012) op cit note 183 at 3.

<sup>189</sup> See articles 14(1)(a) and 14(1)(c) of the Women’s Protocol.

<sup>190</sup> *Purohit and Another v The Gambia* (2003) AHRLR 1(ACHPR 2003).

<sup>191</sup> *Ibid* at para 84.

women's health in danger. The ACHPR further explained that 'the right to health...is crucial to the realisation of all other fundamental human rights and freedoms'.<sup>192</sup> Article 16 is a crucial starting point for African countries to understand the impact that health rights have on the realisation of other human rights for women.

### 3.2.2 RIGHT TO REPRODUCTIVE FREEDOM

Another human right that is inextricably linked to a woman's health is reproductive choice and autonomy.<sup>193</sup> A woman's reproductive freedom is enabled through article 9 of the African Charter, which speaks to the right to receive information. The African Charter expanded on article 9 to place obligations on states to include information relevant to reproductive health, including family planning and emergency contraception.<sup>194</sup> Accurate and neutral information helps women make informed decisions free of discrimination and coercion.

### 3.2.3 RIGHT TO LIFE

The right to life is articulated in article 4 of the African Charter and states that the right is an entitlement for all human beings. It has been argued that article 4 places an obligation on states to protect the life of a person, which is heavily influenced by adequate and accessible health care.<sup>195</sup>

A controversial measure to article 4 is that the African Charter does not specifically note what constitutes a human being or when the right to life begins. This is similar to African Constitutions (besides Kenya) that protects the right to life without giving mention to when a life technically begins.<sup>196</sup> As will be illustrated in the Kenya example, giving explicit mention to when a life begins creates conflict between the rights of the foetus and the rights of the mother. This conflict extends into the application and fulfilment of other rights, including the right to health and health services, as well as the right to life and bodily integrity, among others.

In regards to Kenya's provision, it was recommended that while governments may address a pre-natal life, the health and right to life of the women must always

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<sup>192</sup> Ibid at para 80.

<sup>193</sup> Reproductive choice can also be a sub-category to the right to freedom and security of a person. See section 12(2) of the South African Constitution.

<sup>194</sup> African Charter article 9.

<sup>195</sup> Ipas Africa Alliance 'A Handbook for Advocacy in the African Human Rights System — Advancing Reproductive and Sexual Health' (2006) at 54.

<sup>196</sup> CRR 'In Harm's Way: The Impact of Kenya's Restrictive Abortion Law' (2010) at 11.

take precedence.<sup>197</sup> Priority given to a mother's life is attributed to the number of induced abortions (roughly 30,000) that occur annually in Kenya.<sup>198</sup> The situation where a woman is left to pursue a self-induced abortion due to a lack of available services constitutes a failure of the state to promote, protect and fulfil a woman's right to life. In light of the ambiguity of Kenya's provision, the Center for Reproductive Rights (CRR) suggested that the government remove from its Constitution the phrase 'which begins at conception'<sup>199</sup> when stating when a life begins.<sup>200</sup> The CRR recommended that Kenya insert a clause that highlights that irrespective of when a life begins, termination of pregnancy is still permitted as guaranteed through its obligations under international human rights law.<sup>201</sup>

### 3.3 WEAKNESSES OF THE CHARTER

Though the African Charter contains provisions that, by interpretation, implicitly encompass sexual and reproductive health, the framework has been critiqued for its minimal inclusion of rights for women. For example, the only reference in the Charter that specifically mentions 'women' is in article 18(3), which speaks to family and marriage-related rights and protections.

Chirwa argues the mere mention of women in only one article is 'emblematic of the Charter's recognition of gender in terms of family roles'.<sup>202</sup> The Charter has also been critiqued for its emphasis on the protection of family structures and cultural values, which feminist organisations have identified as being fundamentally at odds with the advancement of gender-based equality.<sup>203</sup> For example, article 17 places obligations on states to promote and protect traditional values in the community, while article 29 aims to preserve and strengthen African cultural values. Such provisions in the African Charter reflect a viewpoint that maintains cultural and

<sup>197</sup> Ibid.

<sup>198</sup> Susan Anyangu-Amu 'Kenya Clash Over Abortion Rights in New Constitution' (2010) Inter Press Service available at [www.ipsnews.net/2010/01/kenya-clash-over-abortion-rights-in-new-constitution/](http://www.ipsnews.net/2010/01/kenya-clash-over-abortion-rights-in-new-constitution/) accessed on 15 December 2012.

<sup>199</sup> See article 26(2) of the Constitution of the Republic of Kenya, 2010.

<sup>200</sup> See CRR (2010) op cit note 196 at 11.

<sup>201</sup> Ibid.

<sup>202</sup> Danwood M Chirwa 'Reclaiming (Wo)manity: The Merits and Demerits of the African Protocol on Women's Rights' (2006) 53 *Netherlands Int'l Law Review* 70 at 85.

<sup>203</sup> Rachel Rebouche 'Health and Reproductive Rights in the Protocol to the African Charter: Competing Influences and Unsettling Questions' (2009) 16 *Washington & Lee Journal on Civil Rights & Social Justice* 79 at 85.

traditional sovereignty, irrespective of its impact on women. Tamale argues that though the Charter highlights women as the ‘custodians of moral values’, the influence of tradition and social norms embedded in a system of patriarchy devalues the rights and freedoms for women.<sup>204</sup>

These articles contradict language from the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Conference on Population and Development (ICPD), which push for the elimination of stereotypes that portray women as inferior to men.<sup>205</sup> However, irrespective of ratification, countries may show little political will to adopt and domesticate provisions that prioritise the rights of women over societal beliefs and customs. For example, Malawi placed a reservation on article 2 of CEDAW, noting that ‘owing to the deep-rooted nature of some traditional customs and practices of Malawians, the Government...shall not, for the time being, consider itself bound by such of the provisions of the Convention as require immediate eradication of such traditional customs and practices.’<sup>206</sup>

Some experts highlight that the Charter is unique as it develops a human rights system that incorporates African culture and values, yet integrates the standards of international human rights instruments.<sup>207</sup> Others, however, argue that the inclusion and preservation of African tradition is, in actuality, what impedes the realisation of rights for women.<sup>208</sup> The CRR argues that the Charter’s inadequate mention of women and its heavy focus on tradition has left states to interpret provisions in a way that permits them to ‘protect customary and religious laws that violate women’s rights, such as the rights to equality and non-discrimination; to life, liberty, and security of the person; and to protection from cruel and degrading treatment’.<sup>209</sup> As a whole, the Charter presents women in a limited, stereotyped role

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<sup>204</sup> See Sylvia Tamale ‘The Right to Culture and the Culture of Rights: A Critical Perspective on Women’s Sexual Rights in Africa’ (2007) 149 at 157.

<sup>205</sup> Ibid.

<sup>206</sup> Ibid at 158.

<sup>207</sup> Fitnat Naa-Adjeley Adjetey ‘Religious and Cultural Rights: Reclaiming the African Women’s Individuality: The Struggle Between Women’s Reproductive Autonomy and African Society and Culture’ (1995) 44 *American University Law Review* 1376 at 1369.

<sup>208</sup> Rebouche op cit note 203 at 85.

<sup>209</sup> CRR ‘The Protocol on the Rights of Women in Africa: An Instrument for Advancing Reproductive and Sexual Rights’ (2006) at 3.

and is especially silent on women-specific needs, particularly in relation to sexual and reproductive rights.<sup>210</sup>

### 3.4 PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS ON THE RIGHTS OF WOMEN IN AFRICA

Banda argues that the Women's Protocol was developed to compensate for the Charter's stereotyped view of women.<sup>211</sup> Women were encouraged to participate in the drafting of the Protocol and help develop provisions that emphasised gender-neutral cultural practices and values.<sup>212</sup>

In relation to sexual and reproductive health rights, the Protocol is groundbreaking: it is the first international treaty to reference HIV/AIDS; express the right to abortion (on prescribed grounds); and acknowledge marital rape as a form of gender-based violence.<sup>213</sup> By inference, the Protocol's wide-ranging provisions that are embedded in gender equality enables states to holistically protect, promote and fulfil the sexual and reproductive health rights of women.<sup>214</sup>

#### 3.4.1 RIGHT TO HEALTH

Article 14 is noteworthy in that it highlights fundamental human rights embodied in key international frameworks, including the right to information, the right to life, right to reproductive freedom and the right to health services.<sup>215</sup> Rebouche adds that article 14's holistic approach to sexual and reproductive health rights illustrates the Protocol's emphasis on 'substantive equality' that resonates with the ICPD and Beijing Platform.<sup>216</sup>

Overall, the Protocol is significant in that it explicitly places an obligation on states to authorise medical abortions (on prescribed grounds).<sup>217</sup> The inclusion of abortion to a human rights framework is substantial in that it affirms a woman's right to abortion and through state obligations, puts into practice an implementation

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<sup>210</sup> Ibid.

<sup>211</sup> Fareda Banda 'Women, Law and Human Rights: An African Perspective' (2005) at 69.

<sup>212</sup> Ibid.

<sup>213</sup> See articles 1(f), 14(1)(d)-(e), 14(2)(c) and preamble of the Women's Protocol.

<sup>214</sup> CRR op cit note 209 at 1.

<sup>215</sup> Ibid at 5.

<sup>216</sup> Rebouche op cit note 203 at 99.

<sup>217</sup> Fareda Banda 'Blazing a Trail: The African Protocol on Women's Rights Comes into Force' (2006) 50 *J. African L.* 72 at 75.

guideline to decrease unsafe and illegal abortions.<sup>218</sup> Ngwena adds that because the Protocol is based on principles of equality and non-discrimination, article 14 has the potential to transform abortion laws from a ‘crime and punishment model...to a reproductive health model that complements the objects of CEDAW and the broader philosophy of the ICPD’.<sup>219</sup>

Including abortion in a human rights treaty makes it a legal imperative for African countries to amend abortion laws and de-criminalise abortion procedures.<sup>220</sup> In order to fulfil the rights of article 14(2)(c), a state is obligated to provide services and care that would enable access to an abortion. Ngwena concludes that article 14 helps develop a theoretical model where the overarching goal is for states to respect, promote and fulfil the reproductive health of a woman and that access to abortion services is the benchmark to monitor compliance against abortion obligations.<sup>221</sup>

#### 3.4.2 RIGHT TO LIFE AND RIGHT TO POSITIVE CULTURAL CONTEXT

The Protocol aims to address supplemental issues by calling for the elimination of harmful practices that impede a woman’s daily life.<sup>222</sup> Rebouche argues that article 14 as a stand-alone provision does not adequately address stereotypes that hinder reproductive autonomy in the family or private sphere.<sup>223</sup> As a result, article 14 must be read in conjunction with article 17 of the Protocol, which obligates states to take *affirmative measures* (emphasis added) to modify social and cultural patterns that exacerbate gender-based discrimination. Article 17 is instrumental as it serves as a tool to enable African women to challenge social norms and cultural practices that are gender-biased.<sup>224</sup>

### 3.5 COUNTRY CASE STUDIES

Though article 14 is crucial for the realisation of rights for women, several African nations have placed reservations on the article, devaluing its potential impact for women. For example, Uganda ratified the Protocol in 2010 and soon after made

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<sup>218</sup> Ibid.

<sup>219</sup> Charles Ngwena ‘Protocol to the African Charter on the Rights of Women: Implications for access to abortion at the regional level’ (2010) 110 *International Journal of Gynecology and Obstetrics* 163 at 163.

<sup>220</sup> Ibid.

<sup>221</sup> Ibid at 165.

<sup>222</sup> See Women’s Protocol articles 2 (1)(b) and 2(2).

<sup>223</sup> Rebouche op cit note 203 at 109.

<sup>224</sup> Tamale op cit note 204 at 158.

reservations to articles 14 (1)(a) and 2(c). Uganda's decision to make reservations was largely due to its Constitution, which states that no one can terminate the life of an unborn child, unless to save a woman's life.<sup>225</sup> The country's decision to place reservations was also due to backlash by conservative and religious groups. For example, in 2005, the Ugandan Catholic Church released a press statement that criticised article 14 for being in contrast with 'Christian beliefs and the culture of African citizens'.<sup>226</sup> Though organisations challenged these petitions, the influence of conservative groups was so dominant that reservations to article 14 remained unchanged. Uganda's stance to preserve tradition and culture is weakened by statistics that highlight national maternal mortality rates. For example, in 2006, Uganda's teenage pregnancy rate was at 25 per cent, making it one of the highest in sub-Saharan Africa and a large cause of maternal mortality.<sup>227</sup> Aware of its continued consequences, the Uganda Association of Women Lawyers (FIDA-Uganda) has urged Uganda to remove its reservations to article 14, noting that the removal will also reaffirm Uganda's compliance with regional and international human rights frameworks.<sup>228</sup>

Other countries, like Rwanda, have taken the critical step to realise the importance of women's access to safe and legal abortion services. In August 2012, the Rwandan government lifted its reservation on article 14(2)(c), placing an obligation on the state to allow medical abortions.<sup>229</sup> In that same year, Rwanda amended its penal code, which reduced criminal penalties for women who proceeded with abortion procedures and for doctors who terminated pregnancies.<sup>230</sup> Though amendments were made, Rwandan legislators did not remove the pre-conditions needed to obtain an abortion, namely a court order and approval by two doctors.<sup>231</sup> In an earlier report, the Solidarity for African Women's Rights Coalition (SOAWR) submitted an appeal to the Rwandan government, noting its concern over the current

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<sup>225</sup> See Susheela Singh et al. 'Unintended Pregnancy and Induced Abortion in Uganda: Causes and Consequences' (2006) *Guttmacher Institute* at 4.

<sup>226</sup> *Ibid* at 8.

<sup>227</sup> CRR and the Uganda Association of Women Lawyers 'Universal Periodic Review of Uganda' (2011) at 3.

<sup>228</sup> *Ibid* at 7.

<sup>229</sup> All Africa 'Govt Takes Critical Step in Recognizing Women's Fundamental Human Rights' available at <http://allafrica.com/stories/201208150807.html> accessed on 18 November 2012.

<sup>230</sup> *Ibid*.

<sup>231</sup> Equality Now 'Rwanda: Ensure Access to Safe Legal Abortions' available at [www.equalitynow.org/take\\_action/discrimination\\_in\\_law\\_action\\_8](http://www.equalitynow.org/take_action/discrimination_in_law_action_8) accessed on 18 November 2012.

penal codes and its mandatory pre-conditions for abortion seekers.<sup>232</sup> The SOAWR notes:

*cases such as rape and incest are rarely reported due to societal stigma and therefore rarely reach the courts. This condition will effectively make it impossible or very difficult for women, in particular poor and rural women, to obtain medical abortions even under the permissible conditions.*<sup>233</sup>

Though Rwanda removed its reservation to article 14(2)(c) and expanded the circumstances in which women are eligible for abortions, the conditions set in the Penal Code reinforce structural barriers to access, particularly against individuals who are disadvantaged under economic or rural conditions.

### 3.6 WEAKNESSES OF THE WOMEN'S PROTOCOL

A significant drawback of the Protocol is its poor status of ratification. To date, only 29 of the 53 African countries have signed and ratified the Women's Protocol, devaluing its ability to translate into national legislation.<sup>234</sup> This is in contrast with the African Charter, which was unanimously ratified by all member states. Mukasa argues that a state's unwillingness to ratify the Protocol and domesticate its provisions is largely due to limited political will, particularly amongst patriarchal states.<sup>235</sup> Though states have embedded principles of equality and non-discrimination in their national laws and policies, ratifying a women-focused framework, like the Protocol, places an obligation on countries to take positive actions to promote and protect the rights and entitlements of women.

Malawi, for example, signed and ratified the Protocol, but continues to only enable medical abortions in instances where the pregnancy threatens the life of the mother.<sup>236</sup> As a result of strict abortion laws, women are opting for illegal abortions.

<sup>232</sup> Solidarity for African Women's Rights Coalition 'SOAWR Appeal on Rwanda Safe Abortion Law Reform' (2012) at 1.

<sup>233</sup> Ibid.

<sup>234</sup> See African Union 'List of Countries which have signed/ratified/acceded to the Protocol' (2010) available at [www.africa-union.org/root/au/Documents/Treaties/List/Protocol%20on%20the%20Rights%20of%20Women.pdf](http://www.africa-union.org/root/au/Documents/Treaties/List/Protocol%20on%20the%20Rights%20of%20Women.pdf), accessed on 4 January 2013.

<sup>235</sup> Sarah Mukasa 'Domesticating the Protocol' in *Breathing Life into the African Union Protocol on Women's Rights in Africa* (2006) Solidarity for African Women's Rights at 28.

<sup>236</sup> See Malawi Penal Code (1930) ch 7:01.

Recent reports indicate that unsafe abortion accounts for 18 per cent of maternal deaths in Malawi.<sup>237</sup> Despite studies that reiterate Malawi's obligations under international human rights law, which highlight the economic burden of post-abortion care (PAC), and which demonstrates the major health implications of unsafe services; resistance to abortion legislation continues to be met by Malawian authorities. Notably, a male director of a local organisation highlighted that 'if we have an open law on abortion, this would be subject to abuse because these women that are willingly getting pregnant will continue doing so knowing that once they are pregnant they have the option to end it'.<sup>238</sup>

Though some African nations have been reluctant to ratify the Protocol, the framework at a minimum serves as an advocacy tool for women's groups. For example, the National Union of Eritrean Women lobbied against Female Genital Mutilation (FGM) through article 5 of the Protocol.<sup>239</sup> Though Eritrea has yet to sign the Protocol, with over 94 per cent of women having been circumcised, on-going pressure from lobbyist groups led to the outlawing of FGM in 2007.<sup>240</sup>

### 3.7 CONCLUSION

The adoption of the African Charter and the Women's Protocol has significantly advanced women's rights. Though the African Charter has been critiqued for its limited feature of women in its provisions, the Charter integrates standards from international human rights frameworks into the African context, being cognizant of traditions, values and standards. Despite these efforts, however, social norms, beliefs and tradition continue to impede on the rights of women.<sup>241</sup>

In response to normative gaps in the Charter, the Women's Protocol succeeds in addressing women's rights, particularly within the scope of reproductive health. The right to abortion is further realised through the Protocol's emphasis on other

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<sup>237</sup> Jackson et al. 'A strategic assessment of unsafe abortion in Malawi' (2011) 19:37 *Reproductive Health Matters* at 133 at 134.

<sup>238</sup> Lameck Masina 'Abortion in Malawi: Nearing Legalisation?' Think Africa Press available at <http://thinkafricapress.com/malawi/battle-legalise-abortion> accessed on 17 October 2012.

<sup>239</sup> New Scientist and AFP 'Female genital mutilation banned in Eritrea' (2007) available at [www.newscientist.com/article/dn11543-female-genital-mutilation-banned-in-eritrea.html](http://www.newscientist.com/article/dn11543-female-genital-mutilation-banned-in-eritrea.html) accessed on 17 October 2012.

<sup>240</sup> Ibid.

<sup>241</sup> Claire Charters 'Universalism and Cultural Relativism in the Context of Indigenous Women's Rights' (2003) *Human Rights Research* 1 at 21.

rights, including the right to privacy, the right to equality and non-discrimination and the right to self-determination, as affirmed by international and regional frameworks.

## CHAPTER 4. SOUTH AFRICAN CASE STUDY

### 4.1 INTRODUCTION

Since the end of Apartheid, South Africa has enacted progressive laws that aim to provide a woman with autonomy, choice and freedom in her sexual and reproductive life. These principles were realised and made concrete when the newly elected South African government included a constitutional guarantee on the right to health, which included reproductive health.<sup>242</sup> Reproductive health is further guaranteed through section 4(3)(a) of the National Health Act, which mandates all South African state-funded clinics and community health centres (CHCs) to provide free health services to pregnant women. Following the enactment of the Constitution, the government changed its previous abortion laws and passed the Choice on Termination of Pregnancy Act (CTOP). The Act placed South Africa as one of the few African countries to legalise abortion and provide post-abortion care. Read with the Bill of Rights in the South African Constitution, the CTOP Act recognises that sexual and reproductive health is a human right and affirms state obligations to promote, protect and fulfil a woman's sexual and reproductive health rights and entitlements.<sup>243</sup>

As will be illustrated in this chapter, though women are guaranteed rights under the CTOP Act, the law has not translated well during implementation. The passing of CTOP helped increase access to abortion services, yet the Act fails to address and provide remedies for the stigma surrounding abortion in South Africa.<sup>244</sup> Beliefs and attitudes toward abortion occur at the interpersonal, community and structural level and influence a woman's reproductive choice. Stefiszyn adds that a woman's limited reproductive freedom has a direct effect on her inability to negotiate safe sex or utilise alternative contraceptive methods, which can lead to unintended pregnancies.<sup>245</sup>

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<sup>242</sup> See section 27(1)(a) of the South African Bill of Rights.

<sup>243</sup> Ngwena (2011) op cit note 8 at 14.

<sup>244</sup> Chris Bateman 'Abortion practices undermining reformist laws: experts' (2011) 101:5 *South African Medical Journal* 302 at 303.

<sup>245</sup> Karen Stefiszyn 'Health and reproductive rights, HIV and the Protocol to the African Charter on the Rights of Women in Africa' (2011) 12:4 *Economic and Social Rights Review* 3 at 3.

Fearing stigma and weighing the pragmatic implications of motherhood, women, particularly young, unmarried women, may choose to terminate their pregnancy. Mundigo argues that a woman's decision to terminate an unwanted and unintended pregnancy is dictated by both her personal agency and by external systemic influences. The systemic forces will ultimately conclude how, when and where to go for a termination of pregnancy service.<sup>246</sup>

Similar attitudes and social stigma from the interpersonal level exist at the structural level and impacts a woman's ability to seek an abortion from a qualified medical practitioner. The South African Medical Research Council (MRC) published a report in 2010 indicating that 50 per cent of abortions undertaken by girls (aged 13-19) were performed outside of a hospital or clinic.<sup>247</sup> There is a shortcoming in the law's effective implementation if women seek abortions outside legal and designated facilities, despite a law that enables abortion based on choice in the first trimester. Since the Act's passing in 1996, the number of legal, state-performed abortions has increased. However, in recent years, legal abortions have decreased and instances of unsafe, illegal abortions have been on the rise.<sup>248</sup>

This chapter looks at the evolution of abortion laws in South Africa and how rights are realised for women who wish to exercise choice and autonomy in their sexual and reproductive lives. It highlights how simply changing a law is not adequate and the chapter will conclude by analysing the multiple barriers that women encounter when attempting to access safe and legal abortion services.

## 4.2 SOCIAL CONTEXT IN SOUTH AFRICA

### 4.2.1. PAST

The historical and social context of South Africa's past offers significant insight into the cultural, racial and traditional views of society that impact a woman's life.<sup>249</sup>

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<sup>246</sup> Mundigo op cit note 21 at 55.

<sup>247</sup> Medical Research Council '*The South African Youth Risk Behaviour Survey 2008*' (2010) at 33.

<sup>248</sup> See R.C. Pattinson (ed) '*Saving Mothers 2005-2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa*' at 11-12.

<sup>249</sup> The historical context of South Africa is an example of the chronosystem level in Bronfenbrenner's Ecological Theory of Development (see page 18).

Kehler argues that the standard of living in South Africa, which by inference includes aspects of poverty and inequality, is closely linked to gender, class and race.<sup>250</sup> Haroz affirms that the intertwined systems of customary law and Apartheid have defined the role of women in South Africa, notably black woman, and their ability to make reproductive choices.<sup>251</sup> Before and during Apartheid, black women in particular, were faced with multiple levels of discrimination: women were impacted by the subordinate gender status prescribed to them, as well as influences of 'class exploitation and racial oppression'.<sup>252</sup>

Until 1975, Roman-Dutch common law governed abortion and considered it an illegal act unless the mother's life was threatened by the continuation of pregnancy.<sup>253</sup> Views toward abortion shifted during the Apartheid era as the government began to accelerate population policies for white and non-white South Africans. According to Guttmacher, abortion policies were largely influenced by a fear of an unstable population amongst different groups, namely black individuals.<sup>254</sup> Efforts by the government to manage population growth was evident in the government's plea to white South Africans to have "...enough children to ensure [South Africa's] continued existence as a Christian and Western country on the continent of Africa".<sup>255</sup>

Camlin adds that the government's policies during Apartheid discriminated against black woman: on the one hand, population policies aimed to decrease fertility amongst black woman, while other policies created barriers to education, work and health care.<sup>256</sup> The intended outcome of the government's population efforts is evident through fertility rates amongst certain groups. While the white population has remained relatively unchanged over the last 50 years, the total fertility rate (TFR)

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<sup>250</sup> Johanna Kehler 'Women and Poverty: The South African Experience' (2001) 3:1 *Journal of International Women's Studies* 1 at 2.

<sup>251</sup> A.E. Haroz 'South Africa's 1996 Choice on Termination of Pregnancy Act: Expanding choice and international human rights to Black South African women' (2007) 30:4 *Vanderbilt Journal of Transitional Law* 863 at 863-904.

<sup>252</sup> Tina Sideris 'Women and apartheid: Collective Trauma and Social Reconstruction' (1998) 93 *The Way* 80 at 82.

<sup>253</sup> See UN publication 'South Africa' available at

[www.un.org/esa/population/publications/abortion/doc/southafrica](http://www.un.org/esa/population/publications/abortion/doc/southafrica) accessed on 15 October 2012 at 98.

<sup>254</sup> Sally Guttmacher 'Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act' (1998) 24:4 *International Family Planning Perspectives* 191 of 192.

<sup>255</sup> Quote cited in June Cope 'A Matter of Choice: Abortion Law Reform in Apartheid South Africa' (1993) in *Ibid* at 191.

<sup>256</sup> Carol Camlin, M Garenne and T.A. Moultrie 'Fertility trend and pattern in a rural area of South Africa in the context of HIV/AIDS' (2004) 8:2 *African Journal of Reproductive Health* 38 at 40-41.

for the black population declined from 6.6 in 1960 to 3.3 in the 1990s.<sup>257</sup> The biggest drop in fertility rate for black women was in the mid-1980s (following the 1975 Abortion and Sterilisation Act). The Human Sciences Research Council adds that South Africa's TFR is noteworthy as it was considered the lowest in sub-Saharan Africa in the 1980s and the decline occurred at a time when racial discrimination and population control efforts were largely visible.<sup>258</sup>

Further efforts by the Apartheid government to segregate groups included preferential treatment to white women for employment and education. When white women began to hold professional jobs, however, reproductive attitudes shifted to having fewer children. This lifestyle change led to a demand from white women for contraception and abortion services.<sup>259</sup> Contrastingly, employment limitations placed on non-white women narrowed their financial options in the event of an unwanted or unintended pregnancy. As a result, certain women were faced with the financial struggle to afford an abortion and find a certified doctor who would agree to perform an abortion on a non-white woman. These hurdles caused a surge in clandestine and unsafe abortions, particularly amongst coloured and black women, and influenced their decision to seek illegal procedures by uncertified individuals.<sup>260</sup>

#### 4.2.2 PRESENT

Despite progressive South African laws that enable women the freedom and autonomy to make reproductive choices, women continue to utilise unsafe, backstreet abortion alternatives. Global figures led the WHO to identify unsafe abortion as one of the five causes of preventable maternal mortality and morbidity.<sup>261</sup> This finding is reflected in studies by Orner, Bruyn and Cooper that show that half of the pregnancies in South Africa in 2004 were unplanned (36 per cent) or unwanted (17 per cent).<sup>262</sup>

Studies shown below indicate that young adults are the most vulnerable to the risk and consequences of being denied sexual and reproductive rights. This

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<sup>257</sup> Martin Palamuleni, Ishmael Kalule-Sabiti and Monde Makiwane 'Fertility and childbearing in South Africa' (2007) *Human Sciences Research Council* 113 at 113-114.

<sup>258</sup> *Ibid.*

<sup>259</sup> Guttmacher (1998) *op cit* note 254 at 191.

<sup>260</sup> *Ibid.*

<sup>261</sup> WHO (2012) *op cit* note 63 at 18-19.

<sup>262</sup> Phyllis Orner, Maria de Bruyn and Diane Cooper 'It hurts, but I don't have a choice, I'm not working and I'm sick' (2011) 13:7 *Culture, Health & Sexuality* 781 at 782.

knowledge is coupled with data that highlights that more than 15 per cent of 15 to 24-year-olds in South Africa live in informal settlements.<sup>263</sup> Providing insight into sexual conduct and behaviour, studies show that HIV prevalence among young adults living in informal settlements is double than any other geographical location in the country.<sup>264</sup> Young women's vulnerability in informal settlements is also exacerbated by a low socio-economic status.<sup>265</sup> Dinkelman, Murray and Leibbrandt highlight that poverty increases a woman's vulnerability to sexual coercion and limited access to family planning information and services.<sup>266</sup> Coovadia concludes that South Africa is unique as trends of teenage pregnancy and sexually transmitted diseases are heavily influenced by the family dynamic and societal norms and attitudes toward sexuality.<sup>267</sup> As discussed earlier, access to services can be discriminatory on the basis of sex and can be exacerbated by circumstances such as a woman's age and race. Cook and Howard conclude that instances of multi-layered discrimination are why young women of disadvantaged racial groups and low socio-economic conditions tend to be the most vulnerable to maternal mortality.<sup>268</sup> In response to youth's increased vulnerability, Dr. van der Westhuizen urges health care providers to disseminate accurate information on the rights of the CTOP Act to young women.<sup>269</sup>

In addition to sexual behaviour and awareness, stigma and attitudes toward abortion also affects the availability of services for women in South Africa. According to the Department of Health (DoH), abortion procedures in state facilities decreased to less than 40,000 in 2010, compared to nearly 550,000 in 2004.<sup>270</sup> Experts fear that the decreased number of legal abortion procedures may indicate that outside factors are leading women to utilise illegal, backstreet abortion services.<sup>271</sup>

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<sup>263</sup> Statistics South Africa (2005) report no. 03-02-46 highlighted in 'Teenage pregnancy in South Africa - with a specific focus on school-going learners' (2009) at 36.

<sup>264</sup> Ibid at 37.

<sup>265</sup> Taryn Dinkelman, David Lam, Murray Leibbrandt 'Linking poverty and income shocks to risky sexual behaviour: evidence from a panel study of young adults in Cape Town' (2008) 76 *South African Journal of Economics* 1 at 13-14.

<sup>266</sup> Ibid.

<sup>267</sup> Coovadia op cit note 4 at 822.

<sup>268</sup> Cook and Howard op cit note 61 at 1060.

<sup>269</sup> Study cited in Dr Christa van der Westhuizen 'Midwives' Roles in Expanding Access to and the Management of Safe Abortion Care' Conference Paper (2001) at 16.

<sup>270</sup> Department of Health 2009/2010 Annual Report cited in Marion Stevens 'Maternal Mortality – HIV and unsafe abortion – a silent epidemic' (2012) at 46.

<sup>271</sup> Ibid.

### 4.3 LEGISLATIVE FRAMEWORKS

#### 4.3.1 PAST: THE ABORTION AND STERILISATION ACT, 1975

In response to population control efforts, the South African government passed the Abortion and Sterilisation Act in 1975. Though the Act intended to provide women with greater access to services, the conditions for legally obtaining an abortion were cumbersome to the point that it limited the number of women eligible to secure an abortion.<sup>272</sup>

Ngwena argues that the Abortion and Sterilisation Act did not position abortion as a legal right (as intended), but rather privileged those who met the strict eligibility requirements.<sup>273</sup> Medical practitioners were also impacted by the restrictiveness of the Act as the administrative requirements to determine eligibility were so burdensome that it deterred practitioners from participating in procedures.<sup>274</sup> The combination of strict eligibility requirements and a disinterest from medical practitioners resulted in a limited number of women gaining access to legal abortions.<sup>275</sup> Morroni states that until the enactment of the CTOP in 1996, roughly 1,000 legal abortions were performed annually, mainly among middle and upper-class white women.<sup>276</sup>

The Act and its discriminatory effects further exacerbated the use of illegal ‘backstreet’ abortions. Studies show that from 1975, nearly 200,000 unsafe abortions took place annually, largely from poor, black women.<sup>277</sup> This surge led to an annual 45,000 hospital admissions and 400 deaths from complications and infections due to illegal abortion procedures.<sup>278</sup>

During the democratic transition, the MRC released a study indicating that 425 black women died in 1994 from illegal and unsafe abortions.<sup>279</sup> The timing of the study influenced the new South African government to change legislation that

<sup>272</sup> Guttmacher et al. (1998) op cit note 254 at 191-192.

<sup>273</sup> Charles Ngwena ‘The History and Transformation of Abortion Law in South Africa’ (1998) 30 *Acta Academica* 32 at 39-40.

<sup>274</sup> RE Mhlanga ‘Abortion: developments and impact in South Africa’ (2003) 67:1 *British Medical Bulletin* 115 at 116.

<sup>275</sup> Ngwena (1998) op cit note 273 at 39.

<sup>276</sup> H. Rees et al ‘The epidemiology of incomplete abortion in South Africa’ cited in Chelsea Morroni, Landon Myer, Kemilembe Tibazarwa ‘Knowledge of the abortion legislation among South African women: a cross-sectional study’ (2006) 3:7 *Reproductive Health* at 1.

<sup>277</sup> Ibid.

<sup>278</sup> Ibid.

<sup>279</sup> Stevens op cit note 270 at 46.

enabled all women, irrespective of race and socio-economic status, to seek and gain access to safe abortion and family planning services.

#### 4.3.2 PRESENT: THE CHOICE ON TERMINATION OF PREGNANCY ACT

In order to address the sexual and reproductive health rights of women, the South African government included relevant provisions in the new Constitution. Sections 27(1)(a) and 12(2)(a) of the Bill of Rights became the cornerstone for woman's reproductive freedom as it states that everyone has the right to reproductive health care and the right to bodily integrity.<sup>280</sup>

Given the negative ramifications of the Abortion and Sterilisation Act, the new government enacted the CTOP Act in 1996. The conditions for terminating a pregnancy under the CTOP Act are as follows:

During the first 12 weeks of the gestation<sup>281</sup> period:

- i. A woman may terminate her pregnancy upon request<sup>282</sup>

From the 13<sup>th</sup> to the 20<sup>th</sup> week of gestation, a termination may take place if the continuation of a pregnancy would:<sup>283</sup>

- ii. Risk the woman's physical or mental health;
- iii. Cause the foetus a physical or mental abnormality;
- iv. Affect the social or economic conditions of the woman; or
- v. If the pregnancy resulted from rape or incest

After the 20<sup>th</sup> week of gestation, a termination may take place if the medical practitioner (following consultation with another practitioner) believes that the pregnancy would:<sup>284</sup>

- vi. Risk the life of the mother;
- vii. Cause a severe malformation to the foetus; or
- viii. Injure the foetus

Additionally, the CTOP notes that:

<sup>280</sup> Annica Lindgren and Maya Vergara 'Attitudes among South African nurse students in relation to youths' sexual and reproductive health issues' (2006) Karolinska Institute available at 15.

<sup>281</sup> See section 1(ii) of the CTOP Act where 'gestation' is defined as 'the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last'.

<sup>282</sup> CTOP section 2(1)(a).

<sup>283</sup> CTOP section 2(1)(b).

<sup>284</sup> CTOP section 2(1)(c).

- ix. The State shall promote counselling before and after pregnancy<sup>285</sup>
- x. The termination may only occur following informed consent of the patient. In the case of a minor,<sup>286</sup> a medical practitioner may only advise the minor to consult with parents or guardians<sup>287</sup>
- xi. A person who prevents a lawful termination of pregnancy or obstructs access to a facility is guilty of an offence.<sup>288</sup>

Replacing the 1975 Act, which once required a physician's approval at all times for an abortion procedure, with the CTOP Act was a significant milestone for South African women.<sup>289</sup> The positive outcomes of the CTOP Act were quickly visible as by 1998, nearly 40,000 women annually were accessing legal termination services.<sup>290</sup>

In 2004, the government passed an amendment<sup>291</sup> to CTOP, which enabled registered and appropriately trained nurses and midwives to perform abortions in the first trimester and extended the facilities that provided abortion services.<sup>292</sup> The amendment aimed to address the shortage of doctors and resources available for first trimester abortions.<sup>293</sup> The amendment's text also inferred that procedures could take place in facilities approved by the Members of Executive Council (MEC) (a responsibility previously held by the Minister of Health).<sup>294</sup> The intention was that by removing administrative barriers, allowing midwives and nurses to perform abortions and expanding who is authorised to approve facilities, women, particularly in rural areas, would gain greater access to services, counselling and support (see Appendix B on page 95 for a diagram on the reproductive health conditions in South Africa).<sup>295</sup>

Following the enactment of CTOP, the South African Constitutional Court was faced with two court cases challenging provisions in the Act. In 1998, the

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<sup>285</sup> CTOP section 4.

<sup>286</sup> Ibid section 1(vi) where 'minor' is defined as female person under the age of 18.

<sup>287</sup> CTOP section 5(3).

<sup>288</sup> CTOP section 10(1)(c).

<sup>289</sup> Guttmacher et al. (1998) op cit note 254 at 191.

<sup>290</sup> Statistic cited in Department of Health 'An Evaluation of the Implementation of the Choice on Termination of Pregnancy Act' (2000) at 7.

<sup>291</sup> The Choice on Termination of Pregnancy (CTOP) Amendment Act No. 38 of 2004; re-enacted as Act No. 1 of 2008.

<sup>292</sup> Hoffman, M et al. 'The status of legal termination of pregnancy in South Africa' (2006) 96:10 *South African Medical Journal* 1056 at 1056.

<sup>293</sup> Ibid.

<sup>294</sup> CTOP Amendment at section 3.

<sup>295</sup> Irene E. Zeijlstra 'Conscientious Objection by South African Healthcare Providers to Involvement in the Process of Abortion' (2006) (Unpublished thesis, University of the Witwatersrand) at 78-79.

Christian Lawyers Association (CLA) used section 11 of the South African Constitution to challenge the CTOP Act on the basis that it was unconstitutional as it violated a foetus's 'right to life'.<sup>296</sup> The court rejected the challenge, as they decided that a foetus is not a person and does not bear rights.<sup>297</sup> The Court asserted that by acknowledging the right to life of a foetus, the rights that the mother is entitled to in the Constitution would be consequently violated.<sup>298</sup> Ngwena adds that the judges' decision illustrates how rights are inter-related as there was a need to consider the implications of all Constitutional provisions against the conflicting interest of one specific provision.<sup>299</sup> Cook and Dickens add that the court's decision echoed other cases (like *Roe v. Wade*, 410 U.S.) whereby the debate between the mother's rights and the rights of the foetus was not based on moral or spiritual grounds, but rather through a legal lens.<sup>300</sup>

In 2004, the CLA brought forth a second case to the Courts, arguing that it was not in the best interest of the child to consent to her own abortion.<sup>301</sup> The CLA argued that there should be no instance where a minor could agree to an abortion without the consent of a parent or guardian.<sup>302</sup> The case was dismissed as the court stated that the consent clause in the CTOP Act was in the best interest of the child.<sup>303</sup>

Since the implementation of CTOP, all women, irrespective of age, race and nationality, can access termination services in state facilities. Unlike the Abortion Act in 1975, which catered mainly to white, affluent women, the CTOP Act has been praised for its 'human rights approach', whereby all women are included and protected.<sup>304</sup> However, as will be illustrated in the following section, influences of social norms and traditional beliefs, as well as stigma toward abortion, impacts the availability and accessibility of abortion services as guaranteed in the CTOP Act.

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<sup>296</sup> *Christian Lawyers Association* (1998) op cit note 132.

<sup>297</sup> Ibid cited in CRR 'Whose Right to Life?' op cit note 129 at 9.

<sup>298</sup> Ibid.

<sup>299</sup> Ngwena (2011) op cit note 8 at 212-213.

<sup>300</sup> Cook and Dickens (2003) op cit note 14 at 26.

<sup>301</sup> *Christian Lawyers Association* (2004) op cit note 166.

<sup>302</sup> CRR 'Legal Grounds, Reproductive and Sexual Rights in African Commonwealth Courts' (2005) at 48.

<sup>303</sup> See case in Trynie Boezaart 'Child Law in South Africa' (2009) at 209.

<sup>304</sup> Mhlanga op cit note 274 at 124.

#### 4.4 BARRIERS: STIGMA AND SOCIETAL EXPECTATIONS

##### 4.4.1 BY THE PARTNER

Research conducted by Orner found that women who were faced with unwanted pregnancies identified their inability to practice safe sex and negotiate male condom use as the underlying cause.<sup>305</sup> As this study highlights, a woman's subordinate role in a patriarchal society<sup>306</sup> influences the outcome of sexual and reproductive decisions and choices. In another study, black South African women told researchers that men held superior roles, often regarding themselves as the 'heads' of women, thus having control over a woman's sexual life and reproductive role.<sup>307</sup> A case-controlled study conducted by Jewkes showed that 72 per cent of the pregnant participants reported being coerced into sex.<sup>308</sup>

A common paradox in South African culture is the instance where a man is economically unwilling to support a new-born child, yet morally against the act of abortion.<sup>309</sup> Women, as a result, are left with few options as either decision is an unfavourable one: a woman will be criticised for bearing a child without a paternal figure, but will be reprimanded for having an abortion. Amongst black communities, Varga found that the acceptance or rejection of paternity for the baby would heavily influence a woman's decision to terminate a pregnancy.<sup>310</sup> Rejection of paternity is said to affect a female's reputation and compromise a family's standing in the community.<sup>311</sup> These influences, as a result, heavily influence a woman's decision to seek abortion, even if it is an illegal procedure.

##### 4.4.2 BY THE FAMILY AND COMMUNITY

In addition to influences from a partner, women face pressure and stigma from family and the community regarding reproductive decisions.<sup>312</sup> Varga

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<sup>305</sup> Orner op cit note 262 at 785.

<sup>306</sup> See the 'woman-protective argument' on page 16.

<sup>307</sup> S Hoosen and A Collins 'Women, Culture and AIDS. How discourses of Gender and Sexuality affect safe sexual behaviour' (2004) available at <http://catalogue.saf aids.net/publications/women-culture-and-aids-how-discourses-gender-and-sexuality-affect-safe-sex-behaviour> accessed on 2 January 2013.

<sup>308</sup> Rachel Jewkes et al. 'Relationship dynamics and teenage pregnancy in South Africa' (2001) 52 *Social Science and Medicine* 733 at 739.

<sup>309</sup> 'Teenage pregnancy in South Africa' op cit note 263 at 65.

<sup>310</sup> Christine A. Varga 'Pregnancy termination among South African adolescents' cited in 'Teenage pregnancy in South Africa' op cit note 263 at 46.

<sup>311</sup> Ibid.

<sup>312</sup> Refer to the 'interpersonal layer' of Bronfenbrenner's model on page 18.

highlights how mothers and older female siblings are heavily involved in reproductive decisions, often basing their decision on the preservation of a family's reputation.<sup>313</sup> The social consequences of having a child out of wedlock is evident in Varga's study which found that young adults categorised a woman's ability to avoid pregnancy as part of her sexual 'respectability and attractiveness'.<sup>314</sup> The social consequences of falling pregnant – at a young age and unmarried – serve as a catalyst to utilise a backstreet service where privacy and confidentiality would be upheld.

#### 4.4.3 BY THE HEALTH CARE PROVIDER

Social and cultural attitudes that inhibit a woman's choice and autonomy also exist within the health care system. A woman's experience in accessing safe and legal abortions is heavily influenced by the beliefs and attitudes of health care providers, who, if opposed to abortion, could create barriers to service availability.<sup>315</sup> Several reports label health staff as 'gatekeepers,' as they can influence or attempt to control women's reproductive decisions.<sup>316</sup>

As discussed, young adults can face backlash from health care providers when seeking abortion services. Anecdotal evidence from Marie Stopes showed that young adults were labelled 'irresponsible' for choosing to abort a foetus rather than continuing with birth.<sup>317</sup> Judgment from the health care provider should be considered within the context of data that shows that young adults are the most prevalent users of illegal and unsafe abortion services.<sup>318</sup> The 2008 National Youth Risk Behaviour Survey found that of the 8.2 per cent of South African young adults who had an abortion, only 51 per cent utilised a state hospital or clinic for the service.<sup>319</sup> Findings that young adults do not utilise legal abortion services to the extent that they should is reiterated by data from the MRC, which found that women under 20 were three times higher to be present at a hospital with an incomplete

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<sup>313</sup> Ibid cited in 'Teenage pregnancy in South Africa' op cit note 263 at 46.

<sup>314</sup> Ibid.

<sup>315</sup> McQuoid-Mason op cit note 57 at 76.

<sup>316</sup> Charles Ngwena 'Inscribing abortion as a human right: significance of the protocol on the rights of women' (2010) 32 *Human Rights Quarterly* 783 at 843-847.

<sup>317</sup> Marie Stopes 'Unsafe Abortion in South Africa: A Preventable Pandemic' available at [www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic](http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic) accessed on 10 January 2013.

<sup>318</sup> Medical Research Council op cit note 247 at 33.

<sup>319</sup> Ibid.

abortion.<sup>320</sup> The data infers that young adults may also seek illegal services due to stigmatisation from designated health care facilities.

#### 4.5 BARRIER: RELUCTANCE BY MEDICAL PERSONNEL

Since the enactment of CTOP in 1996, nurses that are morally, religiously and ethically against termination of pregnancies have used their status and beliefs to deny clients services, including information, procedures, medication and contraceptives.<sup>321</sup> Stigma and discriminatory beliefs may also cause a health care provider to infringe a patient's right to privacy. For example, a nurse may be guilty of violating the confidentiality of a young adult by demanding parental consent to perform an abortion. A focus group in the Western Cape demonstrated how participants reported feeling discouraged to seek contraceptives due to a lack of privacy and confidentiality at local clinics.<sup>322</sup>

Health care providers are not obligated to perform abortion services and can object on the grounds of conscience. Though the right to conscientious objection is not explicit in the CTOP Act, health care providers seek guidance from the rights and freedoms embodied in the South African Bill of Rights.<sup>323</sup> In South African law, the right to freedom of conscience by a health care provider conflicts with the right to reproductive freedom of an individual. The contradiction between the two Constitutional rights has been debated by government officials, advocates and researchers.

Ngwena adds that:

*The right to conscientious objection cannot be exercised ... to permit the health worker to impose anti-abortion views on the pregnant woman or society and vice-versa. The health worker has the freedom to choose to refuse*

<sup>320</sup> Data cited in Guttmacher op cit note 254 at 192.

<sup>321</sup> See generally Jane Harries, Kathryn Stinson and Phyllis Orner 'Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa' (2009) 9:296 *BMC Public Health* 1 at 2.

<sup>322</sup> Elmien Lesch and Lou-Marie Kruger 'Mothers, daughters and sexual agency in one low-income South African community' (2005) 61 *Social Science and Medicine* 1072 at 1076-1077.

<sup>323</sup> Naylor op cit note 54 at 9.

*to participate in abortion procedures ... however, the rights of the pregnant woman and the interests of society must be taken into account.*<sup>324</sup>

As argued by Ngwena, conscientious objection is problematic if it infringes upon the rights of a woman and hinders her access to abortion services.<sup>325</sup> Grounds of conscience are even more problematic if the denial of a service endangers the health and life of a woman. For example, a study conducted in the Western Cape found that 14 per cent of doctors reported that they did not attend to women requesting an abortion, even in emergency circumstances.<sup>326</sup> Similarly, a nurse working at a tertiary institution admitted that her future decision to participate in an abortion was based on the patient's reason for seeking an abortion: 'I first ask for a reason why they come for a TOP, then if it is not necessary at all I advise them to keep the baby because it's a sin to kill, but when I see there is a necessity for that [financial reasons or interrupting studies] then I support them'.<sup>327</sup>

#### 4.5.1 STRUCTURAL FACTORS

A significant structural challenge to the implementation of CTOP is the high turnover rate of staff unwilling to perform abortions.<sup>328</sup> Increased resistance by personnel to terminate pregnancies has resulted in very few facilities capable of offering legal and safe services.<sup>329</sup>

The Western Cape's 2008/2009 report indicates that more than 25 per cent of clinics in the area only perform second trimester abortions.<sup>330</sup> The report infers that amongst the already-few facilities offering services, roughly a quarter of those facilities will not treat a patient whose abortion request is solely based on choice. Nationally, a DoH report highlights that in 2010/2011 only 25 per cent of community health centres (CHCs) authorised to provide abortions were actually implementing the service.<sup>331</sup>

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<sup>324</sup> See Charles Ngwena 'Conscientious objection and legal abortion in South Africa: delineating the parameters' (2003) 28:1 *Journal for Juridical Science* 1 at 11.

<sup>325</sup> Phyllis Orner et al. 'Access to safe abortion: building choices for women living with HIV and AIDS' (2011) 14:54 *Journal of the International AIDS Society* 3 at 9.

<sup>326</sup> Ngwena (2003) op cit note 324 at 4.

<sup>327</sup> WHO (2010) op cit note 176 at 3.

<sup>328</sup> Orner (2011) op cit note 325 at 3.

<sup>329</sup> Ibid.

<sup>330</sup> Report cited in Candy Day and Andy Gray 'Health and Related Indicators' (2010) *The South African Health Review* 211 at 272.

<sup>331</sup> Department of Health 'Annual Report 2010/2011' at 42.

In addition to reluctance by medical personnel, the Act has been criticised for its minimal efforts to educate women about the Act. Many women are unaware of their rights under the Act and due to stigma by partners and health care providers, are often provided with inaccurate and outdated information.<sup>332</sup> For example, health care providers may discourage women from having more than one abortion by exaggerating risks and consequences. Orner found in her interviews that though the CTOP Act makes no mention of the number of permissible abortions, women reported being told that they could only have one abortion in their lifetime.<sup>333</sup> Another study shows that roughly 30 per cent of South African women believe that abortion is still illegal in the country.<sup>334</sup> This finding is reiterated in another qualitative study, which shows that of the women who have had illegal abortions, more than half reported doing so because they were unaware of the CTOP Act.<sup>335</sup>

The denial of information violates a woman's right under section 32 of the South African Bill of Rights and further hinders a woman's decision-making ability. Merkel adds that by interpretation, section 32 infers that information must not be biased or tailored to the practitioner's preference and beliefs.<sup>336</sup> To ensure that women are receiving accurate and current information, South Africa should improve education-based initiatives regarding the provisions of the CTOP Act. This will ensure that women who have limited knowledge of the provisions of the CTOP Act will not be influenced by their health care provider's inaccurate or misleading information.

Studies have been conducted to illustrate why nurses withhold information and deny young adults the abortion services that they seek. A study found that nurses reported feelings of frustration, as they believed that youth viewed abortion as a reliable contraceptive measure, rather than preventing the pregnancy by practicing safe sex or using birth control.<sup>337</sup> The nurses added that they felt youth were ignorant to the consequences of having multiple abortions at their age.<sup>338</sup>

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<sup>332</sup> Orner (2011) op cit note 262 at 791.

<sup>333</sup> Ibid.

<sup>334</sup> Morroni op cit note 276 at 2.

<sup>335</sup> Rachel Jewkes et al. 'Why are women still aborting outside designated facilities in Metropolitan South Africa?' (2005) 112 *International Journal of Gynecology & Obstetrics* 1236 at 1240.

<sup>336</sup> Judy Merkel 'Advocacy Tool – The Sexual and Reproductive Rights and Health of HIV Positive Women in South Africa' (2006) *International Community of Women Living with HIV/AIDS* at 6.

<sup>337</sup> Lindgren op cit note 280 at 27.

<sup>338</sup> Ibid.

The stigma that patients feel when seeking abortion services is a shared sentiment from nurses who agree to perform abortions. A study conducted by Harries, Stinson and Orner illustrates the attitudes of medical personnel who participate in abortion services.<sup>339</sup> One provider in the study notes: ‘you'd often find midwives not providing abortions because they fear the victimisation, being stigmatised, being isolated from their peers, and also within the community itself’.<sup>340</sup> The harassment that abortion providers face from fellow colleagues and community members may discourage them from performing services. This circumstance has enormous implications as practitioners who face ridicule may discontinue their participation in service delivery, thus limiting the already-minimally available abortion facilities in the country.

## **4.6 IMPLEMENTATION OF THE LAW**

### **4.6.1 SOUTH AFRICAN LAW**

As discussed earlier, there is a conflict in law between the right to reproductive freedom of a patient and the right to freedom of conscience of a health care provider.<sup>341</sup> The South African Bill of Rights promotes a woman’s reproductive capacity through section 12(2)(a) and reproductive health care through section 27(1)(a), but simultaneously promotes the freedom of conscience of an individual in section 15. To guarantee a woman complete reproductive freedom, s 27(1)(a) and 12(2)(a), as well as other principles of the Bill of Rights, must be read in line with provisions of the CTOP Act.<sup>342</sup>

Furthermore, section 15(1) of the Constitution enables the right to ‘freedom of conscience, religion, thought, belief and opinion’, thereby guaranteeing individuals with moral autonomy. Though conscientious objection is not featured in the CTOP Act, it is permitted through the application of section 15 of the Constitution. However, provisions in the CTOP Act place limitations on the extent to which a practitioner can exercise their right to object to an abortion procedure. For example, section 10(1)(c) of the CTOP Act states:

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<sup>339</sup> Harries (2009) op cit note 321 at 8.

<sup>340</sup> Ibid.

<sup>341</sup> McQuoid-Mason op cit note 57 at 75.

<sup>342</sup> Naylor op cit note 54 at 10.

*any person, who prevents the lawful termination of pregnancy or obstructs access to a facility for the termination of pregnancy, shall be guilty of an offence and liable on conviction to a fine / imprisonment for a period not exceeding 10 years.*

The provisions of CTOP indicate that medical personnel (and by inference, personnel who also object to an abortion procedure) must provide the patient with access to information. ‘Information’ can be construed as available clinics, their rights in the Act and referrals to providers willing to perform abortions.<sup>343</sup> Additionally, regardless of an objection, practitioners are required to provide pre and post-abortion care to the patient.<sup>344</sup>

Additional guidance to a practitioner’s limitation on their right to conscience derives from section 36 of the South African Constitution.<sup>345</sup> Ngwena has interpreted section 36 to mean that limiting a practitioner’s right to conscientious objection can occur when a mother’s ‘maternal health or life is in danger or there is a medical emergency’.<sup>346</sup>

To date, the South African courts have not addressed how the limitation of rights under section 36 weighs against the realisation of sexual and reproductive rights for women. However, insight can be extracted from the British Court Case of *R. v. Lewis*<sup>347</sup> where the Access to Abortion Services Act<sup>348</sup> was challenged. Lewis argued that the Act, which prohibited abortion protests in designated areas of homes and medical offices, denied his right to freedom of conscience, religion and expression.<sup>349</sup> The British Court agreed that the individual’s right was violated under the Act, but held that it was justified, as the ‘competing right’ (a woman’s right to reproductive health care and right to privacy) took precedence.<sup>350</sup>

Structural barriers also exist when there is limited guidance on how to implement certain provisions of the CTOP Act. While the request for an abortion during the first trimester is made by choice, the decision to terminate a pregnancy

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<sup>343</sup> Ibid.

<sup>344</sup> See section 4 of CTOP.

<sup>345</sup> See section 36(1) of the Constitution of South Africa.

<sup>346</sup> Ngwena (2003) op cit note 324 at 11.

<sup>347</sup> (1996) B.C.J. No. 3001.

<sup>348</sup> (1995) B.C. Reg. 337/95.

<sup>349</sup> Naylor op cit note 54 at 14.

<sup>350</sup> Ibid.

during the second and third trimester is at the discretion of the doctor, based on specified conditions under the CTOP Act.

Since the enactment of the CTOP Act, the number of second trimester abortions performed in South Africa has remained high. A 2005 DoH report shows that 30 per cent of abortions in South Africa take place in the second trimester, compared to only 10 per cent in the United States.<sup>351</sup> The implications of second trimester abortions are high and women face more resistance and administrative difficulty to seek services. A study from Harries et al. has shown that a delay in seeking an abortion until the second trimester is often a result of personal factors (such as difficulty detecting pregnancy) and structural barriers to services.<sup>352</sup>

On a structural level, women have noted the difficulty in securing timely referrals, having to visit multiple facilities before securing a procedure, waiting prolonged periods of time for an appointment and struggling to find facilities that will even provide second trimester abortions.<sup>353</sup> Varkey adds that in addition to structural issues, the general resistance by health care providers to perform second trimester abortions further hinders a woman's access to service.<sup>354</sup> This insight is strengthened by research from Morroni and Moodley who found that nearly half of their study participants had to visit 2.5 facilities (both public and private) before securing a second trimester termination service.<sup>355</sup>

Attitudes toward second trimester abortions vary amongst health care providers, but studies have indicated that many providers struggle to perform services during that time frame.<sup>356</sup> Studies show that a health care provider's willingness to perform a second trimester abortion is dependent on the circumstance or background of the patient. Harries et al. highlights that nearly all providers in their study viewed an unplanned pregnancy as a result of rape or incest as a 'legitimate reason' to have an abortion.<sup>357</sup> The study also showed that doctors were more

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<sup>351</sup> South African Department of Health 'Termination of Pregnancy Update Cumulative Statistics through 2004' (2005).

<sup>352</sup> Harries et al. (2007) op cit note 174 at 9.

<sup>353</sup> S.J. Varkey 'Abortion services in South Africa: available yet not accessible to all' (2000) 26:2 *International Family Planning Perspective* 87 at 87-88.

<sup>354</sup> Ibid.

<sup>355</sup> Chelsea Morroni and Jennifer Moodley 'Characteristics of women booking for first and second trimester abortions at public sector clinics in Cape Town' (2006) 12:2 *South African Journal of Obstetrics and Gynaecology* 81 at 82.

<sup>356</sup> Ibid.

<sup>357</sup> Harries (2009) op cit note 321 at 6.

tolerant toward a patient if the continuation of the pregnancy would result in a foetal abnormality; the study highlighted that the trauma women would face from having a baby with foetal abnormalities would warrant more support and attention, regardless of the staff's view on abortion.<sup>358</sup> Since a patient's eligibility for second and third trimesters is at the discretion of the doctor, the government is limited in their ability to ensure that doctors are not violating their medical duties under law by denying women abortion procedures. South Africa should work to improve accountability mechanisms to ensure that doctors are fulfilling their obligations under the CTOP Act if women were to seek termination services for their second and third trimester pregnancies.

Since second trimester abortions pose a large economic burden on the state, requires investment training and reduces the number of eligible practitioners (to only doctors), Grossman et al. suggests that first trimester abortion services should be accessible for women, so to reduce the number of women demanding services in their second trimester.<sup>359</sup>

Given the structural barriers to accessing services in the second and third trimesters, government must ensure that women are provided with information and education regarding the eligibility requirements of each gestational timeframe. Providing women with information and access to educational services will ensure that women are able to make timely and informed decisions in the case of an unwanted pregnancy.<sup>360</sup>

#### 4.6.2 INTERNATIONAL AND REGIONAL LAW

Under international and regional human rights law, South Africa has an obligation to take positive measures to protect, promote and fulfill the sexual and reproductive rights of women. In addition to general observations and concluding remarks by UN treaty monitoring bodies (TMBs), NGOs have submitted shadow reports that illustrate South Africa's compliance with the human rights frameworks that it has signed and ratified.

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<sup>358</sup> Ibid.

<sup>359</sup> Daniel Grossman et al. 'Surgical and medical second trimester abortion in South Africa: A cross-sectional study' (2011) 11:224 *BMC Health Services Research* 1 at 8.

<sup>360</sup> Harries et al. (2007) op cit note 174 at 6

In 1998, the Centre for Reproductive Law & Policy submitted a shadow report to the CEDAW Committee highlighting the realities of laws and policies impacting the reproductive lives of South African women.<sup>361</sup> The report highlighted that a major issue for the realisation of safe and legal services was that ‘few doctors are trained, and many are reluctant, to perform abortions’.<sup>362</sup> This finding is evident through statistics highlighted in the report which indicate that abortion designated facilities are on the decline. This issue was identified two years after the enactment of CTOP, and nearly 15 years later, resistance by medical personnel to perform abortions continues to be a systematic barrier to the realisation of reproductive freedom for women.

In 2011, an NGO shadow report was submitted to the CEDAW Committee highlighting the shortcomings of South Africa’s duties under the Convention.<sup>363</sup> The report highlights how the liberalisation of abortion laws increased demand for abortion services, which South Africa has been unable to meet.<sup>364</sup> This demand, the report concludes, led to an increase in alternative services, which resulted in a spike in unsafe abortions.<sup>365</sup> The report urged the South African DoH to approve national medical abortion guidelines. Without the framework, the report asserts, service accessibility and the obligations of health care providers remain unclear.<sup>366</sup>

Utilising a rights-based framework<sup>367</sup> to analyse the sexual and reproductive health conditions of South Africa, I would argue that the country has met the minimum obligations of provision 14(2)(c) of the African Women’s Protocol as the country has decriminalised abortion. Ngwena’s points to article 14 as a guideline for states to respect, promote and fulfil the reproductive health of women, and uses access to abortion services as a benchmark to monitor compliance and quality

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<sup>361</sup> Center for Reproductive Law & Policy ‘Women’s Reproductive Rights in South Africa: A Shadow Report’ (1998) available at

<http://reproductiverights.org/sites/default/files/documents/SRSouthAfrica98en.pdf> accessed on 22 December 2012.

<sup>362</sup> Ibid.

<sup>363</sup> Centre for the Study of Violence and Reconciliation, ‘South African Shadow Report on the Implementation of CEDAW’ (2011) available at

[www.advocacyaid.com/images/stories/rrdownloads/SOUTH\\_AFRICA\\_CEDAW\\_SHADOW\\_REPO\\_RT\\_48TH\\_SESSION.pdf](http://www.advocacyaid.com/images/stories/rrdownloads/SOUTH_AFRICA_CEDAW_SHADOW_REPO_RT_48TH_SESSION.pdf) accessed on 28 October 2012 at 1.

<sup>364</sup> Ibid.

<sup>365</sup> Ibid.

<sup>366</sup> Ibid at 43.

<sup>367</sup> See section on ‘rights-based framework’ on page 16.

assurance.<sup>368</sup> Using Ngwena's argument to analyse all of the provisions in article 14, it can be argued that South Africa does not guarantee women the rights and freedoms stated in all of article 14. The barriers identified throughout the dissertation illustrate how they hinder a woman's access to services, thus violating articles 14(1) and (2), specifically, of the Women's Protocol, which speaks about the right to control one's fertility and the right to reproductive freedom.

Furthermore, when a health care provider objects conscientiously to an abortion service in South Africa and does not provide the patient with access to information and a referral to another facility, the provider violates the provisions of the CTOP Act as well as article 14 of the Women's Protocol. Though South Africa permits abortions under the grounds listed in article 14(2)(c), I would argue that state obligations are not adequately fulfilled if a conscientious objector withholds information and a referral that would enable a woman to seek an abortion elsewhere.

The example highlighted above demonstrates why South Africa should evaluate the context of a woman's sexual and reproductive health through a rights-based framework. This issue will be discussed further in Chapter Five.

#### **4.7 CONCLUSION**

Women in South Africa endure criticism and shame for becoming pregnant and for terminating a pregnancy. Layers of influence exist at the personal, interpersonal and structural levels of an individual's life and impact a woman's choice and autonomy in her sexual and reproductive decisions. On an individual and community level, women struggle against their partner's and family's opposition to terminate a pregnancy. On structural levels, social norms, stigma and moral beliefs influence a health care provider's willingness to perform an abortion, as well as make referrals and provide accurate information to a patient.

A focus group conducted by Jewkes highlighted that the main reasons women did not use legal abortion services included: 'not knowing the law (54 per cent); knowing the law, but not knowing where to get one (15 per cent); anticipating staff rudeness (17 per cent); being afraid of being found out (7 per cent) and being too late

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<sup>368</sup> Ngwena (2010) op cit note 219 at 165.

in pregnancy or finding too long a waiting list (7 per cent)'.<sup>369</sup> In the same study, more than 33 per cent of the women who were aware of the provisions of the CTOP Act were still unwilling to access legal abortion facilities due to fear of being chastised and criticised by health care staff.<sup>370</sup>

Jewkes' study indicates that women do not utilise safe and legal abortion facilities due to the social norms and moral stigma associated with terminating a pregnancy. Though South Africa has enacted progressive legislation that realises the sexual and reproductive health rights of women, the law falls short at the implementation level. The government and the CTOP Act inadequately address the root causes and social and cultural determinants that lead to a woman's unintended pregnancy and decision to utilise a backstreet, unsafe abortion service.

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<sup>369</sup> Jewkes op cit note 335 at 1240.

<sup>370</sup> Ibid.

## CHAPTER 5. CONCLUSION & RECOMMENDATIONS

### 5.1 INTRODUCTION

My research aimed to provide insight and suggestions to a question that has formed the premise of the dissertation: why is it that women continue to seek and utilise unsafe abortion services, despite the fact that South Africa has legalised abortion?

This dissertation has found that women in South Africa are not autonomous decision-makers in their sexual and reproductive lives. My research supports the argument that women face resistance, discrimination and barriers at multiple levels of their lives. Barriers to access are exacerbated by the social norms, attitudes and stigma surrounding abortion in South Africa.

#### 5.1.1 BACKGROUND

Prior to the twentieth century, the rights of women were limited as human rights frameworks, like the UDHR, addressed women's rights through gender-neutral terminology and in relation to marriage and family life.<sup>371</sup> Historically, women were granted little decision-making power, particularly related to sex and gender-based issues.<sup>372</sup> The subordinate role of women, influenced by patriarchal beliefs, led men to make reproductive decisions within the family.<sup>373</sup>

A shift occurred in the 1980s as women's rights became individualised and sexual and reproductive health became a predominant issue in the human rights agenda. International conferences began to scrutinise sexual and reproductive health needs within the greater context of a woman's health and well-being.<sup>374</sup> Women's reproductive health expanded to encompass reproductive freedom and autonomy.

Though the right to abortion is not explicit in international human rights law, it is implicit through the realisation of other rights. Regionally, the African Women's

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<sup>371</sup> Charlesworth (1991) op cit note 10 at 622.

<sup>372</sup> Ibid.

<sup>373</sup> Ibid.

<sup>374</sup> Sofia Gruskin et al. 'Using human rights to improve maternal and neonatal health: history, connections and a proposed practical approach' (2008) 86 *Bulletin of the World Health Organization* 589 at 591.

Protocol has been commended for being the first human rights instrument to explicitly address a woman's right to abortion.<sup>375</sup>

### 5.1.2 MOTIVATION FOR RESEARCH

Though sexual and reproductive health has made significant advancement within the human rights discourse, women continue to face barriers to service. Despite UN general recommendations and concluding observations that urge states to address restrictions to access, women seeking services face resistance and discrimination at the personal, interpersonal, community and systemic level.

Irrespective of the human rights frameworks that recognize and promote sexual and reproductive health rights, the dissertation has demonstrated how rights do not translate adequately in practice. The dissertation focused on South Africa given its relatively new sexual and reproductive health-related laws and policies that aim to give women complete control over their reproductive choices.

Since the implementation of South Africa's Choice on Termination of Pregnancy Act, all women, irrespective of age, race and nationality, have been granted access to termination services in state facilities. Despite the country's progressive laws, statistics depicting maternal-related deaths and incomplete abortions imply that the implementation of South African laws remains unrealised for women, particularly poor, non-white women.

## 5.2 FINDINGS

Through detailed findings and recommendations, the following section will demonstrate how the research objectives set out in Chapter One have been satisfied. The research objectives are thematically grouped below.

### 5.2.1 IMPACT OF SOCIAL NORMS, ATTITUDES AND BELIEFS

The research set out to analyse the current and historical social and cultural influences that impact a woman's decision to utilise unsafe and illegal abortion services.<sup>376</sup> This research objective was achieved through the identification of barriers that derive as a result of social norms and personal attitudes toward abortion.

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<sup>375</sup> Women's Protocol article 14.

<sup>376</sup> See research objectives i and iii on page 11.

These barriers are interrelated, operate on all levels of society and influence a woman's reproductive decisions.<sup>377</sup>

The South African chapter demonstrated how, on an interpersonal level, women with limited reproductive freedom struggle to negotiate safe sex and use different contraceptive methods, thereby increasing their chances of an unintended pregnancy.<sup>378</sup>

Patriarchal attitudes and ideologies further contribute to a woman's reproductive capacity. These ideologies are evident through gender-based justifications that reiterate the stereotype of a woman as a wife and caretaker.<sup>379</sup> The belief that women have limited agency to make reproductive choices is worsened by male-dominated ideologies that place the family and spousal decisions in the hands of a man.<sup>380</sup>

On a structural level, social norms and beliefs influence a health care provider's willingness to perform an abortion procedure, as well as make referrals and provide accurate information to a patient. The implications of a provider's reluctance to perform a service will be discussed below.

The dissertation has found that barriers to access and limitations placed on women's reproductive freedom and autonomy influences their decision to utilise unsafe abortion services. My research and analysis has also found that one of the most vulnerable groups to resort to unsafe abortion procedures is young girls. In addition to facing stigma for participating in sexual activity at a young and unmarried age, studies show that young girls are more vulnerable due to their limited knowledge of available reproductive health services.<sup>381</sup>

Given the impact of social norms, attitudes and beliefs toward service accessibility, it is recommended that South Africa identify the structural barriers and underlying root causes that lead women to obtain unsafe and illegal abortions. South Africa should use Bronfenbrenner's Social Ecological framework<sup>382</sup> as an analytical lens in a two-step process: first to understand the root causes and influences of an

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<sup>377</sup> J. P. Elder et al. 'A description of the social- ecological framework used in the trial of activity for adolescent girls' (2007) 22:2 *Health Education Research* at 155–165.

<sup>378</sup> Stefiszyn op cit note 245 at 3.

<sup>379</sup> See the 'woman-protective argument' on page 16.

<sup>380</sup> Manian op cit note 25 at 225.

<sup>381</sup> Olukoya op cit note 68 at 143-144.

<sup>382</sup> Bronfenbrenner op cit note 35 at 330.

unwanted pregnancy and second, to identify the barriers women face when deciding to pursue an abortion (see Appendix A on page 94 as an example).

### 5.2.2 GENERAL HUMAN RIGHTS DISCOURSE

Chapters Two and Three satisfied the research objective to illustrate how sexual and reproductive health rights are realized under human rights law.<sup>383</sup> The chapters demonstrated how sexual and reproductive health is achieved through the indivisibility of human rights, including civil, political, cultural, social and economic.<sup>384</sup>

Under international and regional human rights law, South Africa has an obligation to take positive measures to protect, promote and fulfill the sexual and reproductive rights of women. In addition to country reports by UN treaty monitoring bodies (TMBs), NGOs have submitted shadow reports noting that the liberalisation of abortion laws increased demand for abortion services, which South Africa has been unable to meet.

The progression of sexual and reproductive health rights is a unique case to South Africa given the historical roots and effects of colonialism and Apartheid. The historical social context and racialised nature of laws and policies in South Africa discriminated against women across multiple fronts. The government's population control efforts and the subsequent Abortion and Sterilisation Act demonstrated how government attempted to control fertility and withhold services from specific groups.<sup>385</sup> Prior to and during Apartheid, black women were discriminated on multiple levels, including by a subordinate gender status and influences of 'class exploitation and racial oppression'.<sup>386</sup> The impact of Apartheid offers insight into the current discriminatory effects of access to health care, services and support for women in South Africa.

It is recommended that South Africa evaluate the context of a woman's sexual and reproductive health under a rights-based framework. A rights-based framework helps identify other rights that are subsequently violated within a woman's sexual and reproductive life. For example, the belief that women have a

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<sup>383</sup> See research objective ii on page 11.

<sup>384</sup> Ibid.

<sup>385</sup> See Ngwena (1998) op cit note 273 at 39.

<sup>386</sup> Sideris op cit note 252 at 82.

reproductive obligation, as illustrated above and in the ‘woman-protective argument’, impedes their rights to equality and non-discrimination, the right to liberty and security and the right to reproductive freedom, in addition to their right to health.

### 5.2.3 OBLIGATIONS UNDER LAW AND RESULTING CONFLICTS

In South Africa, health care practitioners are protected under the Constitution to exercise their right to choice, conscience and belief. This right, however, conflicts with the right to reproductive freedom of a patient, which is also granted in the Constitution. This conflict creates a grey area for determining the obligations of a medical practitioner who is expected to assist a woman during an abortion.<sup>387</sup>

The resistance of health care practitioners to perform abortions and who invoke conscientious objection, particularly in state facilities, is a significant barrier to access.<sup>388</sup> On a structural level, studies show how conscientious objection limits the number of eligible facilities that administer abortion services for women.

Though conscientious objection is protected under the Constitution, provisions in the CTOP Act limit the extent to which a practitioner can object. Section 10(1)(c) in the CTOP Act indicates that medical personnel may not prevent a lawful termination or obstruct access to a facility, which has been interpreted to mean that medical personnel must provide a patient with information, which includes available clinics and referrals.<sup>389</sup>

Structural barriers also exist when there is limited guidance on how to implement and interpret certain provisions of the CTOP Act. While the request for an abortion during the first trimester is made by choice, the decision to terminate a pregnancy during the second and third trimester is based on specified conditions under the CTOP Act. Since a patient’s eligibility for second and third trimesters is at the discretion of the doctor, the government is limited in their ability to ensure that doctors are not violating their medical duties under law by denying women abortion procedures.

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<sup>387</sup> See research objective v on page 11.

<sup>388</sup> Louis-Jacques Van Bogaert ‘The limits of conscientious objection in the developing world’ (2002) 2:2 *Developing World Bioethics* at 131-143.

<sup>389</sup> *Ibid.*

In light of the above finding, the South African government should develop and strengthen its accountability mechanisms to ensure that doctors are not violating their obligations under the law and under the provisions of CTOP.

In addition, research should be done that shows if and to what extent doctors deny women services during the second and third trimesters, and whether the denial is targeted to certain women. Research should be done to investigate whether crosscutting issues like race, ethnicity and beliefs and attitudes influence a doctor's willingness to deem a woman eligible for second and third trimester abortions.

#### 5.2.4 KNOWLEDGE AND AWARENESS OF RIGHTS

The research aimed to identify any gaps or shortcomings in the implementation of the CTOP Act.<sup>390</sup> In addition to the findings listed above, the research achieved the particular objective by demonstrating that a barrier to safe and legal abortion services is a woman's overall knowledge of the CTOP Act. A patient who has limited knowledge of the provisions in the CTOP Act is more likely to be influenced by inaccurate information.

To eradicate myths amongst women seeking services, South Africa must educate women and health care providers on the provisions of the CTOP Act. My recommendation for increased education efforts is also reaffirmed by Harries et al. who notes that government should improve reproductive counseling and education initiatives regarding eligibility requirements of gestational timeframes, so that woman faced with unwanted pregnancies can make educated decisions.<sup>391</sup> Considering that abortion is dependent on the strict requirements of each gestational timeframe, women must be granted access to neutral, non-biased information so to increase their knowledge and make informed decisions.

### 5.3 CONCLUDING THOUGHTS

The dissertation investigated whether reproductive autonomy and choice is a reality for women in South Africa and the extent to which social norms and beliefs impact a woman's decision-making ability. The dissertation rejects the view that the liberal provisions of the CTOP Act adequately fulfils the sexual and reproductive

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<sup>390</sup> See research objective vi on page 11.

<sup>391</sup> Harries et al. (2007) op cit note 174 at 6.

needs, freedoms and entitlements of women in South Africa; and also that South Africa is meeting its human rights obligations.

Though South Africa has enacted progressive sexual and reproductive health laws, the law falls short during implementation. The government and the CTOP Act inadequately address the root causes and structural barriers that lead to unintended pregnancies and decisions to utilise unsafe abortion services.

Through the use of normative frameworks related to human rights, laws and policies and jurisprudence, the research highlighted how poor abortion service delivery and accessibility for women is not unique to South Africa. Like many other countries, South Africa has had the opportunity to create a new legal framework that further guarantees women their rights and freedoms.

The case study on South Africa serves as a starting point for further research to address the following question: how can countries guarantee rights and freedoms found in new reproductive policies and laws when the social landscape remains the same?

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University of Cape Town

## APPENDIX A:

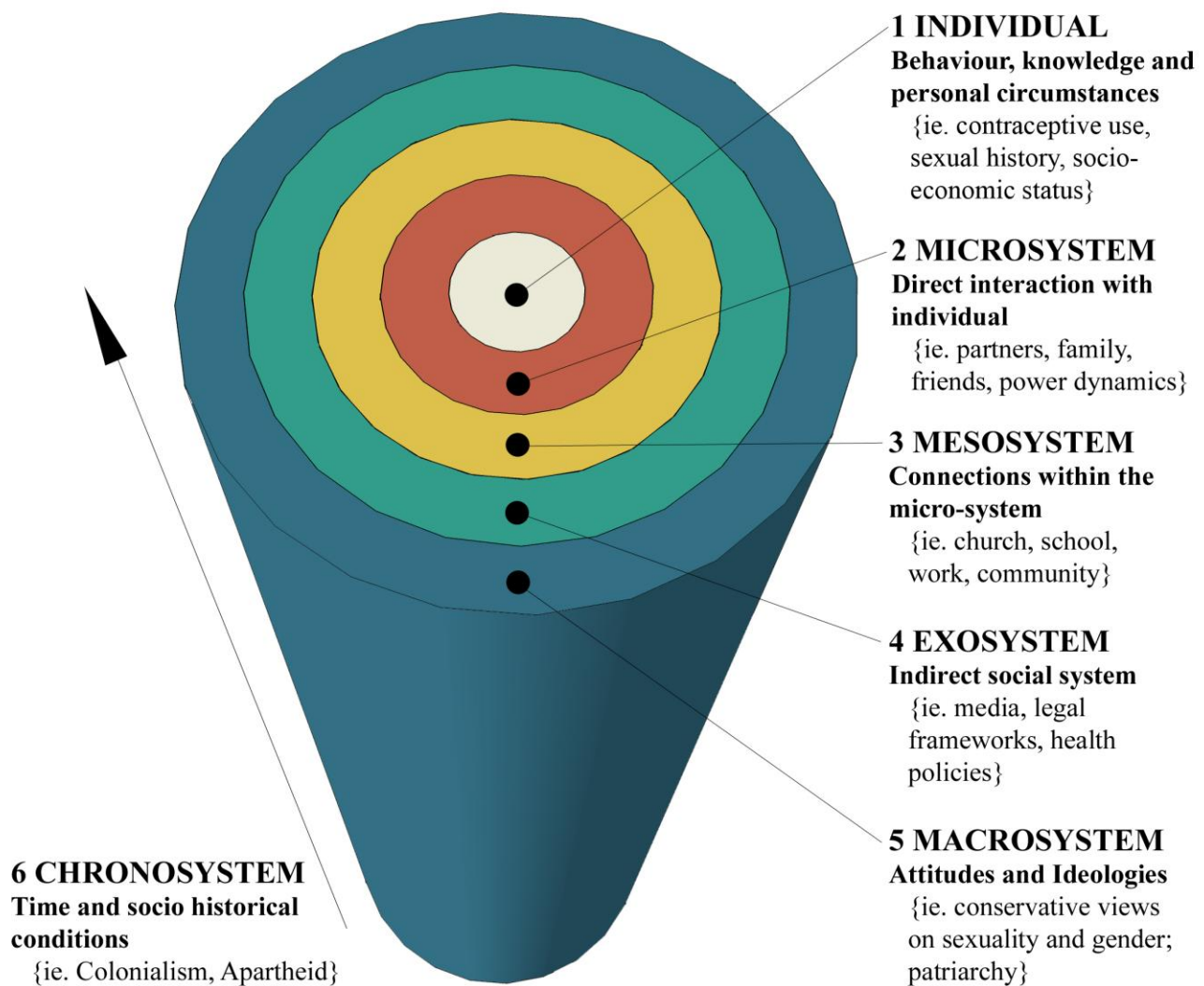
### BRONFENBRENNER'S ECOLOGICAL THEORY – A FRAMEWORK FOR SOUTH AFRICA

(diagram created by Jessica Lomelin, repurposed from Bronfenbrenner's theory)

#### SOCIAL ECOLOGICAL MODEL

South African Example:

Evaluating a Woman's Sexual and Reproductive Life

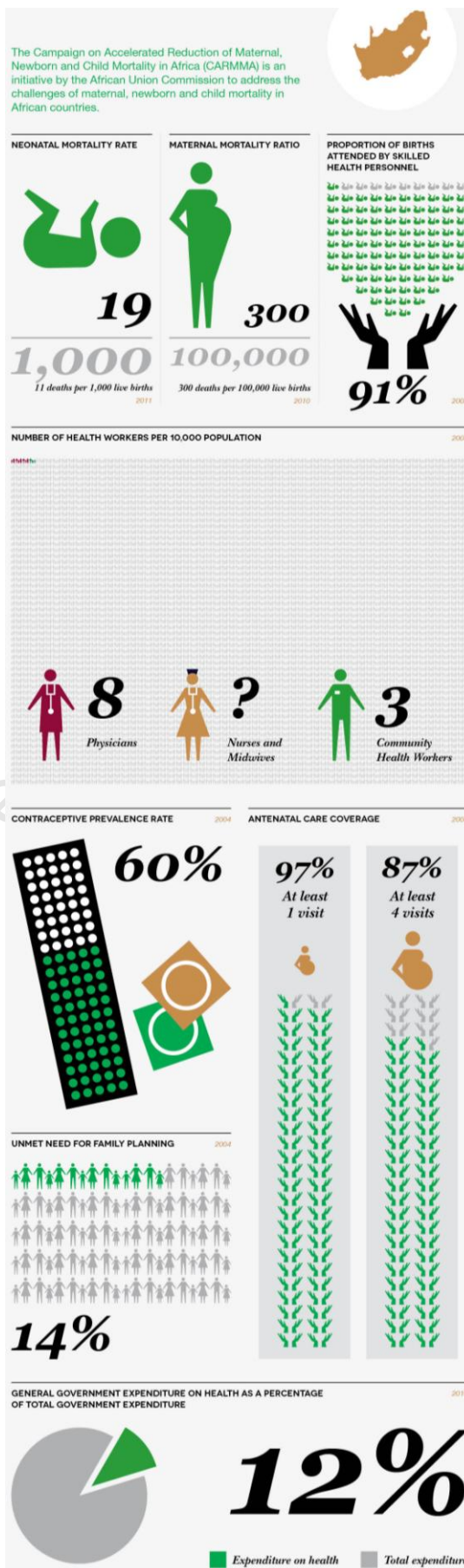


Information based on The Social Ecological Framework by Urie Bronfenbrenner

**APPENDIX B:**

**CARMMA SCORECARD ON SOUTH AFRICA**

(published with permission from [www.carmma.org](http://www.carmma.org))



## APPENDIX C:

### AFRICAN ABORTION LAWS

(diagram created by Jessica Lomelin, repurposed with information from the Center for Reproductive Rights, <http://worldabortionlaws.com/map/>)

