

**Determination of unsafe abortion among adolescents
following the liberalisation of abortion in South Africa**

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DECLARATION

I, Martha Nambuyaga Kavuma, declare that the works as presented in this mini dissertation is original. I do affirm that it has never been produced to any other institution or university. All primary and secondary sources used in this study have been duly acknowledged and referenced in accordance with the departmental requirements. I therefore present this work in partial fulfilment of the requirements of the award of the LLM/MPhil (Sexual and Reproductive Rights in Africa).

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DEDICATION

I dedicate this work to my best friend and husband, Henry Kavuma. You have been an inspiration for me throughout this journey.

It is also dedicated to my parents, Mr and Mrs Kaayi, my brothers and sisters for your continuous love and encouragement.

And to all young women who have committed themselves to improve the health status of other vulnerable young women.

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LIST OF ACRONYMS AND ABBREVIATIONS

List of acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
CEDAW	Convention on the Elimination of all Forms of Discrimination Against Women
CTOP Act	Choice on Termination of Pregnancy Act
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
MDGs	Millennium Development Goals
TOP	Termination of Pregnancy
POPIN	United Nations Population Information Network
UNCRC	United Nations Convention on the Rights of the Child
UNDRC	United Nations Declaration on the Rights of the Child
UNICEF	United Nations International Children's Emergency Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization
WPF	World Population Foundation

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CHAPTER ONE

BACKGROUND

1.1 Introduction

In most of the developing countries and in particular Sub-Saharan Africa, research indicates that there has been a decrease in the occurrence of sex at an early age compared to the past. However, there is still a significant proportion of young girls who are experiencing sex prematurely.¹ This is attributed to various reasons such as early marriages, changing levels of violence like war or civil unrest in which circumstances research has indicated that young women are in lesser positions to negotiate decisions that affect their health.² These changing situations have diverse implications for young women's reproductive health outcomes like the rise in unwanted pregnancies which in most cases has led to the increasing rates of unsafe abortions undertaken by adolescents with the covet to stay in school³ and pursue their future goals.

Unsafe abortion is one of the leading preventable causes of maternal death⁴ and ill health in young women's in Sub-Saharan Africa.⁵ The risk of death from unsafe abortion related complications in Africa is the highest among the regions in the world with a fertility rate (deaths per 100 unsafe abortion procedures) of 0.7 per cent.⁶ In Africa, there are marked disparities amongst countries in abortion-related mortality. These differences range from abortion legalization, socio-economic status, contraceptive coverage and the availability of accessible comprehensive abortion services.⁷ As a result, of these

¹ CB Lloyd (ed.) *Growing Up Global: The Changing Transitions to Adulthood in Developing Countries* (2005). 170-172.

² As above.

³ As above.

⁴ Guttmacher Institute 'Facts on abortion in Africa' (2015).
https://www.guttmacher.org/pubs/IB_AWW-Africa.pdf (accessed 1 February 2016).

⁵ CB Lloyd, 'The role of schools in promoting sexual and reproductive health among adolescents in developing countries.' in S Malarcher (eds) *Social determinants of sexual and reproductive health: informing future research and programme implementation* (2010)122.

⁶ World Health Organization (WHO) *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003* fifth edition (2007) 14-18.

⁷ RS Fawcus 'Maternal mortality and unsafe abortion' (2008) 22 (3) *Best Practice & Research Clinical Obstetrics and Gynecology* 533-548.

importunate disparities unsafe abortion still remains a persistent public health challenge in many African countries.⁸

The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating an unwanted pregnancy carried out either by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards or both.⁹ Additionally, WHO emphasizes that the elements of unsafe abortion do not only end at the process of procuring an abortion, but extend to the unsuitable situations before, during and after procurement of unsafe abortion services.¹⁰

According to studies, it is estimated that 60 per cent of women of reproductive age in the world live in countries where at least abortion is acceptable on one of the specified grounds.¹¹ Grounds for abortion in the majority of countries that permit it include; safety of the woman's life; protection of the physical and mental health of a woman: remedy for incest or rape; fetal impairment and for economic or social reasons in the case of South Africa.¹² However the availability of these laws may not automatically translate into access of safe abortion services since 358 000 women die each year as a result of unsafe abortion¹³ while the majority five million, suffer from permanent or temporary disabilities resulting from abortion-related life threatening complications.¹⁴ Death and disabilities resulting from unsafe abortion therefore, presents a tragic unnecessary risk to women's health and loss of lives yet these deaths can be preventable.¹⁵

⁸ WHO *Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003* fifth edition (2007) 15.

⁹ WHO 'The prevention and management of unsafe abortion: Report of a Technical Working Group' (1992) Geneva 4.

¹⁰ WHO 'Unsafe Abortion: Global and regional estimates of the Incidence of unsafe abortion and associated mortality in 2008' (2011) sixth edition 2.

¹¹ United Nations Population Division, *Department of Economic and Social Affairs. World Abortion Policies*; (2007)1.

¹² C Shannon & B Winikoff 'Unsafe abortion and strategies to reduce its impact on women's lives' in S Kehoe *et al* (eds) *Maternal and Infant Deaths: Chasing Millennium Development Goals 4 and 5* (2010) 152.

¹³ As above.

¹⁴ I Shah & E Åhman 'Unsafe abortion: Global and regional Incidence, trends, consequences, and challenges' (2009) 31(12) *Journal of Obstetrics Gynaecology Canada* 1149–58.

¹⁵ D Grimes *et al* 'Unsafe abortion: the preventable pandemic' (2006) 368 *Lancet* 1908-1919.

1.2 Problem statement

South Africa like many African countries is still struggling with high rates of maternal mortality having one of the greatest contributors in unhygienic and unsafe abortions.¹⁶ Between 1975 and 1996 South Africa saw a large number of clandestine abortions annually ranging from 120 000 to 250 000.¹⁷ However, after the institution of the Choice for Termination of Pregnancy Act (CTOP Act) in 1996, maternal mortality rates begun to decrease as a result of the reduction in 'backstreet' abortions.¹⁸ Complications attributable to unsafe abortion tremendously declined to about 91 per cent.¹⁹ This has been a big success and presents South Africa as one of the model countries in Africa that demonstrate women's rights to abortion.

In spite of the registered success, there still exist a significant number of South African women who have restricted access to safe abortion services and as a result become susceptible to complications associated with unsafe abortion procedures. Sipokazi Fokazi notes that almost 700 women who had second trimester abortions at four provincial hospitals from April to August 2010, 17 per cent had tried to end the pregnancy before using unsafe methods.²⁰ Furthermore, in the study by the *South African Medical Journal*, researchers found out that 15.6 per cent of the women interviewed had used an illegal backstreet abortionist.²¹ About 19 per cent had used medication like antibiotics while 6.2 per cent tried to induce abortion by 'smoking a lot'.²² Additionally, a report from WHO on Trends in material mortality indicated that maternal mortality rates in South Africa had increased standing at 300 deaths per 100 000 live births as a result of the increased backstreet abortions.²³ Similarly, South Africa's Saving

¹⁶ S Guttmacher, *et al* 'Abortion reform in South Africa: A case study of the 1996 Choice on Termination of Pregnancy Act.' (1998) 24 (4) *International Family Planning Perspectives* 191-194.

¹⁷ Guttmacher *et al* (n 16 above) 192.

¹⁸ JC Patel & CM Manqoba 'Attitudes towards abortion in a sample of South African female university students' (2008), 38 (3) *Journal of Applied social psychology* 738.

¹⁹ SA Cohen 'New data on abortion incidence; Safety illuminate key aspects of worldwide abortion debate' (2007), 10(4) *Guttmacher institute* 4.

²⁰ S Fokazi 'Backstreet abortions a first choice for many' *NEWS/CRIME-COURTS* 15 April 2014 <http://www.iol.co.za/news/crime-courts/backstreet-abortions-a-first-choice-for-many-1.1676196> (accessed 15 January 2016).

²¹ As above.

²² As above.

²³ WHO *Trends in maternal mortality: 1990 to 2010*, WHO, UNICEF, UNFPA and The World Bank estimates

the Mothers report 2008-2010²⁴ also revealed that 186 of the 4867 maternal deaths registered between 2008-2010, were attributed to miscarriages in the public health facilities²⁵ and 44 of the 186 were as a result of the maternal complications due to unsafe abortion.²⁶ This presents a significant figure given the fact that South Africa is one of the few countries that have recognized the reproductive rights of women through the liberalisation of abortion.²⁷

Over the years, the issue of unsafe abortion in South Africa has been extensively studied. However, statistics on the prevalence of unsafe abortion are estimated especially since majority of the maternal death due to unsafe abortion happen outside the formal health system and are neither accounted for nor documented.²⁸ This is because in many cases vulnerable women who may not have access to these free health services are likely to die in their homes implying that the numbers could be higher than the estimated.

Several studies in the different parts of Sub-Saharan Africa and South Africa in particular have been undertaken to ascertain the factors that drive women to obtain unsafe abortion. However, there is a need to particularly analyse the determinants for adolescents' continued use of unsafe abortion services in a country where abortion is liberalised taking cognizance of the complex diversities in South Africa. Adolescents have their unique needs, which might vary according to marital status, age, schooling status, location and economic status.²⁹ Much of the available information is provided for either older adolescents, or in school adolescents which may be biased and hence mislead programming. In order to develop effective initiatives that will foster positive outcomes among adolescents, there is need to study and understand the determinants in accessing

(2012) <http://www.who.int/reproductivehealth/publications/monitoring/9789241503631/en/> (accessed 10 may 2016).

²⁴ Department of Health, Saving mothers 2008-2010: Fifth report on the confidential enquires into maternal deaths in South Africa. (2012) Department of Health.2-23.

²⁵ As above.

²⁶ As above.

²⁷ N Naylor & MO Sullivan 'Know your rights: conscientious objection and the implementation of the CTOPA 92 of 1996 in South Africa' (2010) Women's Legal Centre and Ipas South Africa 1.

²⁸ L Say *et al* 'Global causes of maternal death; a WHO systematic analysis' (2014) 2 *Lacent Global Health* 323.

²⁹ P McIntyre (ed) *Growing in confidence: programming for adolescent health and development, lessons from eight countries* (2003) WHO Department of Child and Adolescent Health and Development 2-28.

unsafe abortion services by all adolescents in a country where abortion is liberalised. The generated evidence together with the use of the right-based approach will guide in the designing of effective programmes for adolescents. The use of these two approaches; evidence and rights-based approach, will facilitate identification and addressing of actual health needs which will help in blocking the perceived subjective needs that are created by adults.³⁰

Aside from the above, this research is aimed at adding to the body of knowledge available. It will mainly focus on the determinants of unsafe abortion following the liberalisation of the abortion law. This is primarily because unsafe abortion still remains one of the many reproductive health challenges that are affecting adolescents' health consequently contributing to the high maternal mortality in the country. The identified determinants of unsafe abortion are treated as gaps that have to be addressed by the reproductive health interventions.

1.3 Research Objectives

The overall aim of the study was to examine the determinants of unsafe abortion among adolescents despite the existence of a liberal abortion law in South Africa.

Specific objectives included:

1. To explore knowledge, attitudes and behaviors of adolescents and how these influence their access to unsafe abortion services following the liberalisation of abortion in South Africa.
2. To examine circumstances that influence adolescent access to unsafe abortion services despite the liberalisation of abortion in South Africa.
3. To generate recommendations that could be used by the policy makers and programmers to develop effective programmes that will address gaps in seeking liberalised abortion services by adolescent.

³⁰ J Leerlooijer, 'Improving the quality of sexual and reproductive health rights education programmes for young people: checklist for programmes officers' (2009) *Stop AIDS Now! & World Population Foundation* 2-3.

1.4 Research Questions

The study attempted to answer the following key questions.

1. What are adolescent knowledge levels on safe abortion services?
2. What are adolescents' perceptions towards unsafe abortion services?
3. In what ways do adolescents' knowledge and perceptions influence their decisions to access unsafe abortion services even though abortion is liberalised in South Africa?
4. What adolescents' behaviors influence their access to unsafe abortion services in an environment where abortion is liberalised?
5. What are the circumstances or conditions that prompt adolescents in seeking unsafe abortion services irrespective of the liberalisation of the abortion law in South Africa?
6. What are the implications of the findings to existing adolescent sexual and reproductive health interventions in South Africa?

1.5 Rationale/Justification of the study

This study was intended to generate evidence on the determinants of unsafe abortion among the various categories of adolescents following the liberalisation of the abortion law in South Africa. Due to the sensitivity of abortion as a topic, understanding its magnitude among the different categories of adolescents will influence the design and implementation of effective initiatives that will be tailored to the needs of these adolescents.

Additionally, available evidence will be used by relevant stakeholders in the various communities to identify gaps which need to be addressed, as well as developing best practices which may be replicated in order to minimize the number of adolescents seeking unsafe abortions regardless of their status. In a nutshell, this study evidence will inform stakeholders or sectors not only in the intended area of study but also in other countries with a similar context.

1.6 Methodology

1.6.1 Theories and models for the study

In attempting to answer the research questions, such as adolescents' knowledge, perceptions, behaviors and circumstances that influence their decisions to access unsafe abortion services in an environment where abortion is liberalisation, the theory of planned behavior was used.

The theory of planned behavior is established on three principles; behavioral beliefs, normative beliefs and control beliefs.³¹ Behavioral beliefs acknowledge possible perception of what the significant others view towards the specific behavior which in many ways can result in social pressure or subjective norm. Lastly control beliefs which regards beliefs about existence of aspects that may aid or hinder performance of a behavior;³² such outcomes of the behavior in question and generate constructive or adverse attitudes towards the behavior. Normative beliefs on the other hand, relate to one's attitudes can elevate perceived behavioral control.

The attributes above therefore, can direct development of behavior intentions in human beings. For instance, an individual's rationale to undertake a given action can be persuaded by his or her acquisition of positive attitudes, subjective norms and greater perceived control.³³ This theory therefore, facilitated the research in asserting the attitudes, behavior and external factors that determine adolescent's preferences for unsafe abortion services despite South Africa's liberal law on abortion.

In order to further understand the determinants that influence adolescents' behavior towards seeking unsafe abortion, the World Population Foundation and Stop AIDS Now! Behavior model was also used to guide the interpretation of the findings.³⁴ The planned behavior theory highlighted above is the basis on which this behavior model was developed. The use of this model is vital as it helps us to identify, determine and explain why certain behaviors keep reoccurring as well as help in changing appropriate

³¹ I Ajzen 'The theory of planned behavior' (1991) 50(2) *Organizational Behavior and Human Decision Processes* 179-211.

³² As above.

³³ As above.

³⁴ Leerlooijer (n 30) above 3.

behavior of a given health problem. In determining the factors that are related to the problem, it helps to explore appropriate interventions which are likely to create positive change. In this study we apply the term 'Behavior change' to specifically refer to the 'behavior needs that need to be changed'.

In attempting to understand behavior for young people, research indicates that sexual and reproductive health and rights (SRHR) initiatives for young people that are contrasted on 'behavior change models' are bound to be successful. These Change models assert that all problems particularly health and rights problems are deciphered into behavior. For instance, 'highlighted behavior of the young pregnant girls at risk' could be a result of the negative 'behavior of the people in their environment' like the attitudes of healthcare workers towards teenage pregnant girls and their decision to terminate a pregnancy thus turning to unsafe alternatives. This model also helps us analyse why young girls respond negatively towards access to liberalised abortion services by differentiating several factors that can affect behavior (these can also be indicated as determinates).

Figure 1 illustrates a model with the different determinants that stimulate behavior among adolescents. It further demonstrates how the environment influences knowledge, attitudes, risk perceptions, social influence and self-efficacy to perform an action. This figure continues to elaborate that a combination of any of these factors can form positive or negative intent to execute a given action. If the intentions developed have no interventions from the external factors, and appropriate skills to defy the demands, the proposed behavior will be executed.

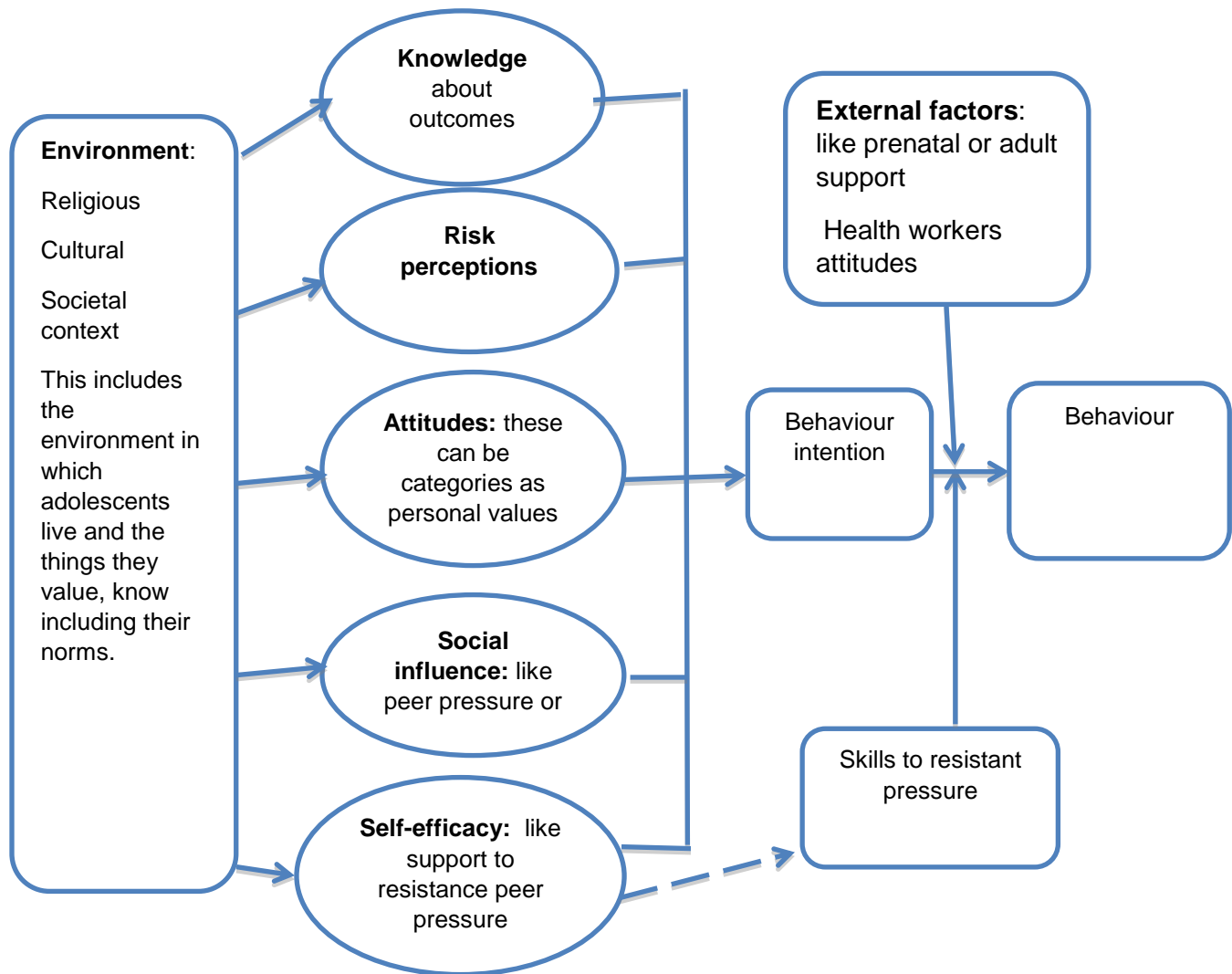


Figure 1: Theory of planned behaviour

Source: Adopted from the World Population Foundation evidence and rights based planning and support tool for SRHR/HIV prevention interventions for Young People, of 2009.³⁵

³⁵ As above.

1.6.2 Research design

Due to the availability of literature on unsafe abortion for both women in general and adolescent girls in particular, this study sought to review and analyse secondary data in order to explore the determinants for unsafe abortion by adolescents in South Africa. The desk review of literature included: (a) Journals articles and books on unsafe abortion following the liberation of the abortion law among adolescents; (b) South Africa's legislation and judicial decisions on the topic of abortion both within and out of South Africa; And (c) International human rights declarations that have a bearing on adolescent reproductive health rights, specifically abortion services.

In attempting to find relevant information to inform the study search engines such as Google scholar, Google and *Pub med* were used. Words such as adolescents, unsafe abortion, termination of pregnancy, South Africa, young people, sub Saharan Africa, CTOP Act, reproductive health and teenage pregnancy.

Another great source of information were websites of different institutions like United Nations, WHO, *Guttmarker institute*, International Planned Parenthood Federation (IPPF) and other development partners working in the area of adolescent and their reproductive rights.

Local websites like Department of Health, Department of Education, Department of Social Development and non-governmental organisations working with adolescent health were also used since these institutions provide up to date information or data in relation to adolescent health. The information considered for the review was within a fifteen year period (January 2000 to December 2015). This timeframe is chosen in order to limit on the sample size of the materials as well as to collect up-to-date materials that will effectively inform this study.

1.6.3 Limitation of the study

This study primarily focuses on the determinants to the access of unsafe abortion by adolescents following the liberalisation of the abortion law (including married and unmarried). It is however not focused on barriers to their access to all reproductive health

care services and yet other reproductive health services have a great role they play in understanding unsafe abortion following liberalisation on of the abortion law.

The study is also limited to female adolescents and therefore it does not include other women of reproductive age nor does it include male adolescents or other male partners yet they are key in understanding adolescent's access to unsafe abortion. In the study adolescent girls are defined as those between the ages of 12 to 18 ages even though WHO defines an adolescent as a person between the ages of 12 to 19 years.³⁶ The reason behind this limitation is that in South Africa a person is regarded as an adult once they reach 18 years.³⁷ This is further emphasized by a number international and regional human rights treaties that also refer to adolescents as adults once they become 19 years.

Additionally the researcher was also challenged with getting up to date information on adolescents particularly as most of the literature available was more focused on all women of reproductive age. Basing on the above the research had to increase the scope of the study from 10 years to fifteen years. Also since most data available is from published materials this left out vast majority of good materials/findings that are not published which could be very useful to enrich this study.

1.7 Definitions

1.7.1 Concept of adolescence

Since there is no universally agreed definition of adolescence with any prejudice to definitions as highlighted by the different states, the United Nations defines adolescence as all persons aged between the ages of 12 to 19 years.³⁸ However, the age ranges of adolescences trends to vary as per a given society or culture. For example there are three identified concepts of age; social age, chronological age and biological age.³⁹ The

³⁶ United Nations, *Report of the Advisory Committee for the International youth year (1981) UN document A/36/215*.

³⁷ Children's Act 38 of 2005 as Amended by Children's Act 41 of 2007 chapter one 12.

³⁸ United Nations (n 36 above) 1.

³⁹ BA Hamburg 'Subsets of adolescent mothers: developmental, biomedical, and psychosocial issues' in JB Lancaster & BA. Hamburg (eds) *school-age pregnancy and parenthood: Biosocial dimensions* (1986) 115-45.

chronological concept used in South Africa measures important biological and cultural highlights.⁴⁰ A case in point is the measure of the average age prescribed for high school level pupils determined as 13 and 18 years.⁴¹

Additionally, according to the Children's Act, a child may consent to his or her medical treatment or surgical operation or that of her his or child if that child is over the age of 12.⁴² Section 129 of the Children's Act directly makes linkages to section 5(2) of the CTOP Act, which provides for treatment or surgical operations of a child only with their consent and within the specified sub sections of the Act.⁴³ Therefore as highlighted above, the term adolescence as used in this research refers to young girls between the ages of 12 to 18 years.

1.7.2 Adolescent pregnancy

Adolescent pregnancy also referred to as teenage pregnancy is the pregnancy that occurs with a teenage girl of 19 years and below and in which case these girls have not reached the legal adulthood age.⁴⁴

1.7.3 Illegal Abortion

Illegal abortions are procedures under taken by anybody who is not skilled or by skilled health workers under conditions that violate the laws on termination of pregnancy.⁴⁵ These include absence of approved clinical environment to provide safe abortions, health workers using poor quality medications and offering abortions beyond 20 week of pregnancy.⁴⁶ This can be self-induced or induced by unauthorized person. Because of the conditions in which they are operated, illegal abortions are often linked with life threatening conditions.

⁴⁰ As above.

⁴¹ Department of Basic Education, Education for all (EFA) 2014 Country progress report (2014) 14-19.

⁴² Children's Act 38 of 2005 Sec, 129 (2)(a),(3)(a).

⁴³ The Choice on Termination of Pregnancy Act (CTOP Act), (Act 92 of 1996) sec, (2),(3),(4),(5), (6), & (7).

⁴⁴ 'Plan your future, plan your families', World Population Day (2008) *Fact Sheet*

http://www.unicef.org/malaysia/Teenage_Pregnancies_-_Overview.pdf (accessed 13 May 2016) 1.

⁴⁵ See Farlex Partner Medical Dictionary, 'illegal abortion' <http://medical-dictionary.thefreedictionary.com/illegal+abortion> (accessed 5 June 2016) 1.

⁴⁶ Marie Stopes South Africa, 'Avoiding illegal/ unsafe abortion: what every woman needs to know to stay safe' <http://www.mariestopes.org.za/wp-content/uploads/2013/12/MSSA-Illegal-Abortions-Brochure.pdf> (accessed 20 June 2016)2.

1.7.4 Contraceptives

According to Ketting and Visser, contraceptives are defined as methods that can be used momentarily or permanently to thwart the occurrence of conception.⁴⁷ These temporarily methods include: barrier methods, hormonal and non-hormonal methods and sterilization as a permanent method. Furthermore, Medical Dictionary defines contraceptives as agents that ‘prevent pregnancy by interfering with the normal process of ovulation, fertilization and implantation.’⁴⁸

1.7.5 Health care providers

According to the Mosby’s Medical Nursing and Allied Health Dictionary a health care provider is described as any person who has acquired skills and is certified by a registered and recognized professional body or government organization to provide health services.⁴⁹ A case in point is a physician, midwife and psychiatrist. For this study health care providers are defined as skilled personnel who are able to provide a friendly environment⁵⁰ or hinder adolescents’ access safe abortion services.

1.7.6 Reproductive health

The United Nations Population Information Network (POPIN) defines reproductive health as ‘a state of complete physical, mental and social well-being. It is not merely the absence of disease or infirmity, in all matters relating to the reproductive health system, its function and processes.’⁵¹ Young people’s reproductive health is therefore very vital as it forms a strong foundation for them as they transcend from childhood into adulthood. If not addressed it can lead to poor adolescent health which can tremendously make them

⁴⁷ E Ketting & AP Visser, ‘Contraception in the Netherlands: the low abortion rate explained’ (1994) *Patient Education and Counselling* 2(31)161.

⁴⁸ See Farlex Partner Medical Dictionary (2012) <http://medical-dictionary.thefreedictionary.com/contraception> (accessed 20 May 2016) 1.

⁴⁹ KN Anderson, LE Anderson & WD Glanze (ed) *Mosby’s Medical, Nursing, & Allied Health Dictionary* fifth edition (1998).

⁵⁰ KS Lundy, & S Janes, *Essentials of community-based nursing* (2003).5.

⁵¹ See United Nations Population Information Network (POPIN) guidelines on Reproductive Health, document prepared by the *Secretariat of the United Nations Inter-Agency Task Force on the Implementation of ICPD Programme of Action* <http://www.un.org/popin/unfpa/taskforce/guide/iatfreph.gdl.html> (accessed 11 May 2016) 1.

vulnerable to diseases and affect their family circumstances thereby reducing on their life expectancy.⁵²

1.7.7 Maternal mortality

This is referred to the death of a woman during or while giving birth or death within 42 days after delivery, miscarriage or termination of a pregnancy in which case the death of this woman is associated with pregnancy or treatment as opposed to any other cause of death.⁵³

1.7.8 Termination of pregnancy (TOP)

Termination of pregnancy also referred to as induced abortion is defined by the legal dictionary 'as the spontaneous or artificially induced expulsion of an embryo or fetus', from the womb before its doable age.⁵⁴ In South African termination of pregnancy is legal depending on the gestation age of the fetus. Commonly used method of TOP in the first trimester is by drugs and surgical procedures in a few cases well as the second trimester there is the use of drugs and dilation and evacuation is used.⁵⁵ TOP in the third trimester is only allowed in situations that pose a life threat to the life of a pregnant.⁵⁶

1.8 Chapter outlines

The study comprises of four chapters. Chapter one presents an overview of the study specifically highlighting the problem statement, research questions, and research objectives, significance of the study, methodology, and limitation of the study plus the research questions the study seeks to answer. Chapter two on the other hand, discusses the context of the abortion law and minors consent to abortion in South Africa while the third chapter deals with discussions on the determinants of adolescent's access to

⁵² Lloyd (n 5 above) 122.

⁵³ L Høj, *et al* 'Maternal mortality: only 42 days?' (2003)110(11) *An international Journal of Obstetrics & Gynaecology* 995-1000.

⁵⁴ See *Collins Dictionary of Law* (2006) <http://legal-dictionary.thefreedictionary.com/Termination+of+pregnancy> (accessed 20 May 2016).

⁵⁵ K Dickson-Tetteh, H Rees & J Duncan, *National adolescent-friendly clinic initiative: a love-life initiative in partnership with the Department of Health* (1999) Johannesburg: Reproductive Health Research Unit, Baragwanath Hospital 20.

⁵⁶ Choice on Termination of Pregnancy Act (CTOP Act) 92 of 1996 Sec, 2(c).

unsafe abortion in a liberalised environment. The last chapter (four) highlights the conclusion and recommendations of this study.

CHAPTER TWO

LIBERALISATION OF THE SOUTH AFRICAN LAW ON ABORTION

2.1 Introduction

This chapter will aim at examining the historical background of the South African laws on termination of pregnancy (TOP) and as it relates to the adolescents. It will also look at the national sources of the TOP law and explore its relevancy to adolescent's right to termination of pregnancy. As much as possible this section will highlight the role of national courts in supporting government to fulfill and protect the reproductive rights of the adolescents.

2.2 The South African Abortion law before 1996

In South Africa under the Roman-Dutch common law, abortion was perceived to be a crime.⁵⁷ Aside from abortion being permitted to save a life of a mother,⁵⁸ Strauss asserts that 'several vital questions regarding termination of pregnancy remained unanswered in our positive law'.⁵⁹ This law was elusive as to whether abortion would be procured with the aim of protecting a woman from mental and physical impairment resulting from the ongoing pregnancy,⁶⁰ or in instances where the unborn child would suffer serious mental or physical deformity.⁶¹ With no authority in law clarifying on the 'defense of necessity to procure an abortion' under these circumstances,⁶² many medical practitioners continued to perform abortions for desperate women as a way of rescuing them from related desperate situations.⁶³ This led to speculative legality in the expanse of therapeutic abortion by different critics.⁶⁴

⁵⁷ PM Hunt & J R L Milton *South African criminal law and procedure*, (1982) 311.

⁵⁸ As above.

⁵⁹ SA Strauss 'Therapeutic abortion and South African law' (1968) 85 *South African Law Journal*: 453-438.

⁶⁰ Hunt & Milton (n 57 above) 313.

⁶¹ C Ngwena, 'The history and transformation of abortion law in South Africa,' (1998) 30(3) *Acta Academica* 35.

⁶² Strauss (n 69.above) 460-461.

⁶³ As above.

⁶⁴ Ngwena 'The history and transformation of abortion law in South Africa' (n 61 above) 36.

Albeit the gaps in this law, there existed the English common law which provided for the 'defense of necessity' aimed at protecting the mental and physical health of a woman.⁶⁵ This law was particularly highlighted in the *R v Bourne* case⁶⁶ where a medical doctor performed an abortion for a rape victim with the reasoning that the continuation of the pregnancy would seriously affect her mental health. The *Bourne* case was used in the judgment of *S v Druten* case⁶⁷ in 1971 where the magistrate held that therapeutic abortion did not only apply to saving the life of pregnant woman but also extended to other clinical conditions.⁶⁸ Despite this ruling, the expansion of abortion had not been put into consideration.

However, in 1972 a landmark case involving a doctor (Dr. Derk Crichton) who was found guilty of undertaking illegal abortions on white teenage girls⁶⁹ took center stage to trigger discussions on the need to formulate the new abortion law. Following the decision of the court there was a formulation of the Commission of Enquiry to cogitate a law that would expance on abortion⁷⁰ and give legal avowal to the ongoing practices of abortion⁷¹ such as the ongoing clandestine abortions that were undertaken by teenage and unmarried white girls.⁷² Despite the escalating backstreet abortion among black women, the new law only took into account the needs of White women who were presumed to be in need of protection to enable them reproduce and multiple the white race⁷³ against the black women. This was evident in the proclamation by a commissioner:

⁶⁵ W Glanville, *The sanctity of life and the criminal law*. (1957).150-170.

⁶⁶ *R v Bourne* case (1938) 3 All ER 615.

⁶⁷ *S v Druten* case (1971) (Unreported). For a summary of the judgment see SA Strauss *Doctor, patient and the law* (1984) 219-24.

⁶⁸ As above.

⁶⁹ S A Strauss, 'Therapeutic abortion: two important judicial pronouncements' (1972) 46(11) *South African Medical Journal* 275–276.

⁷⁰ *Report of the Commission of Enquiry into the Abortion and Sterilization Bill RP 68 of 1974*, as discussed in 1974 Annual Survey report. 456.

⁷¹ SA Strauss *Doctor, Patient, and the law: A selection of practical Issues* (1991) 207.

⁷² SM Klausen, "Reclaiming the White Daughter's Purity": Afrikaner Nationalism, Racialized Sexuality, and the 1975 Abortion and Sterilization Act in Apartheid South Africa' (2010) 22(3) *Journal of women's history* 53.

⁷³ H Bradford 'Herbs, knives and plastic: 150 years of abortion in South Africa' in T Meade & M Walker (ed) *Science, medicine and cultural imperialism* (1991)120-147.

The Bantu and Coloured population groups . . . take it for granted that they have to bear the responsibility of the consequences of their sexual conduct⁷⁴ or that legalising abortion would reduce health resources for 'legitimate patients' due to the high influx of black women demanding for abortion.⁷⁵

Evidently the commission's recommendations were adopted and translated into the 1975 Abortion and Sterilization Act.⁷⁶

Years later the Abortion and Sterilization Act of 1975 was passed. On the whole the Act seemed to provide more freedom for women to access abortion services as compared to the previous abortion laws by specifically outlining the circumstances under which abortion can be obtained. Under the new Act, abortion was permitted under; (a) in cases where the continued pregnancy endangers the life of the pregnant woman or constitutes a serious threat to her physical health;⁷⁷ (b) where the continuation of the pregnancy would pose serious threat to the mental health of the woman and create danger of permanent damage to the mental health of a woman;⁷⁸ (c) where there is serious mental and physical defect of the unborn child that would lead to serious irreparable handicap;⁷⁹ and (d) where the pregnancy is as a result of unlawful canal intercourse such as rape or incest or intercourse with a woman said to be an idiot or imbecile.⁸⁰

However, it was contended that this new law instead created a more restrictive environment for women to procure abortion services.⁸¹ For example, before undertaking legal abortion, women were expected to get written certification from two medical practitioners stating that the continuation of the pregnancy would pose danger to the life of the mother⁸² or that there is scientific evidence that the unborn child will suffer

⁷⁴ Klausen (n 72 above) 52.

⁷⁵ Report of the Select Committee, para 53, as reported by Klausen (n 70 above).

⁷⁶ Abortion and Sterilization Act 2 of 1975, Government Gazette, 478 1975.

⁷⁷ n 78 above, sec, 3(1)(a).

⁷⁸ n 78 above, sec, 3(1)(b).

⁷⁹ n 78 above, sec, 3(1)(c).

⁸⁰ n 78 above, sec, 3(1)(d).

⁸¹ S Guttamacher *et al* 'Abortion reform in South Africa: A case study of the 1996 Choice of Termination of Pregnancy Act '(1998) special report 24 (4) *International Family Planning Perspectives* 191.

⁸² n 78 above, sec,1(b).

defects.⁸³ In its practicability, a woman needed not less than three independent medical practitioners to access an abortion.⁸⁴ In cases of pregnancy resulting from unlawful intercourse, in addition to the written certification from two medical practitioners, a certificate from the magistrate attached to the court⁸⁵ had to be produced after interrogation by the police to ascertain the validity of the unlawful intercourse allegation.⁸⁶

Additionally permitted abortion was to be procured at government-controlled facilities or within facilities that were authorized by the Minister as provided for under the Act.⁸⁷ However many of the permitted health facilities were based in urban centers where they were mainly accessible by the white population who also had the financial capacity to travel to United Kingdom, Mozambique or other parts of the world⁸⁸ to access safe abortion as compared to the majority population who lived in the rural areas.⁸⁹ Furthermore, these approved hospitals were administered by the apartheid laws that prohibited the black population from using white hospitals.⁹⁰

Therefore, stringent law coupled with implementation barriers drove black women to undertake 'backstreet' abortions as reported by Doctor Crichton during his trial that he 'treated 40 000 black women suffering from effects of unsafe abortion' during his medical practice at the King Edward VIII hospital.⁹¹ Obviously the composition of this law fostered racial discrimination in relation to access to abortion⁹² by approving dominant minority (white population) over the majority black population which unfortunately affected the quality of life of the black women.⁹³

⁸³ n 78 above, sec, 3(1)(c).

⁸⁴ n 78 above, sec, 3(2)(a).

⁸⁵ n 78 above, sec, 6(4).

⁸⁶ n 78 above, sec, 6(4)(a)(ii).

⁸⁷ n 78 above, sec, 5(1).

⁸⁸ J Cope, *A Matter of Choice: Abortion Law Reform in Apartheid South Africa* (1993) 130 & Strauss (n 67 above) 214.

⁸⁹ RE Mhlanga, 'Abortion: developments and impact in South Africa' (2003) 67(1) *British medical bulletin* 116.

⁹⁰ As above.

⁹¹ Comments PJ van der Merwe, B Viljoen & *Hansard* (1972), columns 603, as reported by Klausen (70) above.

⁹² Ngwena (n 61 above) 40.

⁹³ JH Sarkin, 'A perspective on abortion legislation in South Africa's bill of rights era' (1993) 56 *Journal of Contemporary Roman-Dutch Law* 83-90.

Despite the existence of the Abortion and Sterilization Act, women's access to safe abortion services was never achieved. According to Fawcus *et al.*, there was an increase in admissions at government hospital gynecological wards due to the increase in number of women with discernible 'incomplete and septic abortions'.⁹⁴ More so, between 1975 - 1996, the estimated number of 'clandestine abortions' ranged between 120 000 to 250 000 annually.⁹⁵ The increasing number of septic abortions greatly contributed to the high maternal mortality in the country.⁹⁶

Additionally further research indicate that 45 000 women were admitted to the hospitals as result of abortion related complications in 1994, where 12 000 manifested moderate to severe complications while about 400 had died as a result of septic abortions.⁹⁷ It is also assumed that these figures could be higher than reported given the fact that some women may not have sought medical care since they never presented any complications. Others like rural poor women with no access to health services could have died before reaching the hospitals or sought TOP from traditional healers⁹⁸ or private health facilities⁹⁹ and therefore were not accounted for.

According to Rees *et al.*, young women below the age of 19 years greatly contributed to the high rates of unsafe abortion as they were more likely to seek unsafe abortion¹⁰⁰ given the high teenage pregnancies rates in South Africa at the time standing at 330/1000 women below 19 years.¹⁰¹

⁹⁴ Fawcus (n 22 above)438-442.

⁹⁵ H Ress *et al* 'The epidemiology of incomplete abortion in South Africa', (1997) 87(4) *South Africa medical journal* 432-437.

⁹⁶ PM Shweni *et al* *Abortions: the king Edward VIII hospital experience* (1992) *Obstetrics & Gynaecologist forum* 25-26.

⁹⁷ Rees *et al.*, (n 93 above) 432-437.

⁹⁸ L Banwari *et al* 'The impact of the Choice on Termination of Pregnancy Act of 1996 (Act 92 of 1996) on criminal abortions in the Mthatha area of South Africa' (2009) 1(1) *African Journal of Primary Health Care & Family Medicine* 2.

⁹⁹ Rees *et al* (n 95 above) 435.

¹⁰⁰ As above.

¹⁰¹ Republic of South Africa *National Social Development Report* prepared for the World Summit on Social Development (1995) Copenhagen, Denmark.

2.3 South Africa Abortion law reform

The transition to democracy within South Africa in 1994 did not only mean political liberation alone but also it aimed at changing laws that would better respond to the needs of the majority population among which were women whose reproductive rights were being violated by the existing laws. As a starting point the new government under the leadership of the Africa National Congress (ANC) decided to deal with one of the 'contentious issues- abortion'¹⁰² by drafting a new law on TOP.

The rationale used for the new law included: First that women's access to abortion services was of paramount importance and those services should be available to all women without providing any justification such as mental health or rape or fetal disability as per the present law.¹⁰³ Secondly, that 'backstreet' abortions were massively contributing to the high maternal mortality in the country. Thirdly that the law would be aligned with the new South African Constitution which makes provisions for everyone to have the right to bodily and psychological integrity. This right includes the right to make decisions about reproduction, the right to access health services.¹⁰⁴ More so it inclined to the constitution which strongly rejects inequality and promotes substantive equality.¹⁰⁵

Additionally South Africa was adopting and yielding to the Programme of Action of the International Conference on Population and Development (ICPD)¹⁰⁶ and the United Nations Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).¹⁰⁷

The proposed new law attracted debates and resistance especially from the 'anti-abortion' and 'prochoice' advocates. These included religious, organizations and groups

¹⁰² Mhlanga (n 89 above)117.

¹⁰³ J McGill 'Abortion in South Africa: How we got here, the consequences and what is needed' (2006) 2 *Tydskrif vir Christelike Wetenskap*.208.

¹⁰⁴ The Constitution of the Republic of South Africa Act 108 of 1996, Assented 18 December 1996 sec, 12(2), (2)(a) & (9).

¹⁰⁵ C Albertyn 'Substantive equality and transformation in South Africa' (2007) 23 *South Africa Journal Human Rights* 253.

¹⁰⁶ UN population and development programme of action adopted at the *International Conference on Population and Development*, Cairo, 5-13 September 1994 (1994).

¹⁰⁷ UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (1979) Art, 12 & Art,16 (e).

like Doctors for life.¹⁰⁸ However, with the available data and evidence based research from various academic and research institutions indicting the burden of ill health resulting from unsafe abortions and need for legislative reform,¹⁰⁹ the proposed bill was passed into law; commonly referred to as the Choice on Termination of Pregnancy Act (CTOP Act) of 1996 (Act 92 of 1996).

The CTOP Act enables abortion on various grounds. Abortion is allowed to up to the 20th week of pregnancy as long as a certification from a physician is provided, in cases where it poses a risk to the mental or physical health of a woman, if a pregnancy is as a result of rape or incest, severe fetal impairment and in cases where the continuation of the pregnancy would significantly have an effect on the woman's economic and social status.¹¹⁰ The CTOP Act further removes restrictions for abortion during the first twelve weeks of pregnancy without having to provide any justification.¹¹¹

The Act also extended the mandate of registered midwives with related skills to perform abortion during the first twelve weeks of pregnancy.¹¹² Similarly, abortion can be obtained after 20 weeks of gestation if two healthcare providers consent (two medical doctors or a doctor and a midwife) that the continuation of this pregnancy is dangerous to the life of the mother or will result in severe abnormality or malformation of the fetus.¹¹³ Important to note is the Act's recognition of reproductive autonomy of adolescents whose provisions provided for their capacity to independently consent to abortion without the interference or approval of parents.¹¹⁴

On the contrary, this law specifically forbids health workers from being hindrances to lawful TOP and imposes penalties like a fine or imprisonment not exceeding ten years for such an offence.¹¹⁵ However, it's worth noting that the CTOP Act does not make specific provisions for contentious objections. It is greatly premised on the provisions of the Constitution particularly section 15 which affirms 'the right to freedom of conscience'.

¹⁰⁸ Guttamacher (n 17 above) 193.

¹⁰⁹ Mhlanga, (n 89 above) 117.

¹¹⁰ n 56 above, sec, 2 (1)(b)(i)(ii)(iii) (iv).

¹¹¹ As above.

¹¹² n 56 above, sec,2.

¹¹³ n 56 above, sec, 5(b)(i)(ii)(iii).

¹¹⁴ n 56 above, sec, 5(3).

¹¹⁵ n 56 above, sec, 10(c).

This provision indirectly covers the right to conscience objection for abortion.¹¹⁶ Although this provision is made under the Constitution, Ngwena argues that this right is not deemed absolute¹¹⁷ given the provisions of section 36 of the Constitution which puts a limitation on this right in situations where this right encroaches on human dignity, equality and freedom¹¹⁸ of a person in which case the right to quality of life of women greatly applies. It is also argued that this section can be useful in enhancing the obligation to provide information to pregnant women as to where they can acquire TOP.¹¹⁹

In view of the above and in the bid to expand access for TOP, the 2004 Amendment Act was developed and came into force in 2005. This Act aimed at increasing the scope of the health facilities where the legal abortions would take place. For example all hospitals and clinics with 24 hour maternity services were authorized to undertake legal abortion services.¹²⁰ In terms of service delivery and bearing in mind the gaps in human resources for health, such as the shortage of doctors, it extended the scope of performing abortion in the first trimester to registered nurses with skills as permitted by the Act to perform TOP.¹²¹

Additionally, the provisions of this law are tautened in as far as provision of abortion in facilities not permitted by the Act and views it as a crime.¹²² This clearly indicates that any healthcare provider who gives an abortion related prescription and operating under 'unauthorized places' like surgeries commits a criminal offense.

2.4 Adolescents consent to TOP under the CTOP Act

Minority right to consent and make decisions about their welfare is fully recognised under international and regional human rights law. Specifically the African Charter on the

¹¹⁶ n 104 above, Sec, 15.

¹¹⁷ C Ngwena 'Conscientious objection and legal abortion in South Africa: delineating the parameters' (2003) 28(1) *Journal for Juridical Science* 5.

¹¹⁸ n 104 above, sec, 36.

¹¹⁹ Ngwena 'Conscientious objection and legal abortion in South Africa: delineating the parameters' n (117 above) 5.

¹²⁰ n 56 above sec, 3.

¹²¹ CTOP Act (n 56 above) sec, 2 As amended by the Choice on Termination of Pregnancy Act of 2008.

¹²² n 120 above, sec, 10(d).

Rights and Welfare of the Child (ACRWC),¹²³ United Nations Convention on the Rights of the Child¹²⁴, and the United Nations Declaration on the Rights of the Child.¹²⁵ In South Africa the recognition for minors consent to treatment came into effect in 1976.¹²⁶

In 1991 the Child Care Act was amended to give minors particularly those above the age of fourteen years 'competence to consent, without the assistance of a parent or guardian, to the performance of any medical treatment'¹²⁷ as compared to those above eighteen years would give consent to any medical procedure without consent from parents or guardians.¹²⁸ The provisions of this Child Care Act lowered parental influence and control in decision making for adolescents thereby giving minors as ascribed under the statutory standards 'exclusive powers' to consent.¹²⁹

Notwithstanding the above and in lieu of the fact that there are minors who would not be in position to consent on their own,¹³⁰ the law makes provisions for parents or the state to act in the 'best interest of the child'.¹³¹ Subsequent to the above are the interim Constitution of 1993 and the final Constitution of 1996 which is the supreme law and therefore overrides the existing laws on consent for minors.¹³² It provides for best interest as being paramount in matters relating to the child,¹³³ right to human dignity¹³⁴ and right

¹²³ ACRWC makes provisions under article 4 for the 'best Interests of the Child' while under article 7 it make provisions for the right to freedom of expression of a child without any restrictions per the law.

¹²⁴ United Nations Convention on the Rights of the Child 1989, Article 3(1) provides that 'all actions concerning children the best interests of the child shall be a primary consideration' while under article 12(1) enjoins state parties to ensure 'children who are capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.'

¹²⁵ See United Nations Declaration on the Rights of the Child of 1960 which acknowledged the right to freedom of discrimination, health care and special protection of children.

¹²⁶ Child Care Act 33 of 1960, section 20(8A). Subsection 8A inserted by section 1 (b) of the Children Amendment Act of 1976.

¹²⁷ Child Care Act (n 126 above) sec, 39(4) substituted by sec, 13 of Act 86 of 1991.

¹²⁸ n 126 above, sec, 39(4)(a).

¹²⁹ C Ngwena, 'Health care decision-making and the competent minor: The limits of self-determination.' 1996 132 *Acta Juridica* 142.

¹³⁰ As above.

¹³¹ n 126 above, sec, 39(1).

¹³² The South African interim Constitution Act 200 of 1993, assented on 25 January 1994 and commenced on 27 April 1994 &The Constitution of South Africa (n 104 above).

¹³³ n 104 above, sec, 30(3).

¹³⁴ See n 104 above, sec, 10 which provides that 'Every person shall have the right to respect for and protection of his or her dignity'.

to privacy¹³⁵ given the fact that the right to consent involves issues of personal decision making and therefore deemed private.

In illustrating minor's consent to medical treatment, the assertion of the CTOP Act digresses from all other previous laws. First it defines 'a woman as any female person of any age'¹³⁶ and then secondly extends full recognition of minor's consent before termination of pregnancy is undertaken within the twelve weeks of pregnancy.¹³⁷ A health worker's role is only to advise the minor to consult her parents, guardian or friends before abortion is undertaken and should she object to the consultation, she should not in any way be denied the service.¹³⁸

The above provision however has been contested in Court. In *the Christian Lawyers Association v Minister of Health (Christian Lawyers case No: 2)*,¹³⁹ the applicant challenged the provisions of section 5(2) and (3) of the CTOP Act which permits minors to procure abortion services without parental assistance or approval as unconstitutional as these are 'children who are incapable of giving consent'.¹⁴⁰ The applicant further contested that the CTOP Act was in contradiction with section 28¹⁴¹ and section 9¹⁴² of the Constitution. However, this application was rejected by the Court which held that measures were already in place to fulfill the requirements of informed consent of adolescent girls before TOP is undertaken. In consideration of section 12(2) that provides for female's right to body integrity which includes decisions relating to reproductive matters, the Court also held the affirmation that this right involves women's right to decide whether or not to terminate a pregnancy irrespective of their age.

¹³⁵ See n 125 above, section 13 it provides, inter alia, that 'every person shall have the right to his or her own personal privacy...'.
¹³⁶ n 56 above, section 1.

¹³⁷ n 56 above, sec, 5(3).
¹³⁸ See n 56 above, sec, 5(3) and sec, 5(4) and (5) that makes special provision for termination of pregnancy in regards to women who are severely mentally disabled or in a state of continuous unconsciousness.

¹³⁹ *Christian Lawyers Association of South Africa & others v. Minister of Health & others (Reproductive Health Alliance as Amicus Curaie)* 2005 1 SA 509 (T).
¹⁴⁰ n 56 above sec, 5(2) & (3).
¹⁴¹ Also see n 104 above Sec, 28(1)(b) which affirms that 'Every child has the right- to family care or parental care, or to appropriate alternative care when removed from the family environment,' while sec, 28(1)(d) affirms that 'Every child has the right- to be protected from maltreatment, neglect, abuse or degradation.'

¹⁴² n 104 above, sec, 9(1) states that 'Everyone is equal before the law and has the right to equal protection and benefits of the law.'

In support of the Court's decisions in as far as child autonomy was concerned was the land mark English case judgment of *Gillick v West Norfolk and Wisbech Area Health Authority and Another*.¹⁴³ In this case the House of Lords were asked to make judgement on whether girls who were sixteen years or younger were capable of consenting to contraceptives treatment without parental involvement and approval. The judgement contested parental authority where a minor possessed intelligence and sufficient maturity to appreciate the importance of the prescribed treatment. In its majority judgement the Court held that:

A minor's capacity to make his or her own decision depends on the minor having sufficient understanding and intelligence to make the decision and is not to be determined by reference to any judicially fixed age limit.¹⁴⁴

In upholding this judgement the court observed the recognition of minor's autonomy which has been referred to as 'an unambiguous acceptance of the fact that developmentally, childhood is not a static condition' but 'incrementally moving through varying degrees of autonomy' by children.¹⁴⁵ However some scholars have expressed concern regarding the balance in the recognition of 'child autonomy' or 'best interest of a child' as expressed by Pearce that:

There is a danger of using 'in the best interests of the child' as an excuse for poor communication and for failing to take the necessary time to explain the proposed treatment properly. At the same time there is also a risk of placing an unacceptably high level of responsibility on the child which can release parents from their own duty of care.¹⁴⁶

2.5 Challenges of the CTOP Act

The CTOP Act has on several occasions been challenged in Court. Some of the cases brought before the Court include; *the Christian Lawyers Association v Minister of*

¹⁴³ *Gillick v West Norfolk and Wisbech Area Health Authority* case 1985 3 ALL ER 402, http://www.hrcr.org/safrica/childrens_rights/Gillick_WestNorfolk.htm (accessed 15 May 2016)

¹⁴⁴ *Gillick* Case highlighted by Lord Scarman.

¹⁴⁵ Ngwena 'Health care decision-making and the competent minor: The limits of self-determination' (n 129 above) 133.

¹⁴⁶ J Pearce, 'Consent to treatment during childhood: The assessment of competence and avoidance of conflict' (1994) 165(6) *The British Journal of Psychiatry* 713.

*Health (Christian Lawyers case No: 2)*¹⁴⁷ and the *Christian lawyers Association v minister of Health case (Christians Lawyers Case No: 1)*,¹⁴⁸ which argued that the provisions of the CTOP Act violates the right to life of the foetus. Conversely the court embraced a 'positivist' approach and held that foetus was not a legal person and therefore its rights do not amount to those of 'everyone' as provided for under the Constitution.

Besides the two cases above, another pro-life group; Doctors for Life embarked on putting pressure on the parliament to revise this law. Doctors for Life using a different slant also brought forward three cases to the High Court challenging the CTOP Act. In their first court application they challenged the procedure in which the passing of the Abortion Amendment Act was undertaken.¹⁴⁹ In the second case they filed a civil case to the court on behalf of a schoolgirl based in Durban against Rose Clinic who was allegedly the victim of an abortion undertaken at 28 weeks of pregnancy, never went through counseling process and were the procedure was undertaken without the involvement of a doctor¹⁵⁰ as stipulated by the CTOP Act. The third case brought forward in the Equality Court by Doctors for life was a civil case on behalf of a nurse in Kopanong in Vereeniging who was removed from her post because she declined to perform abortions which was against her religious beliefs.¹⁵¹ These cases are however before the court waiting for judgment.

In view of the above, it clearly indicates that some aspects of the CTOP Act were not fully embraced. Such as issues related to adolescents with views that adolescents girls access to contraceptive services in friendly environments as a way of preventing unplanned and unwanted pregnancy would be a more effective and acceptable.¹⁵²

¹⁴⁷ *Christian Lawyers Case* (n 136 above).

¹⁴⁸ *Christian Lawyers Association of South Africa & others v. Minister of Health & others* 1998 4 SA 113 BCLR 1434 (T).

¹⁴⁹ *Doctors for Life International v Speaker of the National Assembly and Others* 2006 12 BCLR 1399 (CC).

¹⁵⁰ *Osler (and others) and Doctors for Life International vs Rose Clinic (and others) and Governing Body of Danville Park Girl's High School (and others) and KZN Department of Education.*

¹⁵¹ *Charles and Others v Gauteng Department of Health (Kopanong Hospital) and others* 2007 18 ZALAC JA67/06.

¹⁵² OA Savage-Oyekunle 'Female adolescents reproductive health Rights access to contraceptives information and services in Nigeria and South Africa' unpublished PHD thesis, University of Pretoria, 2014 163.

Despite the resistance, it goes without saying that the availability of the CTOP Act creates an environment where adolescent's girls can access confidential abortion services as long as they are in full consent. This has been viewed as having advantages such as the respect for sexual and reproductive rights of young girls because of the positive legal environment that guarantees privacy, safety and free abortion related services with the anticipation that there will be reduction in the procurement of unsafe and illegal abortions.¹⁵³

In Addition to the above, the South African abortion law has had great impact. Several maternal death reports have indicated that with the presence of this law, it led to the decrease in abortion related maternal mortality. Table 1 provides an overview of the comparison of statistic of clinical discoveries of women admitted in hospitals between 1994 and 2000. According to the study the results of the comparison were related but 'not statistically significant'.¹⁵⁴ For example the study revealed that women seeking incomplete abortions were more less the same although there was reduction in the severity of ill health related to unsafe abortions

Table 1 Incidence (%) of severely ill women admitted with incomplete abortion

	1994 (n=803)	2000 (n=761)	p-value
Signs of infection (not exclusive)			
None	79.5	90.1	0.0051
Offensive discharge	13.5	6.4	0.0041
Tender uterus	8.4	3.7	0.0794
Localized peritonitis	1.7	0.7	0.1863
Generalised peritonitis	0.1	0.1	0.8915
Septicaemic shock	0.3	0.2	
Mechanical or chemical injury to genitals	3.2	0.6	0.002
Offensive Products	12.6	9.4	0.2458
Foreign body	1.3	0	0.00347

¹⁵³ As above.

¹⁵⁴ K Dickson-Tetteh., *et al An evaluation of the implementation of the Choice on Termination of Pregnancy Act (2000)* Pretoria, Department of Health 50-55.

Source: Table 1 above and 2 below are adopted from a research initiated by the Department of Health and conducted by the Reproductive Research Unit in collaboration with the Medical Research Council in 2003 to ascertain the impact of CTOP Act.¹⁵⁵

Table 2 below highlights the shift in the use of relevant technologies in the management of incomplete abortions. For example it reveals that well as in 1994 the use of antibiotics was at 43.6 per cent by 2000 it had reduced to 33.5 per cent and the use of blood products from 13.4 per cent to 8.3 per cent respectively.¹⁵⁶

Table 2 Variations in designated health facilities in the management of incomplete abortion between 1994 and 2000.

1994 (n=803) and 2000 (n=761)

	1994 (%)	2000 (%)	p-value
Antibiotics given	43.6	33.5	0.2384
Blood/blood products	13.4	8.3	0.1
Evacuation of the uterus	88.9	87.8	0.8179
Sharp curettage (method of evacuation)	97.6	82	0.0045

Source: Department of Health study report on the development and impact of CTOP Act.¹⁵⁷

Additionally, research continues to indicate that the proportion of maternal deaths in healthcare facilities that were attributed to abortion fell from 5 per cent in 1990 -2001 to 3.4 per cent in 2005-2007.¹⁵⁸ Nonetheless, even though South Africa has a good model law on abortion in Africa, there is still a mystery in understanding the contribution of unsafe abortion towards maternal mortality in the county. The magnitude may not be well known given the fact that most maternal death occur in rural areas or outside the

¹⁵⁵ n 154 above, 52.

¹⁵⁶ n 154 above, 59.

¹⁵⁷ n 154 above, 58.

¹⁵⁸ National Committee on Confidential Enquiries into Maternal Deaths (NCCEMD), *Saving Mothers 2005–2007: Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa* (2007) Pretoria, Department of Health 12-3.

healthcare facilities and in most cases not reported. It is estimated that 20-66 per cent of maternal deaths fall under this category.¹⁵⁹

In summation, even though the CTOP Act has led to increased access to safe and legal abortion, which has greatly contributed to a reduction in maternal mortality in the country, the CTOP Act is still faced with many implementation challenges ranging from structural to human resource.¹⁶⁰ These impediments create grounds for thriving unsafe abortions even with the liberalisation of the abortion law in South Africa. Unsafe abortion remains a serious reproductive health issue among women but particularly young women which needs to be addressed if South Africa is to meet its commitment to improve the health status of women¹⁶¹ as unsafe abortion has been ranked among the four leading causes of maternal death in the country.¹⁶²

2.6 Conclusion

As indicated above the adolescent right to abortion is well protected under the South African law. The CTOP Act as indicated above specifically bestows minors consent to abortion while also recognizing the parental involvement especially in cases where there is a limitation on self-determination. While the CTOP Act has been in existence for over years, it still faces a lot of challenges originating from social-cultural, religious and economic structures hence affecting its effectiveness.

¹⁵⁹ W Graham and ML Newell 'Maternal deaths in South Africa: what proportion occurs at home?' in RC Pattinson (eds) *Saving Mothers 2005-2007 Fourth Report on Confidential Enquiries into Maternal Deaths in South Africa*, (2007) 4-10.

¹⁶⁰ J Harries *et al* 'Health care providers' attitudes towards termination of pregnancy: a qualitative study in South Africa', (2009) 9 (296) *British Medical Council Public Health* 11.

¹⁶¹ See Statistics South Africa *Millennium Development Goals (MDGs) Country Report 2013: The South Africa I know, the home I understand* (2013) 71- 78.

¹⁶² Graham (n 159 above) 5-15.

CHAPTER 3

AN ANALYSIS OF THE DETERMINANTS OF ADOLESCENTS' ACCESS TO UNSAFE ABORTION IN A LIBERALISED ENVIRONMENT

3.1 Introduction of the chapter

Adolescents' decisions to undertake unsafe termination of a pregnancy greatly depends on the situation these adolescents find themselves in. Such situations therefore affect their decisions to take actions. There are diverse and intertwined social norms and circumstances that determine adolescent choice to access unsafe abortion following the liberalisation of abortion in South Africa. Some of the determinants are facilitated by the environment within which adolescent girls live such as the negative social, cultural and religious perceptions about abortion, while others are more related to the service environment which deals with issues of inaccessibility.¹⁶³ The section below will explore further on the determinants of adolescent girls access to unsafe abortion following the liberalisation of the abortion in South Africa.

3.2 Adolescents' knowledge on termination of pregnancy

In majority of the African countries including South Africa, many adolescents lack access to correct information about reproductive health issues such as safe abortion and contraception. This is due to the fact that issues on sexuality and reproduction are said to be cultural taboos.¹⁶⁴ Adolescents' lack of appropriate knowledge about their reproductive system and rights therefore, greatly influences their ability to make informed reproductive health choices including their fertility. Even in environments where abortion is liberalised like South Africa, adolescents' still lack appropriate knowledge about their reproductive health system and development¹⁶⁵ like detection or avoidance of pregnancy.

¹⁶³ CG Ngwena 'Access to safe abortion as a human right in the African Region: lessons from emerging jurisprudence of United Nations treaty monitoring bodies' (2013) 29 *South African Journal on Human Rights* 409.

¹⁶⁴ E Börjesson *et al* *Youth act for safe abortion: A training guide for future health professionals* (2014) Ipas 103.

¹⁶⁵ CG Ngwena *et al* 'Accessing Termination of Pregnancy by Minors in the Free State: Identifying Barriers and Possible Interventions' (2005) *Centre for Health Systems Research & Development, University of the Free State, Ipas/South Africa* 20.

As a result, adolescent girls as opposed to the adult women are most likely to delay seeking abortion services up until advanced stages of the pregnancy due to failure to identify earlier signs of pregnancy.¹⁶⁶

Opting to seek abortion in the advanced stages will require adolescents to justify undertaking this abortion as prescribed by the CTOP Act. A case in point is when the pregnancy posing a risk to the health of the adolescent¹⁶⁷ or it's as a result of rape or incest¹⁶⁸ or that it would affect her social and economic situation.¹⁶⁹ Adolescents may find it difficult to justify abortion for an advanced pregnancy especially if the health care workers have negative attitudes towards sexually active or pregnant adolescents thereby opting for the unsafe and illegal abortions.

Undeniably when young women are ignorant about their reproductive rights and the law thereof, they are susceptible to distorted information within their social networks or gatekeepers. This is evidenced by a study undertaken in Cape Town which submitted that unsafe and illegal abortions were partially encouraged following the misinformation provided to women concerning 'repeat abortions'¹⁷⁰ which is in contradiction with the law.

The finding above is in agreement with Orner *et al*, who also found that women who sought multiple abortions were usually turned away, or cautioned not to return for another abortion. If they ever did return they faced multiple challenges or better still cautioned that they were being 'remembered' to guarantee none of them will go requesting for another abortion.¹⁷¹ These statements are contradictory to the present law on TOP. Despite the liberalisation of the abortion law, if such 'unofficial messages' by the healthcare providers are emphasized to ignorant pregnant adolescent girls, these girls are left with only one alternative that is seeking unsafe abortion, which are presented as 'non-judgmental'.

¹⁶⁶ AA Olukoya, *et al* 'Unsafe abortion in adolescents.' (2001)75(2) *International Journal of Gynecology & Obstetrics* 137-147.

¹⁶⁷ n 56 above, Sec, 2(1)(b)(i).

¹⁶⁸ n 56 above, Sec, 2(1)(b)(iii).

¹⁶⁹ n 56 above, Sec, 2(1)(b)(iv).

¹⁷⁰ P Orner, *et al* 'A qualitative exploration of HIV-positive pregnant women's decision-making regarding abortion in Cape Town, South Africa' (2010) 7(2) *SAHARA Journal* 44–51.

¹⁷¹ P Orner *et al* 'It hurts, but I don't have a choice, I'm not working and I'm sick': decisions and experiences regarding abortion of women living with HIV in Cape Town, South Africa, (2011)13(7) *Culture, Health & Sexuality*, 791.

In addition to the above, it has been argued that illegal abortions still thrive based on the massive advertising of ‘backstreet’ abortions as opposed to the legal and safe abortion services.¹⁷² Information on the legality of TOP services is mainstreamed through health programs and therefore limited. For adolescents getting such information from formal channels like healthcare facilities, schools, media¹⁷³ sometimes becomes challenging because of the barriers associated with these formal avenues of disseminating this information such as compromising adolescent privacy and time restrictions.¹⁷⁴

Contrary to the above, the unsafe abortion providers commonly referred to as ‘lamp-post providers’ create massive awareness of their services through rigorous public promotion and advertisement. These advertise through posters and flyers which are placed in strategic public spaces such as outside school premises, local newspapers, traffic lights/stop signposts,¹⁷⁵ retail centers, taxi ranks, city walls¹⁷⁶ and inside train carriages.¹⁷⁷ These ‘lamp-post’ providers have strategic and attractive messages on the flyers promising women of ‘pain free abortion of up to six months of pregnancy’¹⁷⁸ and ‘50 per cent discounts or fee cleaning’.¹⁷⁹ This corresponds with the findings of Farber where he found a ‘service provider’ inside a Metrorail carriage advertising 15 minute abortion for any pregnancy ranging from one week to eight months. When adolescents are faced with

¹⁷² R Atkinson ‘Why is there such great demand for illegal abortions?’ *Ground Up* 10 June 2014 http://www.groundup.org.za/article/why-there-such-great-demand-illegal-abortions_1870/ (accessed 2 June 2016).

¹⁷³ Ngwena Access to safe abortion as a human right in the African Region (n 163 above) 42.

¹⁷⁴ J Roberts *Barriers to women’s rights in implementation of the choice of termination of pregnancy Act (CTOP) in KwaZulu-Natal* (2007) 103-104.

¹⁷⁵ R Atkinson ‘Behind the abortion adverts’ *GroundUP* 21 May 2014 http://www.groundup.org.za/article/behind-abortion-adverts_1800/ (accessed 2 June 2016)1.

¹⁷⁶ R Hodes, ‘The Culture of Illegal Abortion in South Africa’, (2016) 42(1), *Journal of Southern African Studies*, 90.

¹⁷⁷ T Farber, ‘illegal abortion drug horror’ *Cape Times* 01 April 2014, <http://www.iol.co.za/capetimes/illegal-abortion-drug-horror-1669072> (accessed 2 June 2016)1.

¹⁷⁸ Marie Stopes South Africa, ‘Avoiding illegal/ unsafe abortion: what every woman needs to know to stay safe’ <http://www.mariestopes.org.za/wp-content/uploads/2013/12/MSSA-Illegal-Abortions-Brochure.pdf> (accessed 20 June 2016)2.

¹⁷⁹ As above.

little or no information it leads to misconceptions about legal terms and conditions for which an abortion can be undertaken.¹⁸⁰

Additionally Atkinson continues to assert that, illegal abortions are not only undertaken on streets alone but also online. A case in point is 'Kelly's Clinic' which claims to have multiple branches across the country. The clinic delivery's pills to clients within South Africa and across the world.¹⁸¹ Additionally it promises a discounted cost for students of R200.¹⁸² Adolescent girls are therefore forced to use this kind of service even though it poses risks because it offers them secrecy and confidentiality as they perform the abortion at home. It is evident that adolescent girls can easily fall prey to 'backstreet' abortions since these services are publically advertised and appear to have conducive terms for terminating a pregnancy as compared to the safe and legal abortions.

Below are photographs of posters that have been taken to illustrate the massive advertisement that is undertaken by the 'Back-street' providers in displayed in different strategic points in various towns within South Africa.



¹⁸⁰ CA. Varga 'Pregnancy Termination among South African Adolescents' (2002) 33 (4) *Studies in Family Planning*, 292.

¹⁸¹ Kelly Clinics, 'Abortion clinics in Pretoria and pills for sale' Backpage Monday 20 June 2016 <http://pretoria.backpage.com/HealthServices/abortion-clinics-in-pretoria-and-pills-for-sale-0725032192/3488346> (accessed 25 June 2016).

¹⁸² R Atkinson 'Behind the abortion adverts' *GroundUP* 21 May 2014 http://www.groundup.org.za/article/behind-abortion-adverts_1800/ (accessed 2 June 2016).



Figure 2: abortion posters

Source figures: 2 and 3 exhibit posters advertising illegal abortions in the different downtown areas. The one below were taken on the streets of East London and Pretoria Central Business District. Figure 4, 5 and 6 adopted from Marie Stopes South Africa.¹⁸³

Furthermore, a study conducted in the Free State revealed that adolescent girls preferred 'backstreet' abortions due to peer influence.¹⁸⁴ This corresponds with a study undertaken in Uganda which highlighted abortion being a private issue which is socially symbolized and jointly determined by the broader social networks such as peers or community.¹⁸⁵ Additionally a study that was conducted in Kenya where 75 per cent of the respondents were young people below 24 years, it revealed the existence of social networks within the community strategically positioned to support and sustain illegal and unsafe abortion providers. These include positioning agents in schools and unsafe providers having close relationships with other health facility personal who offer both clients and abortion pills.¹⁸⁶

¹⁸³ Marie Stopes South Africa (n 46 above) 2.

¹⁸⁴ Ngwena (n 163 above) 43.

¹⁸⁵ S Nyanzi *et al* 'Abortion? That's for women! narratives and experiences of commercial motorbike riders in South-Western Uganda' (2005) 9(1) *African Journal of Reproductive Health* 142-161.

¹⁸⁶ J Osur *et al* 'Social networks and decision making for clandestine unsafe abortions: evidence from Kenya', (2015) 19(1) *African Journal of Reproductive Health* 37-38.

In another study undertaken in Ivory Coast, it also discovered that parents were instrumental in forcing their children to undertake unsafe abortion because they were not ready to support them financially or offer any other practical support.¹⁸⁷

Equally boyfriends have also been implicated in having an important role in adolescents' decision to access unsafe abortions even where the law is liberalised. For instance, in a study conducted in South Africa among adolescents, a respondent drew from her lived experience and highlighted;

(Often) it is a man who says you should abort. Even if you feel you can afford the child. If he says you must have an abortion then you have to do it.¹⁸⁸

Refusal to terminate a pregnancy in this regard will mean absence of 'paternal support' which not only plays a very important role within the African cultural context but also comes with other legal, economic and social implications.¹⁸⁹ In illustrating this further, a rural 12 year girl indicated that adolescents opted for these unsafe abortions if the boys denied paternity of the child which would bring about 'social marginalisation' for both the mother and the child.¹⁹⁰ The lack of support from the paternal side would bring about financial and maternal burden to the girl's family.¹⁹¹ Paternity of a child is therefore very instrumental in determining the adolescent's decision for undertaking secret unsafe abortion in the presence of a liberalised abortion law.

The figure below recapitulates the community structures that facilitate the social interaction, existence and sustenance of unsafe abortion.¹⁹² Specifically the boxes in blue indicate the key social networks that play a big role in sustaining unsafe abortion as they are the direct link between the adolescent girl and the unsafe abortion provider.¹⁹³

¹⁸⁷ J Svanemyr and J Sundby. 'The social context of induced abortions among young couples in Côte d'Ivoire.' (2007)11(2) *African journal of reproductive health* 13-23.

¹⁸⁸ Varga (n 180 above) 290.

¹⁸⁹ CE Kaufman, Thea de Wet & J Stadler 'Adolescent Pregnancy and Parenthood in South Africa.' (2000) Policy Research Division Working Paper Number 136 *Population Council*. 19-22.

¹⁹⁰ Varga (n 180 above) 291.

¹⁹¹ As above.

¹⁹² Osur *et al.*, (n 186 above) 37-38.

¹⁹³ As above.

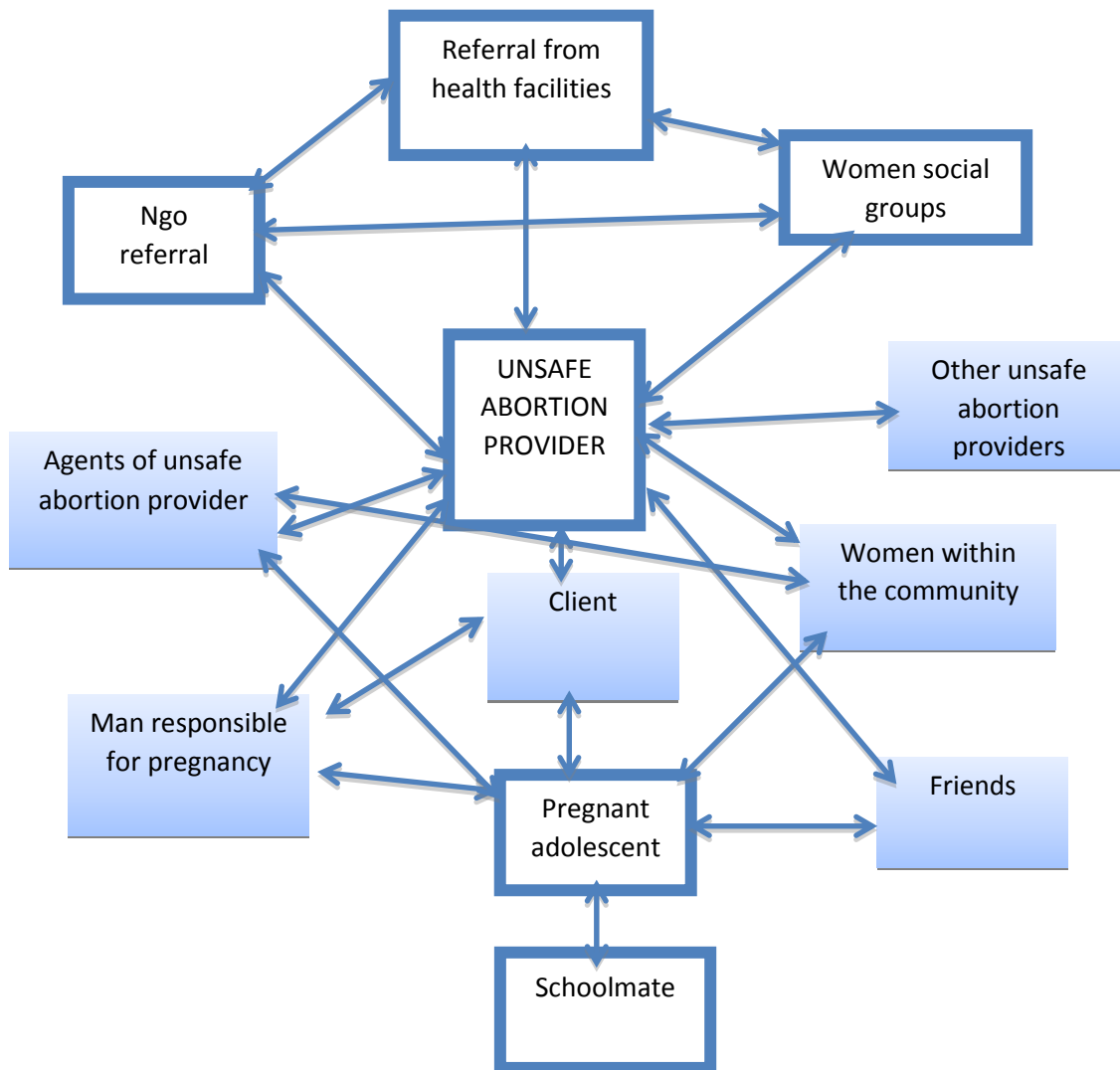


Figure 3 kite network

Source figure 7: The kite network and how it can determinate an adolescent's choice for unsafe abortion against safe TOP. Adopted from *Osuret al.*¹⁹⁴

3.3 Adolescent's attitudes and perceptions towards termination of pregnancy

In many of the South African societies, TOP is considered 'socially uncomfortable and controversial'.¹⁹⁵ These perceptions as evidently reflected in the findings of an urban township study in 1950s were respondents defined women who obtained abortions as

¹⁹⁴ As above.

¹⁹⁵ Orner (n 170 above) 791.

'abnormal' or categorised them as 'witches'.¹⁹⁶ To date despite abortion being legal, it still faces a lot of resistance on moral and religious grounds which is a threat to young women's access to safe and legal abortion.¹⁹⁷ The majority of the adolescents still resent abortion which can be attributed to their moral or social beliefs. For example, they see it as a sin or murder; girls who terminate a pregnancy are viewed as a disgrace and face rejection.¹⁹⁸

Further illustration of the adolescent attitudes towards the CTOP was displayed in a study conducted among minors in the Free State where 66.3 per cent of the respondents felt abortion should not be legal, 55 per cent and 53 per cent resented it due to their religion and culture respectively, while 89 per cent were in full support of parents or partner involvement in the TOP.¹⁹⁹ This clearly indicates that a big percentage of adolescents still have negative attitudes towards abortion that need to be changed. These negative attitudes greatly influence their inability to access liberalised TOP services for fear of being judged or rejected by the community and therefore opting for illegal and unsafe abortions services that bypass social and moral beliefs.

Many scholars have continued to argue that unsafe abortion still persists despite the liberalisation of the abortion law in South Africa largely due to the prevailing principals of gender inequalities. These include the values culture sets on women and power dynamics within society that weaken or challenge women's rights to life and health.²⁰⁰ The moral standards created within a given society are the basis to which policies are formulated including policies addressing reproductive health issues of women.²⁰¹ Specifically policies addressing reproductive health issues of adolescent girls like how, when why and who provides sexuality education, contraceptives and abortion services all have great influence on adolescent girls' decision making process.

¹⁹⁶ L Longmore, *The Dispossessed: A Study of the Sex-Life of Bantu Women in and Around Johannesburg* (1959)139.

¹⁹⁷ *Christian Lawyers case 1* (n 146 above), *Christian Lawyers case 2* (n 136 above) & *Charles and Doctors for Life International case* (n 146 above).

¹⁹⁸ n 163 above, 43.

¹⁹⁹ n 163 above 44.

²⁰⁰ WHO *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008* (2011) 7.

²⁰¹ Shannon & B Winikoff 'Unsafe abortion and strategies to reduce its impact on women's lives' in S Kehoe *et al* (eds) *Maternal and Infant Deaths: Chasing Millennium Development Goals 4 and 5* (2010) 153-4.

Furthermore, gender inequalities are associated with gender stereotypes, violence and discrimination²⁰² which have great influences on young women's attitudes towards unsafe abortion. For instance, with the ascribed inferiority status of the woman, young girls often have less control over the men in terms of negotiating for safer sex in relationships or even experience violence which results in unwanted pregnancies.²⁰³ These unwanted pregnancies in many instances leads to social ramifications and discrimination resulting to majority of the adolescent girls opting for unsafe abortion²⁰⁴ even with the liberalised abortion law. This is because seeking public safe abortion would be challenging the ingrained principles and attitudes about womanhood²⁰⁵ and or avert gender stereotype of hiding promiscuity as ascribed by men.²⁰⁶

3.4 Factors associated with unwanted pregnancies

Aside from the above, there are other determinates of adolescent use of unsafe abortion following the liberalisation of the abortion in South Africa. These factors are directly linked to adolescent girl's fertility behavior like their use and attitudes towards contraceptives.²⁰⁷ Contraceptive choices and practices undertaken by adolescents are closely linked to unwanted pregnancy and termination of unwanted pregnancies.

According to Mundigo, there are a number of reasons for unwanted pregnancy. Like not using contraception, contraceptive malfunction or inappropriate use of a contraceptive method among adolescents; basing on the notion that 'one sexual encounter is insufficient to cause a pregnancy' or that the girls are too young to get pregnant.²⁰⁸ The South African government has tried to revive access to contraception, however there is still unmet need and a wide range of commodities to choose from which

²⁰² Börjesson (n 164 above) 75.

²⁰³ International Planned Parenthood Federation/ Western Hemisphere Region, *How gender-sensitive are your HIV and family planning services?* (2002) 2.

²⁰⁴ n 163 above, 76.

²⁰⁵ A Kumar, 'Everything is not abortion stigma', (2013) 23(6) *Women's Health Issues*, 329–331.

²⁰⁶ CO Izugbara, JK Otsola & A Chika Ezech, 'Men, Women, and Abortion in Central Kenya: A Study of Lay Narratives' (2009), 28(4) *Medical Anthropology*, 397-425.

²⁰⁷ A Mundigo, A 'Determinants of unsafe induced abortion in developing countries' in Warriner, IK & Shah, IH (eds) *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action*(2006) 51-71.

²⁰⁸ As above.

leaves many young adolescents especially those leaving in rural areas with increasing demand thereby restricting their reproductive choices.²⁰⁹

Besides access to contraceptive choices, unwanted pregnancies among adolescents can be as a result of sexual violence like rape.²¹⁰ The 2007 - 2008 rape statistics in South Africa reveal that of the 36 190 reported cases of rape 44.4 per cent of rape took place among children.²¹¹ This clearly indicates that young girls are more at risk of being raped than the older women.²¹² When these young women are faced with unwanted pregnancy as a result of rape or incest, especially by a person they know, like a relative or a teacher or gang rape²¹³, they are left with no other choice than to terminate these unwanted pregnancies. A study conducted for young women, revealed that of the young girls reporting having had an 'unwanted' pregnancies, majority utilised unsafe abortion services.²¹⁴ Therefore when adolescents are faced with an unwanted pregnancy and yet the liberalised TOP services are inaccessible they resort to unsafe abortion providers for assistance.

3.5 Stigma associated with termination of pregnancy

As noted in chapter two the CTOP Act allows adolescent girls to have access to free abortion services²¹⁵ without consent from anybody within the first twelve weeks of pregnancy.²¹⁶ However, even with these provisions many adolescent girls prefer using

²⁰⁹ KA Trueman & M Magwentshu, 'Abortion in a Progressive Legal Environment: The Need for Vigilance in Protecting and Promoting Access to Safe Abortion Services in South Africa' (2013) 103(3) *American Journal of Public Health* 398.

²¹⁰ D Neelofur-Khan, *Adolescent pregnancy: Unmet needs and undone deeds: A review of the literature and programmes* (2007) WHO 1-77. And D Mugawe & A Powell, *Born to high risk: Violence against girls in Africa* (2006) 1-68.

²¹¹ S. Waterhouse, 'Crimes against children'. *Factsheet* (2008) Resources aimed at the prevention of child abuse and neglect (RAPCAN). (<http://rapcan.org.za/research/learning-briefs/>) (accessed 22 June 2016)1-3.

²¹² LA Greenfeld, *Sex offenses and offenders: an analysis of data on rape and sexual assault*,(1997) 1-3.

²¹³ M Makoae, *et al South Africa country report on the situation on prevention of child maltreatment study* (2009)1-65.

²¹⁴ MacPhail, *et al* 'Contraception use and pregnancy among 15–24 year old South African women: a nationally representative cross-sectional survey.' (2007) 5(1) *BioMed Central medicine* 1.

²¹⁵ n 120 above, sec,1.

²¹⁶ After the first trimester, the CTOP Act makes provisions for consideration before abortion can take place. CTOP Act Sec, 2 &5(2)(3)

illegal and unsafe abortion measures because of the 'social stigma' that has been attached to abortion.²¹⁷ There still exist high levels of stigma attached to abortion in most societies in Sub Saharan Africa.

Women who seek abortion are related inferior to the idea of womanhood and expected to feel remorseful even where abortion is liberalised.²¹⁸ For majority of the women especially unmarried adolescents girls stigma can be a very strong determinant to seek unsafe abortion even where abortion is liberalised because of the stigma inferred to them based on their marital status, age, and more so decision to undertake an abortion.²¹⁹

It is argued that abortion stigma is associated with matters of 'disclosure and disclosure of pregnancy for majority of women' including young girls.²²⁰ For majority of women including adolescents, disclosing to family is not agreeable simply because opting to disclose means anger and disappointment from family particularly mothers who can hasten emotional coercion 'not to kill the baby'.²²¹

Contrary to the above, a research study undertaken in south Africa indicated that for some adolescent girls who chose to disclose their pregnancies to their parents, parents forced them into procuring a 'backstreet' abortion in order to preserve 'the family's social dignity' and avoid community denigration.²²² Even though Turner *et al* asserts that no adult is permitted to influence or control an adolescent's abortion decision especially if the adolescent has the ability to make that decision,²²³ parents continue to influence adolescent decision to seek unsafe abortion services to maintain their statuesque.²²⁴

Additionally, despite the presence of the liberalised abortion law young girls still lack proper counselling to facilitate their informed decisions forcing them to secretly make decisions to seek unsafe abortion services. The secrecy surrounding the issue of

²¹⁷ Marie Stopes 'Unsafe abortion in South Africa: A preventable pandemic' SANGONeT Monday 2 July 2012 <http://www.ngopulse.org/blogs/unsafe-abortion-south-africa-preventable-pandemic> (accessed June 9 2016).

²¹⁸ Kumar *et al* 'Conceptualizing abortion stigma' (2009) 11(6) *Culture, Health and Sexuality*, 625–639.

²¹⁹ n 161 above, 103.

²²⁰ n 168 above), 789.

²²¹ As above).

²²² n 168 above), 290.

²²³ KL Turner, *et al* *Abortion care for young women: a training toolkit* (2011) Ipas 33-42.

²²⁴ n 170 above, 290.

abortion leads to misconceptions which adolescents may not be able to overcome in the absence of proper counselling. Demonstrating this, is the *Guttmacher institute* which indicates that women and particularly young women who opt to induce themselves usually undertake dangerous substances such as herbal or natural remedies, manufactured products, pharmaceutical technologies, prayer or magic, physical objects or use of voluntary trauma which are inefficacious methods that can lead to serious complications for these young women.²²⁵

Furthermore, in attempting to explore the level of stigmatization of TOP in South Africa, Trueman asserts that many healthcare providers expansively use conscientious objection exception to preclude pregnant adolescent girls from accessing safe abortion services.²²⁶ However, it's not only the healthcare providers who stigmatize but also healthcare facility workers such as security men, receptionists and other administration workers.²²⁷

This is in agreement with Turner *et al.*, who also asserts that healthcare workers may opt not to provide abortion services because of the stigma attached to it.²²⁸ Healthcare providers who offer TOP services in many ways form part of the society in which adolescents live. These may as well experience societal stigmatisation out of the healthcare facility setting, which in turn affects the way they relate with pregnant adolescent girls seeking abortion. This attitude towards adolescents drives them to seek unsafe abortion. Healthcare worker's attitude plus the stigma they are likely to face not only has negative effects on the number of safe and legal abortion undertaken within the public sector by adolescent's,²²⁹ but also greatly affects adolescent's decision to

²²⁵ The Alan Guttmacher Institute *Sharing responsibility: women, society and abortion worldwide* (1999) The Alan Guttmacher Institute 37.

²²⁶ Trueman (n 209 above) 398.

²²⁷ 'Is the door to safe abortion services slowly closing in South Africa?' *Ipas* April 11 2013 <http://www.ipas.org/en/News/2013/April/Is-the-door-to-safe-abortion-services-slowly-closing-in-South-Africa.aspx> (accessed 19 June 2016)1.

²²⁸ Turner, *et al* (n 223 above)1.

²²⁹ Day *et al* 'Health and related indicators', in A Padarath & R English (eds) (2011) *South African Health Review* 178-179.

undertake unsafe abortion thereby making them and more susceptibility to the negative consequences of unsafe abortion such as excessive bleeding, infertility and death.²³⁰

The figure below clearly illustrates ways in which abortion stigma can affect adolescent's choice of unsafe abortion over the safe abortion in a liberalised environment.

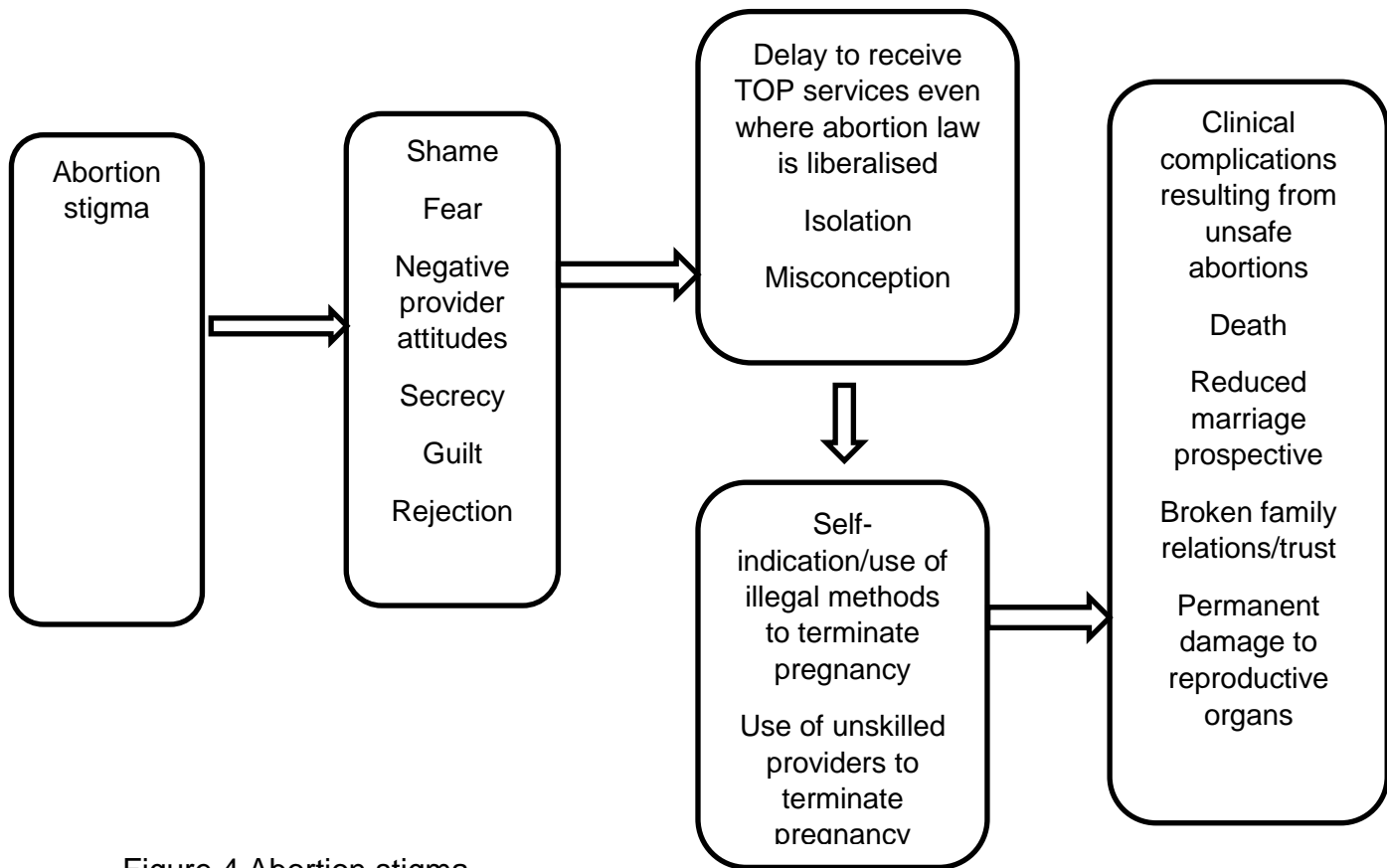


Figure 4 Abortion stigma

Source Figure 8 A Kumar, L Hessini & EMH Mitchell²³¹ Abortion stigma as a determinate for unsafe abortion.

²³⁰ Ratlabala *et al* 'Perceptions of adolescents in low resourced areas towards and the choice on termination of pregnancy (CTOP)' (2007) 30 *Curationis* 29.

²³¹ Kumar, L Hessini & EMH Mitchell 'Conceptualizing abortion stigma: Culture, Health & Sexuality'(2009) 11(6) *an international Journal for research, intervention and care*. 634.

3.6 Systematic challenges to the access of TOP services by adolescents.

Numerous studies indicate that South Africa has one of the best reproductive health care systems in sub-Saharan Africa even though many also continue to indicate that tremendous gaps in access to reproductive health such as TOP services among young women are evident.²³²

According to the South Africa's provincial data 2010, an estimated 260 public, private and non-governmental organisations facilities were licenced to provide reproductive health services particularly TOP services.²³³ However, less than half of the designated public healthcare facilities are offering TOP services to the public.²³⁴ It has been argued that the ineptness of these facilities to provide TOP derives from a number of factors. These include lack of skill by health care workers, negative attitude towards abortion²³⁵ and lack the necessary equipment or requirements to use expensive techniques;²³⁶ which may cause delay in accessing abortion procedures and therefore forcing adolescent girls to opt for unsafe abortions.

Results from a study conducted in KwaZulu-Natal concurred with provisional data indicating that all health facilities as per the CTOP Act²³⁷ in the province were designated to provide abortion services.²³⁸ However many health care providers and facility managers continue to refuse to provide the services to women thereby imposing their personal beliefs to the entire health facility.²³⁹ This increases the service burden to both the public facilities and the healthcare workers offering TOP services.²⁴⁰

Certainly, refusal by some designated health care facilities to provide TOP services creates a big challenge of inaccessibility as adolescent girls would have to travel long distances to get to facilities that offer the services. The unwillingness of healthcare

²³² MacPhail, *et al* (n 112 above)1.

²³³ See *Provincial Data; Tri-provincial workshops*, (2010) data Department of Health South Africa 3.

²³⁴ n 172 above,1 & As above.

²³⁵ As above.

²³⁶ Shannon & B Winikoff (n 12 above) 153 & n 174 above,1-111.

²³⁷ CTOP Amendment Act (2004): The Act as amended allows the MEC of the province for health to designate facilities to provide TOPs. Additionally it makes provisions for all the health facilities that have a 24 hour maternity service in accordance with the Act to provide TOP s of up to 12 weeks without seeking approval from the Member of Executive Councils (MECs).

²³⁸ n 174 above,28.

²³⁹ Roberts (n 137 above) 15.

²⁴⁰ Trueman (n 209 above) 398.

providers especially within the public facilities to provide safe abortion services brings about overcrowding in facilities that offer the services which creates inefficiency. Due to the overcrowding and high demand of TOP, an adolescent girl would have to wait for a long period of time to get an abortion which leads to advanced pregnancy.²⁴¹ Adolescent girls may be faced with a lot of pressure and urgency to terminate the pregnancy and therefore waiting for a long period is not an option hence resorting to unsafe abortion.

To further explain and illustrate the increased burden on facilities and unmet need for TOPs, is a study that was conducted in Johannesburg Metropolitan District which indicated that of the 14 683 and 16 031 TOPS that were requested (including second trimester pregnancies) by women within the space of two years, only 4 921 and 5 338 first trimester were carried out in 2008 and 2009 respectively.²⁴² As indicated these figure only reflect first trimester abortions. This confirms Marijke's revelations that majority of the skilled health workers are not willing to offer second trimester abortions basing on their right to contentious objection.²⁴³

Refusal to provide TOP services to adolescents regardless of which stage of pregnancy they are at will force them to seek illegal or unsafe abortions. This is further supported by Jewkes *et al* who asserted that an estimated two-thirds of women opted for an unsafe abortion or consulted a traditional healer to terminate a pregnancy asserting that they encountered obstacles to the use of the legal services.²⁴⁴

To further elaborate on this is a diagram below that shows a 'Bogus Doctor' who was arrested by police trying to help an adolescent girl to terminate a five month pregnancy. According to the *Daily Sun*, this teenager was one of the many adolescents that were seen procuring unsafe abortion services from this 'lamp-post' provider.²⁴⁵

²⁴¹ n 174 above,15.

²⁴² JK Mendes, D Basu, & JK Basu, 'Addressing the demand for termination of pregnancy services in district health facilities in Johannesburg', (2010) 100(10) *South African Medical Journal*, 614.

²⁴³ A Marijke. 'A week in the life of an abortion doctor, Western Cape Province, South Africa.' (2008) 16(31) *Reproductive health matters* 7.

²⁴⁴ RK Jewkes *et al* 'Why are women still aborting outside designated facilities in metropolitan South Africa?' (2005)112(9): *An International Journal of Obstetrics and Gynecology* 1236–1242.

²⁴⁵ G Nkhwashu, 'House of Abortion Horror', *Daily Sun*, Johannesburg, 10 June 2013, <http://www.politicsweb.co.za/news-and-analysis/house-of-abortion-horror--daily-sun> (accessed 20 June 2016)1–2.



Figure 5 capitation of a back street abortionist

Figure 9 Adopted from the front page of the *Daily Sun*, Monday 10 June 2013.²⁴⁶

Adding to the above, scholars continue to assert that majority of young women who are susceptible to complications related to abortion live in rural areas²⁴⁷ far from where the service points are located. Most importantly these women are not guaranteed that when they travel the long distances they will receive the appropriate services to manage their complications.²⁴⁸ For instance in a rural study, a Doctor revealed that women travel for six hours to get to the nearest hospital to access TOP only to find that the bookings are full and therefore have to travel back wait and return after several weeks.²⁴⁹ Adolescents may not have the resources and time to wait for the safe abortion services as it has been documented that the non-existence of TOP clinics in many rural areas has led to many rural young girls to seek services from traditional healers given the fact that they are easily available, friendly and affordable.²⁵⁰

²⁴⁶ As above.

²⁴⁷ M Kayongo et al 'Making emergency obstetric care a reality – CARE's experiences in areas of high maternal mortality in Africa.(2006) 96 *International Journal Gynecology and Obstetrics* 308-19.

²⁴⁸ n 12 above, 152.

²⁴⁹ n 174 above,22.

²⁵⁰ Banwari et al., 'The impact of the Choice on Termination of Pregnancy Act of 1996 (Act 92 of 1996) on criminal abortions in the Mthatha area of South Africa, (2009) 1(1) *African Journal of Primary Health Care & Family Medicine* 2.

Moreover safe and legal abortions are said to have a lot of bureaucracy and procedures which hinder access as compared to ‘backstreet’ abortions as narrated by a nurse in a rural hospital.

The process involves coming on the first day for counselling, taking an ultra sound to determine gestational age, and a booking. Women then go home and return on their appointment day as booked. They are then given cytotec tablets and return home to take these tablets as instructed, they return to the hospital the following day for an MVA.²⁵¹

For adolescents who have less patience, time or the money to transport themselves to the hospital for the stated number of times in order to access TOP services, unsafe abortion would be the easier option because there are no procedures for delay involved. It is therefore worth noting that the unequal distribution of TOP services within the community, inadequacy in service provision coupled with the bureaucracy within the designated health facilities, increases adolescent girl’s willingness to either consult with traditional healers or ‘lamp-post’ providers or self-medicate to terminate the unwanted pregnancies.²⁵²

Further still, like in majority of the African countries South Africa is also said to have a declining socioeconomic environment, where there is increasing gaps in the access to healthcare services between the poor and the rich.²⁵³ Some scholars have argued that poverty is one of the contributing factors for women’s inability to access safe abortion services even where abortion is liberalised.²⁵⁴ Women from poor backgrounds opt for unsafe abortions because of lack of knowledge about their rights under the prescribed law and most importantly lack resources to travel or pay for safe abortion services. This is revealed by Shannon and Winikoff who assert that the inability of a poor woman to raise money for safe abortion services facilitates unnecessary delays for the procedure which threaten the life of a woman as the pregnancies advances gestational limits.²⁵⁵ Therefore young girls particularly rural young girls who are unable to meet the costs of

²⁵¹ n 173 above, 22.

²⁵² RK Jewkes *et al* ‘Why are women still aborting outside designated facilities in metropolitan South Africa?’(2005)112(9): *An International Journal of Obstetrics and Gynecology* 1236–1242.

²⁵³ n 139 above, 398.

²⁵⁴ n 12 above, 152-3.

²⁵⁵ n 12 above, 154.

private facilities and rely solely on public facilities²⁵⁶ when faced with these financial challenges are forced to access services with other providers like 'lamp-post' or traditional healers.

Another critical component that still drives adolescent to access unsafe abortion even where abortion is liberalised is the lack of privacy and confidentiality at designated facilities that offer TOPs.²⁵⁷ Adolescent's inability to access TOPs greatly contradicts the provisions of the Committee on Economic, Social and Cultural Rights (CESCR) which provides for confidentiality and privacy while seeking health care services by adolescents²⁵⁸ and International Planned Parenthood Federation (IPPF) declaration, which affirms that all sexual and reproductive health care services made to adolescents have to conform to the standards of privacy and confidentiality.²⁵⁹

Regardless of the above provisions, in many societies where abortion is highly stigmatised like South Africa, adolescents are not comfortable seeking abortion services at public facilities for fear of either meeting someone who knows them or their family.²⁶⁰ A majority of the public facilities have no privacy at the waiting rooms and therefore adolescents may fear that they will be recognised or overheard stating intentions of their visit to the facility by the other clients.²⁶¹ This is confirmed by one of the respondents who took part in a study that was conducted in Soweto Johannesburg where she asserted that;

..i won't go to the clinic to shame myself... Let me take pills and help myself, maybe it will help me. People should not see me like this, best I do this, nobody will see me doing like this. Only I will know.²⁶²

²⁵⁶ n 208 above 398.

²⁵⁷ WHO *Safe and unsafe induced abortion: Global and regional levels in 2008, and trends during 1995-2008* (2012) Information sheet 1.

²⁵⁸ United Nations Committee on Economic, Social and Cultural Rights General Comment No 14. The Right to the Highest Attainable Standard of Health Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4) Art, 12 para, 23.

²⁵⁹ International Planned Parenthood Federation (IPPF) '*Sexual rights, an IPPF declaration*' (2009) (abridged version) 1-36.

²⁶⁰ Börjesson (n 118 above) 105.

²⁶¹ As above.

²⁶² Lince-Deroche *et al* '*Assessing 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* 73-81.

Furthermore, healthcare providers in South Africa are by law supposed to report and disclose sexual offenses against children.²⁶³ This law can greatly affect an adolescent girl's right to privacy or confidentiality when seeking TOPs especially if healthcare workers have to report and expose cases of adolescent pregnancy that are a result of rape, incest or any other form of sexual violence.²⁶⁴ When faced with incidences where adolescents do not want to be recognised as victims of sexual violence, they end up seeking unsafe abortion.

3.7 Conclusion

Systematic factors coupled with adolescent girl's knowledge, attitudes or perceptions and stigma attached to either teenage pregnancy or abortion are very key in determining an adolescent behaviour towards access of termination of pregnancy services. The environment within which the adolescent lives also plays a big role in her decision to terminate a pregnancy whether safely or unsafely regardless of the existing abortion laws. Therefore in order to address the determinants to the access of unsafe abortion in the liberalised environment, there has to be sustained political will and commitment from leaders to ensure that the CTOP Act in its totality is fully implemented at all levels.

²⁶³ n 104 above, sec, 28.

²⁶⁴ J Dhillon, *Protecting women's access to safe abortion care: A guide to understanding the human rights to privacy and confidentiality: Helping advocates navigate 'duty to report' requirements*, (2014) 1-14.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 Introduction

As highlighted in the introductory chapter of this study, unsafe abortion still remains a persistent public health challenge in many African countries²⁶⁵ including South Africa. However, it is imperative to note that unlike many African countries, South Africa has a liberal abortion law which has facilitated the reduction in 'clandestine abortions' over the years in the country. In spite of the existence of a liberal abortion law, research indicates that many adolescents still have restricted access to safe abortion.²⁶⁶ As a result many young women perpetually become accustomed to the utilisation of unsafe abortion services which increases their susceptibility to unsafe abortion related complications.²⁶⁷ Therefore, if not addressed and adolescents continue to access unsafe abortions there will not only be an increase in the burden of ill health among adolescents but also an increase in the rates of maternal mortality in the country.²⁶⁸

By virtue of this report, it attempted to explore the determinants to the use of unsafe abortion among adolescents following the liberalisation of abortion in South Africa. We scrutinised the abortion law in South Africa and the facilitators to the use of unsafe abortion in the existence of a liberal abortion law. The theory of planned behaviour and behaviour model were used to understand, analyse and draw conclusions on the determinants of unsafe abortion among adolescents in a liberalised environment.

²⁶⁵ WHO (n 8 above)15.

²⁶⁶ Fokazi (n 20 above)1.

²⁶⁷ Department of Health (n 24 above) 2-23.

²⁶⁸ As above.

4.2 Conclusion

From this report we draw the following conclusions; firstly from the analysis and discussions of the literature above, primarily in relation to legislature and policy, South Africa is a state party to various human rights conventions which provide for the right to sexual and reproductive health care for adolescents. At the national level, there is clear evidence that South Africa's legal framework on adolescent access to reproductive health services particularly safe abortion is consistent with international and regional law on the right to reproductive health. It is therefore evident that South Africa is committed to improving the health status of adolescents. This is demonstrated in South Africa's consistent review of its laws and policies on abortion and sexual and reproductive health in general to accommodate the health needs of adolescents. A case in point is the CTOP Act, the National Contraception and Fertility Planning Policy and Service Delivery Guidelines²⁶⁹, Sexual and Reproductive Health and Rights: Fulfilling our commitments. 2011-2021 and beyond²⁷⁰ all of which indicate South Africa's continues effort to fulfil its human rights obligations under international law.

Secondly, although South Africa has a liberalised abortion law that explicitly accommodates adolescents' reproductive needs, the analysis of available data indicates that there are still tremendous gaps in the implementation of the abortion policy. Additionally, adolescent girls' access to safe abortion and other sexual and reproductive health related services remain inadequate due to the limitations put on adolescent friendly and reproductive health services in general hence failing to meet the needs of young people.

Thirdly, despite the availability of liberal abortion laws, the study reveals that unsafe abortion thrives among adolescents due to their lack of knowledge and negative perceptions towards TOP, social-cultural and religious influences, systematic challenges

²⁶⁹ Department of Health, National Contraception and Fertility Policy and Service Delivery Guidelines: a companion to the National Contraception Clinical Guidelines, South Africa (2012) Department of Health 43-49

²⁷⁰ Department of Health, Sexual and Reproductive Health and Rights: fulfilling our commitments. 2011-2021 and beyond. Pretoria (2011) Department of Health 1-39.

and the persistent unwanted pregnancy associated factors such as sexual violence and inadequacy in contraceptive use.

In conclusion, it's crucial that determinants to the use of unsafe abortion services be addressed in order to curb the dominant effects of unsafe abortion. This can be overturned by adopting Durojaye's submission concerning the use of the 'female adolescent question'. The exploration of the use of the 'female adolescent question' will facilitate the development and implementation of effective and sustainable programmes that will address the existing gaps in policy²⁷¹ but above all meet the reproductive health needs of adolescents as provided for under the law.

4.3 Recommendation

As discussed above, there is no doubt that the government of South Africa have taken measures to ensure that young women have access to safe abortion information and services. However there are still gaps and in order to address these gaps, government needs to form strategic partnerships. For example the limitation to access information can be expanded further by developing partners who with support and broaden the development of information dissemination channels that are friendly to young people. Such channels include the use of electronic and mobile solutions for health.²⁷² This will complement the ongoing government interventions that provide comprehensive information that address issues that surround abortion such as social-cultural, religious, systematic factors and gender related issues.

There is need to review the implementation of the service delivery package for adolescents on abortion and sexual and reproductive health in it's totally as the current package is not meeting the needs of adolescents. And in reviewing the new package it

²⁷¹ E Durojaye 'Realising access to contraception for adolescents in Nigeria: A human rights analysis' unpublished LLD thesis, University of the Free State, 2010 63.

²⁷² Imaginet 'The Reality of Mobile Usage and Social Media Growth in South Africa' <http://www.imagi-social.co.za/reality-mobile-usage-social-media-growth-south-africa/> (accessed 28 August 2016). It is estimated that there are 40.7 million unique mobile subscribers with 11 million estimated to have smartphones which various social media applications like face book twitter, Linked In and Pinterest.

should be developed by young people with support from relevant stakeholders. This package should aim at meeting the needs of adolescents and offered in a youth friendly way to guarantee effective utilisation of the services.

Community and civil society organisations need to intensive advocacy aimed at improving the quality of abortion related service delivery at designated health centres. These advocacy initiatives should be led by the community leaders and young people whose capacity needs to be enhanced in order to support and sustain community initiatives that will complement the safe abortion services.

There is need to develop sexual and reproductive information packages for different segments of adolescent population based on their age, marital status, schooling age and gender. Adolescents should be targeted before they are sexually active with effective strategies that will help them to translate knowledge into practice. For example, effective communication and negotiation skills with sex partners.

As indicated above, men play a critical role in facilitating unsafe abortion among adolescents first as their sex partners and second as the custodians of culture and religion. Therefore it's imperative that government effectively target and involves men to combat unsafe abortions while promoting safe abortion and contraceptive use. This will boost adolescent confidence in the utilisation of abortion services.

Additionally, the government of South Africa should endeavour to take drastic measures to implement the law against illegal and unsafe abortion providers. One of such measures could be building networks within the community that will help in the identification and prosecution of backstreet abortionists. This will reduce on the number of backstreet abortionist who openly advertise and undertake these unlawful services.

This study is of utter importance as it investigated the determinants of unsafe abortion among all the sub groups of adolescents in a single document. During the data analysis process I was challenged with getting studies on unsafe abortion for the different sub groups of adolescents. Majority of the available studies were conducted at regional or community level which is not presentative of the national context. Therefore further research should be undertaken to widely explore the factors to the continuous use of

unsafe abortion among adolescents in their sub groups such as social-cultural, religious and systematic challenges and their impact on adolescent reproductive health in general.

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