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A critical evaluation of the laws pertaining to sterilisations and termination of pregnancies: exposing the gaps and threats

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I, Mendy Mthethwa, declare that:

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ABSTRACT

The right to reproductive health, which is the primary focus of this dissertation, is a component of the right to health. This right has been protected for many years, notably in international human rights instruments, and has over time found recognition in the constitutions of various states, including South Africa. The South African Constitution protects the right to self-determination as well as the right to reproductive health care. In addition to the above, the protection of other Constitutional rights such as the right to dignity, the right to life, the right to equality and the right to access to information further strengthen the right to reproductive health care. The legislature has also given effect to these rights through the enactment of the Choice on Termination of Pregnancy Act (hereinafter referred to as the Choice Act), the Sterilisation Act, as well as the National Health Act.

Notwithstanding the state's efforts to comply with international standards, gaps continue to exist in, firstly, the South African legislative framework and, secondly, the implementation of existing reproductive health laws. These gaps have manifested, *inter alia*, in women having limited access to termination services; the continued threats and subversion of reproductive health rights; as well as the forceful sterilisation of HIV positive women in KwaZulu Natal and Gauteng Hospitals.

These gaps, unfortunately, disadvantage the most vulnerable members of society who rely on public health facilities to enforce their constitutional and legislative rights to reproductive health. Persons affected by these gaps and threats often resort to illegal reproductive health services. It is argued, therefore, that the state has a duty to fulfil and protect reproductive health rights to prevent the inevitable consequence of indirect discrimination against poor women and girls caused by these gaps.

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CHAPTER 1

INTRODUCTION

1.1. INTRODUCTORY REMARKS

The right to terminate one's pregnancy and the right to be sterilised fall under a broad category of reproductive health rights.[1] Reproductive health is an important aspect of one's well-being which enables men and women to have control over their sexual and reproductive well-being.[2] For the purposes of this dissertation, reference to reproductive health is limited to sterilisation and termination of pregnancies as these procedures are specifically regulated by statute. These rights have been protected for many years notably in international human rights instruments and have over time found recognition in the constitutions and statutory frameworks of various states, including South Africa. The United Nations has acknowledged that health rights are human rights, and have defined reproductive health as:

> a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are: the rights of men and women to be informed, have access to safe, effective, affordable and acceptable methods of family planning including methods for regulation of fertility, which are not against the law; and the right of access to appropriate health care services to enable women to have a safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[3]

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[1] United Nations *Convention on the Elimination of all forms of Discrimination Against Women* available at https://www.ohchr.org/documents/professionalinterest/cedaw.pdf, accessed on 2 May 2020 (CEDAW). Article 12 of CEDAW provides that women's health care includes the right to family planning.
[2] BN Okpalaobi & HO Mnamdi 'Global Trend towards the Reproductive Health Right of Nigerian Women: The Health Promotion Perspective' (2011) 2(6) *Journal of Emerging Trends in Educational Research and Policy Studies* 426.
[3] United Nations *Reproductive rights are human rights: a handbook for national human rights institutions* available at https://www.ohchr.org/documents/publications/nhrihandbook.pdf, accessed on 8 May 2021, 18.

From the above definition, it is clear that freedom to regulate one's fertility is an important factor in achieving reproductive health. This right demands the protection of people's right to physical and bodily integrity.[4] The right to physical and bodily integrity which includes the ability have control over one's reproductive health which is free of coercion.[5] International protection of human rights is discussed in chapter 2 of this dissertation and domestic protection is outlined in chapter 3. For the purposes of providing background to the research problem, the discussion below is a brief overview of the recognition of reproductive health as a key human right.

1.2. BRIEF OVERVIEW OF THE PROTECTION OF REPRODUCTIVE HEALTH IN INTERNATIONAL AND REGIONAL LAW

The Universal Declaration of Human Rights (hereinafter referred to as the UDHR) was the first international human rights instrument issued by the United Nations in 1948.[6] It makes specific provision for the right to the highest attainable standard of health and expressly protects the right to have a family.[7] Subsequently, article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) emphasised the importance of providing individuals with mental and physical health care.[8] Notably, these instruments did not define the right to health, especially as it relates to reproductive health.[9] The Convention on the Elimination of all forms of Discrimination against women (hereinafter referred to as CEDAW) was the first treaty to deal exclusively with the protection of women's rights.[10] This Convention states that member states must protect women's right to health, and that such right includes the right to access to information.[11] CEDAW was the first instrument to recognise that the right to health includes family planning services (Article 12), however, the parameters of this right were not fully discussed.[12]

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[4] Supra, 18.
[5] Supra, 18.
[6] J Kossen 'Rights, Respect, Responsibility: Advancing the sexual and reproductive health and rights of young people through international human rights law' (2012) 5 *University of Pennsylvania Journal of Law and Social Changes,* 150.
[7] United Nations 'Universal Declaration of Human rights', available at https://www.un.org/en/about-us/universal-declaration-of-human-rights, accessed on 31 December 2019, Article 16 and 25.
[8] Kossen op cit note 6 at 150.
[9] BN Okpalaobi op cit note 2 at 246.
[10] Kossen op cit note 6 at 151.
[11] CEDAW op cit note 1.
[12] Supra, Article 2.

At a regional level, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (hereinafter referred to as the Maputo protocol) was adopted in 2005.[13] This Protocol was adopted to specifically address women's rights in Africa.[14] Article 14 of the Protocol requires all state parties to ensure that women's health rights, including sexual and reproductive health, are respected and protected.[15] This includes the right to control their fertility, the right to decide if they want to have children, the number of children they wish to have, and the spacing of their children.[16] The Protocol further requested state members to take measures to provide women (especially those in rural areas) with access to adequate, affordable and accessible health services, including education programmes.[17]

These international and regional instruments have created an international standard of human rights on sexual and reproductive health. The South African government has ratified all the aforementioned international and regional instruments and therefore, has a duty uphold such standards by developing a reproductive health framework which complies with these standards. At a domestic level, the South African Constitution[18] protects one's autonomy to make reproductive health decisions as well as the right to access reproductive health care.[19] The Constitution also goes a step further by providing that health services include reproductive health care.[20]

The South African legislature has given effect to the Constitutional rights to reproductive health through amongst others the enactment of the Choice on Termination of Pregnancy Act (hereinafter referred to as the Choice Act)[21], the

[13] F Viljoen 'An introduction to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa' (2009) 11 *Wash. & Lee J. Civil Rts, & Soc. Just* 12.
[14] Ibid, 16. The Mapoto protocol acknowledges that the African Charter on Human and Peoples' Rights was designed to protected the rights of all people in South Africa, including women. However, African women continue to be victims of human rights violations.
[15] African Union 'The Protocol to the African Charter on the Rights of Women in Africa', available at https://www.un.org/en/africa/osaa/pdf/au/protocol_rights_women_africa_2003.pdf, accessed on 16 April 2020, Article 14.
[16] Supra, article 14.
[17] Supra, article 14.
[18] The Constitution of the Republic of South Africa, 1996.
[19] Section 26 of the Constitution.
[20] Supra.
[21] 92 of 1996.

Sterilisation Act,[22] as well as various provisions of the National Health Act.[23] These pieces of legislation replaced the previous Abortion and Sterilisation Act[24] (hereinafter referred to as the repealed Abortion Act) as well as the Child Care Act[25], and brought about a number of changes to reproductive autonomy laws. Such changes will be set out in Chapter 3 of this dissertation.

1.3. OUTLINE AND BACKGROUND TO THE RESEARCH PROBLEM

1.3.1. Research outline

The Choice[26] and the Sterilisation Act[27] have advanced the protection of reproductive health rights. One the one hand, the Choice Act has decriminalised voluntary terminations and, on the other hand, the Sterilisation Act has permitted voluntary sterilisations for all persons over the age of 18. Further to this, the Choice Act has had a positive impact on mortality related to termination of pregnancy.[28] In 1994, a national incomplete termination of pregnancy survey revealed that about 425 deaths were caused by incomplete terminations annually.[29] Follow-up research conducted after the implementation of the Choice Act revealed that there had been a 91.1% decrease in mortalities related to termination of pregnancies in the period of 1998 to 2001.[30]

Despite such positive contributions by the reproductive rights legal framework, gaps and threats continue to exist in our reproductive framework. These gaps have manifested in, *inter alia*, limited access to termination services and the forceful sterilisation of HIV positive women in KwaZulu Natal and Gauteng Hospitals – many women have been forcefully sterilised in South African hospitals. These gaps, unfortunately, disadvantage the most vulnerable members of society who rely on

[22] 44 of 1998.
[23] 61 of 2003.
[24] 2 of 1975.
[25] 74 of 1983.
[26] 92 of 1996.
[27] 44 of 1998.
[28] R Jewkes & H Rees 'Dramatic decline in abortion mortality due to the Choice on Termination of Pregnancy Act' 2005 95(4) South African Medical Journal 250.
[29] Ibid.
[30] Ibid.

public health facilities to enforce their constitutional and legislative rights to reproductive health.

The purpose of this dissertation is, therefore to critically analyse the legal developments pertaining to reproductive rights in South Africa, in so far as the Choice Act, Sterilisation Act and the National Health Act are concerned, with a view to identify the gaps and threats in the laws pertaining to reproductive rights. The consequence of these gaps is indirect discrimination against women and female children.

1.3.2. Background to the research problem

What follows in this section is a discussion of the background to reproductive rights in South Africa. This section is important as it highlights the dangers and consequences of inadequate protection of reproductive health rights.

1.3.2.1. Reproductive health rights in the pre-colonial era:

Before South Africa was colonised or before the arrival of the white settlers effectively from 1652, fertility control and termination of pregnancy, like many other practices, was not well-documented.[31] The reason for this includes, *inter alia,* the fact that indigenous practices were unwritten customs passed from one generation to the next through oral tradition; and that the issue of termination of pregnancy was not dealt with publicly in traditional courts, but was rather regarded as a private family matter.[32] Nonetheless, writers note that 'abortion is an age-old tradition on the African continent. It has been practised by traditional African communities in the same manner as their counterparts elsewhere'.[33] South African women knew about abortifacients and certainly used them. For example the Khoi used a certain thornbush, while the Zulus relied on a shrub which was called uhlungughlungu.[34] Some South African women also inserted sharp objects, such as sticks and umbrellas, into the cervix in order to achieve terminations.[35] In closure, there is not much that can be derived from the pre-

[31] C Ngwena 'Access to legal abortion: developments in Africa from a reproductive and sexual health rights perspective' (2004) 19(2) *South African Public Law* 334. See also: 'The National Contraception Policy Guidelines' available at http://www.kznhealth.gov.za/contraception.pdf, accessed on 27 April 2020, 5.
[32] Ibid, 334.
[33] Ibid, 334.
[34] R Hodes 'The culture of illegal abortion in South Africa' (2016) 42(1) Journal of Southern African Studies 81.
[35] Ibid, 81.

colonial era jurisprudence when it comes to the specific recognition and protection of reproductive rights.

1.3.2.2. Reproductive rights during colonisation*:*

After the arrival of white settlers, which marked the beginning of the colonisation of South Africa, the South African society was no longer able to exercise control over their cultural fertility practices as they did before the arrival of the white settlers, and this resulted in rapid population growth.[36]. The reason why it is asserted that indigenous people were no longer able to exercise control over their cultural fertility is that white settler colonial government came with laws (in the form of the common law) regulating reproductive health.[37] The regulation of reproductive health by the common law made the topic of reproductive health more publicised, thus shifting the topic of reproductive health from a mere private cultural practice to a legally regulated practice.

The South African common law comprises the Roman-Dutch law of the 17th and 18th centuries, English law, as well as South African case law.[38] Roman-Dutch writers regarded terminations of pregnancy as a crime against the foetus.[39] The foetus was given personality status through the manner in which this crime was formulated. As such, after conceiving, the pregnant woman had no autonomy over her reproductive health. The requirement for the commission of this crime was that the foetus must be killed by means of expulsion from the pregnant woman's body. The foetus could be expelled by the use of drugs, instruments, the use of force and/or violence, or any other necessary means.[40]

When considering the appropriate sentence to impose on a woman who committed the crime, the gestation period was a very important consideration.[41] Women who committed the crime at a stage when the foetus was regarded as having a soul were usually punished by death.[42] A foetus was regarded as 'having a soul' after

[36] The National Contraceptive Guideline op cit note 31 at 5.
[37] Ngwena (2004) op cit note 32 at 335.
[38] S.A Strauss 'Therapeutic abortion and South African Law' (1968) 42(28) *S.A medical Journal* 711.
[39] JRL Milton *South African Criminal Law and procedure* 2 ed (1982) 310.
[40] Ibid, 310.
[41] Ibid, 310.
[42] Ibid, 310. There were different views about how long it took for a foetus to be regarded as having a soul. Others regarded the foetus as having a soul after the second half of the gestation period, others regarded it as having a soul after quickening, while others were of the opinion that the foetus attained

quickening.[43] Quickening is regarded as the stage where the foetus makes its first noticeable movements in utero. Roman-Dutch law did, however, recognise that a termination performed to save the pregnant woman's life was not unlawful.[44] A number of Roman-Dutch jurists, including the famous Matthaeus II, were of the opinion that a pregnancy could be terminated if the pregnant women's life was in danger, and could only be saved if her pregnancy was terminated.[45] This marked the beginning of the suppression of reproductive health rights, a phenomenon that was set to characterise much of history.

The English common law on terminations was shaped by the Offences Against the Person Act of 1861 (hereinafter referred to as the Person Act).[46] Section 58 of the Person Act provided that the following acts were punishable in terms of the criminal law: firstly, if a pregnant woman intentionally resorted to 'unlawful' means to terminate her pregnancy; secondly, if any other person intentionally resorted to 'unlawful' means to terminate a pregnancy, regardless of whether the woman was actually pregnant or not.[47] The later part of this section essentially made it punishable for any person who believed that a woman was pregnant, even though she may not have been pregnant, to act with the intention to terminate her pregnancy.

The phrase 'unlawful means' contemplated that there may be instances where a pregnancy could be legally terminated. It was established that necessity could be used as a defence in the crime of termination of pregnancy.[48] For example, if it was

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this status after its body was formed perfectly. Quickening is regarded as the stage in a pregnancy where the foetus starts to make noticeable movements.

[43] *Roe v Wade* 410 U.S 113 (1973) at 132.

[44] JRL Milton op cit note 40 at 305.

[45] Ibid, 305. Moorman and Voet are other Roman-Dutch jurists which shared the same views as Moorman, see Strauss at 711.

[46] Ngwena (2006) op cit note 31 at 336. See also section 58 of the Offences Against the Person Act 1861. In 1803, England enacted its first criminal law statute, called Lord Ellenborough's Act. This Act classified the procurement of an abortion on a quick foetus as a capital crime (Also see *Roe v Wade*, 410 U.S. 113 (1973)).

[47] Milton op cit note 39 at 313. The English common law recognised that abortions could be performed before 'quickening'[47]. Quickening is a stage in the pregnancy whereby the foetus makes noticeable movements *in utero*. Early English law established that quickening occurred before live birth and served to indicate that the foetus was now viable[47]. Before quickening, the foetus was regarded as being part of its carrier (the pregnant woman). Therefore, procurement of an abortion pre-quickening was not an indictable misdemeanour. See also *Roe v Wade*, 410 U.S. 113 (1973). Abortions performed before quickening were a lesser offence. England's legal position changed in 1861 when the Offences Against the Person Act[47] was enacted.

[48] Ngwena (2004) op cit note 31 at 336.

necessary for the women to terminate her pregnancy in order to save her life. However, it was not clear if a woman could legally proceed with a termination in less compelling circumstances.[49] The court in the case of *R v Bourne* [50] provided some clarity on this issue. In this matter, a fifteen year old girl was impregnated as a result of being raped.[51] Her family consulted Dr Bourne and he agreed to terminate the pregnancy upon her parents' request and her consent.[52] He was subsequently charged for contravening Section 58 of the Person Act. Mr Bourne argued that the termination was not unlawful as the continued pregnancy would have resulted in more injury being caused to the girl.[53] In advising the jury, Mr Bourne's legal representative argued that if a doctor is, on reasonable grounds and with adequate knowledge, of the opinion that it is most likely that continuing with the pregnancy would result in the pregnant women being physically or mentally impaired, the jury is entitled to conclude that the doctor who terminate the pregnancy under those circumstances and in that honest belief, does so for the purposes of saving the life of the pregnant woman.[54] This case was ground-breaking as it broadened the grounds upon which a pregnancy could be terminated by including the protection of the pregnant women's physical and mental wellbeing.[55] Mr Bourne was subsequently acquitted. The *Bourne* case was also incorporated into South African common law.[56]

It should be noted that during this period, South Africa simply applied the common law position to the effect that the termination of pregnancy is a crime.[57] The crime of pregnancy termination was punishable in South Africa but there was minimal development of the crime in South African courts. One of the cases which were decided in South African courts was that of *S v AP*.[58] In this case, the accused was convicted of infanticide for procuring a termination of pregnancy on a woman.[59] The Transvaal High Court upheld the conviction finding that 'procuring an abortion is

[49] Milton op cit note 39 at 312. Also see Ngwena (2004) op cite note 32 at 336 where he argues that the parameters within which a pregnancy could be lawfully terminated were not defined.
[50] [1938] 3 ALL EF 615.
[51] Ngwena op cit note 31 at 336.
[52] Ibid.
[53] Ibid.
[54] Ibid.
[55] Ibid, 337.
[56] Ibid, 336.
[57] Ibid.
[58] Milton op cit note 39 at 312.
[59] Ibid.

infanticide'. It later transpired, however, that there was a distinction between infanticide and termination. An expulsion of the foetus was regarded as infanticide when a pregnant woman, or anyone else, attempted to 'kill' the foetus by expelling it but the foetus was in fact 'alive' after the expulsion[60]. The crime of terminating a pregnancy, on the other hand, was committed when a foetus was expelled from the pregnant women's body with the intention of 'killing' it and the foetus is in fact 'killed' in the process. In the case of *R v Davis* it was established that if a foetus is expelled with the intention of 'killing' it, and it is later established that the foetus is already 'dead' at the time of expulsion, the accused could be convicted only for attempting to terminate a pregnancy.[61]

The only statute which addressed termination of pregnancy rights in the territory that would later form part of South Africa was the Native Territories Penal Code of 1886 (hereafter referred to as the Penal Code). This was only applied to the geographical area of the then Transkei.[62] The Penal Code deemed any act that caused death of a 'living child' which has not yet been born punishable with imprisonment of up to seven years, which could be accompanied by hard labour and a fine.[63] The only exception was that 'no one shall be guilty of (this) offence…who by means employed in good faith for the preservation of the life of the mother of the child, causes the death of any such child before or after its birth'.[64] In essence, a woman could only terminate her pregnancy if her life was in serious danger.

When it comes to sterilisation, it is noteworthy that sterilisation was regulated by the common law principles. Sterilisation has never really been illegal in South Africa, except in instances were sterilisations were performed on people who did not have

[60] Ibid,313.
[61] 1956 (3) SA 52 (AD). Also see Milton op cit note 39 at 312.
[62] Strauss (1968) op cit note 38 at 711. The Trankei was recognised as a Territorial Authority under the Bantu Authorities Act of 1894. The Constitution of the Transkei was drafted in Pretoria under the supervision of Prime Minister Hendrik Verword, and in 1976, the Transkei was granted independence. The Transkei was incorporated into South Africa, like all the other homelands, in 1994 when south Africa became a Democratic country (see 'Transkei' *South African History Online* 16 March 2020 available at https://www.sahistory.org.za/place/transkei, accessed on 6 June 2020).
[63] Hodes op cit note 34 at 81. According to Hodes, in the 1820s, there were revelations that the practice of abortion was popular among the Pedi and Xhosa women. This resulted in the colonial power enacting legislation regulating abortion in the Transkei are only.
[64] Ibid.

capacity to consent.[65] Sterilisation processed have been regulated by the common law principle of consent to bodily injury.[66] Roman-Dutch authors were divided in their opinion on which circumstances rendered it unlawful to consent to the infliction of bodily injuries to one's own body.[67] For example, Matthaus warned that a victim is not the owner of his or her own limbs and may, therefore, not consent to the infliction of bodily harm.[68] Voet, on the other hand, maintained that it was not unlawful to inflict bodily 'harm' to a consenting party.[69] English lawyers measured the legality of consent to bodily injury against public policy, i.e. the moral, social and economic interest. For example, persons could not use consent as a defence where they committed dangerous or serious assault.

Considering the aforementioned, sterilisation procedures were regarded to be acceptable if there was a 'just cause' for the procedure (for example, if they were therapeutic, and intended to preserve one's health).[70] Sterilisation procedures which merely sought to prevent conception were generally frowned upon, especially if the patient was unmarried.[71] In circumstances where married couples could justify the need for a sterilisation procedure, the spouse seeking to undergo a sterilisation procedure had to obtain consent from the other spouse.[72] This further supports the argument that reproductive rights have a history of being undermined. Given the foregoing, the continued suppression of reproductive health rights was generally maintained.

1.3.2.3. Reproductive rights during apartheid:

Interestingly, the apartheid regime came into effect in 1948, which was the same year that the UDHR[73] was drafted and adopted by 48 countries, excluding South Africa. The UDHR will be discussed in greater detail in Chapter 2 of this dissertation. During

[65] JH McMillan & M Ross 'Report on a free Sterilisation service' (1977) 52 *South African Medical Journal* 978.
[66] SA Strauss 'Bodily injury and the defense of consent' (1964) 81(2) *The South African Law Journal* 179.
[67] Ibid.
[68] Ibid, 180.
[69] Ibid.
[70] Ibid, 190.
[71] Ibid.
[72] Ibid.
[73] UDHR available at https://www.un.org/en/about-us/universal-declaration-of-human-rights, accessed on 2 August 2021.

apartheid, there was uncertainty relating to the circumstances under which the termination of a pregnancy could be rendered unlawful.[74] As previously mentioned, the common law recognised that a termination of pregnancy could be lawful if it was procured with the intention of saving a pregnant woman's life. English law also identified necessity to save a pregnant woman's life as a valid defence which could negate the element of unlawfulness.[75] However, questions, such as whether the woman's life had to be in immediate danger, or if it was sufficient to merely prove that the woman's life expectancy would be negatively affected by terminating her pregnancy remained unanswered.[76]

The need for legislation became more apparent when a magistrate's court held that 'it was not unlawful for a medical practitioner to perform a termination, under certain clinical conditions, for purposes other than the preservation of the life of the pregnant woman'.[77] This decision created uncertainly in respect of the grounds upon which a pregnancy could be lawfully terminated. The consequence of this decision was that a commission of inquiry was appointed and tasked to consider the laws relating to terminations. The commission found that, from a practical perspective, legislation which regulated the termination of pregnancies was necessary in order to align such laws to medical practices of the time.[78]

During the period of 1960 and early 1970s, doctors and activists also identified inconsistencies between the law and common medical practices.[79] Although common law regulated the grounds for legal termination of pregnancy, many women were admitted in emergency and gynaecology wards for treatment of the harmful effects of illegal terminations of pregnancy.[80] From the abovementioned facts it can be inferred

[74] Milton op cit note 39 at 313. Also see C Albertyn 'Claiming and defending abortion rights in South Africa' 4 November 2017, available at https://www.semanticscholar.org/paper/Albertyn-CLAIMING-AND-DEFENDING-ABORTION-RIGHTS-IN-TEMPO-SOCIEDA/e8bcf0ba3ef12c48d1ce384f33548f3f8349e279#references, accessed on 24 March 2019.
[75] Ibid 312.
[76] Strauss (1968) op cit note 38 at 710.
[77] Milton op cit note 39 at 314.
[78] Swemmer, S 'While you were sleeping – The Choice on the Termination of Pregnancy Amendment Bill as an act of indirect discrimination? Discussion of the Choice on Termination of Pregnancy Amendment Draft Bill' (2018) 29(1) *Stellenbosch Law Review* 108.
[79] Hodes op cit note 34 at 82.
[80] Ibid, 82.

that women continued to terminate their pregnancies under unlawful conditions, regardless of the South African common law position which deemed it illegal for women to terminate their pregnancies on grounds which were not related to their physical and mental health. One would imagine that such findings would have influenced the legislature to promote reproductive health and align it with the lived experiences of South African women in gynaecology wards. Instead, the legislature enacted the Abortion and Sterilisation Act which perpetuated the subversion of reproductive rights.[81]

Although terminations are procured by women, and the majority of women are black in South Africa, the Abortion and sterilisation Act was drafted by a committee which consisted exclusively of white males.[82] The failure of this committee to include women is another indicator of the extent to which reproductive autonomy rights have been subverted. It is also interesting to note that this Act did not discuss the legality of sterilisation procedures. Instead, it only dealt with the sterilisation of persons who are incapable of consenting to such procedures.[83] A discussion of this Act will therefore be centred around termination procedures.

On the face of it, this Act created legal certainty and 'extended' the common law grounds of terminating a pregnancy.[84] Section 3(1) of the act provided that a medical practitioner[85] may terminate a pregnancy under these following circumstances: firstly, where two medical practitioners have certified, in writing, that in their opinion, the continued pregnancy would endanger the pregnant women's life and poses a serious threat to her physical health and that terminating her pregnancy is necessary to protect her; secondly, where the continued pregnancy poses a serious threat to the pregnant woman's mental health and two medical practitioners have certified, in writing, that in their opinion, the continued pregnancy is likely to cause permanent damage to the pregnant woman's mental health; thirdly, where it has been certified, in writing, by two

[81] 2 of 1975. See also Milton op cit note 39 at 314.
[82] S Guttmacher, F Kapadia, J Naude & H Pinho 'Abortion Reform in South Africa: A case study of the Choice on Termination of Pregnancy Act' (1998) 24(4) *International Family Planning Perspective* 192.
[83] Abortion and Sterilisation Act 2 of 1975.
[84] Ngwena (2004) op cit note 31 at 341.
[85] The act defined a medical practitioner as 'a person registered as such under the Medical, Dental and Supplementary Health Service Professions Act, 1974 (Act No. 56 of 1974)'. See section 1 of the Abortion and Sterilisation Act.

medical practitioners that there exists, in their opinion, a serious risk that once the child is born, he or she will suffer from a mental or physical disorder which will result in the child being permanently handicapped; lastly, where the foetus was conceived as a result of rape or incest, the pregnancy could only be terminated after and two other medical practitioners (after interrogating the pregnant woman) have indicated, in writing, that in their opinion, the pregnancy was as a result of rape or incest.[86]

The provisions of this section of the Act had procedural as well as substantive implications on existing regulations of termination. With regard to the substantive effects of this Act, this section of the Act confirmed the common law position that a pregnancy could be lawfully terminated in circumstances where it posed a serious threat to the pregnant woman's physical and mental health.[87] This section also extended the grounds upon which a pregnancy could be terminated by providing that a pregnancy could be lawfully terminated where the continued pregnancy could harm the unborn 'child', or where the foetus was conceived as a result of 'unlawful carnal intercourse' (as set out in section 3(1)(c) and (d)). Interestingly, this Act did not regard socio-economic circumstances as a ground for termination.[88]

The repealed Abortion and Sterilisation Act was not based on a trimester framework. Therefore, pregnant women could legally terminate his/her pregnancy any stage of a pregnancy. Considering this, one would assume that the repealed Abortion Act was more liberal than the current Choice Act. However, a close evaluation of this Act indicate that it made it even more difficult for women to terminate.[89] For instance, pregnant woman required the approval of two medical practitioners (in the form of a certificate) before relying on any grounds for termination.[90] She also had to obtain the approval of head of the facility where the termination was to take place.[91] Further to this, the termination procedure could not be performed by the two medical practitioners

[86] Section 3(1) of the Abortion and Sterilisation Act. Also see E Haroz 'South Africa's 1996 Choice on Termination of Pregnancy Act: Expanding Choice and International Human Rights to Black South African Women' (1997) 30 *Vanderbilt Journal of Transitional Law* 880.
[87] Supra, section 3(1)(a) and (b).
[88] Ngwena op cit note 31 at 341.
[89] Ibid,.
[90] Section 3(2)(a) of the repealed abortion and Sterilisation Act.
[91] Haroz op sit note 86 at 880.

who granted consent.[92] This system also limited the number of doctors who could provide termination services as only a medical practitioner who had been in practice for four year was legible to provide such services.[93]

This Act was also not sensitive to the challenges that rape victims may face in reporting rape crimes. Section 6(4) required women seeking to terminate on the ground of unlawful sexual intercourse to lodge a complaint with the police before relying on this ground.[94] A woman who did not report such a case to the police had the burden of providing reasonable satisfactory reasons as to why she did not report her matter to the police.[95] The Act also required one of the two medical practitioners, giving consent to the termination procedure, to interrogate the pregnant woman and satisfy him/herself that her pregnancy was indeed as a result unlawful sexual intercourse.[96] Further to this, a magistrate had to certify that firstly, the matter had been reported to the relevant authorities or, if the matter had not been reported, that there are acceptable reasons for the matter not being reported; secondly, that on a balance of probability, the pregnancy was a result of unlawful sexual intercourse.[97]

Further to the above, even after a woman had fully satisfied at least one of the grounds to terminate her pregnancy as provided in the act, the state was not obliged to provide her with the necessary services to terminate her pregnancy.[98] This Act did not promote reproductive rights[99]. Instead, it sought to punish those who sought termination.[100] In addition to the procedural requirements of the Act, the administrative procedures presented further challenges.[101] The Act placed a duty of providing certain specified information to the secretary for health on the medical practitioner in charge of the facility performing termination services.[102] This information included, *inter alia*, the name, age, race and place of residence of the woman who performed such termination

[92] The Act required at least one of the medical practitioners to have four years experience in medical practice.
[93] Haroz op cit note 86 at 880.
[94] Section 6(4) of the Abortion and Sterillisation Act 2 of 1975.
[95] Ngwena (2004) op cit note 31 at 342.
[96] Ibid, 342. Also see section 6(4) of the Abortion and sterilisation Act.
[97] Section 6(4) of the Abortion and Sterilisation Act.
[98] Guttmacher op cit note 82 at 192. Also see Ngwena op cit note 32 at 342.
[99] Ngwena op cit note 31 at 341.
[100] Ibid, 341.
[101] Ibid, 341. Also see E Haroz (1997) op cit note 85 at 881.
[102] Section 6(1) of the Abortion and Sterilisation Act.

services.[103] This requirement flies at the face of doctor-patient confidentiality and infringes on the patient's right to privacy.[104]

The provisions of this Act are a striking example of how reproductive rights were historically been undermined. In particular, the Act sought to prevent as may women as possible from terminating their pregnancies by identifying and punishing them, together with the medical practitioners who assisted them with the procedure.[105] This Act was not only discriminatory against women, but between women of different classes.[106] The implications of the Act resulted in health tourists flying to other countries, including the United Kingdom, to procure safe and legal terminations.[107] The number of South African women who sought termination of pregnancies from the United Kingdom increased to a point where a 'private service catering to South Africans seeking safe, discrete, legal abortions' was created in London.[108] Unfortunately, the majority of South African women (particularly black women) could not afford to fly overseas in order to procure termination procedure.[109] Access to termination services became limited to white middle-class women and the reproductive rights of the majority of South African women continued to be subverted under this Act.[110]

For Black women, formal health sector was seen as a last resort, where women sought assistance only if the side effects of illegal termination were severe.[111] The number of women who performed termination services during this period was estimated to be 250 000.[112] 45 000 of these women required hospitalisation as a result of incomplete terminations while 1500 to 3000 died from performing these 'backstreet abortions'.

[103] Section 7 of the Abortion and Sterilisation Act.
[104] Ngwena op cit note 31 at 342.
[105] Hodes op cit note 34 at 83.
[106] Ngwena op cit note 31 at 342.
[107] Hodes op cit note 34 at 83.
[108] Ibid.
[109] Ibid.
[110] Ngwena op cit note 31 at 342. Also see Expanding Choice and International Human rights to Black women op cit note 85 at 881 where she indicates that the legal terminations performed were overwhelmingly conducted on white women. The most common ground that women relied on to access termination services was that the continued pregnancy posed a risk to the pregnant woman's mental health. In order to rely on this ground, approval by a state psychiatrist was necessary. Most of these psychiatrists were located in urban areas, therefore, poor black women in rural areas had little hope of seeing a psychiatrist.
[111] Hodes op cit note 34 at 83.
[112] Haroz op cit note 86 at 882.

Notably, 99% of women who were hospitalised were black.[113] It is evident, therefore, that the Abortion and Sterilisation Act did not curtail the number of illegal terminations in South Africa as was suggested by its parliamentary advocates.[114]

Although the Abortion and Sterilisation Act did not address the legality of sterilisations, voluntary sterilisation has always been legal in South Africa.[115] There were, however, a number of procedural barriers for those wishing to be sterilised voluntarily.[116] Fortunately, there were efforts made to remove such barriers and there were several state projects offering sterilisation services to persons who attended family planning clinics.[117] For example, during October 1975, free sterilisation services were offered to persons who had completed their families at King George V Hospital.[118] Such services were offered to married couples, as opposed to individuals, after being interviewed by a trained supervisor.[119] Such supervisor would enquire about the couple's emotional stability, their reasons for requesting to be sterilised, the age of each partner, the number of their children as well as their desire to be sterilised.[120] The advantage of this interview is that it provided a platform for those seeking sterilisation services to provide informed consent and to ask relevant questions. The disadvantage, however, is that it did not seek to provide these services to unmarried individuals and, even those individuals who were married required spousal consent. Further to this, government's main objective in providing sterilisation services was birth control as opposed to reproductive autonomy. The sterilisation also required written consent signed by both spouses and as well as a witness for the sterilisation procedure.[121] The circumstances under which such written consent was required was undesirable during this period because of the element of spousal consent.

1.3.2.4. *R*eproductive rights during transition from apartheid to democracy*:*

[113] Ibid, 882.
[114] Guttmacher op cit note 82 at 192.
[115] EP Woodrow 'Family Planning in South Africa – A Review' 1976 South African Medical Journal 2103.
[116] Ibid. Such barriers included spousal consent.
[117] Millan (1977) op cit note 66 at 978. Also see EP Woodrow 'Family Planning in South Africa – A Review' 1976 South African Medical Journal 2103.
[118] Ibid, 978.
[119] Ibid.
[120] Ibid.
[121] Ibid.

During the last days of apartheid, the negative effects of the Abortion and Sterilisation Act[122] sparked a debate between the pro-choice advocates (i.e those who advocated for termination of pregnancy laws) and the pro-life or anti-abortion advocates.[123] Prior to 1990, the grounds for advocating for the legalisation of pregnancy terminations were largely based on the effects of illegal terminations on women's health.[124] Feminists and liberalists also cited the effects of existing termination of pregnancy laws on pregnant women's health as reasons for the legalisation of abortion.[125] For most South African women, resistance against apartheid took precedence over issues relating to reproductive rights.[126] Therefore, women's movements focused on issues which united them, and they did not focus on reproductive rights (such as termination of pregnancy and sterilisation) as this topic was perceived as potentially divisive.[127] Although most medical practitioners where in favour of reproductive health autonomy, support for reproductive autonomy was not publicised.[128]

Feminist movements on women's reproductive rights gained momentum after women who were members of the African National Congress (hereinafter referred to as the ANC) were exposed to reproductive health choices while they were in exile.[129] The effects of unsafe and illegal terminations on South African women influenced the women's section of the ANC to advocate for the legalisation of pregnancy terminations in a democratic South Africa.[130] Growing support for legal terminations resulted in the legalisation of pregnancy termination being written in the key policies of the ANC.[131]

1.3.2.5. Reproductive rights in a democratic South Africa:

[122] 2 of 1975.
[123] Guttmacher op cit note 82 at 192. Also see Haroz op cit note 86 at 884.
[124] Albertyn op cit note 74 at 433. See also Hodes op cit note 34 at 85.
[125] Ibid, 433. Also see Hodes op cit note 34 at 84, where she argues that feminism was perceived as a western ideology which was a distraction from liberation politics.
[126] Albertyn op cit note 74 at 192. Hodes also argues that Feminism was perceived as 'divisive distraction from liberation politics'.
[127] Ibid, 433.
[128] Ibid.
[129] Ibid.
[130] Ibid.
[131] Hodes op cit note 34 at 84. Also see Ngwena op cit note 31 at 345 where he argues that "the ANC's position on abortion had been defined prior to taking office. Abortion policy, as defined in a policy document on health care, was to grant access to early safe abortion, not only as part of sound public health practices on account of the incidence of unsafe abortions, but also as part of the recognition of reproductive freedom".

In 1994, the ANC adopted a National Health Plan,[132] in terms of which it was recognised that individuals and couples have rights to freely and responsibly decide how many children they wish to have, and to 'have the information, education and means to do so'.[133] A study was also conducted by the Reproductive Health Research Unit, with the aim of establishing the morbidity and mortality rate resulting from incomplete terminations. This study was based at the University of Witwatersrand (hereinafter referred to as the Wits Reproductive health study).[134] This study revealed, *inter alia*, that South African public hospitals admitted approximately 44 686 women, annually, as a result of incomplete abortions.[135] This study also revealed that unsafe termination of pregnancies 'placed considerable strain on health resources'.[136] The results of the study were regarded as a call for change in South African laws regulating terminations. The result of activism from women's organisations and researchers finally led to the introduction of the Choice on Termination of Pregnancy Bill (hereinafter referred to as the Choice Bill) to Parliament.[137]

As previously discussed, the Abortion and Sterilisation Act did not regulate sterilisation procedures for the purposes of birth control. This Act also limited women's access to terminating their pregnancies by creating procedural barriers. Between the period of 1975 and 1996, illegal abortion procedures rose to between 120 000 and 250 000 per annum.[138] Given the history of South African law regulating termination of pregnancy, it does not come as a surprise that the government's intention to legalise abortion faced resistance both inside and outside parliament. Opposition to the Choice Bill came notably from religious groups, in particular the groups representing Christian and Muslim churches.[139] The ANC government used the Wits Reproductive Health Study to argue for the legalisation of abortion and to, essentially, 'neutralise the abortion

[132] African National Congress 'A National Health Plan for South Africa' 30 May 1994 available at https://www.sahistory.org.za/archive/national-health-plan-south-africa, accessed on 10 March 2019.
[133] Ibid.
[134] H Rees, J Katzenellenbogen and R Jewkes et al 'The Epidemiology of Incomplete Abortions in South Africa' (1997) 87(4) *South African Medical Journal* 432.
[135] Ibid.
[136] Ibid.
[137] Hodes op cit note 34 at 85.
[138] Moyo A 'Revisiting Minor's Reproductive Autonomy Rights Under South African Law: The Rights and Wrongs of the Choice on Termination of Pregnancy Act' (2018) 33(1) *South African Public Law* 20.
[139] Guttmacher op cit note 82 at 193.

debate'.[140] In an attempt to counter public and internal opposition to the Choice Bill, the *Parliamentary Bulletin* of the ANC published a Communiqué stating that '[t]his is not a morality Bill, but a health Bill'.[141]

Turning to sterilisations, even thought, on the one hand, the repealed Abortion and Sterilisation Act did not criminalise sterilisation procedures in South Africa, on the other hand, it did not provide the necessary details or steps guiding individuals who sought sterilisation services. The Sterilisation Act 44 of 1998 was passed two years after the Choice Act. The details of this Act will be discussed in great detail in Chapter 3 of this dissertation.

1.4. RESEARCH QUESTIONS

The key research question is what are the gaps in, and threats to, the laws pertaining to sterilisation and termination of pregnancy as they relate to both adults and children? Closely related to the key question is what could be the solutions to such gaps and threats.

In answering the above main research question, a number of other related questions will also be addressed.

a. What has been the historical journey towards the development of reproductive laws in South Africa and in international human rights instruments?
b. To what extent does South African post-apartheid reproductive laws provide recognition and protection to reproductive health rights?
c. Does the South African reproductive health framework regarding terminations of pregnancy and sterilisations meet international standards?
d. Do threats to reproductive rights still exist in post-apartheid South Africa?
e. What changes are needed to strengthen the current legal framework?

[140] Hodes op cit note 34 at 85. Hodes also argues that the government sought to neutralise the abortion debate by "replacing the emotional appeals regarding the 'right to choice' versus the 'right to life' with epidemiological accounts of the negative effects of illegal abortions on women's health".
[141] Hodes op cit note 34 at 85.

1.5. STRUCTURE OF DISSERTATION

Chapter one, which is the current chapter, introduces the purpose of this dissertation, which is to critically analyse the legal developments pertaining to sexual and reproductive rights in South Africa, and, in the process, lay bare the shortfalls, gaps and threats to the laws pertaining to these rights. This chapter outlines the research methodology, the research questions which are sought to be answered in this dissertation, as well as the outline of the chapters in the dissertation. This chapter also includes a discussion of the background to this study, the history of South African reproductive laws will be explored with a view to highlight the historical shortfalls and gaps within the early reproductive laws.

Chapter two discusses the detail of international and regional instruments pertaining to sexual and reproductive health. This chapter will also consider whether these rights are accessible to ordinary citizens whose rights have been violated. This discussion is important because international legal instruments set a benchmark for domestic reproductive laws of various states, which includes South Africa. This chapter lays a foundation for chapter three to engage the detail of existing South African reproductive laws, these being mainly the Choice on Termination of Pregnancy Act[142], the Sterilisation Act[143] and the National Health Act.

Chapter four is the crux of this dissertation. It examines the shortfalls, gaps and threats to South Africa's prevailing reproductive laws. Chief amongst these is laws is the Choice Act and the Sterilisation Act. It does this by testing the Constitutionality of the South African reproductive framework as well as by comparing the extent to which our laws meet the international norms. This chapter will also discuss the discriminatory nature of reproductive health rights.

The last Chapter, chapter five, provides recommendations and concludes the discussion of this dissertation.

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[142] 92 of 1996.
[143] 44 of 1998.

1.6. RESEARCH METHODOLOGY

This thesis will not embark on an empirical study. Instead, it will be based on the desktop review of the relevant legal materials and literature.

CHAPTER 2

THE RECOGNITION OF REPRODUCTIVE HEALTH RIGHTS WITHIN THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH IN INTERNATIONAL AND REGIONAL LAW

2.1. INTRODUCTION

Reproductive health falls into the broad category of the right to the highest attainable health.[144] This was confirmed by the Committee on the International Covenant on Economic, Social and Cultural Rights in General Comment no. 22 when it indicated that the right to sexual and reproductive health is an integral part of the right to health.[145] The right to health has been protected in a number of international and regional instruments. It is important, therefore, to consider these international norms as well as the development of this right in regional charters. The purpose of this chapter is to discuss the relevant international and regional instruments as well as various World Conferences on population development where this right was acknowledged and defined.

2.2. INTERNATIONAL INSTRUMENTS

International law has made it possible for individuals to be members of the international community.[146] This entails that member of different states, who recognise international law, have rights at an international level and entitled to have such rights recognised and protected. As discussed in Chapter 1, it is impossible to give full effect to the right to reproductive health, which is a socio-economic right, without protecting the right to one's physical and bodily integrity, which is a civil and political right, (and

[144] Section 27 of the Constitution of the Republic of South Africa, 1996.
[145] A Strode, R Sarumi, Z Essack & P Singh 'A feminist critique of legal approaches to adolescent sexual and reproductive health rights in Eastern and Southern Africa: Denial and divergence versus facilitation' (2018) 32(1) *Agenda* 77.
[146] P Perišić 'Some remarks on the international legal personality of individuals' 2016 49(2) *Institute of Foreign and Comparative Law* 321.

visa versa). Below, is a discussion of the international protection of these rights via international instruments.

2.2.1. The Universal Declaration of Human Rights

The Universal Declaration of Human Rights (hereinafter referred to as the UDHR) was the first international instrument to be issued by the United Nations (UN) at a special General Assembly in 1948[147]. It was drafted with the aim of creating a common standard of fundamental human rights for all nations and people.[148] In its preamble, the UDHR recognises that the rights to dignity and equality are inalienable.[149] It also acknowledges the right to life health as well as the right to have a family[150]. Although this instrument did not provide any further detail on the right to reproductive autonomy it was, nonetheless, a step in the right direction. The UDHR was supported by 48 countries, South Africa, however, abstained from voting in favour of the Declaration.[151] This does not come as a surprise as the South African government had just implemented the apartheid regime.[152] Further to that, the UN Commission on Human Rights, which was formed with the purpose of legally protecting human rights at an international level, made it clear that it did not support the apartheid regime.[153] in this

[147] United Nations Universal Declaration of Human Rights, available at https://www.un.org/en/universal-declaration-human-rights/, accessed on 8 February 2021.
[148] Ibid.
[149] Ibid, Preamble.
[150] Article 3 of the UDHR. Also see McLaughlin, L C 'The Price of Failure of Informed Consent Law: Coercive Sterilisation of HIV-positive women in South Africa' (2014) 32 *Law & Inequality: A journal of theory and practice* 79.
[151] Ratification of International Human Rights Instruments – South Africa, available at http://hrlibrary.umn.edu/research/ratification-southafrica.html, accessed on 1 January 2020. South Africa has, in fact, still not ratified the UDHR. However, most human rights protected in the UDHR are embodied in the South African Constitution (see South Africa Celebrates the 70th Anniversary of the Universal Declaration of Human Rights, available at https://www.sahrc.org.za/index.php/sahrc-media/news/item/1686-south-africa-celebrates-the-70th-anniversary-of-the-universal-declaration-of-human-rights-udhr, accessed on 1 January 2020).
[152] L Hinds 'Apartheid in South Africa and the Universal Declaration of Human Rights' (1985) 24 *Crime and Social Justice* 5. Article two of the Declaration provides that everyone has equal protection of all the rights set out in the Declaration, and article 25 deals specifically with socio-economic rights, including the right to health. This was the first time that the right to health was given international recognition.
[153] United Nations Human rights council, available at https://www.ohchr.org/en/hrbodies/chr/pages/commissiononhumanrights.aspx#:~:text=The%20United%20Nations%20Commission%20on,our%20fundamental%20rights%20and%20freedoms.&text=It%20also%20acted%20as%20a,the%20world%20voiced%20their%20concerns, accessed on 26 May 2021.

context it was unlikely that South Africa would support a human rights declaration based on the principle of racial equality.[154]

Later, the United Nations deemed it necessary to create two international instruments which could be signed and ratified by member states as the UDHR was not legally enforceable.[155] These were the International Covenant on Civil and Political Rights (hereinafter referred to as the ICCPR) as well as the International Covenant on Economic, Social and Cultural Rights (hereinafter referred to as the ICESCR).[156]

2.2.2. The International Covenant on Civil and Political Rights

This international instrument was adopted in 1966 but only came to force in 1976.[157] In its preamble, it recognises that equality and respect for human dignity are important to ensure that human beings have full enjoyment of their civil and political rights as well as socio-economic rights.[158] The purpose of the covenant was to protect inherent human rights such as, *inter alia*, the right to dignity and equality.[159] Article 1 of the ICCPR recognised that people have a right of self-determination.[160] A broad interpretation of this right entails that women have a right to determine the future of their pregnancies. Article 2 of the convention urges state parties to treat their civilians with equal respect, eliminating all forms of discrimination, including racial

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[154] Hinds op cit note 152 at 5. The apartheid system was an extreme violation of human rights. It was a system wish sought to divide South Africans and was led by the white minority. By 1980, the South African population was composed of 85% black people (this includes black people, Indians as well as coloureds). Therefore, only 15% od South African benefited from this regime. The Apartheid government used criminal law as well as criminal procedure as a scare tactic to enforce compliance.

[155] Does the Universal Declaration of Human Rights Matter? Available at https://www.facinghistory.org/holocaust-and-human-behavior/chapter-11/does-universal-declaration-human-rights-matter, accessed on 2 January 2021.

[156] A de Baets 'The impact of the Universal Declaration of Human Rights on the study of history' (2009) 48(1) *History and Theory* 20. The UDHR together with the ICCPR and ICESCR are known as the International Bill of Human Rights. Also see https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (for the ICCPR) and https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx (for the ICESCR).

[157] United Nations *International Covenant on Civil and Political Rights*, available at https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx, accessed on 2 May 2020 (hereinafter referred to as ICCPR). Interestingly, while the South African government was implementing rules and laws which sought to divide the country and violate the rights of the majority of South African by, for example, passing the Group Areas Act 41 of 1950, the international community passed a number of international instruments which sought to protect human rights, including reproductive health rights.

[158] Supra, Preamble.

[159] Supra, Preamble.

[160] Supra, Article 1.

discrimination.[161] This instrument also protects the right to life in Article 6.[162] The ICCPRs only refers to reproductive rights in one place, Article 23 recognises that men and women of a marriageable age have a right to start a family and that the family should be protected by the State.[163] In other words it takes a similar approach to the one set out in the UDHRs. One can imagine that the right to the protection of the family includes the right to determine when one wishes to start having a family. Such protection should also extend to the protection of civilians from state interference to their reproductive autonomy rights. This instrument also protects women's right to equal treatment (Article 28), we well as the right to life (Article 6).[164] Women may only enjoy the rights protected in international instruments if they have equal access to such rights, including equal protection of the right to life. General Comment no. 28 of the Human Rights committee has outlined that the right to life extends to sexual and reproductive health rights.[165] This comment requires states to provide a report on birth rates, as well as deaths related to pregnancy and child-birth.[166] States are also required to take measures to assist women in preventing unwanted pregnancies and to protect them from undergoing life-threatening clandestine abortions.[167] The South African government ratified this covenant in 1994.[168]

2.2.3. The Optional Protocol to the International Covenant on Civil and Political Rights

Human rights, like any other rights, are merely words on paper if measures are not taken to implement them. Therefore, the Optional Protocol to the International Covenant on Civil and Political rights (hereinafter referred to as OPICCPR) was adopted in 1976.[169] The purpose of this protocol was to enforce the protection of the rights in the convention by receiving communications on the alleged violations of such

[161] Supra, Article 2.
[162] Supra, Article 6.
[163] Supra, Article 23.
[164] Supra, Article 6.
[165] Human Rights Committee General Comment No. 28: Article 3 (the equality right between men and women) available at http://ccprcentre.org/ccpr-general-comments, accessed on 13 June 2021.
[166] Supra, para 10.
[167] Supra, para 10.
[168] United Nations Human Rights Treaty Bodies available at https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=162&Lang=EN, accessed on 2 January 2021.
[169] United Nations *Optional Protocol to the International Covenant on Civil and Political Rights*, available at https://www.ohchr.org/Documents/ProfessionalInterest/ccpr-one.pdf, accessed on 14 November 2020.

rights from civilians, claiming that such rights have been violated.[170] In this regard, the Protocol establishes a Human Rights Committee whose duty it is to receive and consider communications on alleged violations of human rights.[171] It is important to note that only state parties who have ratified the ICCPR, including South Africa, and acknowledge the jurisdiction of the human rights committee may submit communication on alleged violations of human rights. [172] Another important consideration is that individuals need to have exhausted all their domestic remedies in order to present any information in terms of the Protocol. [173] Once such communication has been received, the committee will notify the state that has allegedly violated a civil and/or political right[174]. Such member state subsequently has six months to provide a written response and/or remedy to the alleged violation of human rights.[175] The committee acts as a mediator by examining all communication received by the affected parties and expressing its opinion. An example of communication on sexual and reproductive rights which was received under this protocol is the matter of *Karen Noelia Llantory v Peru.* [176] A discussion of this communication will be outlined later in this dissertation

2.2.4. The International Covenant on Economic, Social and Cultural Rights

Like the ICCPR, the ICESCR was adopted in 1966 but only came into force in 1976.[177] This was the first international instrument to deal exclusively with socio-economic rights. In its preamble, the ICESCR recognises that true freedom can only be enjoyed when socio-economic rights are recognised and protected. [178] Article 2 of the

[170] Supra, Preamble.
[171] Supra, Preamble.
[172] Supra, Preamble.
[173] Supra, Article 2.
[174] Supra, Article 4.
[175] Supra. Article 4. Article 5 of the Protocol further provides that the committee shall consider all written communication that has been made available to the committee by both parties to the dispute. The committee will only consider the relevant information if it is satisfied that: the matter has not been bought before an alternative international investigative body; and the individual presenting the communication has exhausted all domestic remedies.
[176] Communication No. 1153/2003 adopted 24 October 2005, UN GAOR, HRC, 85th Session, UN Doc CCPR/C/85/D/1153/2003 (2005). Also see International Covenant on Civil and Political Rights Communication no. 1153/2003, available at https://www.escr-net.org/sites/default/files/caselaw/decision_0.pdf.
[177] Unite Nations International Convenant on Economic, Social and Cultural Rights, available at https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx, accessed on 9 November 2020.
[178] Supra, Preamble.

convention recognises the financial challenges faced by developing countries and provides that every party to the convention ought to 'undertake to take steps, individually and through international assistance and co-operation… to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly to the adoption of legislative measures'.[179] Access to these rights need to be made available to both men and women to ensure equality and dignity between the sexes.[180] The right to health is provided for in Article 12, which states that everyone has the right to attain the highest attainable level of health, which includes physical and mental health.[181] The Covenant further highlights that women should not be discriminated against and, therefore, deserve equal rights and protection.[182] The South African government signed this treaty in 1994 but only ratified it in 2015.[183]

Notably, the ICESCR does not refer to reproductive health however, general comment No.14[184] and 22,[185] were passed by its treaty bodies and have given more insight on the aplication of this right. Comments no. 14 indicates that article 12.2 (a) of the ICESCR which advocates for the reduction of infant mortality requires states to improve child and maternal health care services as well as sexual and reproductive health care which includes family planning and access to information.[186] Comment No.22 confirmed the fact that sexual and reproductive health forms part of the mainstream right to health.[187] This comment has also has provided clarity on

[179] Supra, Article 2.
[180] Supra, Article 2. It cannot be denied that women are natural child bearers and, therefore, may only enjoy equality when they have control over their fertility as well as spacing between their children. This echoes the rights recognised in article 11, which include the right to adequate food, clothing, housing and general social status.
[181] Supra, Article 12
[182] Supra, article 3.
[183] Dullah Omah Institute for Constitutional Law, Governance and Human rights 'International Covenant on Economic, Social and Cultural Rights (ICESCR)' available at https://dullahomarinstitute.org.za/socio-economic-rights/international-covenant-on-economic-social-and-cultural-rights-icescr, accessed on 19 December 2020. South Africa was one of the last few countries to ratify this convention, possibly because South Africa is a Third World Country. In my opinion, however, there was no reason for South Africa to delay the signing of the convention as the convention recognized the need for states to progressively realise such rights.
[184] ICESCR General Comment No.14: The right to the Highest attainable standard of health (Art.12) available at https://www.refworld.org/pdfid/4538838d0.pdf, accessed on 6 June 2021.
[185] A Strode et al op cit note 144 at 77. A treaty body is consists of a panel of experts who are appointed to ensure the implementation of international human rights.
[186] ICESCR General Comment no. 14 op cit note 184.
[187] A Strode et al op cit note 145 at 78.

reproductive health services.[188] Such services include 'maternal health, contraceptives, family planning, sexually transmitted infections and HIV prevention, safe abortion and post abortion care, infertility and fertility options, and reproductive cancers'.[189]

2.2.5. Optional Protocol to the International Covenant on Economic, Social and Cultural Rights

The implementation of economic, social and cultural rights is challenging as it depends on the availability of state resources. However, states still have a duty to ensure that such rights are progressively realised. Such a duty resulted in the adoption of the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (hereinafter referred to as the OPICESCR) in December 2008[190]. The adoption of this protocol was motivated for at the 1993 World Conference on Human Rights and it appears that the main objective of this Protocol is ensure the implementation of socio-economic rights, particularly by states who have ratified the ICESCR, and to make such states accountable, by creating a committee which receives information on potential violations of socio-economic rights.[191] Such committee is referred to as the Committee on Economic, Social and Cultural Rights (hereinafter referred to as the committee). Victims of socio-economic rights violations may approach the committee and provide information about such violations.[192] Article 3 of the OPICESCR provides that the committee shall not consider information or communication unless the victim has exhausted all domestic remedies.[193] Further to the above, the victim needs to

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[188] Ibid, 79.
[189] Ibid, 79.
[190] United Nations *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, available at https://www.ohchr.org/Documents/HRBodies/CESCR/OProtocol_en.pdf, accessed on 12 November 2020.
[191] In its preamble, the OPICESCR recalls that all states who have ratified the ICESCR undertook to take steps to progressively realise the best attainable standards of socio-economic rights. The implementation of socio-economic rights, including the right to health, tends to be undermined. This was also noted by F Viljoen and M Orago in their article titled 'An Argument for South Africa's accession to the optional protocol to the international covenant on economic, social and cultural rights in the light of its importance and implications' available at http://www.scielo.org.za/pdf/pelj/v17n6/10.pdf, accessed on 20 December 2020.
[192] Article 1 of the OPICESRC.
[193] Article 2 also provides that the committee will not admit communication and/or information in the following circumstances: if it is not submitted within a year of exhausting domestic remedies; where the facts of the matter occurred before the OPICESCR was adopted, unless the facts continued after the protocol came into effect; where the committee has already considered the communication, or where another international body has considered or ruled on the matter; where the communication is not

prove that he/she has suffered an apparent disadvantage. If the above criterion has been met, the committee informs the relevant state of the alleged violation and the infringing state then has six months to respond and potentially remedy such violation.[194] The committee also encourages friendly settlement of disputes by allowing the affected parties to make use of its offices with the aim of resolving the matter in a friendly manner.[195] If the affected parties have not opted for a friendly settlement, the committee, after examining the relevant information, expresses its views and/or recommendations in writing to the parties[196]. In this instance, the relevant state has 6 months to respond to the recommendations of the committee, and also to discuss how it has remedied the violation.[197] One of the most interesting factors of the OPICESCR is that it strengthens accountability by allowing a state, that has ratified the protocol and acknowledged the competence of the committee, to present communication to another state's violation of the ICESCR.[198] Notably, this Optional Protocol has not received communication dealing with reproductive health rights.

2.2.6. Convention of All Forms of Discrimination against Women

As previously mentioned in Chapter 1, women's reproductive rights have continuously been undermined. The United Nations has adopted an instrument dealing exclusively with women's rights this is the Convention of All Forms of Discrimination against Women in 1979 (hereinafter referred to as CEDAW).[199] CEDAW has been defined as the 'international bill of rights for women' and seeks to guide states on how to enforce women's equality rights.[200] In its preamble, CEDAW recognises that women continue

aligned with the objectives of the OPICESCR; where the communication is not based on accurate information or based on reports not supported by mass media; where it is an exploitation of the right to bring such communication to the attention of the committee; and, lastly, where such communication is verbal and/or anonymous. Article 8 deals with the examination of the information by the committee. In doing so, the committee ensures that all communication is made available to all relevant parties. The committee also considers relevant documents published by the United Nations.

[194] Article 6 of the OPICESCR.

[195] Supra, Article 7.

[196] Supra, Article 9.

[197] Supra, Article 9.

[198] Article 10 of the OPICESCR deals with inter-state communication. Such communication is presented by a state that has concerns about another state's violation of the ICESCR. Interestingly, such communication is initially presented to the state violating the ICESCR, as opposed to the committee. The matter is only referred to the committee if such states have failed to settle the matter independently. The state receiving such communication then has three months to respond to such communication.

[199] CEDAW op cit note 1.

[200] B Rana & V Perrie 'CEDAW: A Tool for addressing Violence Against Women' (2019) *Sustainable Development Policy Institute* 112.

to be discriminated against and, as such, there is a need for the exclusive protection of their rights.[201] This covenant highlights the need to protect women's rights exclusively as, despite the adoption of earlier international instruments, women continued to be discriminated against. Although it focuses on the right to information, it does create some important norms regarding reproductive choices. Article 10 recognises the need to provide women with reproductive health education, and, in particular, to provide them with information on family planning.[202] Article 12 requires States to take appropriate steps to provide women with adequate health care services, which include reproductive health care.[203] This article goes a step further by providing that states need to provide women, who choose to continue with their pregnancies, with adequate health care and nutrition.[204] Article 16 further recognises women's rights to decide on the number and spacing of their children, and their right to have access to the relevant family planning information.[205] The implementation of CEDAW is enforced by a committee which comprises of independent experts (Known as the Committee for the elimination of discrimination against women).[206] CEDAW was ratified by the South African government in 1993.[207]

2.2.7. Optional Protocol to the Convention of the Elimination of All Forms of Discrimination against Women

The United Nations Optional Protocol to the Convention of the Elimination of All Forms of Discrimination against Women (hereinafter referred to as the OPCEDAW) was adopted in 1999 and came into force in 2000.[208] In its preamble, it is noted that the

[201] CEDAW op cit note 1, Preamble.
[202] Supra, Article 10.
[203] Supra, Article 12.
[204] Supra, Article 12.
[205] Supra, Article 16.
[206] B Rana & V Perrie op cit note 200 at 112. Article 18 of CEDAW requires States who have ratified the convention to submit a report after 1 year of ratification and, thereafter, after every 4 years. The reporting requirement is to ensure that States are accountable (See B Rana & V Perrie at 114).
[207] United Nations Human Rights Treaty Bodies, available at https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=162&Lang=EN, accessed on 20 December 2020. As of 2019 189 State parties had ratified CEDAW (see B Rana & V Perrie at 112).
[208] United Nations Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women available at https://www.un.org/womenwatch/daw/cedaw/protocol/, accessed on 16 January 2021.

purpose of the protocol is to reaffirm women's rights as protected in CEDAW.[209] It is important to note that this Protocol is a Convention on its own.[210] Essentially, states need to ratify the protocol separately if they wish to be bound by it.[211] Article 1 and 2 of the OPCEDAW grants jurisdiction to the Committee on the Elimination of Discrimination against Women to receive communication from groups or individuals who belong to states who have ratified this protocol.[212] Such individuals and/or groups may submit communication to the Committee if they believe that their rights, as set out in CEDAW, have been infringed up.[213] Article 5 provides that the committee has a duty to inform the relevant State of the communication received to enable the state party to grant relief to the complainant in order to prevent irreparable harm.[214] The relevant state subsequently has 6 months to respond to the communication as well as to indicate the manner it intends to remedy the matter.[215] Article 8 of this protocol provides that in instances where there is evidence of a grave infringement of women's rights, as provided for in CEDAW, the relevant State shall be invited in examining such communication and also to also comment on such violation.[216] The committee may also nominate some of its members to investigate the alleged violation and thereafter submit a report to the committee.[217] State parties to the protocol have a duty to ensure that all rights in CEDAW are protected.[218] South Africa ratified the OPCEDAW in

[209] Supra, Preamble.
[210] B Rana & V Perrie op cit note 200 at 119.
[211] Ibid, 119.
[212] Article 1 and 2 of the OPCEDAW.
[213] Supra, Article 2. Article 3 required such communication to be in writing and Article 4 provides that an individual or group submitting communication must have exhausted all domestic remedies before approaching such committee.
[214] The process of examining communication and decision-making may take up to two years. Therefore, if there is a potential of irreparable harm, the relevant State may be requested to grant interim relief (see B Rana & V Perrie op cit note 200 at 120).
[215] Article 5 of the OPCEDAW. In the interim, the Committee shall examine the communication provided in closed meetings and express its view and/or suggestions. Such views and/or suggestions shall be made available to the relevant parties – as recommendations (also see Article 7 of OPCEDAW).
[216] Supra, Article 8.
[217] Supra, Article 8.
[218] Supra, Article 11.

2005.[219] The matter of *LC v Peru*[220] is an example of communication received based on the alleged violations of the rights protected by CEDAW.[221] Details of this matter will be discussed later in this chapter.

2.2.8. Convention on the Rights of the Child

The United Nations Convention on the Rights of the Child (hereinafter referred to as the CRC) was adopted in 1989 and came into effect in 1990.[222] In its preamble, this convention identifies that children should be protected and provided with the necessary support in order to be responsible role players in their communities.[223] This convention also recognises children's rights to dignity and equality as a foundation to freedom, justice and peace.[224] Article 6 also recognises the inherent right to life.[225] Turning to reproductive health, this convention recognises the right to provide children with the necessary health care information which will enable them in making informed decisions about their reproduction.[226] Article 24 recognises children's right to health by providing that all children have the right to access the best attainable health care services, which includes family planning.[227] It also emphasises the need to provide pregnant women with pre-natal as well as post-natal health care.[228] This Article further

[219] United Nations Treaty Collection available at https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8-b&chapter=4&lang=en, accessed on 16 January 2021. OPCEDAW has been helpful granting individuals with a platform to address human rights violations they have faced in their countries of origin. One example is the case of *X and Y v Georgia* where a mother and daughter brought a complaint under the protocol. The complainants had informed the state, on numerous occasions, of the emotional, physical and sexual abuse they suffered at the hands of their husband 0and father (respectively). The state failed, however, failed to take action. The Committee found that the committee erred in many respects and subsequently submitted recommendations to the State of Georgia (see B Rana & V Perrie at 120).
[220] *LC v Peru*, Communication No 22/2009, CEDAW/C/50/D/22/2009 (2011).
[221] C Ngwena 'Access to safe abortion as a human right in the African region: lessons from emerging jurisprudence on UN treaty-monitoring bodies' (2013) 29 South African Journal on Human Rights 413.
[222] United Nations Human Rights Treaty bodies, available at https://tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?CountryID=162&Lang=EN, accessed on 20 December 2020.
[223] United Nations Convention on the Rights of the Child, available at https://www.ohchr.org/en/professionalinterest/pages/crc.aspx, accessed on 10 July 2021.
[224] Supra, Article 28.
[225] Supra, Article 6.
[226] Supra, Article 24.
[227] Supra, Article 24.
[228] Supra, Article 24.

places a duty on states to progressively realise this right and ensure that it is available to all children.[229] South Africa signed the convention in 1993 and ratified it in 1995.[230]

2.3. NON-BINDING BUT AUTHORITATIVE STATEMENTS BY INTERNATIONAL BODIES

International conferences are often the cornerstone to the development of international human rights, including sexual and reproductive health rights.[231] It is therefore important to consider their contribution to reproductive health rights. This paragraph will be a discussion of the four world conferences on women, the international human rights conference as well as other statements made by the World Health Organisation relating to reproductive health.

2.3.1. Women's First World Conference

The first conference took place in Mexico City between 19 June 1975 to 2 July 1975.[232] The UN declared 1975 to 1985 as the Decade for Women and this conference was significant as it launched this decade of enormous change.[233] The objective of this conference was to acknowledge the inequalities faced by women globally[234]. Such inequality is worsened by the role of women in nurturing children and lack of employment opportunities.[235] States who attended the conference agreed to promote, *inter alia*, a culture of equal respect and dignity for men and women, particularly by eliminating all obstacles faced by women in achieving equal protection and

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[229] Supra, Article 24.
[230] United Nations Status of Ratification Interactive Dashboard, available at https://indicators.ohchr.org/, accessed on 8 February 2021.
[231] For example, General comment no. 22 on the ICESCR makes reference to the Programme of Action of the International Conference on Population Development in describing reproductive health rights – see General Comment No. 22 on the ICESCR available at http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg, accessed on 8 June 2021.
[232] Report of the World conference of the International Women's year, available at https://www.un.org/womenwatch/daw/beijing/otherconferences/Mexico/Mexico%20conference%20report%20optimized.pdf, accessed on 19 July 2020 (hereinafter referred to as the Report of the First World Conference). The purpose of this conference was to recognized the inequality between sexes and address some of these inequalities. In particular, states who attended the conference recognized that women's child bearing capacity should not exacerbate inequality between men and women.
[233] Ibid, 12.
[234] Ibid, 15.
[235] Ibid, 15.

opportunities.[236] When it comes to reproductive health rights, states who attended the conference agreed that men and women have the right to regulate their fertility though family planning by deciding on the number and spacing of their children. As such, they need access to family planning education and services.[237]

2.3.2. Second Women's Conference

The second world conference took place in Copenhagen, Denmark, between 14 to 30 July 1980. This was a follow-up conference on the Decade for Women and it focused on equality, development as well as peace.[238] With regard to women's health, employment and education – it was noted that these are crucial areas of development to ensure that women are indeed free and equal.[239] It was also stressed that the right to health includes family planning.[240] States were urged to invest in the development of their health systems to ensure that they deliver on socio-economic rights.[241] This includes educating young boys and girls about reproductive health, giving them access to family planning, and informing them of the dangers of performing illegal terminations of pregnancies.[242] This report also stresses the importance of equipping medical workers and practitioners with the relevant skills to progressively realise women's right to health.[243]

2.3.3. Women's Third World Conference

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[236] Ibid, 10.

[237] Ibid, 11. States who attended the conference recognized that women in rural areas deserve the same quality services as all other women. It was also noted that women need to be active participate in health decisions affecting them. Interestingly, a link was drawn between the number of children women have as well as their social status (which includes their level of education). Women coming from poor backgrounds with low levels of education were are most likely to have more children. This obviously has a negative impact on poor countries with scares resources.

[238] Report of the World conference of the United Nations Decade for women: Quality, development and peace, available at https://www.un.org/womenwatch/daw/beijing/otherconferences/Copenhagen/Copenhagen%20Full%20Optimized.pdf, accessed on 27 November 2020, 12 (hereinafter referred to as the report on the second world conference). The purpose of equality is equal opportunity. It was noted in this conference that women have a lot to contribute in economic activities, even though they have a child bearing function.

[239] Ibid, 23.

[240] Ibid, 23. It was also noted on page 40 of the report that women living in rural areas also need to be prioritised. This would ensure equality amongst different classes of women. Family planning includes access to information and services which will equip women to decide whether they wish to have children, how much children they wish to have and the age differences between their children.

[241] Ibid, 39.

[242] Ibid, 40.

[243] Ibid, 41.

The Third World Conference took place in Nairobi between 15 to 26 July 1985, which was the end of the United Nations Decade for Women.[244] In the report for this conference, it is noted that States were encouraged to enact legislation, empowering women, in order to facilitate positive changes in the society.[245] As such, states were motivated to sign the Convention of All Forms of Discrimination Against Women, which, as mentioned earlier in this Chapter, was the first international instrument dealing exclusively with women's rights.[246] Turning to access to health care, the report noted the importance of health education, which includes family planning for both men and women.[247] States have a duty to educate men and women about the reproductive autonomy which includes the medication and medical procedures available to them, and how they can use such medication to regulate their fertility and decide on the number and spacing of their children.[248] Women's ability to control their fertility is essential to ensure the realisation of their rights, as well as in controlling the population.[249] Most importantly, it was noted that that young women and children, whether married or not, are also capable of bearing children and, such, need equal access to reproductive education.[250]

2.3.4. Women's Fourth World Conference

The final world conference on women was held in Beijing between 4 to 15 September in 1995 and resulted in the Beijing Declaration and Platform for action (hereinafter

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[244] Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, available at https://www.un.org/womenwatch/daw/beijing/otherconferences/Nairobi/Nairobi%20Full%20Optimized.pdf, accessed on 14 December 2020 (hereinafter referred to as the Report on the Third World Conference, page 22.

[245] Ibid, 22. It was noted that legislation was necessary to promote and maximise equality between men and women. Such equality should extent to equal education, employment opportunities, social security and, most importantly, equal access to health care.

[246] Ibid, 24.

[247] Ibid, 42.

[248] Ibid, 42. Interestingly, the World Health Organisation has created a list of essential medicines, which all member of society needs access to. The latest edition of this list was published in 2019 and is titled WHO Model List of Essential Medicines: 21th List 2019, and is available at file:///C:/Users/mnmthethwa/OneDrive%20-%20Independent%20Institute%20of%20Education/WHO-MVP-EMP-IAU-2019.06-eng.pdf, accessed on 15 December 2020. This list includes the use of Contraceptive, which includes oral contraceptives, the injection, intrauterine devices, barrier methods (including condoms), implantable contraceptives, intravaginal contraceptives, as well as ovulation inducers.

[249] Ibid, 43.

[250]Ibid, 44.

referred to as the Beijing Declaration).[251] States who attended this conferenced recognised the inequalities faced by women globally and undertook to advance women's rights[252]. Turning to reproductive health, this declaration defined reproductive health as complete physical, mental and social well-being in all matters relating to the reproductive system, and not just absence of disease.[253] This definition includes the rights of men and women to have access to family planning which is legal, safe, effective and affordable.[254] The Beijing declaration confirmed that that certain international human rights embrace reproductive rights. These include the rights of all men and women to decide the preferred number, timing and spacing of their children, and to be have access and means to enforce these rights[255]. Women's human rights include their right to "have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence".[256] This declaration has set the tone in the advancement of women's rights and its implementation continues to be accessed and promoted after every five years.

2.3.5. The1993 World Conference on Human Rights

The Vienna World Conference on Human Rights, in 1993, led to the adoption of the Vienna Declaration and Programme of Action (hereinafter referred to as the Vienna Declaration).[257] In its Preamble, *inter alia*, this declaration affirms the importance of the Human right to dignity, which is available to all human beings.[258] It further stresses concern over the difficulties and discrimination faced by women across the world.[259]

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[251] World Conferences on Women, available at https://www.unwomen.org/en/how-we-work/intergovernmental-support/world-conferences-on-women#:~:text=The%20United%20Nations%20has%20organized,series%20of%20five%2Dyear%20reviews., accessed on 7 February 2021.
[252] Beijing Declaration and Platform for Action, available at https://www.un.org/en/events/pastevents/pdfs/Beijing_Declaration_and_Platform_for_Action.pdf, accessed on 15 April 2020, Annex I (hereinafter referred to as the Beijing Declaration).
[253]Ibid, para 94.
[254] Ibid, para 94. See also C Pickles *Pregnancy Law in South Africa – Between reproductive autonomy and foetal interests* (2017) 56. See also V Balogun 'The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive rights' (2011) 11 *African Human Rights Law Journal* 373.
[255] Ibid, para 95.
[256] Ibid, para 96.
[257] Vienna Declaration and Programme of Action available at https://www.ohchr.org/Documents/ProfessionalInterest/vienna.pdf, accessed on 16 January 2021.
[258] Ibid, Preamble.
[259] Ibid, Preamble.

The Declaration emphasises the importance of equal protection of human rights, as well as the importance of the right to self-determination, as provided for in the International Bill of Rights.[260] Turning to the protection of women's rights, the Declaration recognises that the rights of women and children are intertwined and deserve equal protection.[261] When it comes to women's right to health, it states that women deserve the highest standard of physical and mental health, which includes reproductive health care.[262]

2.3.6. Statements by the World Health Organisation

The right to the highest attainable standard of health was first mentioned in the preamble of the Constitution of the World Health Organisation in 1945.[263] It defined health as a right which extends beyond the mere absence of decease.[264] The right to health is a state of complete physical, mental and social well-being.[265] The WHO has played a significant role in the enforcement of health rights at an international stage.[266] This organisation has also provided guidelines for the enforcement of health rights. For instance, it has provided a list of mandatory services enabling member states to achieve optimum reproductive health standards. Such services includes:

> high quality services for family planning; combating sexually transmitted infections (including HIV); treatment of reproductive tract infections (RTIs); eliminating unsafe abortion; promoting of sexual health; providing age-appropriate comprehensive sexuality education; improving antenatal, perinatal, postpartum and new-born care; providing infertility services and treatment of cervical cancer and other gynaecological morbidities.[267]

Further to the above, WHO has provided safe abortion and female sterilisation guidelines. These guidelines will be discussed in the following paragraphs:

<u>Safe abortion guidelines</u>:

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[260] Ibid, Para 1 and 2.
[261] Ibid, Para 18.
[262] Ibid, Paragraph 41.
[263] E Durojaye 'The approaches of the African Commission to the right to health under the African Charter' (2013) 17 *Community Law Centre, University of the Western Cape* 394.
[264] Ibid.
[265] Ibid.
[266] World Health Organisation available at https://www.who.int/about, accessed on 5 June 2021 (hereinafter referred to as WHO).
[267] A Strode et el op cit note 145 at 79.

The 2012 Safe Abortion guidelines provide international standards for abortion services.[268] The WHO recommended, *inter alia*, the following: the duration of the pregnancy is critical in establishing the appropriate method of termination as well as the necessary information during counselling;[269] the use of ultrasound machinery is not necessary in determining the gestation period;[270] health care professionals should provide women seeking abortion services with as much information as possible regarding the process of termination;[271] counselling by a qualified health-care professional should be offered to the pregnant woman (it is important to note that such counselling is not mandatory);[272] third party authorisation is not necessary as women have autonomy over their bodies and may freely decide to obtain abortion services (without the influence of their partners, spouses or parents);[273] health authorities must maintain high levels of confidentiality and privacy as failure to do so may compel abortion seekers to resort to unlawful terminations; lastly, health professionals are instrumental in executing the aforementioned health standards, therefore, they need to be trained and upskilled regularly on updated safe abortion guidelines.[274]

Female sterilisation guideline:

The 1992 guidelines on female sterilisation also provide international standards for female sterilisation.[275] The WHO recommended, *inter alia*, the following: there is no legal basis for the requirement of spousal consent for females wishing to be sterilised;[276] due to the permanent nature of a sterilisation procedure, it should only be provided to persons who have given informed consent and understand that they may never have more children;[277] counselling is instrumental in providing sterilisation

[268] Safe Abortion: technical policy guidance for health systems available at http://apps.who.int/iris/bitstream/handle/10665/70914/9789241548434_eng.pdf;jsessionid=BF3F8B1E9C75B13B0086A488D23A26DB?sequence=1, accessed on 5 June 2021 (hereinafter referred to as WHO abortion guidelines).
[269] Ibid, 32.
[270] Ibid, 34.
[271] Ibid, 35.
[272] Ibid, 36. The WHO noted that while counselling is important in assisting the women in making an informed choice, such counselling should not be mandatory as most women approach abortion clinics once they are sure of their decision to terminate.
[273] Ibid, 68.
[274] Ibid, 69.
[275] Female Sterilisation: A guide to provision of services available at https://apps.who.int/iris/handle/10665/40133m, accessed on 5 June 2021 (hereinafter referred to as WHO sterilisation guidelines).
[276] Ibid, 8.
[277] Ibid, 13.

patients with all information relating to this procedure and the person providing such counselling should stress its permanent nature;[278] counselling should be provided to all women who request the use of contraceptives and, if a women opts to be sterilised, her informed consent must be documented;[279]sterlisation services should be provided in existing public and private health care establishments as it forms part of mainstream family planning services;[280] the minimum requirement for a team health professionals performing a simple sterilisation procedure includes a surgeon, a surgeon assistant as well as a theatre attendance;[281] lastly, the partner of the women who has opted to be sterilised should also be counselled, however, the purpose of the counselling is not to obtain his consent.[282]

2.4. THE RECOGNITION OF REPRODUCTIVE HEALTH RIGHTS WITHIN THE RIGHT TO HEALTH IN REGIONAL CONVENTIONS

2.4.1. The African Charter on Human and People's Rights

The African Charter on Human and People's Rights (hereinafter referred to as the African Charter), was adopted by the Organisation of African Unity in 1981.[283] The Charter was drafted by the Organisation of African Unity (hereinafter referred to as the OAU) in 1981 and was adopted in Nairobi, Kenya.[284] The AOU was established in 1963 and its main objective of this was to create unity among African countries and most of the international instruments protected the state rather than the individual. It sought to create a human rights framework for the African community.[285] The purpose of this Charter was to adopt and adapt international human rights so that they could be ratified by countries on the African continent. In its preamble, the Charter recognises that African people are struggling, as a result of colonialism, and outlines the need to create a human rights framework that is tailored for African people. The

[278] Ibid, 49.
[279] Ibid, 61.
[280] Ibid, 27.
[281] Ibid, 29.
[282] Ibid, 63.
[283] R Gittleman 'The African Charter on Human and People's Rights: A Legal Analysis' (1982) 22 (4) *Virginia Journal of International Law* 667.
[284] J Dugard *International law: A South African Perspective* 4th ed (2016) 346.
[285] Ibid, 540.

Charter recognises the inherent human right to dignity as well as the right to life.[286] Article 16 provides that every person has the right to the best attainable health, and state parties have a duty to ensure that such right is accessible to all individuals.[287] This Charter also acknowledges the equality of men and women.[288] Article 18 encourages each State to eliminate gender discrimination and, lastly, Article 20 protects the right to self-determination.[289] This instrument does not, however, provide details on the right to health. As the African Charter is a general instrument, it is argued that it fails to provide adequate protection for women[290] and does not give adequate protection to reproductive health as it only focuses on the generic right to health.[291] The African Charter was ratified by the South African government in 1996.[292]

2.4.2. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of women in Africa

The Protocol to the African Charter on Human and Peoples' rights on the Rights of women in Africa was drafted in 1995 but was only adopted in July 2003 (hereinafter referred to as the Maputo Protocol).[293] This protocol responds to the abuse, discrimination and the inequalities faced by women in the African continent.[294] Article 1 identifies the right to life, health, dignity, education, and physical integrity as

[286]African Charter on Human and people's rights, available at https://www.achpr.org/legalinstruments/detail?id=49, accessed on 20 December 2020 (Article 4 and 5).
[287] Supra, Article 16.
[288] Supra, Article 18.
[289] Supra, Article 16 and 18. Article 18 refers to CEDAW as the benchmark for African states when It comes to gender equality.
[290] J Oder 'Reclaiming Women's Social and Economic Rights in Africa – The Protocol to the African Charter on Human and Peoples' (2004) (5)4 Rights on the Rights of Women in Africa' *Economic and Social Rights in Africa* available at https://hdl.handle.net/10520/AJA1684260X_156, accessed on 19 January 2019.
[291] A Strode op cit note 145 at 78.
[292] Ratification Table: African Charter on Human and People's Rights, available at https://www.achpr.org/ratificationtable?id=49, accessed on 20 December 2020.
[293] African Union, Available at https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa, accessed on 19 November 2020. The Preamble to the Maputo Protocol reaffirms rights of women as recognized by other international instruments but aims to create a regional instrument dealing specifically with the protection of women's rights. As such, it recognises that Article 18 of the African Charter on Human and People's rights condemns all forms of discrimination against women and requires all member states to treat women with equal respect and dignity. It all acknowledges the crucial role played by women in preserving African customs and values.
[294]J Order op cit note 290 at 13.

fundamental rights for women and children.[295] Equal protection of men and women is recognised in Article 8 of this Protocol and Article 14 deals with the right to health.[296] This article defines the parameters of the to health rights by providing that it includes the right to regulate one's fertility; the right to determine whether one wishes to have children, the number of children they wish to have, as well as the age difference between their children; this right also includes the choice to use contraceptives of one's choice; the right to receive protection against sexually transmitted diseases; lastly, it acknowledges the right to receive information on family planning.[297] As Africa is a continent with a vast number of rural communities and villages, the protocol pays particular attention to women in rural areas. It provides that member states need to ensure that women in rural areas have access to information as well as family planning services.[298] Interestingly, the protocol requires state parties to take appropriate measures to provide termination services to a specific category of women.[299] This includes women who fell pregnant as a result of rape and/or incest.[300] It also specifies that such termination services should be available where there is a good chance that the continued pregnancy will have a negative impact in the pregnant woman's physical and/or mental health, or will result in severe malformation of the foetus.[301] Authors have argued that this article is vague as, on the one hand, it promotes reproductive autonomy (which includes the right to decide on the number and spacing of one's children as well as to have access to reproductive health care, including termination of pregnancy), on the other hand, it limits reproductive choice by providing that termination services may only be provided in limited circumstances.[302] General comment no.2 of this protocol, passed in 2014, provides more clarity by requesting states to take measures, which may be direct or indirect, to ensure that family planning services are indeed accessible and to enact legislation with the aim of decriminalising

[295] African Union The Protocol to the African Charter on the rights of women in Africa, available at https://www.un.org/en/africa/osaa/pdf/au/protocol_rights_women_africa_2003.pdf, accessed on 19 November 2020.
[296] Supra, Article 8.
[297] Supra, Article 14.
[298] Supra, Article 14.
[299] Supra, Article 14.
[300] Supra, Article 14.
[301] Supra, Article 14. These specific provisions were included in South Africa's Choice on termination of Pregnancy Act. This will be discussed in greater detail in Chapter 3 of thus dissertation. Many states have ratified this protocol without reservations however, they have not amended their domestic legislation to be in line with Article 14 of this protocol (See Ngwena (2013) op cit note 221 at 402.
[302] K Ebeku 'Considering the Protocol on the Rights of Women in Africa' (2006) 36(1) *Africa Insight* 31.

terminations of pregnancies.[303] This protocol is, however, not binding and has, as a result, received much criticism.[304] This protocol was adopted by South Africa in December 2004.[305]

2.4.3. The African Charter on the Rights and Welfare of the Child

The African Charter on the Rights and Welfare of the Child (hereinafter referred to as the Children's Charter)[306] was adopted in July 1990. This Charter also defines a child as a person below the age of 18 and also recognises that the Child's best interests are of paramount importance in every matter concerning the Child.[307] In its preamble, it notes that many African children live in critical conditions and that steps need to be taken to ensure that such children's physical and mental health care is protected and promoted.[308] Article 5 protects children's right to life and Article 14 provides that children have the right to the best attainable physical, mental and spiritual health care.[309] Article 33 establishes a committee on the rights of the child and the purpose of this committee is to promote the protection of the rights of the child.[310] In 2003 this committee required states to specify the children's age of consent to sexual intercourse and that such age should be applicable to male and female children equally.[311] South Africa ratified this Charter in January 2000.[312]

2.5. THE RECOGNITION OF THE RIGHT TO REPRODUCTIVE AUTONOMY WITHIN SUB-REGIONAL INSTRUMENTS

[303] A Strode op cit note 145 at 79.
[304] R Sigsworth & L Kumalo 'Women, peace and security: Implementing the Maputo Protocol in Africa' (2016) 295 Institute for Security Studies, 16.
[305] Centre for Human Rights University of Pretoria, available at https://www.maputoprotocol.up.ac.za/index.php/countries/interactive-map, accessed on 20 December 2020.
[306] African Union 'African Charter on the Rights and Welfare of the Child' (1990) available at https://au.int/en/treaties/african-charter-rights-and-welfare-child, accessed on 10 June 2020.
[307] Supra, Article 2 and 4.
[308] Supra, Preamble.
[309] Supra, Article 5 and 14.
[310] Supra, article 23.
[311] A Strode op cit note 145 at 78.
[312] ACERWC Ratification Table, available at https://www.acerwc.africa/ratifications-table/, accessed on 7 February 2021.

The Southern African Development Community (SADC) was formed to promote and achieve growth and enhance the quality of life for people living in Southern Africa.[313] SADC aims to achieve its goals by creating legal and institutional instruments in order to guide its members and create a common Standard.[314] One of the instruments created by SADC is the protocol on gender and development[315] which was adopted in 2008[316] and revised in 2016.[317] In its preamble, the SADC protocol notes the importance of gender equality as stated in CEDAW. In its definitions section, it defines sexual and reproductive rights as follows:

The universal human rights relating to sexuality and reproduction, sexual integrity and safety of the person, the right to sexual privacy, the right to make free and responsible reproductive choices, the right to sexual information based on scientific enquiry, and the right to sexual and reproductive health care.[318] The fact that the drafters of this protocol saw it fit to define reproductive rights indicates the significance of these rights as well as the willingness to realise them. Article 4 of the protocol encourages member states to eliminate all obstacles preventing men and women from accessing their fundamental rights, including the right to life, health, dignity, education and physical integrity.[319] Article 11 of the protocol deals with children's rights. It states that all children should have access to education and health care. This entails ensuring that female children have equal access to education as well as sexual and reproductive rights (as defined in the aforementioned definitions section).[320] Article 20 deals with gender based violence and provides that victims of rape should be treated and cared for.[321] This includes providing such survivors with emergency contraceptives as well as post exposure prophylaxis to reduce the risk of contracting HIV.[322] It is unfortunate

[313] Southern African Development Community 'SADC Objectives' available at https://www.sadc.int/about-sadc/overview/sadc-objectiv/, accessed on 31 January 2021.
[314] Supra.
[315] SADC Protocol on Gender and Development available at https://www.sadc.int/files/8713/5292/8364/Protocol_on_Gender_and_Development_2008.pdf, accessed on 31 January 2021.
[316] Southern African Development Community 'Gender', available at https://www.sadc.int/issues/gender/, accessed on 31 January 2021.
[317] Revised Protocol on Gender Development available at https://genderlinks.org.za/wp-content/uploads/2016/01/ADOPTED-REVISED-PROTOCOL-ON-GAD.pdf, accessed on 31 January 2021.
[318] SADC Protocol op cit note 314.
[319] Supra, Article 4.
[320] Supra, Article 11.
[321] Supra, Article 20.
[322] Supra, Article 20.

that this article does not identify termination of pregnancy as a services to be provided to victims of rape. Article 26 discusses health, sexual reproductive health as well as reproductive rights.[323] It encourages states to implement policies and legislation which aim to enhance health care services.[324]

2.6. DISCUSSION

2.6.1. Although sexual and reproductive health rights fall under the broad category of the right to access the highest attainable health care, it has taken some years for the content of sexual and reproductive health to be developed

Notably, the broad category of the right to health is given wide protection. The right to the highest attainable standard of health is protected in international instruments such as the UDHR[325], the ICESCR[326], the CEDAW[327] and the CRC.[328] The right to health is also protected at a regional level in the African Charter,[329] the Maputo Protocol,[330] the African charter on the welfare of the Child,[331] as well as the SADC protocol.[332] Although some of these international instruments (such as CEDAW, the Maputo Protocol, as well as SADC protocol) have defined and provided specific protection to sexual and reproductive health rights, it is apparent that the development of the actual right to sexual and reproductive health has lagged behind and has often found protection in general comments of various treaty bodies of international instruments as well as other non-binding international conferences and comments by the WHO. This is a gap in the international protection of sexual and reproductive health care, as women have to rely on non-binding sources to assist in interpreting and implementing these rights.

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[323] Supra, Article 22.
[324] Supra, Article 22. This article refers to the International Conference on Population Development as well as the Beijing Declaration as the standard that states should used to develop and promote reproductive health rights.
[325] UDHR op cit note 7, Article 25.
[326] ICESCR op cit note 177, Article 12.
[327] CEDAW op cit note 1, Article 12.
[328] Vienna Declaration op cit note 257, paragraph 41.
[329]UDHR op cit note 7, Article 16.
[330] ICESCR op cit note 177, Article 14.
[331] Children's Charter op cit note 306, Preamble.
[332] SADC op cit note 313 Article 4 and 11.

For instance, the UDHR (adopted in 1948) protects the right to health[333] and the ICCPR (adopted in 1966) protects the generic right to self determination (Article 1),[334] the right to start a family (Article 23),[335] the right to equality (Preamble),[336] and non-discrimination (Article 20).[337] The full extent of the these rights, as they relate to sexual and reproductive health, are not outlined in these instruments. In 1995 the Beijing Declaration has provided clarity by providing that the right to bodily integrity extends to women's autonomy over all expects of their health including sexual and reproductive health.[338] In 2004, the United Nations also confirmed that 'equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the bodily integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences'.[339]

The ICESCR, which also protects the right to the highest attainable standard of health in Article 12,[340] follows the same trend as the ICCPR by not outlining reproductive health rights. Context to this right has been given in international conferences, comments by the WHO, as well as other General comments by its treaty bodies. As already outlined earlier in the chapter, sexual and reproductive health rights were acknowledged in all four international women's conferences. These conferences, which were held between the year 1975 to 1995, identified the rights of men and women to regulate their fertility through family planning by discussing the number and spacing of their children.[341] It was only in the year 2000 that General Comment no. 14 of this convention confirmed that the right to health imposes a duty on states to improve child and maternal health care services as well as sexual and reproductive health care which includes family planning and access to information.[342] Much later (in 2011) Comment No.22 confirmed the fact that sexual and reproductive health forms part of the mainstream right to health.[343]

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[333] The UDHR op cit note 7.
[334] The ICCPR op cit note 12.
[335] Supra.
[336] Supra.
[337] Supra.
[338] Beijing Declaration op cit note 252, para 34.
[339] United Nations Human Rights handbook op cit note 3 at 19.
[340] The ICESCR op cit note 156.
[341] Refer to paragraph 2.3 above.
[342] ICESCR General Comment no. 14 op cit note 184.
[343] ICESCR General comment no.22 (2016) available at, http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0

2.6.2. Certain elements of the definition of sexual and reproductive health care are now enforceable legal norms at an international and regional level

International law standards provide full recognition of reproductive health as an element of the right to health.[344] In this regard, men and women have a right to the highest attainable standard of reproductive health care. It is important to note that the right to health is not limited to the right to be healthy but should be understood to contain freedoms and entitlement.[345] Such freedoms include the ability to make decisions concerning sexual and reproductive health free of coercion, violence and discrimination.[346] Reproductive health care services are wide enough to include maternal health, the use of contraceptives, family planning, safe abortion, post abortion care, as well as infertility and fertility options.[347] State parties have a duty to equally distribute such services in sufficient quantity.[348] Further to this, states have a duty to remove all obstacles which prevent women from accessing sexual and reproductive health rights.[349] They are also obligated to take reasonable steps, with due regard to their available resources, to ensure that reproductive health rights are progressively realised.[350]

At a regional level, state parties to the African Charter have a duty to illuminate gender inequalities and to provide human rights protection as stated in international instruments, including CEDAW.[351] The Maputo protocol explicitly provides for the protection of reproductive rights.[352] Such reproductive health rights include one's ability to regulate their fertility, the freedom to decide on whether one wishes to have children as well as the number and spacing of their children, the use of contraceptives, as well as the right to receive the relevant information with regard to family planning.[353] It is disappointing to note, however, that although the Maputo Protocol makes

oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg, accessed on 10 July 2021.

[344] A Strode et al op cit note 145 at 79. Also see ICESCR General comment no. 22.
[345] ICESCR General Comment no. 14 op cit note 184.
[346] ICESCR General Comment no. 22 op cit note 343.
[347] A Strode et al 145 at 79.
[348] ICESCR General Comment no. 14 op cit note 184.
[349] ICESCR General Comment no. 22 op cit note 343.
[350] Supra.
[351] African Charter op cit note 286, Article 18.
[352] Maputo Protocol op cit note 293, Article 14.
[353] Supra, Article 14.

reference to termination services, such services are limited to a category of women who fell pregnant as a result of rape and/or incest or where the continued pregnancy is likely to endanger the life of the pregnant women and/or foetus.[354] According to this instrument, women's right to terminate is not based on based on reproductive choice. This is a gap in regional protection of sexual and reproductive health care as, on the one hand, this protocol promotes sexual and reproductive health rights, while on the other hand, it limits termination services to a specific category of women.[355] At a regional level, therefore, women may not merely choose to terminate their pregnancies.

2.6.3. Sexual and reproductive health rights are now enforceable at an international and regional level

Individuals who experience violations of their health rights must have access to judicial and other effective remedies.[356] Such individuals are also entitled to appropriate remedies which include compensation, restitution, satisfaction or guarantees that such violations are never to be repeated.[357] Contents of the optional protocol to the ICCPR, ICESCR, and CEDAW were outlined earlier in these chapters. These protocols play a crucial role in the enforcement of human rights. The common purpose of these protocols is to provide victims of human rights violations an opportunity to send written communication setting out such violations to the relevant committee. The relevant committee has a duty to consider such communication and make recommendations to the relevant member state. The committee to the Optional Protocol to ICESCR has not received communication relating to sexual and reproductive health rights. The discussion below will be therefore limited to communication received by the Optional Protocol to the ICCPR, and the Optional Protocol to CEDAW.

An example of communication on sexual and reproductive rights which was received by the Optional Protocol to ICCPR is the matter of *Karen Noelia Llantory v Peru.*[358]

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[354] ICESCR General Comment no. 22 op cit note 343.
[355] Maputo Protocol op cit note 293 at 31.
[356] ICESCR General Comment no. 14 op cit note 184.
[357] Supra.
[358] Communication No. 1153/2003 adopted 24 October 2005, UN GAOR, HRC, 85th Session, UN Doc CCPR/C/85/D/1153/2003 (2005). Also see International Covenant on Civil and Political Rights Communication no. 1153/2003, available at https://www.escr-net.org/sites/default/files/caselaw/decision_0.pdf.

This matter involved a pregnant 17 year old girl who was carrying an anencephalic foetus.[359] She was advised by a gynaecologist that her continued pregnancy posed a risk to her life and advised her of the option to terminate.[360] She subsequently requested to terminate her pregnancy, relying on Article 119 of the Peruvian Penal Code which permitted termination on the ground that the continued pregnancy endangered the pregnant women's life or is likely to cause irreparable harm to her health.[361] The relevant authorities did not, however, accept her request and she was compelled to carry the pregnancy to term.[362] On 13 January 2002 she gave birth to an anencephalic baby, who only survived for four days.[363]

As a result of the aforementioned experience, Miss Llantary sent communication to the Human Rights Committee.[364] In her communication, she alleged that her state party, Peru, violated numerous provisions of the ICCPR. The below table identifies the alleged violations of international human rights protections by Peru as well as the Committee's responses:

Alleged violated provision of the ICCPR	**Response by the committee**
Article 2 which grants the right to an effective remedy.[365]	The committee noted that the hospital authorities we aware of the threat that Miss Llantary's pregnancy posed to her mental and physical well being.[366] The committee held that hospital authorities refusal to grant her permission to terminate, as well as the absence of any information to counter the above claims

[359] Ngwena (2013) op cit note 221 at 411.
[360] Communication no. 1153/2003 op cit note 358.
[361] Ngwena op cit note 221 at 411.
[362] Ibid, 411
[363] Communication no. 1153/2003 op cit note 358.
[364] Supra.
[365] Supra.
[366] Supra.

	from the state, reveal a violation of article 2 of the ICCPR.[367]
Article 3 which stipulates that everybody has the right to equal treatment – she argued that she was denied access to health services because of her sex.[368]	The committee was of the opinion that this allegation was not supported with enough evidence and was therefore inadmissible.[369]
Article 6 which protects the right to life – she motivated for a broad interpretation of this right.[370]	The committee did not deem it necessary to decide on this alleged violation as it goes hand in hand with the below discussion of Article 7.[371]
Article 7 which ensures that everyone is free from degrading and inhumane treatment – it was argued that forcing her to continue with her pregnancy, with the knowledge that her baby had a short life expectancy, amounted to cruel and inhuman treatment.[372]	The committee noted that the harm suffered by Miss Llantary was foreseen as her foetus was diagnosed as an anencephaly foetus. The protection in article 7 extends to mental suffering. In light of the state's failure to provide information to counter Miss Llantary's claims, the committee gave due consideration to her claims. The committed found that there was a violation of article 7.[373]
Article 17 which protects the right to privacy – it was argued that the state violated her right to life by depriving her the opportunity to make a decision concerning her reproductive health.[374]	As Miss Llantary was informed of the risk that the pregnancy posed to her life, the grounds for a lawful termination as set out in the Penal code were present. The committee found that the hospital's

[367] Supra.
[368] Supra.
[369] Supra.
[370] Supra.
[371] Supra.
[372] Supra.
[373] Supra.
[374] Supra.

	refusal to terminate her pregnancy amounted to a violation of Article 17.[375]
Article 24 which offers protections for minors – the health authorities did not take her age into consideration.[376]	The commission noted that the state party did not provide Miss Llantary with the care she needed as minor. The committee found that Article 24 was also violated.[377]
Article 26 which guarantees the right to equal protection – she argued that by refusing to identify her abortion as a therapeutic abortion, which was lawful under the Penal Code, the hospital authorities left her unprotected.[378]	The committee was of the opinion that this allegation was not supported with enough evidence and was therefore inadmissible.[379]

In light of the above findings, the committee recommended Peru to provide an effective remedy to the complainant, including compensation.[380] Peru was also advised to take note of the above violations and ensure that they are not repeated in future.[381]

Turning to communication received by the Optional Protocol to CEDAW, the matter of *LC v Peru*[382] was brought by a 13 year old who became pregnant as a result of sexual assault by an older man.[383] She became depressed as a result of the pregnancy and attempted to commit suicide by jumping from a building.[384] The suicide attempt left her severely injured (her injuries included damage to her spine), and she required emergency surgery to prevent her injuries from worsening as well as to mitigate permanent disability.[385] The relevant hospital authorities did not carry out the required

[375] Supra.
[376] Supra.
[377] Supra.
[378] Ngwena op cit note 221 at 411.
[379] Communication no. 1153/2003 op cit note 358.
[380] Supra.
[381] Supra.
[382] *LC v Peru*, Communication No 22/2009, CEDAW/C/50/D/22/2009 (2011).
[383] Ngwena (2013) op cit note 221 at 413.
[384] Ibid, 413.
[385] Ibid.

surgery on the basis that it would harm the foetus.[386] *LC* decided to appeal the hospital's decision by relying on a hospital report, proving that the continued pregnancy would cause severe harm to her mental and physical health.[387] She, however, spontaneously miscarried before the appeal was considered and was finally operated on (three and a half months after it was established that she needed emergency treatment).[388] The hospital's delay in carrying out the emergency operation resulted in a dramatic deterioration of *LC*'s health care.[389] It was for the aforementioned reasons that *LC* brought communication before the CEDAW commission.[390] In her communication, she alleged that her state party, Peru, violated numerous provisions of CEDAW. The below table identifies the alleged violations of international human rights protections by Peru as well as the Commission's responses:

Alleged violation of CEDAW	**Response by the commission**
Article 1 which prohibits discrimination against women.[391]	The committee did not see it necessary to rule on the alleged violation of this article as it was similar to the allegated violation of Article 5 (discussed below).[392]
Article 2(c) encourages states to put measures in place to promote equal protection of women's rights through national tribunals and other institutions.[393]	The committee found that article 2(c) was violated as there was no legal framework in place for L.C to seek termination services rapidly, considering

[386] Ibid. Such a refusal by the hospital authorities was despite the fact that Article 119 of the Peruvian Penal Code legalised termination services carried out with the intention to save a pregnant women's life or to prevent serious injury.
[387] Ibid.
[388] Ibid. It is interesting to note that despite the physical harm suffered by LC, the hospital authorities indicated that they would still have declined LC's appeal as it was not subject to appeal.
[389]Ibid. Such a delay resulted in LC being a quadriplegic and being confined to a wheelchair for the rest of her life.
[390] Ibid. The CEDAW committee found that such communication was acceptable as *LC* exhausted all domestic remedies. She even appealed the decision which was made by the hospital commission was informed that the appeal would have still not been granted.
[391] Ibid.
[392] Committee on the Elimination of Discrimination against women communication no. 22/2009, available at https://www2.ohchr.org/english/law/docs/CEDAW-C-50-D-22-2009_en.pdf, accessed on 26 May 2021.
[393] Communication No 22/2009 op cit note 382.

	the risk her pregnancy posed on her life.[394]
Article 2(f) which requires states to abolish laws which discriminate against women.[395]	The committee found that article 2(f) was violated.[396] This is possible because the legal framework on therapeutic abortions only affects pregnant women.
Article 3 which requires states to take positive action to ensure that women's rights are protected and developed.[397]	The committee was of the opinion that Peru did not take appropriate measures to protect LC's rights and, therefore, violated this article.[398]
Article 5 which requires states to remove religious and cultural prejudices which perpetuate gender stereotypes and superiority of men over women.	Article 5 was violated as the refusal to terminate LC's pregnancy was based on the stereotype that the survival of a foetus trumps a pregnant woman's health rights.[399]
Article 12 which guarantees equal treatment and access to healthcare services.[400]	The committee noted that the state was aware that LC's pregnancy posed a threat to her mental and physical health.[401] Further to this, she did not have access to a remedy that suited her condition as a pregnant woman.[402] In light of these circumstances, the committee found that article 12 was violated.
Article 16(1)(e) which provides women with freedom to decide the number and spacing of their children, and requires	The committee did not deem it necessary to determine whether article 16(1)(e) had

[394] Supra.
[395] Supra.
[396] Supra.
[397] Supra.
[398] Supra.
[399] Supra.
[400] Supra.
[401] Supra.
[402] Supra.

states to make reproductive health.[403] Services and information available to women.	been violated because of the positive findings of article 12.[404]

The committee made the following recommendations: (a) that L.C. be compensated for the damages she suffered because of the human rights violations in order to improve her quality of life; (b) a review of Peru's laws which promote access to therapeutic abortions which promote physical and mental health; (c) for training to be provided to health practitioners in all health facilities to ensure compliance with CEDAW and General comment no.24 of CEDAW; and (d) decriminalisation of termination procedures performed as a results of rape or sexual abuse.

At a regional level, it is much more difficult to implement sexual and reproductive health rights. This is owing to the fact that the Maputo Protocol is not supported by a committee protecting women's rights in Africa.[405] Further to this, there is no specialised platform for women in Africa to address human rights violations relating to sexual and reproductive health as the protocol relies on the generic protection of human rights, founded by the African Charter.[406] This Charter established an African Commission on Human and People's Rights (hereinafter referred to as the commission) and the duty of this commission is to ensure the protection of human rights in Africa.[407] A fundamental flaw with this Commission is that it generally accepts communication on human rights violations from states as opposed to individuals.[408] Prior to accepting communication from individuals, the secretary of the commission is required to present such communication to other members of the commission, who may then decide to consider such communication.[409] The commission has received and resolved over 400 communications, however, it has only presided on 10 matters relating to women's rights.[410] The majority of this communication deals with sexual

[403] Supra.
[404] Supra.
[405] A Rudman 'Women's access to regional justice as a fundamental element of the rule of law: The effect og a women's right committee on the enforcement of the African women's Protocol' (2018) 18 *African Human Rights Law Journal* 323.
[406] Ibid, 323.
[407] African Charter op cit note 286, Article 30.
[408] Supra, Article 47.
[409] Supra, Article 55.
[410] A Rudman op cit note 405 at 331.

violence and, to-date, no communication has been received on sexual and reproductive health care.

The African Court on Human and People's Rights (hereinafter referred to as the African Court) was established after the Commission and may also be used to address human rights violations. This court was established pursuant to Article 1 of the Protocol to the African Charter on Human and People's rights, which came into effect in January 2004.[411] 31 states, including South Africa, have ratified the protocol. However, only 6 of the 31 states have recognised the African Court's competence to receive cases from NGO's and individuals.[412] These 6 states are Burkina Faso, The Gambia, Ghana, Mali, Malawi and Tunisia.[413] In this regard, South African individuals do not have direct access to this court and South African matters may only be heard in this court when they have been referred by the Commission, or when a member of South Africa is a victim of huma rights violations, alternatively, where the case was brought by an Intergovernmental organisation.[414] It does not come as a surprise, therefore, that notwithstanding violations of women's rights in the African continent, the African court has not passed any judgment enforcing any rights in the Maputo Protocol since its adoption almost eighteen years ago.[415] The Judge-President of the African court, Oré J, has expressed his concern by stating the following:

> [I]n spite of the massive ratification of the [African Women's Protocol] on the rights of women, expectations about the volume of litigation have been disappointing … [t]his … is disappointing in view of the serious violations experienced by African girls and women.[416]

Therefore, although the African Region has numerous instruments which sought to protect health rights, the enforcement of these rights is difficult for ordinary women in Africa. Further to this, international law requires victims of human right violations to

[411] African Court on Human and People's Rights available at https://www.african-court.org/wpafc/welcome-to-the-african-court/, accessed on 8 June 2021.
[412] Ibid.
[413] Ibid.
[414] Ibid.
[415] A Rudman op cit note 405 at 323.
[416] Ibid, 323.

exhaust all domestic remedies before relying on international remedies.[417] Therefore, accessing international health rights is a lengthy and complicated process which may discourage women from accessing such health rights.

2.6.4. The use of international law to enforce sexual reproductive health raises many complexities for African women

Women's human rights may only be realised if they have access to justice.[418] Ngwena has argued that it is inadequate to merely repeal laws that criminalise terminations of pregnancies.[419] It has already been established that regional instruments limit one's right to terminate to specific grounds.[420] It has also been stablished that accessing health care rights through the structures created by the regional framework proves to be difficult for women in Africa as these frameworks are focused on member states as opposed to individuals. It does not come as a surprise, therefore, that Africa continues to suffer the burden of sexual and reproductive ill health.[421] For instance, 1 in 39 women are likely to die from childbirth in Africa, compared to other counties such as Malta were the odds are 1 in 3600 women.[422] The reasons for this are as follows: firstly, there is a lack of political will from African governments in meeting the health needs of Africans;[423] secondly, many African communities place a large emphasis on marriage and motherhood for women,[424] therefore, women are expected to be fertile and to have children soon after getting married (sexual and reproductive autonomy rights are not respected)[425]; thirdly, various factors such as the low status of women (male primogeniture), limited resources to address sexual and reproductive health care, and the attitudes of health care workers.[426]

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[417] Rudman op cit note 405 at 321.
[418] Ibid, 320.
[419] Ngwena (2004) op cit note 31 at 331.
[420] Durojaye op cit note 263 at 398.
[421] Ibid, 401.
[422] Ibid, 399.
[423] Ibid, 401.
[424] S Bi & T Klusty 'Forced sterilisation of HIV Positive women: A Global Ethics and Policy Failure' (2015) 17(10) *American Association of Journal Ethics* 954.
[425] Ibid, 954. Also see Haroz op cit note 87 at 875 where it is argued that the payment of lobola often symbolizes that such a woman may not refuse her husband's sexual advances. The results of such a belief is that a woman's right to make any decisions concerning reproduction are taken away.
[426] V Balogun & E Durojaye 'The African Commission on Human and Peoples' Rights and the promotion and protection of sexual and reproductive health' (2011) 11 *African Human Rights Journal* 383 – 384. Also see E Haroz op cit note 86 at 874 where it is indicated that women who adhere to traditional

2.7. CONCLUSION

The right to reproductive health has undoubtedly been protected in a number of regional and international instruments. The issue, however, is not the lack of recognition of the right to health. The greatest challenge to the implementation of this right by African States through the implementation of a detailed framework.[427] This begs the question: has the South African government taken appropriate and adequate steps to ensure that reproductive health care is accessible to an average South African woman? The South African reproductive framework will be discussed in Chapter 3.

customary law principles are regarded as perpetual minors. Therefore, such women are unable to make their own reproductive choices.

[427] Ngwena (2004) op cit note 31 at 331.

CHAPTER 3

THE LEGAL FRAMEWORK DEALING WITH SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN SOUTH AFRICA

3.1. INTRODUCTION

The purpose of this chapter is to describe the South African legal framework regulating termination of pregnancies and sterilisations. This will be achieved through a critical analysis of the Constitutional protection of reproductive health rights[428] the Choice Act[429] as well as the Sterilisation Act[430]. This chapter will also consider specific provisions of the National Health Act[431] in so far as it has an impact on termination and sterilisation services. Lastly, this chapter will consider the guidelines provided by the Health Professions Council of South Africa.

3.2. CONSTITUTIONAL PROTECTION OF REPRODUCTIVE HEALTH

The South African transition to a democracy in the early 1990's created an opportunity for women to successfully claim equality and reproductive health choice.[432] A combination of advocacy by civil society organisation as well as pressure from ANC feminists led to the constitutional protection of reproductive health.[433] The Constitution of the Republic of South Africa is supreme and all other laws must be measured against it.[434] Reproductive health rights are advanced in a number of sections including; section 12(2) which protects the right to psychological and bodily integrity.[435] This protection extends to one's freedom to make decisions regarding reproductive

[428] Constitution of the republic of South Africa, 1996.
[429] 92 of 1996.
[430] 44 of 1998.
[431] 61 of 2003.
[432] Albertyn op cit note 74.
[433] Ibid.
[434] Section 2 of the Constitution. Also see D McQuoid-Mason 'Freedom of conscience, termination of pregnancy and the duty to refer and not prevent of obstruct access to termination of pregnancy under the Choice on Termination of Pregnancy Act: A clarification' (2011) 4(1) *South African Journal of Bioethics and Law* 6.
[435] Section 12(2) of the Constitution. Also see M du Tolt 'Involuntary Sterilisation of HIV-positive women in South Africa: A legal perspective' 2018 11(2) *South African Journal of Bioethics Law* 81.

health which includes security and control over their bodies.[436] This was confirmed by Judge Majapelo in *Christian Lawyers Association v Minister of Health and Others* (hereinafter referred to as *Christian Lawyers*, 2005).[437]: He noted that the right to terminate is protected by the South African Constitution in two ways: firstly, section 12(2)(a) protects one's right to bodily and physical integrity and such right includes the right to terminate; secondly, section 12(2)(b) states that everyone has control over their bodies. It has also been argued that the right to bodily integrity underlies the right to seek and obtain medical care.[438] The enforcement of this right is also enshrined in 27 which protects the right to reproductive health care and burdens the state with the responsibility of progressively realising this right.[439]

This right is also recognised in other Constitutional provisions such as section 9[440] which protects the right to equality, section 10 which protects the right to dignity, section 11 which protects the right to life, and section 14 which protects the right to privacy, as well as section 27 which protects the right to reproductive health care.[441] These rights are relevant to sexual and reproductive health for the following reasons: (1) as women are natural bearers of children, they may only achieve equality if they have control over their reproductive health;[442] (2) the right to privacy is instrumental in a patient's access to reproductive health as there is a high likelihood that a patient will not access such services if their privacy is not guaranteed;[443] (3) providing women with reproductive health care services promotes their right to life as it sometimes prevents death with may result from, *inter alia*, future pregnancies or unsafe termination of pregnancy;[444] (4) lastly, the right to dignity is of particular important as

[436] Section 12(2)(a) and (b) of the Constitution. Also see C Albertyn op cit note 74 at 431 and Z Essack & A Strode '"I feel like half a woman all the time": The impacts of coerced and forced sterilisations on HIV-positive women in South Africa' 2012 26(2) *Agenda* 25.
[437]Reproductive Health Alliance as amicus curie 2005 (1) SA 509 (T).
[438] M Pieterse 'The Interdependence of rights to Health and Autonomy in South Africa' (2008) 125(3) *South African Law Journal* 580.
[439] Constitution of the Republic of South Africa, 1996. Also see C Albertyn op sit note 74 at 435, O Savage-Oyekunle & A Nienaber 'Adolescent girls' access to contraceptive information and services in South Africa: What is going wrong?' (2015) 78 *Journal for Contemporary Roman Dutch Law* 368, and DJ McQuoid-Mason 'Are the restrictive provisions of sections 2(1)(c) and 5(5)(b) of the Choice on Termination of Pregnancy Act 92 of 1996 unconstitutional?' 2006 31(1) Journal for Juridical science 122.
[440] Also see Christian Lawyers, 2005.
[441] Constitution of the Republic of South Africa, 1996. Also see C Albertyn op sit note 74 at 435, Savage-Oyekunle (2016) op cit note 439 at 368, and McQuoid-Mason op cit note 439 at 122.
[442] ICESCR op cit note 176.
[443] Savage-Oyekunle (2015) op cit note 439 at 375.
[444] As discussed in Chapter 1, reproductive health care is sometimes necessary to save a pregnant women's life.

it is the 'characteristic that gives a person intrinsic worth'.[445] The right to reproductive health care is therefore linked to this rights as it protects the dignity of pregnant women who may not be ready to accept the role of motherhood and who may not have the ability to provide their children with basic needs.

Turning to children's reproductive health care, section 28(1)(c) realises a child's right to basic health care.[446] This entails that as reproductive health care forms part of the mainstream right to health, children also have the right to reproductive health care. Section 28(2) also prescribes that a child's best interests is of paramount importance in every matter concerning the child.[447] This was confirmed in the case of *Van Deiji v Van Deiji*[448] where the court held:

> The interest of the minor means the welfare of the minor and the term welfare must be taken in its widest sense to include economic, social, moral and religious considerations. Emotional needs and ties of affection must also be taken into account and, in the case of older children, their wishes in the matter cannot be ignored.[449]

In interpreting the reproductive health rights, one has to promote the values that underlie an open and democratic society based on equality, human dignity and freedom and must consider international law.[450]

3.3. THE STATUTORY FRAMEWORK ON SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

3.3.1. The Choice of Termination of Pregnancy Act, 92 of 1996

3.3.1.1. <u>The importance of the Choice Act</u>

As already outlined in Chapter one, the repealed Abortion Act failed to decriminalise abortions. Instead, it sought to prevent as many women as possible from accessing termination services.[451] Constitutional rights such as the right to equality, dignity,

[445] Savage-Oyekunle (2016) op cit note 439 at 369.
[446] Section 28 of the Constitution.
[447] Supra, Section 28(2).
[448] 1966 4 SA 260.
[449] 1966 4 SA 260, para 261H.
[450] Supra, Section 39(1).
[451] Ngwena op cit note 31 at 341.

privacy and freedom and security of the person in the interim Constitution, as well as the ratification, by South Africa, of international instruments protecting sexual and reproductive health choices led to the enactment of the Choice Act.[452] The following paragraphs are a study of the changes brought by the Choice Act. Such a discussion will also compare some of these changes to the provisions of the repealed Abortion Act. Notably, this act also protects children's reproductive rights by providing that a woman, as referred to in the Act, includes a female person of any age.[453] As such, the discussion of the Choice Act in the below paragraphs also relates to women below the age of 18.

3.3.1.2. Dramatic shift in termination of pregnancy laws: promoting the spirit, purport and objects of the Bill of Rights

The short title of this Act, being the 'Choice on Termination of Pregnancy Act', brought a radical change to the previous termination of pregnancy laws as it removes the term 'abortion' and places an emphasis on a pregnant women's 'choice' to terminate.[454] It is clear from the onset that pregnant women have autonomy over their bodies. The term 'abortion' was also replaced by the phrase 'termination of pregnancy'. This change displays the legislature's conscious decision to a move away from the old terminology which was associated with immorality and illegality.[455] The long title of the Act indicates that it aims is to determine the circumstances in which a pregnancy may be lawfully terminated, and to regulate termination of pregnancy.[456]

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[452] C Humonga & A Cooke 'A Child's Autonomy with special reference to reproductive medical decision-making in South African Law: Mere illusion or Real autonomy' (2007) 15 *International Journal of Children's Rights* 325.

[453] Section 1 of the Choice Act 92 of 1996 (hereinafter referred to as the Choice Act). Reproductive health rights are particularly important when it comes to children and teenagers as sexual intercourse is quite prevalent among teenagers, with almost half of them admitting to being sexually active before grade 12. Also see N Rajoo 'Adolescents, contraceptives and termination of pregnancy' (2018) 28 Obstetrics and Gynaecology Frorum 19. Research has indicated that, annually, approximately 16 million pregnancies and 3 million termination of pregnancies, worldwide, may be attributed to sexual intercourse involving teenagers. Such information confirms that children are indeed sexually active and, as such, they need access to contraceptives in order to prevent early pregnancies and sexually transmitted diseases.

[454] F Van Oosten 'The Choice on termination of Pregnancy Act: some comments' (1999) 116(1) *South African Law Journal* 60 (hereinafter referred to as Some comments on the Choice Act).

[455] Ibid, 60.

[456] The Choice Act, long title.

The legislature emphasises the importance of the right to dignity, equality, and security of the person.[457] Further to this, it acknowledges the Constitutional protection of sexual and reproductive health rights which includes security and control over one's body.[458] The importance of having access to safe, effective and affordable fertility control methods of one's choice is emphasised as sexual and reproductive health rights may only be achieved if persons are informed and have access to reproductive health care services.[459] The preamble also recognises that a woman's decision to have children is directly linked to her physical, psychological and social health, therefore, reproductive health care services include family planning, contraceptives, termination of pregnancy, access to information and counselling programmes.[460] The state has a responsibility to provide reproductive health care to all South Africa citizens and to ensure that sexual and reproductive health care rights are exercised in a safe environment, without fear or harm.[461] Notably, the preamble outlines that termination of pregnancy is not a form of contraceptive.[462]

3.3.1.3. Circumstances and conditions under which a woman may terminate her pregnancy:

Before considering the circumstances under which a pregnancy may be terminated, it is important to take note of the following definitions. The Act defines a termination of pregnancy as the use of medical or surgical means to separate and expel the contents of a pregnant woman's uterus.[463] It is submitted that the legislature carefully worded this section by refraining from using words such as foetus and/or baby. The Act also defines a woman broadly enough to include minor females.[464] It is important, therefore, for this dissertation to consider the protection of minor's reproductive health care.

Section 2 of the Act introduces a trimester framework by separating the right of pregnant women to terminate into three stages. This framework did not exist in the

[457] Supra, Preamble.
[458] Supra.
[459] Supra. Also see Humonga op cit note 452 at 325.
[460] Supra.
[461] Humonga op cit note 452 at 325. Also see Savage-Oyekunle (2016) op cit note 439 at 375 and D McQuoid-Mason (2011) op cit note 434 at 6.
[462] Preamble of the Choice Act.
[463] Section 1 of the Choice Act.
[464] Supra.

repealed abortion Act[465] and a pregnancy could be terminated at any stage of the gestation period.[466] At the first stage,[467] a pregnant woman has the choice of terminating during the first twelve weeks of her pregnancy by simply requesting the termination procedure.[468] At this stage, she does not even have to provide reasons for the termination, she has complete autonomy over her body.[469] Such termination may be performed by a medical practitioner or a registered midwife.[470] This provision is welcomed as the repealed Abortion Act only permitted terminations of pregnancy is certain cases such as incest, rape or life threatening conditions.[471]

The second stage[472] regulates the right to terminate between thirteen and twenty weeks.[473] At this stage, a pregnant woman may terminate her pregnancy if: (1) there is a risk of injury to her physical and/or mental health; (2) there is a great risk that the foetus will suffer grave physical and/or mental abnormality; (3) where her pregnancy is a result of rape and/or incest; alternatively, (4) if the continued pregnancy would have a negative impact on her social or economic circumstances[474]. This provision is welcomed because, compared to the repealed Abortion Act, victims of rape are not required to provide any documentation in order to access termination services.[475] What is also clear from this section is that there is a limitation on reproductive health choices as the Act shifts from a pure autonomy to a medical or social criteria approach.

The third and final stage of this Act regulates the termination of pregnancy after 20 weeks.[476] The autonomy of women to terminate is extremely limited at this stage as

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[465] Abortion and Sterilisation Act 2 of 1975.
[466] McQuoid-Mason (2006) op cit note 439 at 122.
[467] Section 2(1)(a) of the Choice Act. Also see K Turner, A Hyman & M Gabriel 'Clarifying Values and Transforming Attitudes to Improve Access to Second Trimester Abortion' (2008) 16 (31) *Reproductive health matters* 108.
[468] Section 2(1)(a) of the Choice Act. Also see Guttmacher op cit note 82 at 191, and M Stevens & M Xaba M 'Choice on Termination of Pregnancy Act 1996: Republic of South Africa' (1997) 5(9) *Reproductive Health Matters* 116.
[469] Supra, Section 2(1)(a). Also see Humonga op cit note 452 at 327 and Van Oosten op cit note 454 at 65.
[470] Haroz op cit note 86 at 887.
[471] E Nohaji & E Yako 'Attitudes of midwives towards the implementation of the Choice on Termination of Pregnancy Act' (2014) 20(1) *African Journal for Physical, Health Education, Recreation and Dance* 226.
[472] Section 2(1)(b) of the Choice Act.
[473] McQuoid-Mason (2006) op cit note 439 at 122. Also see Stevens op cit note 468 at 117.
[474] Section 2(1)(b) of the Choice Act. Also see Humonga op cit note 452 at 327 and Guttmacher op cit note 83 at 193.
[475] Guttmacher op cit note 82 at 193. Also see Van Oosten op cit note 454 at 69.
[476] Section 2(1)(b) of the Choice Act. Also see Stevens op cit note 468 at 117.

she may not terminate her pregnancy as a result of her socio-economic circumstances, as well as on the grounds of rape and/or incest.[477] At this stage, the medical practitioner is not required to consult with the pregnant woman. Instead, he/she is required to consult with another medical practitioner or a registered midwife. The grounds for termination are strictly based on health reasons rather than reproductive choice. Although this section does not require the medical practitioner to consult with the pregnant woman, such medical practitioner will have to obtain the pregnant women's consent as contemplated in section 7 of the National Health Act.[478]

The fact that, at the first stage of the pregnancy, a termination procedure may be carried out by a medical practitioner, a registered nurse who has completed the relevant training course, or by a registered midwife, creates more scope and makes it easier for a woman to terminate in this stage. In the second and third stages, the termination may only be carried out by a medical practitioner.[479] This section has the effect of limiting the number of health care workers who may perform termination services. This provision is an appropriate balance based on public policy to ensure that skilled medical practitioners carry out termination procedures in later stages of pregnancy.

3.3.1.4. Reproductive autonomy is supported by providing women with the option to obtain counselling

Section 4 of the Act makes it clear that it is not compulsory for women to undergo counselling before and/or after the termination procedure.[480] It is evident, therefore, that the procedural restrictions of the repealed Abortion Act taught the legislature an important lesson, i.e. legislation which seeks to expand the grounds for termination while, in the same breath, frustrating the process is ineffective when it comes to promoting reproductive health. Section 6 of the Act also provides that a woman who requests a termination procedure must be informed of her rights in terms of the Act.[481] It is important to draw a distinction between counselling and informed consent. On the

[477] Guttmacher op cit note 82 at 193.
[478] The National Health Act 61 of 2003.
[479] Section 2(2) of the Choice Act. Haroz op cit note 86 at 888.
[480] Supra, Section 4 Also see M Stevens op cit note 459 at 117 and Haroz op cit note 86 at 888.
[481] Supra, Section 6. Also see Stevens op cit note 468 at 118.

one hand, it is not mandatory for women seeking to terminate to undergo counselling. On the other hand, medical practitioners are required to provide pregnant women with all the relevant information for the termination procedure. The wording from section 6 of the Health Act suggests that 'informed consent' relates to the medical and procedural aspects of the termination. This entails that women should not be coerced into counselling on the basis of 'informed consent' if they opt not to not be counselled. The consequences of these provisions will be discussed in greater details in chapter 4 of this dissertation.

3.3.1.5. A pregnancy may only be terminated once the pregnant women has provided her informed consent

Section 5 promotes a woman's physical and bodily integrity by providing that a pregnancy may only be terminated after the pregnant woman has given her informed consent.[482] Further to this, only the pregnant woman is required to provide such consent therefore, third party authorisation is not required.[483] The only exception to third party authorisation is where the pregnant woman does not have capacity to act.[484] With regards to a minor's consent to such termination, section 5(3) provides that health care workers must advise minors to consult with their parents, guardians, family members or friends before the pregnancy is terminated.[485] A minor's reproductive rights must not be denied if she chooses not to consult with the aforementioned people.[486] The application of this provision will be discussed in greater detail in the next chapter.

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[482] Supra, Section 5(1).
[483] Supra, Section 5(2).
[484] Supra, Section 5(4).
[485] Section 5(3) of the Children's Act. Also Guttmacher op cit note 82 at 193 and Haroz op cit note 86 at 888.
[486] Section 5 of the Choice Act. Subsection 4 and 5 regulates termination procedures for women who are severely mentally disabled or those who are in a state of unconsciousness with no reasonable prospects of gaining consciousness in term to terminate a pregnancy. As such women do not have the ability to chose to, or not to, undergo termination procedures. As this thesis is centred around the exercise of 'autonomy' by pregnant women, it will not unpack terminations of women who are not capable of giving consent. Also see C Morroni, G Buga & L Myer 'Understanding Aspects of the Termination of Pregnancy Legislation' (2006) 24(1) *Continuing Medical Education* at 38.

3.3.1.6. Protecting the patient's right to privacy

As mentioned in chapter 1 of this thesis, the repealed Abortion Act required medical practitioners to provide a report with detailed information about the abortion procedure, including the name, surname, sex, race, marital status, place where the procedure took place, the reasons for the procedure, as well as the details of the practitioner who operated on the patient.[487] The purpose of this report was to identify and punish women who received abortion procedures, as well as practitioners who provided termination procedures.

Section 7(3) of the Choice Act provides that the person in charge of a facility which provides abortion services needs to collate and provide the 'prescribed information' to the relevant Head of Department within one month of the termination procedure.[488] Such information shall exclude the women's identity and place of residence, unless the women choses for their names to be disclosed.[489] This is a dramatic change from the repealed Abortion Act which sought to identify everyone who has participated in a termination procedure and has the effect of encouraging women to seek termination services without fear of being exposed. This promotes the Constitutional right to privacy, equality and non-discrimination.

3.3.1.7. Penalties for offences

Section 10(1) of the Act provides that the following persons are guilty of an offence and are liable on conviction to a fine or imprisonment not exceeding 10 years: those who perform termination services even though they are not authorised to do so; persons who terminate or allow for a pregnancy to be terminated in a facility not approved by the Act; lastly, those who prevent a woman from accessing a lawful termination of pregnancy.[490] Further to this, Section 10(2) of the Act further strengthens confidentiality by providing that any person who contravenes the provisions of section 7 (discussed above) may be subjected to a fine or imprisonment not exceeding six months.[491] The word 'any person' extends liability to every health

[487] Supra.
[488] Section 7(3) of the Choice Act.
[489] Supra.
[490] Supra Section 10(1). Also see Haroz op cit note 87 at 889.
[491] Supra, Section 10(2). Also see Haroz op cit note 87 at 889.

care worker working in the termination facility. This section is welcomed is it strengthens women's reproductive autonomy right.

3.3.2. The Sterilisation Act 44 of 1998

3.3.2.1. The importance of the Sterilisation Act

As discussed in Chapter 1, the repealed abortion and sterilisation Act did not provide a legal framework for sterilisation services and only regulated sterilisations in so far as they related persons who did not have capacity to consent. In this regard, sterilisation procedures were largely regulated by the common law. Therefore, the enactment of the sterilisation was necessary in creating a legal framework for sterilisation services.

3.3.2.2. The Sterilisation Act was enacted to promote the spirit, purport and objects of the Bill of Rights

The long tittle of the Sterilisation Act provides that it seeks to determine the circumstances under which a sterilisation procedure may be performed[492]. This is an important provision because, as previously mentioned in chapter 1 of this dissertation, the repealed Abortion and Sterilisation Act only regulated sterilisation for persons incapable of consenting.[493]

In its preamble, the Act recognises the constitutional right to bodily and physical integrity.[494] This provision is welcomed because it promotes and protects reproductive autonomy by allowing people to have control over their bodies and make decisions about their fertility. The Act also recognises people's right to receive information about their reproductive rights, and to be able to exercise such rights through safe and legal fertility regulation methods. Sterilisation is defined as 'a procedure whereby a person could be permanently rendered incapable of fertilisation or reproduction'.[495]

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[492] Preamble of the Sterilisation Act 44 of 1998.
[493] Supra, Section 4.
[494] Supra, Preamble.
[495] Supra, Section 1. Also see C Pickles 'Involuntary contraceptive sterilisation of women in South Africa and the criminal law' 2016 (2) *South African Journal of Criminal Justice* 92.

3.3.2.3. <u>The Act promotes a Patient's reproductive autonomy rights by proving access to information and consent to sterilisation</u>

Section 2 of the Act regulates people's rights to consent to be sterilised. It provides that person's may be sterilised if they are above the age of 18 and have capacity to consent. [496] This Act therefore protects and promotes a patient's reproductive autonomy and the right to physical and bodily integrity.[497] Persons who are capable of consenting may not, under any circumstance, be sterilised without their consent.[498] Persons under the age of 18 may only be sterilised if such sterilisation is necessary to preserve their life.[499] As this section allows only people who are 18 years or above to be sterilised, the sterilisation of minors for purposes of fertility control is prohibited. In contrast, the Choice Act allows for termination procedures to be performed by anyone, including pregnant minors.

Further to this, the Act strictly provides that persons capable of consenting do not require third party authorisation.[500] The Act does not define persons who are capable of consenting. However, as discussed earlier in this chapter, a person is cable of consenting if they have reached a certain level of intellectual development, which allows them to understand and appreciate the nature and consequence of such sterilisation procedure.[501] The act defines consent in the following manner: firstly, consent has to be given freely and voluntarily without undue influence; secondly, it needs to provide adequate and clear information about the proposed plan of the procedure, the risks, consequences and irreversible nature of sterilisation procedures; thirdly the patient must be aware that he or she has the right to withdraw such consent

[496] Section 2(1) of the Sterilisation Act. Also see C Badul, A Strode & P Singh 'Obtaining informed consent for a sterilisation in the light of recent case law' (2018) 108(7) *South African Medical Journal* 557. Also see A Strode, S Mthembu & Z Essack '"She made up a choice for me": 22 HIV-positive women's experiences of involuntary sterilisation in two South African provinces' (2012) 20(39) *Reproductive health matters* 62.
[497] Pickles (2016) op cit note 495 at 92.
[498] Section 2(2) of the Sterilisation Act.
[499] Section 3(2)(a) of the Sterilisation Act. In such a case a medical practitioner is required to examine such a minor and confirm that a sterilisation procedure would be in their best interests. Consent to the sterilisation of a minor may be provided by someone who is entitle to provide such consent (example: parent or guardian).

[501] H Kruger & Skelton, A *The Law of Persons in South Africa* (2015) at 63.

any time before the sterilisation, and; lastly, patient must understand and sign the prescribed consent form.[502]

The WHO has also identified the following important pieces of information to be provided to a patient before a sterilisation: (1) patients must be informed that sterilisation is a surgical procedure; (2) there are both risks and benefits to sterilisation procedures; (3) sterilisation will prevent future pregnancies; (4) the sterilisation procedure may not be reversed; (5) refusing to be sterilised will not result in a loss of any benefit; (6) there are alternate contraceptive methods which are not permanent.[503]

3.3.2.4. Protecting the patient's right to privacy

In relation to confidentiality and record keeping, section 6 of the Act provides that the person in charge of a facility designated to conduct sterilisation procedures must be notified and keep a record of every sterilisation that has taken place in such a facility.[504] The Act is silent about whether such records must include the name and residential address of all persons who have undergone a sterilisation procedure.

3.3.2.5. Penalties for breach

Section 9 provides that any person who fails to comply with the provisions of this Act may be fined or sentenced to imprisonment not exceeding five years.[505]

3.3.3. National Health Act 61 of 2003

3.3.3.1. Importance of the National Health Act

This Act is the backdrop for all health care legislation. The long title of the Act provides that it aims to provide a health framework which takes into account the obligations

[502] Section 4 of the Sterilisation Act. Also see M du Tolt op cit note 435 at 81; Badul et al 496 at 557 and Strode (2012) et al 436 at 62.
[503] C Badul & A Strode 'LM and Others v Government of Namibia: The first sub-Saharan African case dealing with coerced sterilisation of HIV-positive women – *Quo vadis*?' (2013) 3 *African Human Rights Journal* 223.
[504] Sterilisation Act, section 6.
[505] Supra, section 9.

imposed by the Constitution as well as other national legislation regulating health care services.[506] The preamble of this Act acknowledges the state's obligation, as provided in section 27(2) of the Constitution, to take reasonable legislative an other measures within its available resources to progressively realise South African's right to health care, which includes reproductive health care.[507] According to section 4(3)(b), states and clinics funded by the state must provide women with free termination services in accordance with the Choice Act.[508]

3.3.3.2. The patient's right to know

A patient's right to have access to information is regulated in section 6 of the Act which places an obligation on health care practitioner to provide the following information to a patient: details relating to the patient's status, except in cases where such details are against the patient's interests; the range of treatment options that are available to the patient; the associated risks, costs and consequences of each option; as well as the patient's right to refuse health care services and the risk associated with such a refusal.[509] Section 6(2) of the Act requires the aforementioned information to be communicated with the patient in a language that the patient understands, having due consideration of the patient's level of literacy.[510]

3.3.3.3. The Act promotes reproductive autonomy by promoting a patient's consent to health services

In addition to a patient's right to access to information, this Act recognises a patient's right to consent and participate in medical decisions.[511] Section 7(1) provides that health care services may not be provided without the patient's consent, unless the patient does not have capacity to consent, is unable to provide such consent, failure to treat the patient will cause serious risk to the public, or, a delay in health services might result in the death of the patient.[512] A health care provider has a duty to take all reasonable steps to obtain the patient's informed consent.[513] Informed consent is

[506] National Health Act 61 of 2003.Also see Savage-Oyekunle (2016) op cit note 439 at 376.
[507] Preamble of the National Health Act.
[508] Supra, Section 4(3)(c).
[509] Supra, Section 6(1). Also see M du Tolt op cit note 435 at 81.
[510] Supra, Section 6(2).
[511] Savage-Oyekunle (2016) op cit note 439 at 377.
[512] Section 7(1) of the National Health Act. Also see M du Tolt op cit note 435 at 81.
[513] Supra, Section 7(2).

defined as the: (a) consent to receive a specific health service by a patient who has the legal capacity to do so; and (b) who has received all the information relating to such a health service as contemplated in section 6 of this Act.[514]

3.3.3.4. Confidentiality of a patient's health records

According to section 14(1), a patient's information concerning his or her health status, treatment or stay in a national establishment is confidential and may only be disclosed where a patient has consented to such disclosure in writing; where a court orders for the disclosure of such information; alternatively, where a failure to discloses such information represents a serious threat to public health.[515]

3.3.3.5. Functions of the state to ensure compliance with the Health Act

Section 21 deals with general functions of the national department to ensure compliance with the national health policies.[516] The director general is required to ensure adherence to norms and standards on health matters which includes sterilisation and termination of pregnancy.[517] Municipalities also have a duty to ensure that health care services are effectively and equitably provided in their specific areas.[518] Further to this, the Minister of health has duty to upskill health care workers to ensure compliance with the national health systems.[519] This includes the duty to ensure that sufficient resources are available to educate and train health care professionals.[520] The minister also has a duty to identify shortages of skills, expertise and competencies within the South African reproductive health system.[521]

3.3.4. The Health Professions Council of South Africa (hereinafter referred to as the HPCSA) sets a standard of good practice for medical practitioners

In addition to the legislation discussed above, the HPCSA has provided legal practitioner with guidelines for good practice.[522] These guidelines provide that patients

[514] Supra, Section 7(3).
[515] Supra, Section 14. Also see Savage-Oyekunle (2016) op cit note 439 at 377.
[516] Supra, Section 21.
[517] Supra, Section 21(2)(b).
[518] Supra, Section 32(1).
[519] Supra, Section 52.
[520] Supra, Section 52(b).
[521] Supra, Section 52(d).
[522] HPCSA Guidelines for good practice, available at https://www.hpcsa.co.za/Uploads/Professional_Practice/Conduct%20%26%20Ethics/Booklet%204%2

must be provided with sufficient information to enable them to make and informed decision.[523] An emphasis is placed on effective communication and health care practitioners are encouraged to take appropriate steps to establish the patient's wishes.[524] Once the medical practitioner has established the patient's wishes, he or she may not exceed the scope of authority given by the patient, except in an emergency.[525] The HPCSA guidelines also specify that it is the responsibility of the health care practitioner providing treatment to ensure that the patient's informed consent has been obtained.[526] The health practitioner may delegate this authority to obtain the patient's informed consent however, he remains responsible for ensuring that the patient has been given sufficient information and opportunity to make an informed decision.[527] These guidelines also provide that where a patient has given written consent, the health practitioner must ensure that that the patient understands the details of the procedure and not simply rely on the consent form.[528]

3.4. CONCLUSION

The South African reproductive framework, as discussed above, recognises the importance of not only recognising and protecting reproductive health care, but also the enforcement of these rights. The South African legislature has also highlighted important elements in the protection of reproductive health rights. These elements are: (1) reproductive health care patients must be provided with the information they need in order to make an informed choice; (2) counselling is not mandatory; (3) third party authorisation is not necessary; (4) the patient's privacy must be protected as a breach in confidentiality could affect a patient's choice in receiving reproductive health care; (5) the state has a duty to provide access to reproductive health care services; (6) Persons who contravene reproductive autonomy law commit a crime. An analysis of the state's success in providing the rights set out above, and compliance with international standards will be discussed in great detail in chapter 4 of this dissertation.

0Informed%20Consent%20September%20%202016.pdf, accessed on 4 July 2021 (Hereinafter referred to as HPCSA Guidelines for good practice).

[523] Supra, 3.
[524] Supra, 3.
[525] Supra, 5.
[526] Supra, 7.
[527] Supra, 7.
[528] Supra, 12.

CHAPTER 4

GAPS AND THREATS IN THE SOUTH AFRICAN REPRODUCTIVE HEALTH FRAMEWORK

4.1. INTRODUCTION

The purpose of this chapter is to identify gaps and threats to the current reproductive rights legislative framework, which was discussed in the previous chapter. This will be achieved by using international and regional reproductive health norms as a yardstick to measure the protection of reproductive health at a domestic level. Thereafter, this chapter will consider how reproductive health laws are applied in practice with a view to expose systematic gaps and failures. Lastly, this chapter aims to highlight that the consequences of these gaps fall on the shoulder of poor South African women who cannot afford private reproductive health services.

4.2. THE CONSTITUTIONAL PROTECTION OF REPRODUCTIVE HEALTH RIGHTS: DOES IT COMPLY WITH INTERNATIONAL STANDARDS?

The discussion of the international protection of reproductive health care in chapter two has highlighted common standards of reproductive health care. These standards are determined by the recurring protection of specific rights in international law. The purpose of this section of the dissertation is to determine whether the Constitution of the Republic of South Africa meets these international standards in so far as reproductive health rights are concerned.

4.2.1. The right to health and access to reproductive health

As already mentioned in Chapter 2, Comment No.22 of the OPICESCR confirmed the fact that sexual and reproductive health forms part of the mainstream right to health.[529] The right to health is recognised in the UDHR, the ICESCR, CEDAW, the CRC, the

[529] A Strode et al op cit note 145 at 78.

African Charter, the Maputo protocol, the African Children's Charter as well as SADC Protocol.[530] International law also places a duty on states to take measures progressively realise reproductive health care by implementing policies and legislation.[531] The South African Constitution complies with international standards as it protects the right to reproductive health in section 27(1) of the Constitution and also imposes a duty on the state to progressively realise this right in section 27(2).[532]

4.2.2. The right to self-determination

The right to self-determination (also known as the right to physical integrity) includes the right to determine whether one wishes to have children. The right to determine the number and spacing of one's children and is protected in the UDHR, the ICCPR, CEDAW, the African Charter as well as the Maputo Protocol.[533] Likewise, the Constitution in Section 12(2) recognises the right to physical and bodily integrity which includes the right to make reproductive decisions and to have security over your body.[534] Therefore, the South African constitution complies with the international protection of the right to self-determination.

4.2.3. The right to dignity

International standards identify that the right to dignity as a fundamental right which affirms worth of the human person.[535] This right is an integral part of reproductive health care and is protected in the ICCPR, CEDAW, CRC, the African Charter, the Maputo Protocol, the Children's Charter, and the SADC Protocol.[536] The South African Constitution recognises this right in section 10 by providing that all persons have the right to dignity and to have their dignity respected and protected.[537]

4.2.4. The right to life

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[530] Article 12 of the UDHR, Article 12 of the ICESCR, Article 12 of CEDAW, Article 24 of the CRC, Article 16 of the African Charter, Article 14 of the Maputo Protocol, Article 14 of the African Children's Charter and Article 4 of SADC.
[531] Article 2 of ICESCR, Article 14 of the Maputo Protocol and SADC.
[532] Section 27 of the Constitution.
[533] Article 12 of the UDHR, Article 1 of the ICCPR, Article 16 of CEDAW, Article 20 of the African Charter and Article 14 of the Maputo Protocol.
[534] Section 12(2) of the Constitution.
[535] Preamble of the ICCPR and CEDAW.
[536] Preamble of the ICCPR, Preamble of CEDAW, Article 28 of CRC, Article 5 of the African Charter, Article 1 of the Maputo Protocol, Preamble of the Children's Charter, and Article 4 of SADC Protocol.
[537] Section 10 of the Constitution.

The right to life is protected in the UDHR, ICCPR, CRC, the African Charter, the Maputo Protocol, the Children's Charter and the SADC Protocol.[538] The Human Rights Committee, in general Comment no. 28 has outlined that the right to life extends to sexual and reproductive health rights.[539] The Constitution of the Republic of South Africa also states that everyone has the right to life.[540]

4.2.5. The right to equality and non-discrimination

The right to equality and non-discrimination is also a fundamental right in the promotion of reproductive health care. This right is protected in international and regional instruments such as the ICCPR, the ICESCR, CEDAW, the CRC, the African Charter, the Maputo Protocol, the CRC and the SADC Protocol.[541] Section 9 of the Constitution also recognises the right to equality as it provides that everyone is equal before the law and prevents the state from discriminating against anyone on specified grounds, which includes the ground of sex, gender and pregnancy.[542] The South African Constitution therefore, satisfies international standards in this regard.

4.2.6. The right of access to information

Access to information plays an important role in providing informed consent to receiving health care services.[543] The right of access to information is protected in the ICCPR, CEDAW, the CRC, the African Charter, the Maputo Protocol, the Children's Charter, and the SADC Protocol.[544] As outlined in the previous chapter, the right to access to information is protected in section 32 of the Constitution.[545]

4.2.7. The Child's best interests

[538] Article 3 of the UDHR, Article 6 of ICCPR, Article 6 of CRC, Article 4 of the African Charter, Article 4 of the Maputo Protocol, Article 5 of the Children's Charter, and Article 4 of SADC.
[539] Human Rights Committee General Comment No. 28: Article 3 (the equality right between men and women) available at http://ccprcentre.org/ccpr-general-comments, accessed on 13 June 2021.
[540] Section 11 of the Constitution.
[541] Article 2 and 28 of the ICCPR, Article 3 of the ICESCR, Preamble of CEDAW, Article 28 of the CRC, Article 18 of the African Charter, Article 8 of the Maputo Protocol, Article 12 of the CRC and the Preamble of SADC.
[542] Section 9 of the Constitution of the Republic of South Africa.
[543] Article 10 of CEDAW.
[544] Article 19 of ICCPR, Article 10 of CEDAW, Article 24 of CRC, Article 9 of the African Charter, Article 14 of the Maputo Protocol, Article 13 of the Children's Charter and Article 1 of the SADC Protocol.
[545] Section 32 of the Constitution.

Lastly, international standards recognise the child's best interests as being of paramount importance in all matters pertaining to the child. This is confirmed in the CRC and the Children's Charter.[546] Likewise, the Constitution of the republic of South Africa recognises this norm in section 28(2) of the Constitution.

In light of the above analysis, it appears that, for the most part, the South African Constitution does provide adequate protection to reproductive health care. It is interesting to note, however, that the Constitution does not protect the right to family.[547] This is despite the fact that this right is recognised in numerous international treaties.[548] The right to family and/or parental care is only referred to in section 28(1)(b) which deals with Children's rights.[549] The court in the case of Dawood v Minister of Home Affairs and Others has, however, indicated that the right to dignity extends to the right to have a family.[550]

4.3. THE SOUTH AFRICAN REPRODUCTIVE HEALTH LEGISLATIVE FRAMEWORK: DOES IT COMPLY WITH INTERNATIONAL AND CONSTITUTIONAL STANDARDS?

As discussed above, international and constitutional law has set common standards for the right to health and access to reproductive health. The below discussion seeks to identify gaps in the South African reproductive health framework by evaluating level of protection that the South African Legislature has afforded to the common standards identified above.

4.3.1. The right to health

As discussed in Chapter 3, the National Health Act recognised the right to health as well as the state's obligation to progressively realise reproductive health care.[551] This piece of legislation goes a step further and confirms that this right includes

[546] Preamble of the CRC and Article 4 of the Children's Charter.

[547] *Dawood and Another v Minister of Home Affairs and Others* 2000 (3) SA 936.

[548] Supra.
[549] Section 28(1)(b) of the Constitution.
[550] Dawood op cit note 547.
[551] Preamble of the National Health Act.

reproductive health care.[552] Article 21 provides that the Director-general must issue, and promote compliance to, norms and standards on health matters which include sterilisation and termination of pregnancy.[553] The Choice Act and the sterilisation Act created a legal framework for the enforcement of reproductive health care rights.[554] The preamble of the Choice Act identifies health care services to include family planning, termination services, contraceptives, access to information and counselling.[555] When it comes providing free health services, the National Health Act requires the state to provide free termination of pregnancy services.[556] The Act is silent on the free provision of sterilisation services. This is a gap in the South African reproductive framework as it does not guarantee equal access to sterilisation services. Therefore, the South African reproductive framework meets the international standard in so far as protecting reproductive health care. However, there may be unequal access to sterilisation services as the state does not have an obligation to provide free sterilisation services.

4.3.2. The right to self-determination

As discussed in the previous chapters, the right to self-determination includes the right to make reproductive health decisions which includes decisions on whether one wishes to have children and the number and spacing of such children.[557] The right to self-determination is therefore at the centre of reproductive autonomy. This right is advanced in section 8 of the National Health Act. This section protects the right of all persons to participate in decisions which have an impact on health as well as treatment.[558]

When it comes to the Choice Act, the purpose of this Act was to ultimately advance reproductive choice.[559] As discussed in Chapter 3, the Choice Act created a trimester framework for the termination of pregnancy. This framework has an impact on the right to self-determine as a woman's ability to make reproductive decisions is progressively

[552] Preamble of the National Health Act.
[553] Supra, Article 21.
[554] Preamble of the sterilisation Act.
[555] Preamble of the Choice Act.
[556] Section 4 of the National Health Act.
[557] Article 16 of CEDAW and Article 14 of the Maputo Protocol.
[558] Section 8 of the National Health Act.
[559] Preamble of the Choice Act.

limited as her pregnancy advances.[560] In the first trimester, women have complete reproductive autonomy and may opt to terminate without providing any reasons.[561] Such choice is, however, limited after 12 weeks. It will be recalled that a gap in the regional protection of sexual and reproductive health care was identified in Chapter 2 of this dissertation. This gap exists in the Maputo Protocol which limits the right to terminate to a specific category of women (I.e. where the pregnancy resulted from rape, incest, or where such termination is necessary to save a woman's life).[562] It appears that the Choice Act offers more protection to women as it protects reproductive autonomy.

Ferdinand van Oosten has argued that the provisions of the Choice Act are not consistent with the title of the Act.[563] He argues that the title 'Choice Act' seems to suggest that women have complete choice when it comes to terminating their pregnancies, however, the pregnant woman's unlimited choice to terminate is only present at the first stage of the pregnancy.[564] The majority of the provisions of the Act impose restrictions on the manner in which a pregnancy may be terminated.[565] He further highlights the fact that between 13 and 20 weeks, it is the medical practitioner who suggests (to the pregnant woman) that a pregnancy should be terminated, and likewise, after 20 weeks it is the medical practitioner who consults with another medical practitioner to determine whether such pregnancy should be terminated.[566] While this is indeed correct, the state has an interest in protecting the dignity of potential human life and in ensuring the safety of the pregnant woman. In this regard, the pregnant woman's right to choose had to be weighed against the state's interest.

Turning to the Sterilisation Act, as discussed in Chapter 3, the Preamble of the Sterilisation Act recognises constitutional right to physical and bodily integrity.[567] The Act permits persons over the age of 18, who are able to provide informed consent, to be sterilised by merely requesting to do so.[568] Therefore, this Act promotes

[560] Haroz op cit note 86 at 887.
[561] Van Oosten op cit note 454 at 62.
[562] Ebeku op cit note 302 at 31.
[563] Ibid, 74.
[564] Ibid, 74.
[565] Ibid, 74.
[566] Ibid, 74.
[567] Preamble of the Sterilisation Act.
[568] Supra, Section 2.

reproductive autonomy the right to self-determination. The Act does not allow children below the age of 18, however, to choose to be sterilised. As discussed in chapter 3, such children may only be sterilised if the procedure is necessary to preserve the health of such minor.[569] In this instance, a minor's autonomy to choose undergo a sterilisation procedure is limited.

From the above discussion, it is clear that the South African reproductive framework acknowledges and protects the right to physical and bodily integrity. However, one's autonomy over one's reproductive health is subject to limitation. The Constitutionality of the limitations set out above will be discussed later in this chapter.

4.3.3. The right to dignity

The right to dignity is protected in section 19 of the National Health Act which requires all health care providers to treat their patients with dignity.[570] The Preamble of both the Choice Act and the Sterilisation Act recognise the right to dignity as a cornerstone in the achievement of reproductive health care.[571] The South African reproductive legal framework therefore meets the Constitutional and international standards in so far as the right to dignity is concerned.

4.3.4. The Right to life

Reproductive health rights increases one's quality of life. In the context of termination of pregnancies, it can decrease the number of deaths relating to pregnancy and child-birth.[572] In the context of sterilisation procedures, it can advance a patient's mental and physical well-being. The National Health Act, in its preamble, recognises the need to improve the quality of life of all citizens.[573] The Choice Act Allows for a termination procedure to be performed in the late stages of gestation if such termination is necessary to save the life of the pregnant woman.[574] The Sterilisation Act also advances this right by allowing persons under the age of 18 to be sterilised if such sterilisation is necessary to save the life of the minor. Although the Choice Act has

[569] Supra, Section 3(2)(a).
[570] Section 19 of the National Health Act.
[571] Preamble of the Choice Act and the Sterilisation Act.
[572] Human Rights Committee General Comment No. 28 op cit note 165 at para 10.
[573] Preamble of the National Health Act.
[574] Section 2(1)(b) and 2(1)(c) of the Choice Act.

reduced the number of deaths due to abortions, a vast number of women continue to procure illegal terminations.[575] Septic abortions have been listed as one of the major causes of female deaths in South Africa.[576] It seems, therefore, that women continue to die as a result of unsafe termination of pregnancies despite the Constitutional and legislative protection of this right.

4.3.5. The right to equality and non-discrimination

The very nature of reproductive autonomy and reproductive health care is necessary in the advancement of equality among the sexes as women bear the responsibility of reproduction. The Preamble of the National Health Act acknowledges the importance of developing a health system based on equality.[577] Section 2 recognises the importance of the equitable division of health care services across the population of South Africa within the state's available resources.[578] The Choice Act also highlights the importance of equality and non-discrimination in so far as reproductive health care services are concern as an unequal distribution of these services could result in the majority of black poor women suffering the same consequences they suffered under the repealed Abortion Act (discussed in Chapter 1).[579] The sterilisation Act, on the other hand, recognises the right of both men and women to have access to sterilisation services.[580] The Act is silent on the equal distribution of sterilisation services. This is a gap which needs to be addressed by the legislature.

4.3.6. Right of access to information

The right of access to information is necessary in reproductive health care as patients many only consent to such services if they have access to all the relevant information. As already set out in chapter 3, section 6 of the National Health Act requires health care workers to provide patients with the necessary information, except to the extent where such information is harmful to the patient.[581] This information must be delivered

[575] Hodes op cit note 34 at 86.
[576] South Africa's National Policy Framework for Women Empowerment and Gender Equality, available at http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/94056/110252/F-221628375/ZAF94056.pdf, accessed on 8 July 2021.
[577] Preamble of the National Health Act.
[578] Supra, Section 2.
[579] Preamble of the Choice Act.
[580] Preamble of the Sterilisation Act.
[581] Section 6(1) of the National Health Act.

in a manner that will be understood by the patient.[582] Section 6 of the Choice Act also provides that a women requesting termination services must be informed of her rights as they relate to the Act.[583] Turning to sterilisation services, the Sterilisation Act requires patients to be informed about the nature and consequences of the sterilisation.[584] The 4 q3's Act also provides for children to have access to reproductive health information.[585] This information needs to be delivered in a manner that will be understood by the child.[586]

4.3.7. The child's best interests are of paramount importance

The Children's Act provides that the child's best interests are of paramount importance in all matters concerning the child.[587] Therefore, the South African legislature is in line with Constitutional and international instruments in this regard.

4.4. REPRODUCTIVE HEALTH CARE IN PRACTICE: GAPS IN THE APPLICATION OF THE CHOICE AND STERILISATION ACT

From the above discussion, it is evident that the South African legislature has considered international standards in drafting reproductive health legislation. South African reproductive autonomy laws are eminently progressive.[588] However, the lived experiences of South African women indicate a failure in implementing these laws. Some of these experiences are the forced sterilisation of HIV positive women, limited access to reproductive health care, and violations of patient's reproductive health rights. This section of the dissertation seeks to discuss the application of reproductive health laws. This will be achieved through an evaluation, of the application, of the essential elements of reproductive health care.

It will be recalled that the essential elements of reproductive health care were identified in Chapter three of this dissertation as : (1) reproductive health care patients must be

[582] Supra, Section 6(2).
[583] Supra, Section 6.
[584] Section 4 of the Sterilisation Act.
[585] Section 13 of the Children's Act.
[586] Supra, Section 13(2).
[587] Section 7 of the Children's Act.
[588] S Bi, & Klusty T, 'Forced Sterilisation of HIV positive women: A global Ethics and Policy failure' (2015) 17(10) *American Medical Association of Ethics* 952.

provided with the information they need in order to make an informed choice; (2) counselling is not mandatory; (3) third party authorisation is not necessary; (4) the patient's privacy must be protected as a breach in confidentiality could affect a patient's choice in receiving reproductive health care; (5) the state has a duty to provide access to reproductive health care services; (6) Persons who contravene reproductive autonomy law commit a crime.

4.4.1. Reproductive health care patients must be provided with the information they need in order to make an informed decision

The element of informed consent is important as it encourages rational decision making by allow the patient an opportunity to weigh and balance the advantages and disadvantages of the proposed medical intervention and to make an enlightened choice on whether to continue with such intervention.[589] Informed consent is based on the doctrine that an injury is not done to a willing person (*volenti non fit injuria*).[590] Reproductive health care services carried without the patient's informed consent may amount to human rights violations.[591] The court, in the case of Castell v De Greef, indicated that the requirements of informed consent include the following:

> a) The consenting party 'must have had knowledge and been aware of the nature and extent of the harm or risk';
> (b) The consenting party 'must have appreciated and understood the nature and extent of the risk';
> (c) The consenting party 'must have consented to the harm or assumed the risk';
> (d) The consent 'must be comprehensive, that is extend to the entire transaction, inclusive of its consequences'.[592]
> From the above, it is noted that consent is only informed where there is knowledge, agreement as well as appreciation of all the elements of the transaction including the consequences.[593]

[589] Van Oosten op cit note 454 at 72.
[590] Du Toit M 'Involuntary Sterilisation of HIV-positive women in South Africa: A current Legal perspective' 2018 11(2) *South African Journal for Bioethics Law* 82. Also see Strode (2012) et al 496 at 62.
[591] E Durojaye 'Involuntary Sterilisation as a form of violence against women in Africa' 2017 53(5) *Journal of Asian and African Studies* 721.
[592] 1993 (3) SA 401 (C).
[593] *Christian Lawyers Association v Minister* of Health 2005 1 SA 509.

Judge Mojapeloa confirmed the elements of informed consent when he the stated that the cornerstone of legal termination is informed consent of the pregnant women, regardless of her age.[594] He noted that the principle of informed consent forms part of our common law and has three elements, i.e. knowledge, appreciation and consent.[595] The element of knowledge is met when the pregnant woman is fully aware of the termination procedure, such knowledge includes knowledge of risk, harm as well as the extent of the procedure.[596] The element of 'appreciation' goes a step further as it requires the pregnant women fully comprehend the risk, harm as well as the extent of the procedure.[597] The last element of consent requires the woman to agree to the termination procedure after being fully informed.[598] A medical practitioner who fails to provide the pregnant woman with all the necessary information faces the risk of incurring liability for breach of contract, civil or criminal assault or injuria or negligence in delict.[599]

The Sterilisation Act prescribes that a patient's informed consent must be evidenced in writing.[600] The court in the case of LM v Namibia (discussed below) found that a patient's signature in a pre-populated consent form is not decisive of what information was given to a patient.[601] The court placed a duty on medical practitioner to show that a patient's consent was informed.[602] It is clear, therefore, that a pre-populated consent to sterilisation for may not be used as a tick-box by medical practitioners prior to performing a sterilisation procedure.

4.4.1.1. The practice of forced sterilisation of HIV Positive women in South Africa highlights gaps in the reproductive health legal framework

[594] Supra, para 515.
[595] Supra, para 515.
[596] Supra, para 515.
[597] Supra, para 515.
[598] Supra, para 515.
[599] Van Oosten op cit note 449 at 72.
[600] Strode (2012) et al 512 at 62 at 65.
[601] *Government of the Republic of Namibia v. L.M.* & 2 Others [2014] Case No. SA 49/2012, NASC 19 Namibia, Supreme Court (Hereinafter referred to as LM v Namibia)
[602] Strode (2012) et al op cit note 436 at 65.

Historically, there has been numerous instances where women were forcefully sterilised due to their social and/or economic standing in society.[603] Such sterilisation occurs when a person is sterilised without their knowledge, without informed consent or without the opportunity to refuse to undergo such sterilisation.[604] The Commission for Gender Equality has defined forced sterilisation as sterilisation which occurs when 'an individual is sterilised without their knowledge, coerced into giving consent, or consent is obtained based on false or incomplete information'.[605] During the period of 1870 and 1945 numerous countries passed legislation enabling them to forcefully sterilise their citizens.[606] The objectives of such sterilisation were initially to improve the genetic construction of humans and, overtime, it was practised as a means of birth control.[607] In recent times, women living with HIV and AIDS have been subjected to forced sterilisations for reasons which include, inter alia, prevention of mother-to-child transmission; that HIV positive women should simply not be having children; to prevent more children being left as orphans; lastly, pregnancy could be harmful to the woman's health status.[608] Such sterilisation procedures have become dominant in the African continent and, in particular, South Africa.

Strode, Mthembu and Essack published a study in 2012 which identified 22 women who were involuntarily sterilised in Gauteng and KwaZulu-Natal between 1996 and 2010.[609] This led to a women's advocacy organisation lodging a complaint with the Commission for Gender Equality(hereinafter referred to as the Commission) on behalf of 48 women who had been sterilised involuntarily in 2015.[610] These matters could not be heard in a court of law as they had prescribed.[611] The Commission released a

[603] Durojaye op cit note 591 at 3.
[604] Ibid, 2.
[605] Investigation report on the forced sterilisation of women living with HIV in South Africa, available at https://srjc.org.za/2020/03/03/investigation-report-on-the-forced-sterilisation-of-women-living-with-hivaids-in-south-africa/, accessed on 11 April 2021. It is seen as a gross human rights violations and ultimately goes against reproductive autonomy.[605] The United Nations has gone as far as to describe it as cruel and degrading treatment which amounts to torture (see page 5 of commission report). Also see Durojaye op cit note 591 at 721. He has also defined forced sterilisation as sterilisation which occurs after an individual has explicitly refused to be sterilised, where they have not been given a chance to consent or where they are not aware of such sterilisation. He went to describe coerced sterilisation as sterilisation which occurs when tactics and or incentives are used to compel a person to undergo sterilisation.
[606] Ibid.
[607] Ibid.
[608] Badul (2013) op cit note 503 at 216.
[609] Pickles (2016) op cit note 495 at 92. Also see Strode (2012) et al 436 at 62.
[610] Ibid, 92.
[611] Ibid, 94.

report on forced sterilisation of women living with HIV/AIDS in South Africa in March 2020.[612] All the complainants were HIV positive women who were sterilised during the process of giving birth in KZN and Gauteng hospitals.[613] In some instances, these women signed the consent to sterilisation forms under duress (for example, they were told that they would be denied reproductive health services if they refused consent), in other instances they were not even aware that they were signing consent forms.[614]

One of the Complainants was booked for a caesarean section in Nkandla hospital in September 2011.[615] Upon arrival at the hospital, the doctor informed her that she was also booked for a sterilisation procedure and that she had to undergo this procedure as she had 'too many children'.[616] This complainant made it clear that she did not wish to be sterilised, however, the nurses were not pleased with her, and indicated that she will have to be sterilised as future pregnancies will result in death.[617] She also indicated that her mobile device was confiscated so she could not seek advice or communicate with her family members. Further to this, she was told that she had to sign the consent form for the hospital personnel to assist her with delivering her unborn baby.[618] In this instance, the patient's right to self-determination, dignity and access to information were infringed upon.

Some of the patients also indicated that they lacked the capacity to appreciate the consequence of signing such consent forms as they were in extreme labour pains.[619] One of the complainants indicated that she was told she had to be booked for a sterilisation procedure in order to prevent her from bleeding to death in future pregnancies.[620] In her affidavit, she indicated that she did not understand the term 'sterilisation' and was therefore not aware of the consequences of sterilisation. She was also given consent forms to sign while she was experiencing labour pains.[621] She

[612] Commission for Gender Equality Complaint Ref No: 414/03/2015/KZN available at http://srjc.org.za/wp-content/uploads/2020/03/Forced-Sterilisation-Report.pdf, accessed on 10 July 2021.
[613] Supra, 36. Also see Pickles op cit note 511 at 92.
[614] Supra.
[615] Supra, 41.
[616] Supra, 41.
[617] Supra. 42.
[618] Supra, 42.
[619] Supra.
[620] Supra, 44.
[621] Supra, 44.

therefore was not in the right state of mind to provide consent to the sterilisation procedure.

From the above, it is clear that the health care providers not only failed to provide the patients with the relevant information but went to the extent of providing false information.[622] This is a gross violation of fundamental human rights such as the right to bodily integrity, dignity, access to information and equality. Although some of the hospital files had signed consent forms, such forms were not a true reflection of consent as the nature and consequences of sterilisation were not explained to the complainants.[623]

The cases of Isaacs v Pandie[624] and Pandie v Isaacs[625] are the only cases on involuntary sterilisations in South Africa.[626] The cases concern a civil claim for damages by Ms Isaacs who was allegedly sterilised without her informed consent.[627] Ms Isaacs was admitted to hospital for a caesarean-section delivery and when she was presented with a pre-drafted consent form, she refused to sign it, and told the nurse that she did not want to be sterilised.[628] While in theatre, Ms Isaacs also repeatedly expressed that she did not wish to be sterilised.[629] Dr Pandie, however, continued to sterilised Ms Isaacs after an assisting scrub sister confirmed that he should do so.[630] This is despite the fact that the Sterilisation Act acknowledges a patient's right to withdraw their consent at any point prior to the procedure.[631] Ms Isaacs became aware of the sterilisation procedure when a nurse showed her the severed portion of her fallopian tubes.[632]

From the above discussion, it is evident that there are gaps in the application of the patient's right to informed consent. The forced sterilisation of an individual, is a

[622] Pickles op cit note 495 at 93.
[623] Commission for Gender Equality op cit not 612 at 53-54.
[624] *Isaacs v Pandie* [2012] ZAWCHC 47.
[625] Pandie v Isaacs (A135/2013, 1221/2007), [2013] ZAWCHC 123.
[626]Pickles (2016) op cit note 495 at 93.
[627] Badul (2018) et al 496 at 557.
[628] Pickles (2016) op cit note 495 at 101. Also see Badul *et al* op cit note 496 at 557.
[629] Commission for Gender Equality op cit not 612 at 101.
[630] Supra, 101.
[631] Section 4(b) of the Sterilisation Act.
[632] Badul (2018) et al 496 at 557.

violation of constitutional rights such as the right to dignity, equality and access to information, physical and bodily integrity as well as equality and non-discrimination.[633]

4.4.1.2. Cases of forced sterilisation in South Africa are similar to the case of Government of Namibia v LM and Others

The case of *Government of the Republic of Namibia v LM and others* (hereinafter referred to as the Namibian case) dealt with matters of involuntary sterilisation brought by 3 Namibian women.[634] These women were allegedly sterilised, during the process of giving birth, at state hospitals during the period of 2005 to 2007.[635] The plaintiffs based their argument on their common law rights to personality and; in the alternative, their constitutional right to dignity, liberty and family.[636] The first plaintiff tested positive while she was pregnant and was subsequently given antiretroviral (ARV) treatment.[637] She was admitted to the Oshakati Hospital in June 2005 and was informed that she had to undergo a caesarean section as she was too tired to give birth naturally.[638] Further to that, she indicated that a nurse informed her that all HIV positive women had to undergo sterilisation and told her to sign the consent forms in a 'forceful manner'.[639] This plaintiff testified that she did not know what she was signing as the contents of the consent form were not explained to her.[640] She explained that she only realised that she could no longer have children when she returned to the hospital for contraceptives and was informed that such contraceptives would not be prescribed to her as she was 'closed'.[641]

The second plaintiff had also tested positive for HIV while she was pregnant and was given counselling regarding her HIV status by Red Cross clinic. During one of her antenatal care check-ups, she was informed that she will have to undergo a caesarean section as her foetus was in a breech position.[642] The doctor also informed her that, as a result of her HIV status, she should never have children again and had to be

[633] Commission for Gender Equality op cit not 612 at 51.
[634] *LM v Namibia* op cit note 604.
[635] Supra.
[636] Supra, para 1.
[637] Supra, para 6.
[638] Supra, para 7.
[639] Supra, para 7.
[640] Supra, para 7.
[641] Supra, para 8.
[642] Supra, para 12.

sterilised.[643] She alleged that the doctor also did not advise her on the consequences of sterilisation and did not enquire if she wanted to have more children in future.[644] Further to this, one of the nurses in the hospital rushed her into signing certain documents threatening that she would not be taken to theatre if she refused to cooperate.[645] We have learnt that such documents were consent forms for the caesarean section as well as the sterilisation procedure.[646] She explained that she was not aware that she was sighing such consent forms as the forms were titled 'BLT', and the patient was not aware of what the abbreviation meant.[647] According to the plaintiff, she was shocked to find out, six months later, that she had been sterilised.[648]

The third plaintiff was 46 years of age and had already given birth seven times.[649] She explained that she experienced complications in the early stages of her pregnancy (she was experiencing severe pains which were preventing her from walking and moving normally) and approached the hospital to terminate her pregnancy.[650] She was informed, however, that her foetus was developed to a stage were she could not terminate her pregnancy.[651] When she arrived at the hospital to give birth, the nurse gave her a document and simply told her to write her name. She explained that the contents of the documents were not explained to her and she did not receive counselling on sterilisation, or any other contraceptives.[652] She testified that the nurses were impatient with her and were quick to humiliate her by stating that she should not have fallen pregnant because of her HIV status.[653]

In analysing the evidence produced by the respondents, the Namibian High Court dismissed the allegation that they were forcefully sterilised as a result of their HIV/AIDS status on the basis of lack of evidence.[654] It is possible that the court was

[643] Supra, para 12.
[644] Supra, para 12.
[645] Supra, para 13.
[646] Supra, para 13.
[647] Supra, para 13.
[648] Supra, para 14.
[649] Supra, para 17.
[650] Supra, para 14.
[651] Supra, para 17.
[652] Supra, para 18.
[653] Supra, para 19.
[654] Supra, para 2. Also see C Pickles 'Sounding the Alarm: Government of the Republic of Namibia v LM and Women's Rights during childbirth in South Africa' (2018) 21 *PER / PEJ*.

erring on the side of caution. However, seeing that all the applicants were HIV positive, the court missed an opportunity to address the issue of discriminating against HIV positive women. Further to this, Chantal Badul and Ann Strode noted that the patients provided evidence on why they perceived the actions of the doctors and nurses to be discriminatory however, such evidence was not given sufficient attention.[655] The court's failure to consider the link between the sterilisation of these HIV positive women with their HIV positive status has been identified as 'a key weakness in the judgment'.[656]

The court found that, in all three matters, there was no evidence of informed consent for the sterilisation procedure.[657] These women went to hospital because they sought to access other reproductive health rights, they had no intention to be sterilised.[658] The court also found that even though they had signed the consent to sterilisation forms, they were not in the correct state of mind as she was experiencing labour pains.[659] The court found, therefore, that it is incorrect to say that such consent to sterilisation was properly obtained.

4.4.2. Counselling is not mandatory

As discussed in chapter 3, the Choice Act provides that counselling services are not mandatory .This provision is welcomed as a study conducted in the United Sates revealed that the majority of women who decline counselling do so because they have already made their decision to terminate.[660] Some of them decide the fate of their pregnancies before they even take the pregnancy test, while others consult with people they trust, such as their general practitioner, before coming to the abortion facility.[661] Compelling women to undergo counselling could quickly result in long waiting lists for women awaiting termination, and result in a delay in the termination

[655] Badul (2013) op cit note 503 at 225. For instance, the first plaintiff testified that a nurse informed her that she had to be sterilised as all HIV positive women are required to undergo such a procedure.
[656] Ibid. Derojaye op cit note 247 has also stated that the court was so focused on the principle of informed consent that it missed an opportunity to address human rights violations.
[657] *LM v Namibia* op cit note 601, para 90.
[658] Supra.
[659] Supra, para 90. The forms signed by the applicant indicated that she was consenting to 'caeser and BTL due to previous caeser'. The court was of the opinion, therefore, that the applicant would not have know what she was consenting to.
[660] S Swemmer op cit note 78 at 116.
[661] Ibid, 116.

procedure. Nurses who do not agree with the pregnant woman's decision to terminate may also use the counselling session as an opportunity to convince her otherwise. This provision in the Choice Act is also in line with the WHO guidelines which states that health care professionals should offer non-mandatory counselling to pregnant women seeking termination services.[662]

Surprisingly, the Sterilisation Act is silent on the issue of counselling. Section 4 of the Act, dealing with consent, merely provides that the patient must be given 'a clear explanation and adequate description of the consequences, risks and reversible or irreversible nature of the sterilisation procedure'.[663] It is argued that this provision merely deals with access to information and does not touch on the issue of counselling. There is a link between providing the patient with the necessary information and counselling the patient. However, these are two different concepts. Counselling has been defined as the process of listening and giving support to a person who needs help.[664] Providing information, on the other hand, relates to facts or details about specific topic.[665] The WHO sterilisation guidelines also emphasises the importance of counselling in sterilisation procedures due to the permanent nature of such a procedure.[666] The guidelines also acknowledge the fact that a client's choice might also be in conflict with the wishes of the client's spouse, her family and even community.[667] Considering that many South African communities place a large emphasis on marriage and motherhood for women, the Sterilisation Act should, at the very least, offer counselling services to persons seeking sterilisation services.[668]

The Sterilisation Act does not comply with the WHO guidelines on female sterilisations which provide that counselling is instrumental in providing sterilisation patients with all

[662] WHO abortion guidelines op cit note 268 at 36.
[663] Section 4 of the Sterilisation Act.
[664] Oxford Learners Dictionary, available at https://www.oxfordlearnersdictionaries.com/definition/english/counsel_2, accessed on 30 June 2021.
[665] Oxford Learners Dictionary, available at https://www.oxfordlearnersdictionaries.com/definition/english/information?q=information, accessed on 30 June 2021.
[666] WHO Sterilisation guidelines op cit not 275 at 61.
[667] Supra, 63.
[668] Bi op cit note 424 at 954. Also see Strode et al (2012) op cit note 496 at 69.

the information they require.[669] The fact that the Sterilisation Act does not address the issue of counselling is a gap in the South African reproductive framework.

4.4.3. Third party authorisation is not necessary

As discussed in Chater 3, the Choice Act only requires the informed consent of a pregnant woman before a pregnancy may be terminated.[670] Pregnant minors should be advised to consult with their parents, guardians or friends before making the decision to terminate.[671] The minor may, however, not be refused termination services on the grounds of opting not to consult with such individuals.[672] Likewise, the sterilisation Act provides that consent to sterilisation must be given freely, voluntarily and without any inducement, by a person over the age of 18 and who has capacity to consent.[673]

These provisions are in line with General Recommendation No. 21 of the CEDAW Committee.[674] In this comment, the committee expressed that while the decision to have, or not have children, should be made after consultation with one's spouse or partner, the final decision should not be made by the partner or spouse, parent or government.[675] The WHO safe abortion guidelines also provides that third party authorisation is not necessary in termination of pregnancy services as women have autonomy over their bodies.[676] Likewise, the WHO guidelines on female sterilisations state that there is no legal basis for the requirement of informed consent for females wishing to be sterilised.[677] Ultimately, each individual, whether married or unmarried, has full control over their reproductive choices. Therefore the state, through its organs, has no right in determining the number of children one should or should not have.

4.4.3.1. Third party authorisation in termination procedures

[669] WHO Sterilisation Guidelines op cit note 275 at 49.
[670] Section 5 of the Choice Act.
[671] Supra, Section 5(3).
[672] Supra, Section 5(3).
[673] Section 4 of the Sterilisation Act.
[674] CEDAW General Recommendation No.21: Equality in Marriage and Family Relations, available at https://www.refworld.org/docid/48abd52c0.html, accessed on 15 March 2021.
[675] Supra.
[676] WHO Abortion guidelines op cit note 268 at 68.
[677] Who Sterilisation guidelines op cit note 275 at 8.

As discussed earlier in this chapter, section 2(1)(b) of the Choice Act provides that between 13 and 20 weeks of the gestation period, a pregnancy may only be terminated if a medical practitioner, after consulting with the pregnant woman, is satisfied that certain grounds have been satisfied.[678] Similarly, section (1)(c) of the Act provides that after 20 weeks, a pregnancy may be terminated if a medical practitioner, after consulting with another medical practitioner, is of the opinion that the pregnancy should be terminated on certain specified grounds.[679] It is argued, therefore, that in these circumstances, the act requires third party authorisation (i.e. the medical practitioner's authority). Although this provision limits a pregnant women's complete autonomy, it may be justified on the grounds that the state has an interest in protecting the dignity of potential human life.

4.4.3.2. Third party authorisation in sterilisation procedures

The forceful sterilisation of HIV Positive women by medical practitioners undermines the independent right of such women to consent, or refuse to consent, to such sterilisation procedures. Some of the justifications for these wrongful sterilisations include, *inter alia*, that such women will infect their babied with HIV and AIDS, that they already have too many children, and/or that they are promiscuous.[680] Such decisions potentially amount to medical paternalism. Medical paternalism is an outdated principle, based on patriarchal views, where doctors use their professional positions to override a patient's autonomy.[681] The judge in the Namibian case of LM v Namibia stated that there is no place for medical paternalism in a modern society.[682] This is a gap in the application of reproductive autonomy laws as the laws indicate that the decision to be sterilised lies with the patient. In practice, however, health care workers sometimes undermine the patient's rights.

4.4.3.3. Third party authorisation in relation to minors

The topic of consent to termination by a pregnant minor is very contentious. As already indicated, the Choice Act states that minors do not require parental consent to obtain

[678] Section 2(1)(b) of the Choice Act.
[679] Supra, Section 2(1)(2).
[680] Commission for Gender Equality op cit not 612 at 603.
[681] Castell v De Greef 1994 (4) SA 408.
[682] *LM v Namibia* op cit note 601, para 106.

access to such services. Although section 5(3) is a radical departure from the common law and legislative provisions relating to children's capacity to consent, this section can be justified on the basis that pregnancy and childbirth could hardly be in the child's best interests.[683] Some academics are of the opinion that parental rights and responsibilities should not be ignored in termination procedures because parents know what is best for their children and can help them make the right decision.[684] Liberal academics, on the other hand, are of the opinion that minors should be allowed to make reproductive decisions without mandatory consent. They believe that forcing minor's to obtain parental consent might push them straight to the hands of illegal termination providers because of the confidential nature of sexual intercourse and reproduction.[685] In their opinion, illegal termination is more harmful than safe termination without consent.[686]

This issue was legally settled in *Christian Lawyers*, 2005 where the court overruled the common-law requirement of parental consent in the case of minors who have capacity to consent.[687] The plaintiffs in this matter sought an declaring sections 5(2) and 5(3) of the Choice Act, read together with the definition of a woman in section 1, unconstitutional.[688] They further alleged that pregnant minors are not capable of making informed reproductive decisions without parental consent as (a) they are incapable of fully appreciating the value of parental consent as well as the need for counselling (which is not mandatory); and (b) they lack capacity to consent as required by the Act.[689] The judge noted that the act permits termination in instances where the pregnant woman has capacity to consent. Therefore, if young and immature children do not have the aforementioned capacity to terminate, their consent would not qualify as consent under the Choice Act.[690] The court upheld section 5(3) of the Choice Act on the basis that it protected the constitutional rights to bodily integrity, access to health, dignity and privacy.[691]

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[683] Van Oosten op cit note 454 at at 66.
[684] Humonga op cit note 452 at 345.
[685] Moyo op cit note 138 at 19.
[686] Moyo op cit note 138 at 19.
[687] 2005 (1) SA 509 (T).
[688] Supra, para 512. Also see Humonga op cit note 452 at 328.
[689] Supra, para 512.
[690] Supra, para 516.
[691] M Pieterse op cit note 438 at 563.

4.4.4. A patient's privacy must be protected

As discussed above, the right to privacy is instrumental in a patient's access to reproductive health care. The English case of *Gillick v West Norfolk and Wishbech Area Health Authority* 1986 1 AC 112[692] emphasised the importance of keeping access to contraceptives confidential as there is a high chance that persons will not access such services if confidentiality is not guaranteed.[693] Despite all the constitutional and legislative provisions protecting patients rights to privacy, women continue to express concern about the lack of privacy in public health facilities.[694] A young woman in Soweto indicated, for instance, that she went to a family planning clinic and proceeded to ask a nurse about the administration of contraceptive injections in a low voice.[695] The nurse responded by screaming 'Hey sit down here. This is the place for injections'.[696] The young lady walked out of the clinic as she felt that the nurse had 'caused a scene'.[697] Another lady indicated some women prefer to go to illegal termination of pregnancy places, or to try and abort on their own out of fear of 'shaming' themselves publicly.[698] Lack of privacy in public facilities was also confirmed by a doctor who indicated that women 'hang around in rooms… waiting and having foetuses between their legs for hours and nobody really cares'.[699] Therefore, despite legislative protection of the right to privacy, the lived experiences of vulnerable South African women who cannot afford private health care indicate a gap in accessing this right.

4.4.5. The state has a duty to provide access to reproductive health

General Comment No.14 of the ICESCR clearly states that, like all human rights, the right to health imposes three obligations on state parties, i.e., to respect, protect and fulfil human rights.[700] The obligation to respect requires states to refrain from

[692] O Savage-Oyekunle (2015) op cit note 439 at 375.
[693] Ibid, 375.
[694] C Pickles 'Lived Experiences of the Choice on Termination of Pregnancy Act 92 of 1996: Bridging the gap for women in need' (2013) 29(3) *South African Journal on Human Rights* 520. Also see N Lince-Deroche, A Hargey & T Shochet 'Accessing sexual and Reproductive Health information and Services: A mixed Methods Study of Young Women's needs and Experiences in Soweto, South Africa' (2015) 19(1) *African Journal of Reproductive Health* 74.
[695] Lince-Deroche op cit note 694 at 76.
[696] Ibid, 76.
[697] Ibid, at 77.
[698] Ibid, 77.
[699] Pickles (2013) op cit note 694 at 520.
[700] ICESCR General Comment no. 14 op cit note 184.

interfering with people's enjoyment of this right; the obligation to protect requires states to ensure that third parties do not obstruct people's enjoyment of this right; and the obligation to fulfil requires states to enact legislation, adopt administrative, budgetary, promotional and other necessary measures to ensure that the right to reproductive health care is realised.[701] Section 21 of the National Health Act also places a duty on the health department to ensure compliance with national health policies.[702] Despite the state's efforts to provide its citizens with access to reproductive health care, which includes providing women with free termination of pregnancy services,[703] the experiences of women in South Africa leads one to believe that the state has failed to fulfil the second and third obligation as set out above.

4.4.5.1. The state's failure to fulfil and protect reproductive health rights

In 2008 the WHO reported that an estimate of 120 000 women had accessed unsafe termination of pregnancies in Southern Africa, resulting in 500 maternal deaths.[704] These figures indicate that the provisions of the Choice Act are not being fully adhered to.[705] This is as a result of systematic failures within the South African public health care system which result in the indirect discrimination of poor women who cannot afford to access the public health care systems.[706] The reasons for women to continue accessing illegal termination of pregnancies as opposed to relying on public health care include, *inter alia*, the attitude of health workers, limited state resources, fear of stigmatisation by the community, and the state's failure to protect the privacy of reproductive health care professionals.

Numerous authors have stated that the attitude of health care workers is often obstructive.[707] When the Choice Act came into effect, health authorities had difficulties with training nurses and midwives in terminations of pregnancies as a majority of them reluctant to receive training.[708] A study conducted in a rural hospital in KwaZulu-Natal

[701] Ibid, para 33.
[702] Section 21 of the National Health Act.
[703] Supra, Section 5(3)(c).
[704] Pickles (2013) op cit note 694 at at 516.
[705] Ibid, 516.
[706] Ibid, 516.
[707] De Roubaix, M 'Ten years hence – Has the South African Choice on termination of Pregnancy Act, Act 92 of 1996, realised its aims? A moral-critical evaluation' (2007) 26 *Medicine and Law* 145. Also see Guttmacher op cit note 82 at 193.
[708] Nohaji op cit note 471 at 227.

revealed that 20% of the doctors did not support termination of pregnancies, 50% claimed that the community had been consulted and objected to termination of pregnancy services and 30% of the doctors threatened to leave if termination of pregnancy services were introduced.[709] The attitudes of health care workers as well as the stigma associated with terminating a pregnancy has resulted in women being reluctant to seek these services in their own communities out of fear of being recognised.[710] Women also often encounter rude and judgmental health care workers who sometime quote the bible and/or delay termination services.[711] One of the woman who experienced judgment and hostility from health care workers indicated that a nurse informed her that she was not acting in the interests of her 'baby' and proceeded to ask her if she had informed her partner that she planned to 'murder' his 'child'.[712]

The forced sterilisation of HIV positive women is another classical example of the state's failure to protect reproductive health care. The health care professionals not only denied these women the right to reproductive health care but also infringed on their rights to dignity. One of the complainants indicated the following in her affidavit:

> 'When I asked the nurse what the forms were for, the nurse responded by saying: "you HIV people don't ask questions when you make babies. Why are you asking questions now, you must be closed up because you HIV people like making babies and it just annoys us. Just sign the forms, so you can go to theatre.'[713]

The state, therefore, needs to take positive action to prevent third parties from obstructing women's access to reproductive health care.

Further to the above, there is a limit in the availability of state resources which means that some women have to travel long distances in order to obtain termination of pregnancy services.[714] The refusal of some hospitals to offer termination services has

[709] Nohaji op cit note 471 at 228. Also see Pickles (2013) op cit note 705 at 521 where C Pickles argues that there is a negative attribute ascribed to women who opt to terminate their pregnancies. These women are regarded as inferior for disregarding the principles of female identity which include nurturing motherhood and sexual purity.
[710] K Tuner, A Hyman & M Gabriel 'Changing values and transforming Attitudes to improve access to second semester abortion' (2008) 16 (3) *Reproductive Health Matters* 113.
[711] Ibid, 113.
[712] Pickles (2013) op cit note 694 at 519.
[713] Commission for Gender Equality op cit not 612 at 48.
[714] Nohaji op cit note 471 at 226.

also resulted in the rest of the hospitals, which offer these services, to be overcrowded.[715] Such high demands sometimes lead to women being denied termination of pregnancy services because their pregnancies would have advanced to point where they may no longer terminate – despite the fact that such delays were caused by a lack of state resources.[716] A study conducted in KwaZulu Natal in 2006 revealed that more than 69% of facilities designated to perform terminations of pregnancy in KwaZulu-Natal were not rendering these services.[717] Further to this, only 17 public sector facilities offered these services throughout the province.[718] The South African Commission on Human Rights Commission also conducted an enquiry on access to health Services in 2010.[719] The commission was informed that one of the issues faced by women in rural areas is that most facilities who perform termination procedures are non-operational as only 50% perform such procedures.[720]

Charles Ngwena has argued that liberal termination of pregnancy laws does not always mean that these laws will be fully implemented and, therefore, it is possible that reproductive health right may be reduced to merely words on paper.[721] From the above discussion, it is evident that there are gaps in the implementation of the Choice and Sterilisation Acts. These Acts Protect fundamental rights such as the right to self-determination, dignity, equality, privacy and access to information. Systematic failures which are fuelled by the state's inaction, continue to make access to these rights a distant reality.[722] There state has therefore failed in its obligation to protect and fulfil reproductive health care rights.

4.4.6. Persons who contravene reproductive autonomy law commit a crime

As discussed in Chapter 3, persons who contravene the Choice Act may be subjected to a fine or a period of imprisonment not exceeding 10 years.[723] Section 10(c) is of

[715] Guttmacher op cit note 82 at 193. Also see Nohaji op cit note 471 at 226.
[716] Guttmacher op cit note 82 at 193. Also see Pickles (2013) op cit note 694 at at 520.
[717] Nohaji op cit note 471 at 228.
[718] Ibid, 228.
[719] SAHRC comments to the Portfolio Committee on Private Members' Legislative Proposals and Special Petitions, available at https://pmg.org.za/committee-meeting/12173/, accessed on 28 December 2020.
[720] Ibid.
[721] Pickles (2013) op cit note 694 at 518.
[722] Ibid, 516.
[723] Section 10 of the Choice Act.

particular relevance as it provides that persons who prevent lawful termination of pregnancies or obstruct access to facilities which provide such access may also be subjected to the prescribed sentence.[724] Section 9 of the Sterilisation Act also provides that persons who contravene the Sterilisation Act are guilty of an offence may be subject to a fine or a period of imprisonment not exceeding 5 years.[725] The South African legislative framework has therefore created statutory crimes for those who contravene reproductive health law. As discussed earlier in this chapter, health care workers continue to obstruct women's access to termination services.[726] Despite these findings, the South African court have, to date, not recorded any criminal cases on the obstruction of access to reproductive health care rights.

It is also argued that the maximum sentence of 5 years is not sufficient in cases of forced sterilisation of women. The CEDAW committee in General Recommendation No.19 indicated that the forced sterilisation of women is a form of violence as, not only does it affect women's physical and mental health, but also infringes on their reproductive autonomy right.[727] As the maximum sentence of 5 years is similar to that of the repealed Abortion and Sterilisation Act, it appears as though the legislature simply copied the sentence provision of the repealed Abortion Act. This is a gap which needs to be revisited by the South African legislature.

It is also interesting to note that there are no reported criminal cases which apply the common law principles of assault in medical services without informed consent.[728] Camilla Pickles noted that victims of involuntary sterilisations may rely on section 9 of the Sterilisation Act, together with section 2(2) (which provides that no one may be sterilised without their consent) and section 4 (which provides that such consent needs to be informed).[729] Further to this, such victims may rely on the common-law of assault, provided that the crime has not prescribed in terms of section 18 of the Criminal Procedure Act 51 of 1977.[730] Assault is defined as the unlawful and intentional application of force to a person, or inspiring a belief that force will immediately be

[724] Supra, Section 10(c).
[725] Section 9 of the Sterilisation Act.
[726] Pickles (2013) op cit note 694 at at 519.
[727] Ibid.
[728] Pickles (2016) op cit note 495 at 98.
[729] Ibid, 96.
[730] Ibid, 95.

applied.[731] As both the common law and the sterilisation Act require consent to be voluntary, the crime of assault may only be negated where the victim has consented to the harm.[732] C Pickles has also argued that there is a gap section 4 of the sterilisation Act as it does not indicate who is responsible, between the nurse and the doctor, for obtaining informed consent.[733]

The court had an opportunity to identify and potentially rectify this gap in the case of Isaacs v Pandie (discussed above).[734] However, the court found that, in practice, obtaining the patient's informed consent was the responsibility of the nurse, and not the doctor.[735] The effect of this judgment is that the responsibility to obtain informed consent lies with the nurse, even though it is the doctor who performs the sterilisation procedure.[736] This decision goes against the guidelines of the Health Professions Council of South Africa which provides that the health practitioner is responsible for obtaining a patient's informed consent.[737] The guidelines also provide that in instances where the medical practitioner has delegated the responsibility of obtaining informed consent, he has a duty to ensure that such consent was obtained before proceeding with treatment.[738] In light of the above, the court's decision needs to be revisited.

4.5. LIMITATIONS TO REPRODUCTIVE HEALTH RIGHTS: CAN THEY BE JUSTIFIED?

What is clear from the above analysis of the reproductive rights framework is, like all other rights, reproductive health care rights are subject to limitation. The following limitations of reproductive health care rights were identified: firstly, women do not have complete autonomy to terminate a pregnancy, and; secondly persons below the age of 18 may not choose to be sterilised. In addition to the above, legislation may limit a minor's right to privacy in termination services if a medical practitioner suspects that such minor was subjected to sexual abuse. This section of the dissertation aims to explore whether such limitations to reproductive health care rights may be justified in

[731] Ibid, 97.
[732] Ibid, 98.
[733] Ibid, 98.
[734] Isaacs v Pandie (A135/2013, 1221/2007) [2013] ZA WCHC123.
[735] Badul et al (2018) op cit note 496 at 557.
[736] Pickles (2016) op cit note 497 at 98.
[737]Ibid, 98.
[738] Ibid, 98.

terms of section 36 of the constitution. This section provides that constitutional rights may only be limited if the limitation is reasonable and may be justified in a democratic South Africa.[739] Such limitation may only be in terms of the law of general application in a society based on dignity, equality and freedom.[740] In limiting any right in the Bill of Rights, the legislature has to consider all relevant factors including: (1) the nature of the right; (2) the importance of the reason of the limitation; (3) the nature as well as the extent of the limitation; (4) the link between the limitation and its purpose; (5) whether there are less restrictive means to achieve the purpose of the limitation.[741]

4.5.1. A limitation on women's rights to terminate

As already indicated in this dissertation, a woman's right to choose to terminate her pregnancy is limited after 12 weeks.[742] This is in line with the preamble of the Act which states that the purpose of the Act is to afford women an opportunity to have a safe and early termination.[743] Therefore, the purpose of this limitation is to ensure that women have safe terminations of pregnancy. As the Constitution provides that everyone has the right to life,[744] the state has a duty to protect the lives of South African's, including the lives of pregnant women. A women's right to termination is therefore limited by the women's own right to live.[745] At the early stages of pregnancy, a termination procedure has minimal threat to a women's life.[746] As the pregnancy progresses, the risk of mortality and morbidity increases.

Further to this, the state has an interest in preserving prenatal life. Our common law provides that life begins at birth, therefore, the unborn does not have the rights of a child who has been born alive.[747] However, as stipulated in the American case of *Roe*

[739] Section 36(1) of the Constitution.
[740] Supra, Section 36(1).
[741] Supra, Section 36(1).
[742] Section 2(1)(b) and 2(1)(c) of the Choice Act.
[743] Ibid, Preamble.
[744] The Constitution of the Republic of South Africa, 1996.
[745] Moyo op cit note 138 at 24.
[746] Ibid, 24.
[747] Kruger op cit note 501 at 23-27. The nasciturus fiction was created to benefit the unborn in situations where the unborn would have been entitled to a specific benefit if he/she was already born at the time when the benefit was due. The Will's Act 7 of 1953 incorporated this common law principle into section 2D(1)(c) by creating a rebuttable presumption that where a testator wishes to benefit children or members of a class of a group, such benefits shall also extend to those who were already conceived at the time of his or her death, but not yet born.

v Wade[748], a state might have an interest in the unborn, and such an interest becomes more compelling as the pregnancy progresses.[749] It appears that South African courts have followed in the same approach. In the case of *Christian Lawyer's association of South Africa v Minister of Health*[750] it was held that:

> the state has an important and legitimate interest in the preservation and protection…of the potential life of the foetus. When its interest in doing so becomes sufficiently compelling, it warrants State intrusion upon the woman's privacy and self-determination.[751]

Such an interest does not extent the rights of a foetus to include the right to life, instead, it protects the dignity of the human species.[752] The Choice Act seeks to balance, on the one hand, the pregnant women's Constitutional right to freedom and security of the person as well as reproductive health, and, on the other hand, it seeks to regulate the manner in which potential human life may be dealt with. Such a balance results in the limitation of the termination rights of a pregnant woman as the pregnancy progresses.

Denise Meyerson has also argued that as a pregnancy progresses, destroying the foetus becomes 'a matter of increasing regret and the value of human dignity is increasingly under threat'.[753] The foetus also becomes more prone to experiencing pain as it becomes more viable and capable of existing independently.[754] Therefore, a pregnant woman needs more compelling reasons to terminate in the later stages of her gestation period. The Choice Act, therefore, strikes a balance between the above completing interests.[755] Now that the purpose of limiting a pregnant woman's autonomy has been identified, the question remains – are there less restrictive means to achieve this limitation?

McQuoid-Mason has argued that section 2(1)(c) of the Choice Act is unconstitutional as this section does not make provision for terminations which resulted from rape or incest.[756] He has based his argument on the premise that the preamble to the Choice

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[748] 410 U.S 113 (1973).
[749] Supra.
[750] 2005 (1) SA 509 (T) para 38-39.
[751] Christian Lawyers association, 2008.
[752] Section 10 of the Constitution protects the right to dignity. Although the foetus does not have right to dignity, potential life has to be treated with dignity.
[753] D Meyerson 'Abortion: The constitutional Issues' (1999) 116 *South African Law Journal* 5.
[754] Ibid, 5.
[755] Ibid, 5.
[756] McQuoid-Mason (2006) op cit note 439.

Act recognises the restrictiveness of the previous Abortion Act and promotes reproductive choice and freedom.[757] The repealed Abortion Act was not based on a trimester framework, and one of the grounds for termination was rape and/or incest.[758] The effect of this repealed Abortion Act was that a woman could rely on rape and/or incest to terminate her pregnancy at any time as there were no limits on time frames for termination.[759] Although the state has an obligation to protect human life, an exception should be made to allow pregnant women to terminate if the pregnancy was a result of rape and/or incest and if the termination may be performed without harming the pregnant women, provided that the foetus is not yet viable.

McQuoid-Mason's view is favoured because rape victims often delay reporting and/or taking action. To support his argument, McQuoid-Mason made the following examples:

> A very overweight single woman with irregular *menses* discovers that she is 22 weeks pregnant after she was raped at a party where she had been given a drink "spiked" with a drug. She wishes to terminate the pregnancy.[760]

> A 17-year old girl from a rural area is impregnated by her father. In order to protect the reputation of the family and to prevent her father being prosecuted she is preventing from leaving home to report the matter to the police. Six months later she manages to escape from the family home in the country to the city, reports the case to the police, and wishes to terminate her pregnancy.[761]

In both these examples, it would be illegal for the pregnant women to terminate their pregnancies under the Choice Act. The Choice Act is successful in promoting reproductive autonomy before 20 weeks of pregnancy.[762] However, the Act has failed to protect and expand reproductive autonomy after the 20 week period. This limitation cannot be justified under section of the Constitution, and section 2(1)(c) of the Act should be amended to include the ground of rape and/or incest.[763]

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[757] Preamble of the Choice Act.
[758] DJ McQuoid-Mason op cit note 439 at 125.
[759] Ibid, 125.
[760] Ibid, 126.
[761] Ibid, 126.
[762] Ibid, 131.
[763] Dudley's private proposal to amend Choice on Termination of Pregnancy Act, available at https://pmg.org.za/committee-meeting/11642/, accessed on 10 July 2021 (hereinafter referred to as the 2010 Amendment Bill).

4.5.2. A limitation on children's rights to be sterilised

Although children have the right to autonomy, as stated in section 12 of the Constitution, the Sterilisation Act limits this right by stating that persons under the age of 18 may not be sterilised voluntarily.[764] Children may only be sterilised if a failure to sterilise such children would jeopardise their life or result in their health being seriously impaired.[765] It seems that the purpose of this limitation is to promote the child's best interests as provided for in the Children's Act and the Constitution.[766] This limitation may be justified as because of the permanent nature of sterilisation procedure. Children have the opportunity to exercise this right once they reach majority status.

4.5.3. A limitation on a child's right to privacy in termination services

It has already been established, in Chapter 3 of this dissertation, that the Children's Act grants women, including female children, the right to terminate a pregnancy upon request.[767] In addition to this, section 7(5) of the Act requires the identify of the women requesting to terminate her pregnancy to remain confidential.[768] Therefore, children too have the right to doctor-patient confidentiality prescribed in section 14 of the National Health Act.[769] Notwithstanding the aforementioned, Section 57 of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (hereinafter referred to as the Sexual Offences Act) prescribes that persons below the age of 12 are incapable of consenting to sexual intercourse.[770] So even though a female of any age (including female children below the age of 12) may terminate a pregnancy, it is a criminal offence for a person over the age of 12 to have sexual intercourse with such a minor. Further to this, any person who engages in sexual intercourse with a minor who is above the age of 12 yet below the age of 16 commits an offence (statutory offence) unless: (a) such person is also above the age of 12 yet below the age of 16; or (b) such person is 16 or 17 years of Age and the age gap between him/herself and the alleged victim is not over 2 years.[771]

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[764] Section 12 of the Constitution. Also see E du Plessis, G van der Walt & A Govindjee 'The constitutional rights of children to bodily integrity' 2014 *Obiter* 3.
[765] P Mahery 'Consent Laws Influencing Children's Access to Health Care Services' 2006 South African Health Review.
[766] Section 9 of the Children's Act and section 28(2) of the Constitution.
[767] Humonga op cit note 452 at 325.
[768] Choice on Termination of Pregnancy Act 92 of 1996.
[769] National Health Act 61 of 2003, section 14.
[770] Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
[771] Supra, Section 15.

In an attempt to guard minors against the sexual offences discussed above, the legislature has imposed a duty on any person who suspects that a sexual offence has been committed against a child, to report such a suspicion to the police.[772] Therefore, if a doctor terminates the pregnancy of a child below the age of 16, and suspects that the pregnancy was a result of statutory rape, such a doctor has a duty to report the minor's pregnancy and, consequently, her termination of pregnancy.[773] In such circumstances, the right to privacy as protected in section 14 of the Constitution[774] is indeed compromised. As illustrated above, the right to privacy is an integral element to reproductive autonomy and is also protected by the Choice Act.[775]

It is argued that a limitation on a child's right to privacy is necessary in protecting minors from becoming victims of sexual abuse. Doctors who perform termination services on such children should, however, be sensitive in their approach and avoid reporting each and every matter to the police as this might result in children resorting to illegal termination of pregnancy service providers.[776] Therefore, medical practitioners should enquire on the age of the person who caused such a pregnancy and report such a matter if, after taking the necessary steps to enquire, the doctor is still of the opinion that the pregnant girl was sexually assaulted.

4.6. THREATS TO THE SOUTH AFRICA REPRODUCTIVE HEALTH LEGAL FRAMEWORK: THE CHOICE ACT

As indicated in Chapter 1 of this dissertation, in an attempt to counter public and internal opposition to the Choice Bill, the *Parliamentary Bulletin* of the ANC published a Communiqué stating that '[t]his is not a morality Bill, but a health Bill'.[777] Despite this attempt to neutralise the abortion debate, the Choice Act continues to counter opposition from different members of society.

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[772] Supra.
[773] McQuoid-Mason D 'Termination of Pregnancy and Children: Consent and confidentiality issues' 2010 100(1) *South African Medical Journal* 213.
[774] Constitution of the Republic of South Africa, Section 14.
[775] Section 7(3) of the Choice Act.
[776] Rajoo op cit note 453 at 19.
[777] Hodes op cit note 34 at 85.

4.6.1. Christian Lawyers Case, 1998

The Choice Act was first challenged in *Christian Lawyers Association of SA and Others v Minister of Health and Others* 1998 (4) SA 1113 (T) (hereinafter referred to as Christian Lawyers 1998).[778] The plaintiff argued that section 11 of the Constitution protects the right to life, the foetus has a right to life which begins at conception and, therefore, the Choice Act is unconstitutional and must be struck down.[779] In its argument, the plaintiff completely disregarded the pregnant women's constitutional rights which include, *inter alia*, the right to freedom and security of the person as well as reproductive health care.[780] The defendants argued that the plaintiff's particulars of claim failed to disclose a cause of action, and noted an exception to the plaintiff's summons.[781] In its exception, the defendant stated that the right to life as contemplated in section 11 does not extend to the foetus, and that the Constitution protects the pregnant women's right to terminate in the manner contemplated in the Choice Act.[782]

In determining whether the right to life extends to the foetus, the court distanced itself from answering the question of when life begins. Judge McCreath stated that 'the answer hereto does not depend on medical or scientific evidence as to when the life of a human being commences and the subsequent development of the foetus up to date of birth. Nor is it the function of this Court to decide the issue on religious or philosophical grounds. The issue is a legal one to be decided on the proper legal interpretation to be given to s 11'.[783] This approach is similar to the approach taken by the court in the American case of *Roe v Wade* where the court argued that:

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.[784]

[778] Christian Lawyers, 1998, para 1116.
[779] Supra Para 1116.
[780] Sections 12 and 27 of the Constitution.
[781] Para 1117 of the *Christian Lawyers* case, 1998.
[782] Section 9 protects the right to life, section 10 protects the right to dignity, section 11 protects the right to life, section 12 protects the right to freedom and security of the person, section 14 protects the right to equality, section 15 protects the right to freedom of conscious, religion, thought and opinion, and section 27 protects the right to reproductive health care services.
[783] Para 1118 of the Christian Lawyers case, 1998.
[784] *Roe v Wade* 410 U.S 113 (1973) at 159.

In determining whether the foetus has the right to life, the court began by noting that there is no express provision in the Constitution which grants the foetus the right to life.[785] The next step for the court was to determine whether other Constitutional provisions tacitly protected the foetus' right to life. The court evaluated section 28 of the Constitution which protects children's rights[786]. This section defines a child as a person below the age of 18.[787] A person begins to count their age from birth, and not pre-conception. Therefore, the court found that section 28 does not extend to the unborn.

In contrast, the Constitution protects a person's right to freedom and security of their bodies and supports people's decisions to make reproductive choices.[788] Such rights are, of course, subject to limitation in terms of section 36. The plaintiff's arguments did not recognise such rights, nor did it seek to strike a balance between these Constitutional rights. In light of the above, the court noted that for the purposes of the law, the foetus is not a person and does not enjoy the right to life as contemplated in section 11 of the Constitution. [789]

4.6.2. Recent threats to the Choice Act: Christian Democratic Party

Despite the court's decision above, reproductive health rights continue to be threatened and under attack. Such threats are as recent as 2017 when the Christian Democratic Party (hereinafter referred to as the ADCP) attempted to amend certain provisions of the Choice Act. This was not the first time that the ACDP attempted to amend the Choice Act. Below is a discussion of threats to reproductive autonomy laws by these proposed amendments and the harm it would have cause to South African women.

[785] Para 1121 of the Christian Lawyers case, 1998.
[786] Supra.
[787] Section 28(1)(3) of the Constitution.
[788] Para 1122 of the Christian Lawyers case, 1998.
[789] Supra.

4.6.2.1. The 2010 Amendment Bill

The 2010 Amendment Bill[790] was formulated as a member's private bill which allows members to submit bills in terms of section 73(2) read with section 76 of the Constitution.[791] In its long title, it is stated that the purpose of the bill is to assist women seeking to terminate by ensuring that they are fully informed of their decision.[792] This suggests that the proposed amendments are there to facilitate safe termination of pregnancies.

The proposed amendments to the Choice Act include, *inter alia*, that a pregnancy should only be terminated at a facility which has access to ultrasound machinery in order to accurately determine the duration of a pregnancy and to accurately determine the 'unborn child's' state of development as such information would be helpful in assisting the pregnant woman make an informed choice about her pregnancy.[793] The effect of this provision is that all abortion clinics would require ultrasound machinery in order to legally perform termination procedures. This proposed amendment was against the WHO guidelines which indicate that the use of ultrasound machinery is not necessary in determining the gestation period.[794] This would place a major burden on state resources and ultimately force such termination clinics to close down due to non-compliance.[795] As already stated in this chapter, there is already a limitation on state facilities providing termination services. This provision, if implemented, would have had the effect of further limiting women's access to reproductive health.

The Bill also proposed that such facility should give access to counselling which includes illustrations such as electronic pictures and/or diagrams which will, again, assist the pregnant 'mother' by giving her full details of the development of her 'unborn child'.[796] There are problems with the wording of this section as, firstly, it gives the

[790] Dudley's Legislative Proposal on Choice on Termination of Pregnancy Amendment Bill: rejected, available at https://pmg.org.za/committee-meeting/12173/, accessed on 24 December 2020 (hereinafter referred to as the 2010 Amendment Bill). Also see Swemmer op cit note 78 at 110.
[791] Swemmer op cit note 78 at 110.
[792] 2010 Amendment Bill op cit note 774.
[793] Section 3(1)(h)(i) 2010 Amendment Bill.
[794] WHO abortion guidelines op cit note 267 at 34.
[795] The SAHRC warned that such a provision needs to be weighed against the costs of obtaining such ultrasound machinery as many private termination facilities rely on donations. Such a provision has the effect of limiting access to termination and this would have a negative impact, particularly on women living in rural areas (see SAHRC comments on 2010 Bill op cit note 730).
[796] Section 3(1)(h)(ii) 2010 Amendment Bill.

foetus personality status by referring to it as a child as opposed to a foetus.[797] The possible effect of this on the pregnant women is making her feel or believe that terminating her pregnancy is 'killing' her unborn child. Secondly, it refers to the pregnant women as a 'mother' – as if the child is already alive. When it comes to the issue of providing the pregnant women with the relevant information about the state of development of the unborn child, it is hard to imagine the relevance of this provision in assisting pregnant women to make an informed decision. The South African Human Rights Commission was of the opinion that this provision would do more harm than good.[798] For instance, there are many victims of rape and incest in South Africa. Forcing a pregnant women to see pictures of her unwanted foetus could be very traumatic and result in her reliving the pain which caused her pregnancy.[799]

Further to this, it was suggested that such counselling aught to include a 'discussion of the extent of the risks involved in continuing the pregnancy as set against the risks involved in terminating the pregnancy including breast cancer, depression and future difficulties in conceiving and bearing children'.[800] Such a provision is not supported by medical evidence and has been used by many anti-abortion activists in order to deter women from accessing termination services.[801] The Commission believed that such a provision is a tactic to prevent as many women as possible from accessing termination services. [802] Again, this raises concern about the true intention of the ACPD's Amendment Bill.

Lastly, the Bill indicated that such counselling should advise the pregnant 'mother' on alternatives to termination which includes adoption and state resources available to pregnant women like the social grant.[803] Notwithstanding the wording of this section (which continues to refer to the pregnant woman as a mother) there is no harm in advising such a woman about alternatives to termination, provided: (a) she has consented to such counselling, and (b) the social worker provides valuable information

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[798] SAHRC comments on 2010 Bill op cit note 730.
[799] Ibid.
[800] Section 3(1)(i)(iv) of the 2010 Amendment Bill.
[801] SAHRC comments on the 2010 bill op cit note 730. Claims that termination procedures increase a women's risk for breast cancer are not supported by medical or scientific evidence and have been dismissed in many occasions in the past.
[802] Ibid.
[803] Section 3(1)(i)(v) of the 2010 Amendment Bill.

to assist the pregnant woman in make and informed choice instead of using counselling as an opportunity to convince her otherwise.

It is argued that the aforementioned changes had the effect, it they had been implemented, of making it more difficult for women to terminate, and not assisted them in making an informed choice as suggested by C Dudley.[804] In deciding on whether to accept C Dudley's amendment bill, the portfolio committee consulted with many stakeholders which include the Commission on Gender Equality, the Portfolio Committee on Women, Children, and Person's with Disabilities, as well as the Department of Health. Interestingly, the Gender Commission on Equality supported C Dudley's submission. This is a surprise considering what that the Gender Commission is a Chapter 9 institution of the Constitution – which is meant to protect the rights enriched in the Constitution.[805] The Portfolio Committee ruled, however, that the proposals made by C Dudley could not be accepted as it was not practical to implement it. The decision of the Portfolio Committee is welcomed. It is disappointing to note, however, that portfolio committee did not comment on the potential human rights violations proposed in this bill.

[804] SAHRC comments to the Portfolio Committee on Private Members' Legislative Proposals and Special Pertitions available at https://pmg.org.za/committee-meeting/12173/, accessed on 28 December 2020 (hereinafter referred to as the SAHRC report on the proposed 2010 bill). In its comments, the Commission expressed concerns about the true intentions of the proposed bill as it appeared to run contrary to the objectives of the Choice Act. Such intention seems to frustrate women's rights to access termination services, rather than to advance them.

[805] In its comments, the commission recognizes its responsibility to promote gender equality in South Africa. However, it then went to state that it supports C Dudley's proposal as the suggestions in the bill (such as the use of ultrasound machinery and informing the pregnant women of her right to terminate) as it promotes reproductive health care. I strongly disagree with this reasoning as the Commission fails to consider the wording and motives behind these provisions. The Commission also did not draw a link between promoting the constitutional reproductive right to health and the propositions made in this bill. Instead, the commission submitted its own submissions which were described as 'gaps' in the Choice Act. These gaps, as identified by the Commission, include: (1) the fact that children can also terminate by simply requesting to do so. It is difficult to imagine why this is a gap as children above the age of puberty are capable of having unwanted pregnancies and it is difficult to imagine how bearing unwanted children at a young age could be in their best interest; (2) the second gap is that the act does not make a distinction between surgical and medical terminations. The commission does not elaborate on this gap – it will, however, be explored later in this chapter; (3) the final gap is that the termination of women who are infected with HIV/AIDS has not been discussed in this legislation. It is difficult to see how this would help advance the rights of HIV positive women to terminate. Again, the Commission did not elaborate this point further. (See Commission on Gender Equality Submission, available at https://pmg.org.za/committee-meeting/12173/, accessed on 30 December 2020).

4.6.2.2. 2017 Amendment Bill

As the 2010 Amendment Bill was rejected, C Dudley challenged the Choice Act once again by submitting the Choice on Termination of Pregnancy Amendment Bill, 2017[806] (hereinafter referred to as the 2017 Amendment Bill). Most of the proposed amendments in the 2010 Amendment Bill were repeated in the 2017 Amendment Bill and, therefore, will not be discussed in further detail.[807]

Firstly, this bill proposed to delete Section 2(1)(iv) of the Choice Act, which provides that a pregnancy may be terminated from the 13th to the 20th week if the medical practitioner believes that such pregnancy would have a negative effect on the pregnant women's socio-economic circumstances.[808] This deletion would be substituted by the following paragraph:

> *(b*A*)* from the 13th up to and including the 20th week of the gestation period if **a medical practitioner and a social worker**, after consultation with the pregnant woman, are of the opinion that the continued pregnancy would significantly affect the social or economic circumstances of the woman;''[809]

The consequences of this provision were that a social worker would be required to give an opinion of the pregnant women's social as well as economic circumstances.[810] This provision was likely to delay the process of termination and, subsequently result in the denial of this right as time is of the essence in termination services.[811] The World Health Organisation has also advised that the involvement of more parties in

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[806] Choice on Termination of Pregnancy Amendment Bill available at https://static.pmg.org.za/ChoiceTermination.pdf, accessed on 23 December 2020 (hereinafter referred to as the 2017 Amendment Bill).

[807] Like the 2010 Amendment Bill, the 2017 Amendment Bill also included:the provision that the term 'gestation period' as defined in the Choice Act should be amended by providing that it needs to be confirmed by ultrasound machinery; that Section 3 of the Choice Act by inserting subparagraph cA which provides that termination of pregnancy may only take place in a facility that has access to access to ultrasound equipment and also gives counselling; it provided that such counselling should provide the pregnant woman with images of the her foetus in order for her to be fully informed of the state of development of her foetus. Further to this, the 2017 Amendment Bill also suggested that such counselling aught to inform the pregnant women about alternatives to termination, which include adoption, and also inform the pregnant women about the support that the state provides to mothers, including social grants. Lastly, the social worker responsible for counselling the pregnant women aught to advise her on contraceptive measures she may use to prevent future unwanted pregnancies.

[808] 2017 Amendment Bill.

[809] Supra.

[810] Supra. C Dudley is of the opinion that a medical practitioner does not have the expertise to determine whether a pregnancy would be detrimental to a pregnant women's socio-economic circumstances.

[811] WHO Abortion guidelines op cit note 317 at 87.

termination of pregnancy matters is a potential barrier to accessing reproductive health care rights.[812]

This Amendment Act also provided that counselling aught to be mandatory as opposed to non-directive.[813] Although some women opt to undergo counselling as they may need support when making the decision to terminate, other women refuse to be counselled as they take the decision to terminate the moment they realise that they are pregnant.[814] As already indicated above, a study conducted in the United States indicated that although women were offered counselling, many declined the offer as they had already spoken to someone they trusted, like their medical practitioner.[815] Mandatory counselling is against the Constitution as it goes against the right to physical and bodily integrity as recognised in section 12(2).[816] It also does not support reproductive autonomy rights.[817] Further issues with mandatory counselling is that it places a burden on state resources and this has the effect of causing delays on accessing this right.[818]

It is interesting to note that despite the findings of the parliamentary committee on the 2010 Amendment Bill, as discussed above, the ACDP persisted to impose mandatory counselling and the use of ultrasound machinery.[819] It is not doubtful that undergoing pre-termination counselling might assist many women seeking to terminate. Some of the proposed contents of the counselling are, in my opinion, important – for instance, informing the pregnant women about the use of contraceptives in future and informing her of the risks of pros and cons of terminating the pregnancy or otherwise. The problem with the proposed amendments is that it sought to force women to undergo counselling, even though they may not wish to.

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[812] Supra.
[813] Section 4 of the 2017 Amendment Bill.
[814] Swemmer op cit note 78 at 116.
[815] Ibid, 116.
[816] Ibid, 117.
[817] Ibid, 117.
[818] Ibid. 117.
[819] The ACDP argues, in the background to the 2017 Amendment Bill, that informed consent is seldom obtained by a pregnant women who undergoes counselling as 'insufficient' information is made available to the pregnant women. This is a generic and unsupported statement as there is nothing to prove that the information provided to a women being counselled is insufficient.

This bill was subsequently presented to the Portfolio Committee by C Dudley in March 2018.[820] The Committee rejected the Bill as it found that the requirement of undergoing ultrasound examination was not prescribed as a guideline in the 2012 Safe Abortion Guidance as prescribed by the World Health organisation. It is good to note that the Department of Health was also invited to respond to the proposed bill.[821] The department expressed concern about showing such women ultrasound images as such a requirement had the potential of causing counselling to be bias.[822] It could also deter such women from terminating their pregnancies by causing them to feel guilty.[823] It was also noted that mandatory counselling would go directly against the WHO guidelines which requires counselling to be voluntary and non-directive.[824]

The department also found that requesting a social-worker to comment on the pregnant women's socio-economic circumstances could be another barrier to the right to health by causing medically unnecessary delays.[825] This requirement also goes against the WHO guidelines.[826] Further to this, the WHO advised the Department by stating that 'The proposed pre-conditions to provision of care are not evidence-based, nor aligned with WHO recommendations. They are likely to further hamper access to safe abortion within the public sector and contribute to a rise in unsafe abortions which carry a higher risk of morbidity'.[827] Another concern, when it came to the implementation of this bill, was that it was likely to cost the government R47 billion over a period of five years.[828] The health department, therefore, did not support the proposed bill. The decision of the health department is welcomed as, as it stands, reproductive health rights are not adequately protected and these provisions would have worsened women's access to reproductive health.

[820] Choice on termination of Pregnancy Amendment Bill: Briefing; National Public Health Institute on South Africa Bill available at https://pmg.org.za/committee-meeting/26259/, accessed on 21 February 2021.
[821] Supra.
[822] Supra.
[823] Supra.
[824] Supra.
[825] Supra.
[826] Supra.
[827] Supra.
[828] Supra.

4.7. GAPS IN REPRODUCTIVE AUTONOMY LAWS UNFAIRLY DISCRIMINATE AGAINST WOMEN

Gaps in the reproductive legislative framework, as well as in the application of reproductive autonomy laws amount to unfair discrimination against poor women. Section 9 of the Constitution provides that all people should be treated equally and protects against unfair discrimination.[829] Section 9(4) also provides that no person may be directly or indirectly discriminated against on a ground listed in the Constitution.[830] Such grounds include, inter alia, race, gender, sex and pregnancy.[831] The test for unfair discrimination, as provided in *Harksen v Lane*[832] is two-fold: (1) it must first be established whether persons have been treated differently and, if a differentiation does indeed exist, a link must exist between the differentiation as well as a legitimate government purpose; (2) the second leg of the test is to determine whether such a differentiation is discriminatory in nature, it is indeed discriminatory, it must be established whether the discrimination was fair.[833] If the differentiation is based on a listed ground, it automatically amounts to discrimination.[834]

As was illustrated earlier in this chapter, there is limited access to termination of pregnancy services, caused by systematic failures in the implementation of reproductive health rights.[835] These gaps in the implementation of the right to terminate indirectly discriminate against women and female children on listed grounds (i.e. sex and pregnancy). In applying the first leg of the above test of *Harksen v Lane*[836]*,* these gaps differentiate wealthy and middle-middle class women from those who are poor and therefore rely on state resources. We have established that the National Health Act aims to provide free termination of pregnancy services.[837] Limited access to free termination of pregnancy facilities, therefore, is not aimed at achieving a legitimate government purpose. in applying the second leg of the test, limiting access

[829] Constitution of the Republic of South Africa, 1996.
[830] Supra, Section 9(4).
[831] Supra, Section 9(3).
[832] 1998 (1) SA 300 CC.
[833] Supra, para 42.
[834] Du Toit op cit note 590 at 82.
[835] Guttmacher op cit note 82 at 193. Also see Pickles (2013) op cit note 694 at 520.
[836] 1998 (1) SA 300 CC.
[837] Section 4(3)(c) of the National Health Act.

to state resources amounts to unfair discrimination as it has a direct impact on reproductive autonomy rights of poor women.

The same can be said about the forced sterilisation of HIV positive women. The Commission for Gender Equality found that the involuntary sterilisation of HIV positive women amounted to discrimination as it aimed to deny a specific population the right to reproduce on the basis that they are not good enough to bear children.[838] HIV positive women also have this right and it should not be restricted as a result of their HIV status.[839] The Commission acknowledged that HIV positive women are prone to be coerced into sterilisation.[840] A person's HIV status is not listed as a ground for discrimination, however, it does negatively impact on a person's right to dignity.[841] The forced sterilisation of HIV positive women amounts to unfair discrimination as it denies them the right to bear children on the basis of their HIV status. Medical practitioners who proceed to sterilise these women do so on the basis of preventing mother-to-child transmission of the virus.[842] The premise of such an argument is flawed as the use of antiretrovirals is very effective in preventing mother-to-child transmissions.[843] Such sterilisation also creates the perception that women are promiscuous and are therefore responsible for infecting men with the virus.[844]

4.8. CONCLUSION

Rights protected in international treaties and conventions such as the right to reproductive health, the right to self-determination, the right to dignity, the right to equality and non-discrimination, and the right of access to information are all protected in the South African Constitution and reproductive rights legislative framework. Notwithstanding the state's efforts in recognising these rights, gaps and threats

[838] Du Toit op cit note 590 at 80.
[839] Commissions report op cit note 612 at 47. The Commission referred to the case of Khosa v Minister of Social Development where the court held that the term 'everyone' includes all persons, including those living with HIV. The Commission also found that forcefully sterilising women as a result of their HIV status amounted to discrimination.
[840] Ibid, 47.
[841] Ibid. In the case of *Hoffman v SAA* 2001 (1) SA 1 (CC), the employment policy of the airline stated that HIV positive persons may not be hired as cabin attendants. The court found that this policy could not be justified as it had the consequences that HIC positive persons could not work as cabin attendants.
[842] Ibid.
[843] Ibid.
[844] Ibid.

continue threaten women's access to these rights. Most of these gaps are rooted in beliefs held by community members, as well as the negative attitudes of health care workers towards reproductive health care rights. The continued infringement of reproductive health care rights is also exacerbated by the state's inaction.

It unfortunate that the consequences of these gaps fall on the shoulders of poor black women, who cannot afford private reproductive health care. It will be noted in Chapter one of this dissertation that state's refusal to provide women with reproductive health care during the apartheid era (in particular, termination of pregnancy services) resulted in white middle-class women flying overseas in order to access such services.[845] The majority of black South African women, who could not afford to fly overseas resorted to back-street abortions.[846] Post the Choice Act, poor women continue to resort to unsafe termination, while middle class-women access reproductive health services in private facilities.[847] Could history be repeating itself in a democratic South Africa?

[845] Hodes op cit note 34 at 83.
[846] Hodes op cit note 34 at 83.
[847] Pickles (2013) op cit note 694 at 516.

Chapter 5

RECOMMENDATIONS AND CONCLUSION

5.1. INTRODUCTION

Gaps and threats to reproductive autonomy rights are worsened by state inaction. The state must, therefore, take positive action to ensure that these gaps cease to exist. The purpose of this chapter is to provide answers to the research questions and to propose measures that the state must take to ensure that it fulfils its international obligations to protect and fulfil reproductive health rights.

5.2. WHAT ARE THE ANSWERS TO THE RESEARCH QUESTIONS

a. *What has been the historical journey towards the development of reproductive laws in South Africa and in international human rights instruments?*
   The journey towards the development of reproductive health rights was not an easy one. When the international community adopted international instruments which sought to advance the protection of reproductive health, the South African government failed to ratify these instruments until post democracy. The journey of transition was particularly difficult in termination of pregnancy laws as pro-life advocates were against the enactment of pro-choice legislation. Hence, the South African government had to put a disclaimer that the Choice Bill was a health Bill as opposed to a morality bill.[848] There is limited information on the enactment of the Sterilisation Act (i.e. whether the legislature had any challenges with rolling out the Act). One may conclude, therefore, that the Sterilisation Act was not contested.

b. *To what extent does South African post-apartheid reproductive laws provide recognition and protection to reproductive health rights?*

[848] Hodes op cit note 34 at 85.

The preamble of both the Choice and Sterilisation Acts provide that the purpose of these Acts is to advance the Constitutional protection of sexual and reproductive health laws. The Choice Act advances the protection of reproductive health laws by providing women with a choice to terminate during early stages of pregnancy. The impact of this, however, is a limitation on this right as the pregnancy advances. This is a result of health and moral considerations. It is submitted, however, that the legislature aught to permit victims of rape and/or incest to terminate their pregnancy at later stages of pregnancy in cases where the foetus is not yet viable. Lastly, one of the biggest challenges in advancing reproductive health law is the implementation of these laws. The sentencing provisions in the Choice Act do not adequately protect reproductive health laws.

Turning to sterilisation procedures, the Sterilisation Act permits contraceptive sterilisation for all persons over the age of 18. This is great news as it promotes reproductive autonomy. Despite such positive advancements, gaps continue to exist in the legislative framework. Firstly, the Sterilisation Act permits sterilisation procedures on the basis of informed consent, however, it does not indicate whose responsibility it is to obtain such consent. This has the consequence of blame shifting and no accountability. Another gap in the Sterilisation Act is that it does not offer counselling to persons who wish to be sterilised. Although counselling should not be mandatory – it should, at the very least, be offered. The sentencing provisions of the Sterilisation Act also do not sufficiently protect reproductive health laws,

c. *Does the South African reproductive health framework regarding terminations of pregnancy and sterilisations meet international standards?*

Despite the legislature's attempts to comply with international standards, shortfalls continue to exist. For instance, the South African Constitution does not recognise one's right to have a family, even though this right is protected in numerous international instruments. The Courts have, however, recognised that this right forms part of the right to dignity.[849] Another shortfall is that the

[849] Dawood op cit note 550.

Sterilisation Act is silent on the issue providing sterilisation patients with counselling services, even though the WHO sterilisation guidelines emphasise the importance of offering counselling. The National Health Act also does not place a burden on the state to provide free sterilisation services. This is despite the state's duty to respect, fulfil and protect reproductive health rights.[850]

d. *Do threats to reproductive rights still exist in post-apartheid South Africa?*
Threats to reproductive autonomy laws continue to exist in a democratic South Africa. These threats were discussed in great detail in paragraph 4.6 of this dissertation.

e. *What changes are needed to strengthen the current legal framework?*
The necessary changes to advance reproductive health laws are set out in the next paragraph.

5.3. RECOMMENDATIONS

Gaps in reproductive health laws are two-fold. Firstly, there are gaps in the existing reproductive health legislative framework. Secondly, there are gaps in the application of reproductive health legislation.

5.2.1. The legislature must make the following amendments to existing reproductive health framework.

Firstly, As the National Health Act requires the state to provide free termination services, the same should apply to sterilisation services.[851] This will ensure equal access to reproductive health rights. Secondly, because of the permanent nature of a sterilisation procedure, the Sterilisation Act should be amended to include a provision which requires health care workers to offer counselling to persons who wish to undergo sterilisation procedures. This is necessary in the context of South Africa where a large emphasises in placed on pregnancy and motherhood.[852] Thirdly, the

[850] ICESCR General Comment no. 14 op cit note 184.
[851] Section 4 of the National Health Act.
[852] Bi op cit note 424 at 954.

sentence of a fine or imprisonment not exceeding 5 years is inadequate in cases of forced sterilisations of HIV positive women as they amount to a crime of violence against women.[853] The legislature should consider increasing the maximim sentence to at least 10 years, as is the case with unlawful termination of Pregnancies. the legislature should also consider the suspension or revocation of medical practitioners licenses in circumstances of sterilisation without properly obtained consent.[854] Fourthly, When it comes to the issue of obtaining a patient's informed consent in termination services, section 4 of the sterilisation Act needs to be more specific in determining who is responsible, between nurses and doctors, in obtaining a client's informed consent.[855] Lastly, Section 2(1)(c) of the Choice Act must be amended to allow women who fall pregnant as a result of rape and/or incest to terminate after 20 weeks provided that the following criterion is met: (1) the foetus is not yet viable; and (2) the termination will not cause a serious threat to the pregnant woman's life.[856]

5.2.2. Recommendations for the enforcement of existing reproductive health laws

When it comes to the issue of protecting and fulfilling pregnant women's right to terminate, the state should implement a goal-directed programme designed to educate members of society about matters concerning termination of pregnancy.[857] This should include influential members of society such as traditional leaders, nurses, midwives, as well as religious leaders.[858] These stakeholders educated about the advantages of respecting a pregnant woman's choice to terminate. For example, it prevents the possible rejection and child abuse that might result from an unplanned pregnancy.[859]

Health care workers also need to be encouraged and supported in the field of work as their work environment has a direct impact on the quality of reproductive health

[853] General Recommendation Adopted by CEDAW (No.19), available at https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_GEC_3731_E.pdf, accessed on 10 July 2021.
[854] McLaughlin op cit note 150 at 88.
[855] Pickles (2016) op cit note 495 at 98.
[856] McQuoid-Mason (2006) op cit note 439 at 121.
[857] De Roubaix op cit note 707 at 174.
[858] Ibid, 174.
[859] Nohaji op cit note 471 at 232.

services women receive.[860] The Basic Conditions of Employment Act[861] provides that each sector has a duty to create a caring environment for its employees.[862] Numerous studies have shown that there is a generally a lack of human resources and equipment in public health facilities.[863] Nurses have also expressed that there is a general lack of support from colleagues and management, which results in them feeling unappreciated.[864] The state, together with the health department, has to improve the working conditions of health care workers.

Turning to the issued of forced sterilisations, in 2016, the United Nations Committee on Economic, Social and Cultural Rights published General Comment no. 22.[865] This comment imposed a duty on the state to take positive steps to prevent forced sterilisation by health professionals in public hospitals through monitoring. [866] Therefore, government a duty to ensure that women are not forcefully sterilised and that that those who violate the right to sexual and reproductive health are prosecuted.[867] As medical practitioners and nurses play an important role in the implementation of the Sterilisation Act, they need to understand the importance of informed consent as well as patient autonomy.[868] It is important for them, therefore, to undergo training which will assist them with separating their view from the responsibilities they have when assisting HIV positive women.[869] These health care workers should also avoid sterilising women who are in the process of giving birth as this will allow them the opportunity to consider their decision and make an informed choice.[870]

[860] Pickles (2013) op cit note 694 at 516.
[861] Basic Conditions of Employment Act 75 of 1997.
[862] Nohaji op cit note 471 at 233.
[863] Pickles (2013) op cit note 694 at 522.
[864] Ibid, 516.
[865] General Comment no. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights, available at http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW1a0Szab0oXTdImnsJZZVQfQejF41Tob4CvIjeTiAP6sGFQktiae1vlbbOAekmaOwDOWsUe7N8TLm%2BP3HJPzxjHySkUoHMavD%2Fpyfcp3Ylzg, accessed on 15 March 2021.
[866] Supra.
[867] Supra.
[868] Supra, 89.
[869] Supra, 89.
[870] L McLaughlin 'The Price of Failure of Informed Consent: Coercive Sterilisation of HIV-Positive Women in South Africa' 2014 32(1) *Law & Inequality: A Journal of Theory and Practice* 87.

5.3. CONCLUSION

Gaps in reproductive health care deprive the most vulnerable South Africans of numerous constitutional and legislative rights. The state must, therefore, consider these gaps and implement the above recommendations to protect these rights.

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UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

Miss Mendy Nolwazi Mthethwa (212529582)
School Of Law
Pietermaritzburg

Dear Miss Mendy Nolwazi Mthethwa,

Protocol reference number: 00011325
Project title: A critical evaluation of the laws pertaining to sterilisation and termination of pregnancy: Exposing the gaps and threats

Exemption from Ethics Review

In response to your application received on 13 May 2021 , your school has indicated that the protocol has been granted **EXEMPTION FROM ETHICS REVIEW.**

Any alteration/s to the exempted research protocol, e.g., Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through an amendment/modification prior to its implementation. The original exemption number must be cited.

For any changes that could result in potential risk, an ethics application including the proposed amendments must be submitted to the relevant UKZN Research Ethics Committee. The original exemption number must be cited.

In case you have further queries, please quote the above reference number.

PLEASE NOTE:
Research data should be securely stored in the discipline/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours sincerely,

[redacted]

Mr Simphiwe Peaceful Phungula
obo Academic Leader Research
School Of Law