Adolescent girls' access to contraceptive information and services in South Africa: What is going wrong? (1)*

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OPSOMMING

Adolessente meisies se toegang tot voorbehoedsinligting en -dienste in Suid-Afrika: Wat gaan verkeerd?

Die realiteit is dat adolessente deesdae vroeër in seksuele verhoudings betrokke raak, en sal kwesbaar word vir geslags- en reproduktiewe gesondheidsprobleme. Veral adolessente meisies word blootgestel aan seksueel-oordraagbare infeksies soos MIV, en loop verder die risiko van ongewenste swangerskappe. Ten spyte van die bestaan van internasionale en regionale menseregte-instrumente wat die reg van adolessente meisies op toegang tot voorbehoedsinligting en -dienste verskans, en eweneens ten spyte van Suid-Afrika se grondwetlike en siviele regsraamwerk wat hierdie regte waarborg, is daar vele struikelblokke wat verhinder dat adolessente meisies toegang tot voorbehoedsinligting en -dienste geniet. Hierdie artikel ondersoek dus, eerstens, die Suid-Afrikaanse regsraamwerk wat die reg op toegang tot seksuele en reproduktiewe gesondheidsorginligting en -dienste van adolessente meisies waarborg en, tweedens, die struikelblokke wat hierdie meisies teëkom wanneer hulle poog om toegang tot sodanige dienste te verkry. Derdens word die reperkussies van die bestaan van hierdie struikelblokke vir adolessente meisies ondersoek. Ons voer aan dat om adolessente meisies te verhinder om toegang te geniet tot realistiese en omvattende voorbehoedsinligting en -dienste baie nadele vir die gemeenskap inhou. Aangesien die verwesenliking van goeie geslags- en reproduktiewe gesondheidsuitkomste nie net daarvan afhang dat 'n staat regionale en internasionale menseregte-instrumente ratifiseer nie, of die regte ook in sy munisipale regstelsel inkorporeer nie, moet ouers en ander belanghebbendes ook gewillig wees om 'n gesindheidsverandering te ondergaan teenoor adolessente se seksualiteit.

1 INTRODUCTION

The world's adolescent population – the largest in its history – stands at 1.2 billion, 88 per cent of whom reside in developing countries.[1] In sub-Saharan

* The article is based on sections of the first author's LLD thesis entitled *Female adolescents' reproductive health rights: Access to contraceptive information and services in Nigeria and South Africa* (UP 2014).

1 UNICEF "Demographic trends for adolescents: Ten key facts", available at http://uni.cf/1zN5UmH (accessed on 8 May 2013).

Africa adolescents constitute more than one in every five inhabitants.[2] In South Africa, adolescents make up 20 per cent of the total population.[3] Such a large population of adolescents presents an opportunity to hasten economic development and to minimise poverty. An investment in the sexual and reproductive health (SRH) of this group builds the foundation to remodel the futures of many countries in the sub-Saharan African region.[4]

In previous decades, international and regional bodies called for the recognition of the right of adolescents to access SRH care services as a means of fulfilling their human rights and meeting their developmental needs. Specifically, adolescent girls'[5] access to contraceptive information and services has been advocated. These calls resulted in international and regional human rights instruments that guarantee adolescents' rights to health care and associated rights,[6] and in numerous consensus documents, such as the International Conference on Population and Development Programme (ICPD) Programme of Action[7] and the Beijing Platform of Action[8] that advocate female adolescents' access to SRH information and adolescent-friendly health care services.

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2 *Ibid*. Statistics reveal that over 88% of adolescents reside in the developing world, and Africa is home to over 220 million of them.

3 Statistics South Africa *Census 2011: Methodology and highlights of key results* (2012) 10, available at http://bit.ly/1BKbz2y (accessed on 21 March 2013).

4 Population Reference Bureau *The time is now: Invest in sexual and reproductive health for young people* (2012) available at http://bit.ly/1FcA8UF (accessed on 20 June 2013); Chaaban and Cunningham *Measuring the economic gain of investing in girls: The girl effect dividend* (2011) 3 available at http://bit.ly/1DOLTyn (accessed on 20 June 2013); Jimenez *et al World development report 2007: Development and the next generation* (2006) 26–28 available at http://bit.ly/1BKbStY (accessed on 19 June 2013).

5 According to the World Health Organisation, adolescents are young persons between the ages of 10 and 19. Early adolescence is between 10 and 14 years, while late adolescence is the period between 15 and 19 years; see Cook *et al Reproductive health and human rights, integrating medicine, ethics and law* (2003) 276.

6 Rights that have a bearing on adolescents' rights to health care include the right to privacy, the right to equality, the right to human dignity and the right to physical integrity, to name but a few. International and regional human rights instruments that guarantee adolescents' rights to health care and associated rights are the International Covenant on Economic Social and Cultural Rights GA Re. 2200A (XXI) 1966; International Covenant on Civil and Political Rights GA Res 2200A (XXI) 1966; Convention on the Rights of the Child GA Res 44/25CRC 1989; African Charter on Human and Peoples' Rights CAB/LEG/67/3 rev 5, 21 ILM 58 1981; African Charter on the Rights and Welfare of the Child – CAB/LEG/24.9/49 1990; and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa CAB/LEG/66.6 2003. Particularly, in relation to the right of everyone to enjoy the highest attainable standard of physical and mental health guaranteed in a 12(1) of the International Covenant on Economic Social and Cultural Rights (ICESCR), the ICESCR Committee has explained that the minimum core essentials that must be satisfied by state parties include those of availability, accessibility, acceptability and quality. See para 12 General comment 14 of the ICESCR Committee (2000) available at http://bit.ly/1FcAHhj (accessed on 10 April 2014).

7 International Conference on Population and Development Programme of Action 1994, available at http://bit.ly/1vmYw45 (accessed on 2 April 2014). Other documents include the Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development (ICPD +5) 1999 and, most recently, the Bali Global Youth Forum Declaration 2012, available at http://bit.ly/1G0laRB (accessed on 2 April 2014).

8 Beijing Platform of Action 1995, available at http://bit.ly/1aMmb6F (accessed on 12 April 2014).

Today, the provisions in international and regional human rights instruments that guarantee adolescents access to contraceptive information and services have been incorporated into the domestic legislation and policy documents of several countries, including South Africa.[9] It is accepted that ensuring that adolescent girls have access to SRH information and services from an early age, facilitates the development of their autonomy and allows them to make informed reproductive health choices later in life.[10] In addition, guaranteeing adolescent girls access to quality SRH care services, including family planning services, ensures that they enjoy the right to health guaranteed in numerous human rights instruments[11] and domestic laws[12] and also affords them the opportunity to realise their educational and developmental potential, thereby achieving economic security and independence for them and their communities.[13]

There are several additional reasons why it is expedient that adolescents have access to SRH information and services and why countries should invest in adolescent SRH. Apart from the fact, as indicated above, that there are over a billion adolescents in the world and, consequently, an investment in them is an investment in a better future, the SRH choices made during adolescence have a lasting impact on individual health.[14]

Furthermore, statistics indicate that adolescents engage in sexual relations earlier than in the past;[15] so they face various SRH risks about which they need to be knowledgeable to enable them to make informed choices.[16] Guaranteeing adolescents' access to contraceptive information and services, therefore, is a means to combat the reproductive health hazards occasioned by the expression of adolescents' sexuality. Adolescence requires careful managing as, to a large extent, the health and sexual choices made during this phase shape the adolescent's future.

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9 See para 2 below.

10 UNFPA *Comprehensive sexuality education: Advancing human rights, gender equality and improved sexual and reproductive health* (2010) 12, available at http://bit.ly/1ALB1ix (accessed on 8 October 2013).

11 A 12 ICESCR; a 24 Convention on the Rights of the Child (CRC); a 16 African Charter on Human and Peoples' Rights; a 14 African Charter on the Rights and Welfare of the Child; a 14 African Women Protocol.

12 Ss 27(1)(a) and 28(1)(c) of the Constitution of the Republic of South Africa, 1996; s 134(1) of the Children's Act 38 of 2005; etc.

13 International Center for Research on Women (ICRW) *Girls' education, empowerment, and transitions to adulthood: The case for a shared agenda* (2012) 8–9, available at http://bit.ly/1M8085J (accessed on 8 October 2013).

14 UNICEF *The state of the world's children 2011: Adolescence an age of opportunity* (2011) 4–5, available at http://uni.cf/1lThGdx (accessed on 9 May 2013).

15 Statistics reveal a drastic reduction in the current average age, at first intercourse, from the median age recorded in the early 1950s. For example, in France the average age at first intercourse is now 17 years, unlike in the past when it was in the early 20s. See Madkour *et al* "Early adolescent sexual initiation and physical/psychological symptoms: A comparative analysis of five nations" 2010 *J of Youth and Adolescence* 1213.

16 Jejeebhoy *Sexual and reproductive health of young people: Expanding the research and program agenda* (2006) 1, available at http://bit.ly/1FcB9Mr (accessed on 9 May 2013).

The situation is even more precarious for adolescent girls because, apart from experiencing the same peer pressure as their male counterparts to engage in early sexual relations,[17] they are more likely to fall victim to sexual violence.[18] In addition, achieving socio-economic growth and escaping poverty are especially taxing for adolescent girls in developing countries where culture and gender stereotypes position them as subordinate to their male counterparts.[19] Gender imbalances in many developing countries are such that young girls grow up in the belief that they are meant to satisfy men's sexual needs and to defer to them in decision-making. Such beliefs have the potential to set up adolescent girls to suffer sexual and reproductive ill-health.[20] Furthermore, adolescence is the phase when poverty and inequity are passed on to future generations: adolescent girls fail to complete their schooling as they give birth to children whose lives, in turn, are often impoverished.[21]

Another vital reason for promoting the SRH of adolescent girls, is the public health imperative of curbing the HIV pandemic. The prevention of HIV transmission through advocating good SRH practices among this group will lead to a significant slowing of the epidemic as 40 per cent of new HIV infections worldwide occur in young people.[22] Statistics, based on 2011 data released by UNICEF, reveal that South African female adolescents and young women constitute a larger percentage of adolescents infected with HIV than male adolescents: the HIV prevalence rate among this group amounts to 11.9 per cent as compared

17 Ankomah *et al* "Reasons for delaying or engaging in early sexual initiation among adolescents in Nigeria" 2011 *Adolescent Health, Medicine and Therapeutics* 78–80; Selikow *et al* "I am not 'umqwayito': A qualitative study of peer pressure and sexual risk behaviour among young adolescents in Cape Town, South Africa" 2009 *Scandinavian J of Public Health* 109–110; Bingenheimer *et al* "The peer group context of sexual behaviors among Ghanaian youth", available at http://bit.ly/1Kq0lG3 (accessed on 8 May 2013).

18 Jewkes "Non-consensual sex among South African youth: Prevalence of coerced sex and discourses of control and desire" in Jejeebhoy *et al* (eds) *Sex without consent: Young people in developing countries* (2005) 88; Akanle "Sexual coercion of adolescent girls in Yoruba Land of Nigeria" 2011 *Current Research J of Social Sciences* 132–138; Family Health International "Non-consensual sex" 2005 *Network* 3–4, available at http://bit.ly/1DOZohq (accessed on 8 May 2013); Ankomah *et al* (fn 17) 81–82.

19 Mbambo *et al* "Factors influencing adolescent mothers' non-utilisation of contraceptives in the Mkhondo Area" 2006 *Health SA Gesondheid* 22–31; Adjetey "Reclaiming the African woman's individuality: The struggle between women's reproductive autonomy and African society and culture" 1995 *American University LR* 1356.

20 Human Rights Watch *This old man can feed us, you will marry him: Child and forced marriage in South Sudan* (2013) 48–49 available at http://bit.ly/1zZT6u1 (accessed on 20 June 2013); Loaiza and Wong *Marrying too young: End child marriage* (2012) 39 available at http://bit.ly/YUF1Cx (accessed on 20 June 2013); Chaaban and Cunningham (fn 4); Cusack and Cook "Combating discrimination based on sex and gender" in Krause and Scheinin (eds) *International protection of human rights: A textbook* (2009) 222; Bayisenge "Early marriage as a barrier to girl's education: A developmental challenge in Africa" in Ikekeonwu (ed) *Girl-child education in Africa* (2010) 7–8.

21 UNICEF *The state of the world's children 2011* (fn 14) 3.

22 Biddlecom *et al Protecting the next generation in sub-Saharan Africa: Learning from adolescents to prevent HIV and unintended pregnancy* (2007) 6 available at http://bit.ly/1w6geuA (accessed on 9 May 2013).

to 5.3 per cent among male adolescents.[23] Supporting this statistic is the 2011 National Antenatal Prevalence Survey which reveals that the HIV prevalence rate among 15 to 24 year old pregnant women was 20.5 per cent.[24]

An important reason for investing in the SRH of female adolescents is the high teenage birth rates in sub-Saharan Africa.[25] South Africa is amongst the countries in sub-Saharan Africa with the highest adolescent birth rates,[26] despite the fact that it has one of the lowest total birth rates in the region and a significantly high contraceptive prevalence rate.[27] Linked to this, is the fact that adolescent girls constitute over 14 per cent of women who undergo unsafe abortions every year as a result of unplanned pregnancies.[28] Whereas the majority of teenage girls choose to give birth, as evidenced by the large number of adolescent mothers in South African society,[29] many do have abortions because of fear, shame, or a wish to continue schooling and as a result of financial constraints.[30]

In light of the context outlined above, the article aims to scrutinise adolescent girls' access to contraceptive information and services in South Africa. The article examines South Africa's domestic legislation, policies and other mechanisms aimed at advancing the right of adolescent girls to contraceptive information and services. The obstacles that prevent adolescent girls' access to comprehensive contraceptive information and adolescent-friendly services are highlighted, as are the consequences occasioned by lack of such access. The article concludes by arguing that hindering adolescent girls' access to factual and comprehensive

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23 UNICEF *South Africa statistics* available at http://uni.cf/1w6glX6 (accessed on 28 October 2013). See also UNFPA *HIV prevention: Fact sheet* (2012) available at http://bit.ly/1wXuuRD (accessed on 28 October 2013).

24 Department of Health *The national antenatal sentinel HIV and syphilis prevalence survey South Africa 2011* (2012) v available at http://bit.ly/1FcPBnw (accessed on 12 November 2013).

25 In 2013, while the global fertility rate among 15–19 year olds was 52 births per 1 000 adolescents, in sub-Saharan Africa fertility rates among the same group were 101 births per 1 000 adolescents. See Population Reference Bureau *The world youth: 2013 data sheet* (2013) 11, available at http://bit.ly/1B9Nal3 (accessed on 3 April 2014). See also Ramos "Interventions for preventing unintended pregnancies among adolescents" (2011) *WHO Reproductive health library commentary* available at http://bit.ly/1Kq2x08 (accessed on 10 March 2014).

26 According to the WHO, the adolescent birth rate in the country stands at 54 for every 1 000 live births among girls aged 15 to 19 years. See Statistics South Africa *General household survey* (2012) 18 available at http://bit.ly/1B9NiRF (accessed on 9 November 2013); WHO *The state of the midwifery: Delivering health, saving lives* (2011) 133 available at http://bit.ly/1DOZZQj (accessed on 9 November 2013).

27 WHO *The state of the world's midwifery* (fn 26) 132–133. In the *South African Health Review* 2011, it was revealed that as at 2008, 21.9% adolescents were already mothers. See Day *et al* "Health and related indicators" 2011 *South African Health R* 180 available at http://bit.ly/18SSQqm (accessed on 11 November 2013).

28 Cook *et al* "Respecting adolescents' confidentiality and reproductive and sexual choices" 2007 *Int J of Gynecology and Obstetrics* 183.

29 According to facts from the 2003 demographic health survey, the number of teenagers who have begun childbearing rose from 2% at 15 years to 27% at the age of 19. See Department of Health and Medical Research Council *South Africa demographic and health survey* (2003) 161 available at http://bit.ly/1B5XZpm (accessed on 3 November 2013). See Day *et al* (fn 27) 180.

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

contraceptive information and services does great harm and that the achievement of good SRH outcomes for adolescent girls is dependent not only on human rights instruments and national legislation adopted by South Africa's government, but also on the willingness of parents and gatekeepers to effect attitudinal changes and to encourage young people's access to contraceptive information and services.

We begin our discussion with an examination of the South African legal framework guaranteeing adolescent girls' access to contraceptive information and services. Note that due to space limitations, not all the provisions in the different statutes and policies will be discussed – we focus on the most relevant.

2 SOUTH AFRICA'S LEGISLATIVE FRAMEWORK FOR ENSURING ADOLESCENT GIRLS' ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES

2 1 Introduction

As a state party to most[31] of the international and regional human rights instruments that guarantee adolescents access to contraceptive information and services, South Africa is obliged under international law to respect, protect and fulfil the right of adolescent girls to access contraceptive information and services.[32] Below we focus on a consideration of South Africa's legislative and policy framework that gives effect to the country's international law obligations. We scrutinise laws, policies and other mechanisms that have been adopted in South Africa to advance the right of adolescent girls to contraceptive information and services. We begin with the Constitution of the Republic of South Africa, 1996.

2 2 Constitution of the Republic of South Africa, 1996

Rights that are relevant to female adolescents' access to contraceptive information and services are the rights to equality,[33] dignity,[34] life,[35] freedom and security of the person,[36] privacy,[37] freedom of expression,[38] access to health care, including reproductive health care,[39] children's rights to basic health care services,[40] to

31 South Africa ratified the ICESCR in January 2015.

32 An examination of the international and regional human rights instruments that guarantee adolescents access to contraceptive information and services falls outside of the scope of this article. For more on the international law guarantees of adolescents access to contraceptive information and services, see Savage and Nienaber "Female adolescents' evolving capacity in relation to their right to access contraceptive information and services: A comparative study of South Africa and Nigeria" 2015 *CILSA* (in press).

33 S 9 of the Constitution of the Republic of South Africa, 1996.

34 S 10.

35 S 11.

36 S 12. Especially, the right to bodily and psychological integrity which includes the right to make decisions on reproduction guaranteed in s 12(2)(a).

37 S 14.

38 S 16. Especially the freedom to receive and impart information recognised in s 16(1)(b).

39 S 27(1)(a).

40 S 28(1)(c). Apart from the right of children to basic health care services, some of the other children's rights guaranteed in s 28 are also important, eg, children's right to basic nutrition, shelter, social services and to be protected from maltreatment, abuse or degradation.

education,[41] and access to information.[42] Once again, because of space limitations, we limit ourselves to the right to dignity, access to health care and children's rights.

Section 10 of the Constitution guarantees everyone the right to dignity. The importance of the need to treat adolescent girls with dignity when accessing contraception and other SRH care services cannot be emphasised enough. Unlike the other rights recognised under international human rights law, such as the rights to equality, privacy and information, which may be subject to limitations in exceptional situations, the right to dignity cannot be limited as it is the "characteristic that gives a person intrinsic worth".[43] This view was confirmed by the Constitutional Court in *S v Makwanyane*.[44]

A major obstacle to the right of adolescent girls to reproductive health care is the refusal of health providers, as a result of cultural or religious bias,[45] to treat them with dignity when they access contraception. Female adolescents will endeavour to access contraceptive services and information only in a situation in which they are assured of receiving dignified treatment in adolescent-friendly environments. In light of the high rates of STIs and HIV, which disproportionately affect female adolescents, there is an urgent need to overcome prejudice so that various international, regional and national efforts to curb the spread of the epidemic can yield fruit.

Adolescent girls' access to contraceptive information and services is guaranteed in section 27 of the Constitution.[46] Because of this guarantee, the South African government specifically needs to take note of the special needs of women (including adolescent girls) who, in order to live dignified lives, require access to essential information and services as a result of their biological make-up and the huge burden of disease related to the performance of their reproductive function.[47] Ngwena states that the provision of section 27 of the Constitution of the Republic of South Africa, which confers a positive right to receive reproductive health care from the state, is egalitarian since it strives to secure

41 S 29.
42 S 32.
43 Devenish *The South African constitution* (2005) 61.
44 *S v Makwanyane* 1995 3 SA 391 (CC), 1995 6 BCLR 665 (CC).
45 As a result of cultural and religious beliefs, adolescent girls are prevented from accessing contraceptive services and information. In South Africa, especially in relation to abortion services, health care providers use conscientious objection to refuse to participate in abortion procedures. However, such providers are under the obligation to refer the woman or adolescent to another provider or facility where the procedure can be carried out. See Harries *et al* "Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study" 2014 *Reproductive Health* 3–4; Harries *et al* "Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa" 2009 *BMC Public Health* 2. Conscientious objection is the refusal to perform a legal role or responsibility as a result of personal beliefs. In health care, conscientious objection involves health care providers' refusal to carry out certain treatment on patients as a result of their moral or religious beliefs.
46 S 27(1)(a) of the Constitution of the Republic of South Africa, 1996.
47 Women play a major role in reproduction and have an elaborate reproductive system that is vulnerable to disease. See Cook *et al* (fn 5) 8–9.

not only formal equality[48] so that factors like gender, age, marital status and race cease to be issues that affect access to health care services, but also substantive equality so that other social disadvantages that prevent access to health care[49] are eliminated, or reduced to a minimum.[50]

A feature which distinguishes the South African Constitution from many others on the African continent, is the specific inclusion of children's rights in its provisions. According to Sloth-Nielsen, the inclusion of a detailed provision on the protection of the rights of children in section 28 of the Constitution can be traced to international law, which advocates, in various human rights instruments,[51] the protection of children's rights.[52]

In recognition of the vulnerable situation of children, apart from the specific protections provided to children in section 28, the Constitution recognises the right of children to enjoy all other rights guaranteed in the Bill of Rights.[53] Although various rights pertaining to children are specifically guaranteed in section 28,[54] attention will be given to the right of children to basic health care as provided in section 28(1)(c).[55] It is important to highlight from the outset that the rights recognised in section 28(1)(c) are socio-economic rights which have already been guaranteed to 'everyone' in the Constitution. As Robinson notes,[56] the inclusion of socio-economic rights in the rights guaranteed in section 28 is to give a qualitative content to the child's right to care and protection as it provides for baseline necessities which children are entitled to in order to live dignified lives.

Furthermore, whereas the right of everyone to the socio-economic rights assured in sections 26(1) and 27(1) is subject to the availability of resources,[57]

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48 Formal equality involves the treatment of "like things in a like manner". This mode of equality promotes the recognition of the equal treatment of individuals without consideration of the existence of extraneous factors or vulnerability.

49 Social impediments which affect adolescent girls' access to contraception include those related to income, culture, religion and geographical location as girls living in rural areas in the majority of situations do not have access to reproductive health care due to the reason that either the facilities are far away or they cannot afford paying user fees.

50 Ngwena "The recognition of access to health care as a human right in South Africa: Is it enough?" 2000 *Health and Human Rights* 29.

51 International human rights instruments (such as those mentioned in fn 6) advocate the protection of the rights of people generally while the Convention on the Rights of the Child and its African counterpart, the African Charter on the Rights and Welfare of the Child, specifically guarantee the rights of children.

52 Sloth-Nielsen "Children" in *South African constitutional law: Bill of rights* (2012) 23-2. See also *Government of the Republic of South Africa v Grootboom* 2001 1 SA 46 (CC) para 75.

53 Robinson "Children's rights in the South African Constitution" 2003 *PELJ* 16. An exception in this regard relates to the right to vote which is only accorded to adult citizens – s 19(3)(a) of the Constitution of the Republic of South Africa, 1996.

54 Apart from children's rights protected under s 28(1)(c), other rights recognised in the section include the right of children to family care or parental care – s 28(1)(b); the right of children to be protected from maltreatment, abuse or degradation – s 28 (1)(d); children's right to be protected from exploitative labour practices – s 28(1)(e).

55 S 28(1)(c) recognises the right of children to basic nutrition, shelter, basic health care services and social services.

56 Robinson (fn 53) 41.

57 Ss 26(2) and 27(2) of the Constitution of the Republic of South Africa, 1996.

the entitlement of children with regard to the rights contained in section 28(1)(c) is unqualified and not subject to the availability of resources.[58] The above will be the basic interpretation of the provision of the section. However, in *Government of the Republic of South Africa v Grootboom*,[59] the Constitutional Court rejected the application of the right under section 28(1)(c), unqualifiedly, on the basis that it produces anomalous results in the sense that people who have children would have direct and enforceable rights to housing under section 28(1)(c), whereas others who have none, or whose children are adults, are not entitled to housing under the section, no matter how old, disabled or otherwise deserving they may be.[60] In addition, there is the danger of children being used as 'stepping stones' to housing by their parents instead of being valued for who they are.[61]

In *Minister of Health v Treatment Action Campaign (TAC)*,[62] an action was instituted as a result of the government's refusal to expand its pilot programme on the provision of Nevirapine, a drug administered to prevent the transmission of HIV from pregnant women to their unborn children. The Constitutional Court attempted to clarify its earlier decision in *Grootboom* by declaring that the state's duty to guarantee and provide children's socio-economic rights under section 28(1)(c) is triggered not only when children are physically separated from their parents, but also in situations in which, though the children reside with their parents, the parents are indigent and unable to effectively provide basic necessities for their children.[63] Despite this clarification, the Court did not base its decision on section 28(1)(c) by concluding that children were directly the bearers of individual rights to health care if they had indigent parents, but instead, declared that a violation of section 27(1) and (2) of the Constitution had occurred. The Court required the government to devise and implement within its available resources a comprehensive and co-ordinated programme progressively to realise the right to health care.[64]

Notwithstanding the fact that the Constitutional Court did not centre its decision on the provisions contained in section 28(1)(c), the constitutional obligation

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58 Robinson (fn 53) 42.

59 *Government of the Republic of South Africa v Grootboom* (fn 52). At the High Court, the judge had reached a decision that, in view of s 28(1)(c) which guarantees children the right to basic nutrition, shelter, basic health care services and social services in an unqualified manner, the right in s 28(1)(c) had been violated.

60 *Government of the Republic of South Africa v Grootboom* para 71.

61 *Ibid.* To "cure" the perceived defect, the Constitutional Court decided that the provisions of s 28(1)(c) create an obligation on the state to provide shelter to those children who are removed from their families, but for children being cared for by their parents or families, s 28(1)(c) does not create any primary state obligation to provide them shelter on demand – see para 77.

62 2002 5 SA 721 (CC).

63 *Idem* para 79. See also Liebenberg "Taking stock: The jurisprudence on children's socio-economic rights and its implications for government policy" 2004 *ESR Review* 4.

64 *Treatment Action Campaign* (fn 62) para 135. Instead, the court used the provision of s 28(1)(c) to support its findings that the government's rigid and restrictive policy on Nevirapine was "unreasonable" as it excluded and harmed a particularly vulnerable group. See Liebenberg (fn 63) 5. Probably to highlight the fact that the rights of children contained in s 28(1)(c) are not unqualified but in fact subject to the availability of resources, s 4(2) of the Children's Act specifically notes that, in achieving the realisation of the objects of the Act, all arms of government must take reasonable measures to the maximum extent of available resources.

imposed on the South African government to ensure the guarantee of the right of children to basic health care services, doubtlessly will include female adolescents being entitled, at a minimum, to basic reproductive health care services, of which their access to contraceptive information and services is an integral part.

Apart from the specific guarantee of the rights of children in section 28(1), section 28(2) of the Constitution provides that the best interests of children are of paramount importance in every matter concerning them. In interpreting the 'best interests' of children principle, the Constitutional Court, in *Minister of Welfare and Population Development v Fitzpatrick*[65] explained that the 'best interests' of children principle recognised as paramount in section 28(2) of the Constitution extends beyond the rights enumerated in section 28(1) to create a right on its own.[66]

In addition, the courts have used the principle in reaching appropriate decisions in divergent cases where determining the best interests of the child was an important factor.[67] Recently, in the *Teddy Bear Clinic* case,[68] the Gauteng High Court, in declaring some portions of the Criminal Law (Sexual Offences and Related Matters) Amendment Act[69] unconstitutional, repeated the position adopted by the courts in relation to the 'best interests' principle by declaring that the provisions of section 28(2) have a wide ambit and must be considered in all matters affecting children.[70]

Finally, in alignment with international and regional human rights instruments relating to children, it is necessary to highlight that the Constitution of the Republic of South Africa not only restates the 'best interests' of the child principle, but also defines a child as 'any person under 18 years'.[71] The insertion of section 39(1) in the Constitution, which provides that South African courts are to consider international law and promote the values of human dignity, equality and freedom, serves as a further guarantee of South African adolescent girls' right to contraceptive information and services. The courts have no choice but to take note of international human rights standards in actions relating to the interpretation or violation of adolescents' right to reproductive health care.

2 3 Legislation

2 3 1 Introduction

Currently, apart from the Constitution, the principle statutes that protect the rights of adolescent girls in South Africa to contraceptive information and services are

65 *Minister of Welfare and Population Development v Fitzpatrick* 2000 3 SA 422 (CC).
66 *Idem* para 17.
67 *Mfolo v Minister of Education, Bophuthatswana* 1992 3 SA 181 (BG); *Minister of Welfare and Population Development v Fitzpatrick* (fn 65) para 18; *Director of Public Prosecutions, KwaZulu-Natal v P* 2006 1 SACR 243 (SCA) para 18; *S v M (Centre for Child Law as Amicus Curiae)* 2008 3 SA 232 (CC) para 22.
68 *Teddy Bear Clinic for Abused Children and RAPCAN v Minister of Justice and Constitutional Development* case no 73300/10.
69 Ss 15, 16 and 56(2)(b) of the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007. See also, the definition of "sexual penetration" in s 1 of the Act.
70 *Teddy Bear Clinic* (fn 68) para 72.
71 S 28(2) and (3) of the Constitution of the Republic of South Africa, 1996.

the Children's Act,[72] the Choice on Termination of Pregnancy Act[73] and the National Health Act.[74] Selected provisions are discussed below.

2 3 2 Children's Act

The Children's Act was adopted in 2005[75] to give effect to children's rights already guaranteed in the Constitution of the Republic of South Africa, and sets out principles relating to their care.[76] Noting that actions or decisions pertaining to children must respect, protect and fulfil children's rights as set out in the Constitution,[77] the Act provides that all organs of government at the national, provincial and local levels must take reasonable measures to the "maximum extent of available resources" to achieve the realisation of its provisions. Furthermore, it advocates that a uniform approach aimed at integrating the services delivered to children must be adopted.[78]

The duty to fulfil the socio-economic rights of children – including adolescent girls' right to access contraceptives and other health care services – without being subject to the availability of resources is the preferred position and argument, yet the provision of section 4(2) of the Children's Act is in agreement with earlier decisions of the Constitutional Court in *Republic of South Africa v Grootboom*[79] and *Minister of Health v Treatment Action Campaign*.[80]

In agreement with the position adopted in human rights instruments in recognising children's rights and in going further, the Children's Act provides that the best interests of the child are paramount and must always be considered when taking decisions pertaining to children.[81] In addition, the Act recognises the right of children to be involved in the decision-making process on issues relating to them.[82] The "best interests" of children principle which the Children's Act declares as "paramount", apart from having been entrenched in the Constitution of the Republic of South Africa[83] in recognition of the international law obligation

72 38 of 2005.
73 92 of 1996.
74 61 of 2003.
75 Further commitment to the protection of the rights of the child was added through the Children's Amendment Act.
76 Preamble, Children's Act.
77 S 6(2) of the Children's Act.
78 Ss 4(1) and (2) and 5 of the Children's Act. As explained in fn 64, the provision of s 4(2) may have stemmed from the argument that fulfilling children's rights were unqualified and not subjected to the availability of funds.
79 *Republic of South Africa v Grootboom* (fn 52) para 71.
80 *Minister of Health v Treatment Action Campaign* (fn 62) para 135.
81 Ss 7 and 9 of the Children's Act. This is in line with provisions on the best interest of children already contained in the Constitution.
82 S 10 of the Children's Act.
83 S 28(2) of the Constitution of the Republic of South Africa, 1996. It should, however, be noted that while the Convention on the Rights of the Child declared the "best interest of children" principle as a "primary consideration" in a 3(1), and the African Charter on the Rights and Welfare of the Child declared it "the best interest principle" as "the primary consideration" in a 4(1), the Constitution of the Republic of South Africa had already raised the bar of the "best interest" principle by declaring it as being of "paramount importance" in any matter concerning the child. See Davel and Skelton *Commentary on the Children's Act* (2007) 2–6 2–7 and *Minister of Welfare and Population Development v Fitzpatrick* (fn 65) para 17, where the Constitutional Court declared the provision of s 28(2) as a right on its own apart from it being used to support other rights protected in s 28(1).

that state parties are to adhere to the best interests of children standard in determining issues involving children, has been used by South African courts in reaching decisions on divergent matters where the interests of children were affected.[84]

In reaction to criticisms that the "best interests" of children principle is vague and indeterminate, and its interpretation subject to different influences, thereby creating room for prejudice and discrimination,[85] the South African courts, over the years, have endeavoured to develop guidelines which will assist in interpreting the principle. In *Van Deijl v Van Deijl*,[86] in reaching a decision on the best interests of the child in a case of custody and guardianship, the court stated:

> "The interest of the minor means the welfare of the minor and the term welfare must be taken in its widest sense to include economic, social, moral and religious considerations. Emotional needs and ties of affection must also be taken into account and, in the case of older children, their wishes in the matter cannot be ignored."[87]

As Davel and Skelton explain, the factors to be considered in determining the best interests of children vary, depending on the different cases and issues that need to be resolved. According to them, the court is not only under a duty to carefully weigh and balance the factors highlighted in the cases so as to reach a conclusion that can be regarded as being in the best interests of the child in the particular case, but it also has an obligation to ensure that a child-centred approach which is based on constitutional values and sensitive to culture and religion is adopted in reaching its decision.[88] Also, while applying the best interests of children principle does not mean that the rights of children will 'always' outweigh the rights of other parties involved, it means that a careful weighing and balancing of the varied interests involved must be done so as not to obliterate other valuable constitutionally-protected interests.[89]

By recognising the right of children to participate in taking decisions,[90] the Children's Act is in line with international and regional children's rights

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84 *Mfolo v Minister of Education* (fn 67); *Minister of Welfare and Population Development v Fitzpatrick* (fn 65) para 18; *Director of Public Prosecutions, KwaZulu-Natal v P* (fn 67); *S v M (Centre for Child Law as Amicus Curiae)* (fn 67) para 22; *Teddy Bear Clinic* (fn 68) para 72.

85 The arguments against the application of the principle include the fact that decisions can be made subject to factors like the cultural, historical, political, economic and social views of the decision-maker. See Davel and Skelton (fn 83) 2–7; Heaton "Some general remarks on the concept 'best interest of the child'" 1990 *THRHR* 95.

86 *Van Deijl v Van Deijl* 1966 4 SA 260 (R); Bonthuys "The best interests of children in the South African Constitution" 2006 *Int J of Law, Policy and the Family* 23.

87 *Van Deijl* 261H. See also *McCall v McCall* 1994 3 SA 201 (C) 205B–G, where King J set out factors to be borne in mind when determining children's best interest; *Krasin v Ogle* [1997] 1 All SA 557 (W) 567i–569e.

88 Like all other rights, the right to have the best interest of children protected has to be balanced with the rights of other persons or groups. See Davel and Skelton (fn 83) 2–9 2–12; *Christian Education South Africa v Minister of Education* 2000 4 SA 757 (CC) paras 15 30–31.

89 Davel and Skelton (fn 83) 2–14.

90 S 10 of the Children's Act.

instruments[91] which recognise children as specific bearers of human rights who can participate in issues affecting them according to their level of maturity and understanding.

In relation to the right of female adolescents to reproductive health and contraceptive information and services, a progressive step adopted in the Children's Act relates to the right of children to be granted access to information on health care, including, specifically, that associated with the promotion of reproductive health and the prevention of ill-health, in a format that will be easily accessible and understandable by them.[92] The inclusion of this provision in the Children's Act illustrates the realistic step that needs to be adopted to prevent the further spread of STIs and HIV, which are particularly widespread among the adolescent population due to ignorance and the lack of relevant and factual information on safe sexual practices, including the media through which preventive SRH care services can be accessed.

The Act recognises the age of eighteen as the age of majority, but sets the age of twelve as the threshold for medical consent by children based on their maturity and ability to understand the risks and benefits attached to medical treatment.[93] The position adopted in the Children's Act is particularly welcome, especially in relation to adolescent girls' access to contraceptive information and services as this coincides with the House of Lords' view in the often-quoted *Gillick* case which is that, once the adolescent understands the nature of the treatment requested and there is a likelihood that she will engage in sexual activities with or without protection, it is in her best interests to allow her access to contraceptives and that this is done confidentially. This approach corresponds with that of Cook *et al* who explain that female adolescents will not access needed contraceptive health care services if their rights to privacy and confidentiality are not assured.[94]

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91 A 12(1) of the CRC and a 4(2) of the African Charter on the Rights and Welfare of the Child. Protecting children's best interests includes guaranteeing their right to express their views which should be given weight according to their levels of maturity and understanding. See Archard and Skivenes "Balancing a child's best interests and a child's views" 2009 *Int J of Children's Rights* 1.

92 S 13(1)(a) and 13(2) of the Children's Act.

93 Ss 17 and 129. It should, however, be noted that, in relation to termination of pregnancy, the age of 12 does not apply as s 5 of the Choice on Termination of Pregnancy Act 92 of 1996 allows a woman of any age to consent to the termination of her pregnancy. The view adopted by the South African legislature is in line with the position of the English House of Lords in *Gillick v West Norfolk and Wisbech Area Health Authority* 1986 1 AC 112, [1985] 3 All ER 402. In this case the "mature minor" doctrine was laid down in English law. The doctrine resulted in the "liberation" of adolescent girls who, though below the age of sixteen, became entitled to independently access and consent to SRH care services in confidential settings without parental involvement, as long as the adolescent possessed the understanding and intelligence to comprehend the nature of the proposed treatment and its implications. *Gillick* was subsequently confirmed in *R (Axon) v Secretary of State for Health* 2006 EWHC 37, where the court refused to make a declaration that allows doctors to break the confidentiality of their adolescent patients who seek to assess SRH care services without parental consent.

94 *Gillick* (fn 93) 174; Cook *et al* "Respecting adolescents' confidentiality and reproductive and sexual choices" 2007 (98) *Int J of Gynaecology and Obstetrics* 183. See also Cook and Dickens "Recognizing adolescents' 'evolving capacities' to exercise choice in reproductive healthcare" 2000 (70) *Int J of Gynaecology and Obstetrics* 17.

Apart from the above, the Act specifically guarantees children access to contraceptives on request, without parental consent, from the age of twelve, and provides that 'no person may refuse to grant a child's request to access contraception'.[95] In suitable circumstances, proper medical advice is to be given to the child, as well as a medical examination in order to determine the appropriate type of contraception to be provided.[96] It should also be noted further that the refusal by adults and other gatekeepers to sell or provide contraception to adolescents where it is meant to be made available, is a criminal offence under the Children's Act.[97]

Furthermore, like adults, children are entitled to confidentiality when accessing health care services with information relating to their health status remaining confidential, unless consent to disclose such information is granted by the child.[98] The same position on confidentiality applies where female adolescents access contraceptive services and information,[99] except if the health care provider has reason to believe that the adolescent girl has been a victim of sexual abuse, or if maintaining confidentiality will not be in the child's best interests; in which case, a report is to be made to the appropriate authorities.[100]

Finally, it can be concluded that South Africa's Children's Act, apart from being progressive, is realistic as it takes note of current trends relating to adolescent sexuality and takes steps to ensure adolescent girls' effective protection by allowing them to exercise their autonomy while engaging in sexual relations. Davel and Skelton declare that the provisions of the Children's Act go further than other legislative enactments on the protection of children's rights in the African region and beyond in the recognition to the right of children to autonomy in the reproductive health care context.[101]

2 3 3 National Health Act

The National Health Act came into operation in 2005 and provides a framework for the progressive realisation in South Africa of the constitutional guarantee of the right to access health care services, including reproductive health care, and children's rights to basic health care services.[102] The Act seeks to regulate national health and provide uniformity in respect of health services across the nation. It establishes a national health system made up of both the public and private health sector, highlights the rights and duties of health providers and users, and strives to protect, respect, promote and fulfil the rights of South Africans to health care.[103]

95 S 134(1) of the Children's Act.
96 S 134(2).
97 S 305(1)(c). This particular paragraph came into effect in July 2007.
98 Ss 13(1)(d) and 133.
99 S 134(3).
100 S 110(1).
101 Davel and Skelton (fn 83) 7–41.
102 Preamble, National Health Act.
103 S 2.

Apart from providing that health users must have full information about their health status,[104] the Act, recognising the importance of consent and participation in medical decisions, provides that the informed consent of a patient must be obtained before the commencement of medical treatment and also that health care users must participate in decisions affecting their health.[105] Furthermore, recognising the role confidentiality plays in guaranteeing access to health care services generally, the Act provides for the confidential keeping of health records, except if disclosure is needed to protect public health, and is based on court orders or the user personally consenting to the disclosure being made.[106]

In addition to the above, the National Health Act protects children, including adolescents, by providing that, before medical experiments for therapeutic purposes involving them can be conducted, their best interests and consent must be considered and obtained (if they are capable of understanding), as well as the consent of their parents.[107] If the research is for non-therapeutic purposes, in addition to the minor's and parents' consent, the Minister of Health must also consent to the experimentation.[108]

The continued reiteration of provisions on informed consent and the participation of children and adolescents in health decisions and confidentiality reinforces provisions already contained in the Children's Act and the Constitution on the rights to health care, access to information, dignity and privacy. These provisions will encourage adolescent girls to seek access to much-needed contraceptive information and services instead of relying on charlatans who constitute a serious health risk.

2 3 4 Choice on Termination of Pregnancy Act

The Choice on Termination of Pregnancy Act (CTOP Act)[109] which came into operation in 1996 was passed into law so as to put into effect the constitutional guarantee of the right of women (including adolescent girls) to exercise autonomy over reproduction and their bodies and to ensure that such choice is made

104 S 6. Disclosure of health status must be provided to the patient in a language the patient understands, except if there is evidence to show that such disclosure will be contrary to the best interests of the patient.

105 Ss 7 and 8. Informed consent must always be obtained except in circumstances provided under s 7(1)(a–e).

106 S 14.

107 S 71(2). This section provides that consent of the minor is to be obtained; it also provides that the consent of parents or a child's guardian should be obtained. Research for "therapeutic purposes" is research aimed at finding a cure or treatment for a disease that the child research participant suffers from.

108 S 71(3). The Minister can refuse to give his consent if he is of the opinion that the objects of the research can be achieved if conducted on an adult, is of the belief that the research or experiment is not likely to improve the minor's condition, where the proposed experimentation is contrary to public policy, the research poses significant risk to the health of the minor or where the risk involved outweighs the proposed benefits to be achieved. Research for "non-therapeutic purposes" is research that is not aimed at finding a cure or treatment for a disease that the child research participant suffers from, eg, research in healthy children to find a vaccine for smallpox when the child research participants are unlikely ever to contract smallpox.

109 Choice on Termination of Pregnancy Act 92 of 1996.

without fear or harm.[110] Based upon the recognition that the termination of pregnancy is not a form of contraception or birth control, the CTOP Act repealed the Abortion and Sterilization Act[111] and promotes the observance of female reproductive rights by seeking to create an environment in which women and adolescent girls can choose to procure the early, safe and legal termination of their pregnancies according to their individual beliefs.[112]

Stipulating the circumstances upon which a termination of pregnancy may be procured, the CTOP Act provides that termination services may be provided solely upon a woman's request within the first trimester of pregnancy,[113] after which termination will occur based on the obtaining of the progressive opinion of a medical practitioner or practitioners (in accordance with the level of pregnancy)[114] and the existence of several factors, including the opinion that continuing the pregnancy will have an adverse effect on the woman's (or adolescent girl's, as the case may be) physical or mental health or endanger her life,[115] among other factors.[116] In addition to providing that people who wish to access termination of pregnancy services are to be provided with non-mandatory counselling services, the Act also stipulates the provision of counselling services after a termination of pregnancy has occurred.[117]

The Act has a strict provision that termination of pregnancy services should not occur unless the informed consent of the woman has been obtained.[118] In relation to adolescent girls' access to termination services, the CTOP Act, in agreement with the decision of the English courts *Gillick* and *R (Axon)*,[119] provides that the only person whose consent is required for termination purposes is that of the adolescent[120] and that the health care provider cannot refuse to perform the service even if the adolescent cannot be persuaded to inform her parents of her intention to procure a termination.[121]

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110 Preamble, CTOP Act.

111 Act 2 of 1975. Under the Act, the procurement of legal abortion was unnecessarily difficult as a result of the stringent grounds laid down in the Act and even in situations where any of the conditions applied, the doctor who intended performing the procedure had to apply for permission from the hospital's management while certification from two other doctors had to be obtained. See ss 3–6 of the Abortion and Sterilization Act.

112 Preamble, CTOP Act.

113 S 2(1)(a).

114 S 2(1)(b) and (c).

115 Ss 2(1)(b)(i) and 3(1)(c)(i).

116 S 2(1)(b)(iii) and (iv).

117 S 4.

118 S 5(1).

119 In the first case, the principle of the *Gillick*-competent child who can personally consent to medical services, including contraceptives, was laid down with the House of Lords, agreeing that the competence of adolescents to consent to treatment has evolved to the extent that it is to be measured based on their level of maturity and not age. In the *R (Axon)* case, the courts adopting the decision in *Gillick*, reached the decision that female adolescents (who are *Gillick* competent) were entitled to confidential health care services, just like adults, in order to forestall situations where the adolescents will be further exposed to SRH ills.

120 According to the provision of the Act, a "woman" means any female person of any age including children and adolescent girls. See ss 1(xi) & 5(2) of the CTOP Act.

121 S 5(3) of the CTOP Act.

An action was brought before the courts to declare the CTOP Act unconstitutional in *Christian Lawyers Association v Minister of Health*[122] on the basis that it infringes on the right to life of the foetus. In a subsequent case, *Christian Lawyers Association v Minister of Health*,[123] the court rejected the plaintiff's argument that the provisions of some sections in the CTOP Act,[124] which allows an adolescent under the age of 18 to procure an abortion without parental consent, is unconstitutional due to the reason that children are 'incapable of giving consent'. The court held that the legislature had put in place requirements to be fulfilled in order to ensure that the informed consent of the girl is obtained before a termination of pregnancy occurs and that no woman, regardless of age, can have her pregnancy terminated unless she is capable of giving informed consent.[125]

The indiscriminate termination of pregnancy is not supported: adolescent girls, instead, should be encouraged to visit facilities where they can access contraceptive services in youth-friendly environments in order to prevent the occurrence of unplanned pregnancies and STIs. The progressive nature of the CTOP Act, which allows female adolescents access to confidential abortion services after giving informed consent, is welcomed: adolescent girls' access to private abortion services ultimately serves a twofold purpose; first, the SRH rights of adolescent girls are respected because girls are guaranteed access to safe and legal termination of pregnancies and, second, the ability to obtain safe and free abortion services will hopefully prevent the procurement of illegal and dangerous back-street abortions.

(continued)

122 *Christian Lawyers Association of South Africa v Minister of Health* 1998 4 SA 1113 (T).

123 *Christian Lawyers Association v Minister of Health (Reproductive Health Alliance as Amicus Curaie)* 2005 1 SA 509 (T). In this case, the plaintiffs sought an order declaring s 1 (definition of a woman) and s 5(2) and 5(3) of the CTOP Act unconstitutional on the grounds that the provisions which allow adolescent girls to terminate their pregnancies without parental consent did not take into consideration adolescent girls' inability to reach informed decisions.

124 S 5(2) and (3) of the CTOP Act.

125 *Christian Lawyers* (fn 123) 515.