Revisiting Minors' Reproductive Autonomy Rights under South African Law: The Rights and Wrongs of the Choice on Termination of Pregnancy Act

Admark Moyo
Senior Lecturer in Law, Great Zimbabwe University
admoyo@gzu.ac.zw or admarkm@gmail.com

Abstract

This article examines the interface between children's autonomy, parental responsibility and state intervention in reproductive decisions of a particular type, namely the termination of pregnancy. Children asserting their autonomy in reproductive decision-making often confront counterclaims of legitimate intervention by parents or guardians responsible for caring for the child. Locating the right balance between competing interests is very important because uninformed decisions, with or without the support of parents, often carry heavy consequences for the education, health and life of the pregnant child. More specifically, this article seeks to investigate the extent to which South African law protects and empowers sexually active adolescents to make decisions concerning the termination of pregnancy. This involves an analysis of the degree to which relevant legislation appropriately reconciles children's reproductive autonomy rights——particularly the right to terminate a pregnancy without parental consent or approval——with parental responsibility and state intervention. Parental responsibility and state intervention embody children's right to and need for protection (from the immaturity that characterises youth) when decisions to terminate pregnancies are made. Accordingly, this article focuses on whether or not the Choice on Termination of Pregnancy Act strikes an appropriate balance between children's autonomy, parental responsibility and state intervention in reproductive decision-making.

Keywords: minor; reproductive autonomy; children's rights; wrongs; termination of pregnancy

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Introduction

Reproductive decision-making includes, among other things, matters relating to sterilisation, contraception and termination of pregnancy. These areas divide parents, lawyers, philosophers and even healthcare professionals on the issue of what is legally or morally right for children. Reproductive autonomy revolves around 'the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children.'[1] This article examines the interface between children's autonomy, parental responsibility and state intervention in reproductive decisions of a particular type, namely, the termination of pregnancy. The primary reason for locating the discussion in the context of termination of pregnancy is that uninformed decisions, with or without the support of parents, often carry heavy consequences for the health and life of the pregnant child. More importantly, teenage pregnancies may lead to unsafe abortion and denial of access to educational opportunities. These consequences threaten the life, survival and intellectual development of sexually active adolescents. It is therefore necessary to investigate whether the domestic regulation of this field of the law in South Africa is in keeping with the best interests of the child. There are further reasons for revisiting the laws regulating the termination of pregnancy: while there was a flurry of academic writing about the termination of pregnancy in the late 1990s and the early years of the new millennium,[2] the main focus of much of the writing was on the tension between the unborn foetus's right to life and the pregnant woman's reproductive choice. Even less was written about the interaction between children's autonomy, parental responsibility and state intervention. This article adopts a holistic approach to the termination of pregnancy, exploring as it does the triadic relationship between children, parents and the state, and examining the strengths and shortcomings, respectively referred to as the rights and wrongs, of the Choice on Termination of Pregnancy Act (Choice Act).[3]

Children asserting their autonomy in reproductive decision-making often confront counterclaims of legitimate intervention by parents or guardians responsible for caring for the child. Many adults believe that children should abstain from sex or that they are sexually innocent. These beliefs are inconsistent with the reality that sexually active minors do participate in sexual activities of different sorts without the knowledge of parents.[4] It must be emphasised that this article is not concerned with the question

1 International Conference on Population and Development (ICPD), *Summary of Programme of Action*, DPI/1618/POP United Nations Department of Public Information Conference, Cairo, 5–13 September 1994, ch 7, para A.

2 See, for example, Tjakie Naudé, 'The Value of Life: A Note on *Christian Lawyers Association of SA v Minister of Health*' (1999) 15(4) South African J on Human Rights 541 and Denise Meyerson, 'Abortion: The Constitutional Issues' (1999) 116 South African LJ 50.

3 Act 92 of 1996.

4 See Catherine Campbell, Yugi Nair and Sbongile Maimane, 'AIDS Stigma, Sexual Moralities and the Policing of Women and Youth in South Africa' (2006) 83 Feminist Review 133–134; Pamela Mda

whether or not minors should have sex (sexually active minors participate in sexual activities regardless of what parents, society and the law may say). Rather, it seeks to investigate the extent to which South African law protects and empowers sexually active adolescents who engage in sexual activities earlier than society anticipates they will. This involves an analysis of the degree to which the relevant legislation appropriately reconciles, on the one hand, children's reproductive autonomy rights – particularly the right to terminate a pregnancy without parental consent or approval – and, on the other, parental responsibility and state intervention. Parental responsibility and state intervention embody children's right to and need for protection (from the immaturity that characterises youth) when decisions to terminate pregnancies are made. Accordingly, this article focuses on whether or not the Choice Act strikes an appropriate balance between children's autonomy, parental responsibility and state intervention in reproductive decision-making.

The termination of pregnancy raises sensitive moral, philosophical and legal questions concerning the degree to which children, particularly girls, should be allowed to determine how to use their own bodies. Firstly, whereas the child's best interests, right to life and right to privacy may be promoted by giving children relative autonomy from parental control, many parents or guardians prefer to retain control over the child's reproductive decisions. Secondly, even if it were accepted that parents or guardians should make reproductive decisions for sexually active adolescents, it would be difficult to monitor children's compliance with parental decisions even where parents make

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and others, 'Knowledge, Attitudes and Practices about Contraception amongst Schoolgirls aged 12–14 years in Two Schools in King Sabata Dalindyebo Municipality, Eastern Cape' (2013) 5(1) African J of Primary Health Care and Family Medicine 4, where the authors observed that '[m]ost participants agreed that parents were not happy with young girls being involved in relationships. Some mentioned that their mothers shouted at them whenever they talked about sexual matters and they did not like that'; and Deborah Brand, 'Sugar, Spice and Criminalised Consent: A Feminist Perspective of the Legal Framework Regulating Teenage Sexuality in South Africa' (2013) 29 South African J on Human Rights 193 at 197–98, who argues:

> Young women are culturally-set beacons of sexual innocence, gatekeepers of sexual activity and bearers of the moral and physical consequences related to teenage sexuality. Yet, there is public anxiety about the potentially corrupting effects of sexual knowledge. In spite of the anxiety about teenage sexuality, sex is still a potent social force fuelled by the particular circumstances of teenagers' lives … South African girls also exist in a social environment of violence, poverty and disease as well as *the stigmatisation of the sexuality of women and young people. Many parents, guardians and community leaders will not acknowledge the possibility of youth sexuality or the fact that their own children may be sexually active. The denial of teenage sexual desire is particularly strong in relation to girls* and is related to the lack of respect for adult women's sexual autonomy as well as the wider demonisation of women. Within communities the 'weakness of women' is believed to fuel the spread of HIV/AIDS in a social context where women are responsible for promoting sexual morality. Nonetheless, young women remain sexually active, despite adult attempts to control their behaviour and, in order to fulfil their potential as fully-fledged adults, first they need to navigate their way through adolescence.

decisions that are in the child's best interests.[5] Thirdly, the reproductive autonomy of children, particularly girls, is evinced in a way that is so different from other fields of the law.[6] For instance, it is difficult to justify the practical challenges and psychological pain experienced by a pregnant minor who has been forced to carry a pregnancy leading to the birth of a child whom she will not be able to support.[7] These challenges portray reproductive decision-making as an area in which sexually active adolescents are better protected by expanding rather than limiting their autonomy.

Focusing on the termination of pregnancy, this article examines the degree to which the legal framework governing access to reproductive healthcare services deals with some of the challenges referred to above. This introduction constitutes the first section of the article. The second section briefly explores the scope of the constitutional rights grounding minors' reproductive autonomy in South Africa. In the third section, the article examines the historical evolution of the laws regulating reproductive freedom and gives a general description of the statutory grounds justifying the termination of pregnancy. In the fourth section, the writer provides a detailed exposition of the rights (strengths) of the Choice Act. These rights include the elements of informed consent to terminate a pregnancy and the choice on termination of pregnancy; the limits imposed on parental responsibility over matters relating to the minor's decision to have an abortion; and the fact that the Choice Act foresees the need for state intervention, particularly through medical doctors, in the minor's decision to abort in the later stages of the gestation period. The fifth section identifies two wrongs (shortcomings) of the Choice Act and proposes a way to overcome them. These wrongs include the fact that the Choice Act does not stipulate the minimum age of consent to an abortion and the failure of the Act to deal with the circumstances in which a child dangerously refuses to

5 For instance, a child forced to carry her pregnancy to term in the third trimester may use the services of a backstreet abortionist. Similarly, parents, society and the state would face difficulties in monitoring children's compliance with, for instance, a statutory provision requiring sexually active adolescents to use condoms and oral or injectable contraceptives.

6 In *Casey v Planned Parenthood of South Eastern Pennsylvania* (1992) 120 Led 2d 674 (hereinafter *Casey v Planned Parenthood*) 698–699, O'Connor J, for the US Supreme Court, held as follows:
Abortion is a unique act … That is because the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear.

7 See *Roe v Wade* (1972) 35 Led 2ed 147 (hereinafter *Roe v Wade*) 177, where the court held:
The detriment that the State would impose upon the pregnant woman by denying this choice altogether, is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, the additional difficulties and continuing stigma of unwed motherhood may be involved.

terminate a pregnancy that a medical practitioner rightly believes to be life-threatening and against the child's best interests. The sixth section closes the discussion.

The Constitutional Basis of Reproductive Autonomy

The rights to privacy,[8] human dignity[9] and access to health-related information have all been partly interpreted to ground every person's reproductive health and autonomy rights. The usefulness of these rights in conferring reproductive autonomy rights on minors is mainly evident in jurisdictions that do not directly extend to individuals the right to make decisions concerning reproduction. Under South African constitutional law, the right to freedom and security of the person (particularly the sub-right to bodily integrity) directly grounds children's autonomy in reproductive decision-making. Section 12(2) of the Constitution stipulates that:

> everyone has the right to bodily and psychological integrity. This right includes every person's right 'to make decisions concerning reproduction; to security in and control over their body; and not to be subjected to medical or scientific experiments without their informed consent.[10]

It follows that everyone, including every child, has the right to security in and control over their body.[11] This right empowers adults and children, and especially adolescents, to make decisions about whether to exercise control over their bodies and, if so, how to use them.[12] Generally, every rational person is entitled to decide what is or is not done to their body. Therefore, section 12(2) of the Constitution enshrines the right to bodily self-determination and protects an individual's physical integrity against infringement from private persons and public functionaries.[13]

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8 *Teddy Bear Clinic for Abused Children & Another v Minister of Constitutional Development & Another* 2014 (2) SA 168 (CC) paras 60 and 63 and *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) para 32. See also CM van der Bank, 'The Right to Privacy – South African and Comparative Perspectives' (2012) 1(6) European J of Business and Social Sciences 78; Michelle O'Sullivan, 'Reproductive Rights' in Stu Woolman and others (eds), *Constitutional Law of South Africa* (2 edn, Juta 2005) 37–23; Ig Rautenbach, 'The Conduct and Interests Protected by the Right to Privacy in Section 14 of the Constitution' (2001) J of South African Law 119; and Sarah Lai and Regan Ralph, 'Female Sexual Autonomy and Human Rights' (1995) 21 Harvard Human Rights J 222–223.

9 Stu Woolman, 'Dignity' in Woolman and others (n 8) 36-7–36-9. See also Oscar Schachter, 'Human Dignity as a Normative Concept' (1983) 77(4) American J of Intl L 848.

10 Section 12(2)*(a)–(c)* of the Constitution, 1996.

11 Section 12.

12 In the American case of *Schloendorff v Society of the New York Hosp* 211 NY 125, 129–130 105 NE 92, 93 (1914), Cardozo J observed that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his or her own body.' In South Africa, this reasoning is likely to apply to mature minors since autonomy-related rights belong to 'everyone'.

13 See Iain Currie and Johan de Waal, The Bill of Rights Handbook (6 edn, Juta 2013) 269, 287.

Attached to the concept of bodily self-determination is the idea that all forms of coercive contact with the physical person of another, including that of a child, are unlawful and violate their bodily integrity. Further, the phrase 'psychological integrity' suggests that even if the unauthorised 'touching' of another person were to benefit the person 'touched' and were to result in little or no physical injury to them, it would still be unlawful. This is because such 'touching' may result in trauma and therefore violates an individual's 'psychological integrity'. Preserving every child's physical and psychological integrity is part of acknowledging their separate personhood and identity.[14] Therefore, the right to security in and control over one's body directly grounds every child's right to bodily self-determination.

More importantly, the right to bodily integrity also includes everyone's 'right to make decisions concerning reproduction'.[15] This provision should be read with the command, enshrined in section 27(1)(*a*) of the Constitution, that everyone has the right to healthcare services, including reproductive healthcare. The fact that healthcare is a right to which every child is entitled raises questions about the reach of parental direction and guidance on matters related to medical treatment, surgical operations, sexuality and reproduction. While matters of choice and sexual autonomy depend on the child's capacity to make informed decisions, it is commonly accepted that section 12(2) protects children's bodily self-determination and reproductive autonomy, including matters relating to 'whether or when to have children (including whether or not to terminate a pregnancy).'[16] In constitutional terms, the rights to 'security in and control over' one's body and 'to make decisions concerning reproduction' lie at the heart of children's right to request the termination of pregnancy.[17] In *Christian Lawyers Association of South Africa v Minister of Health,* the court held that:

> [t]he Constitution recognises and protects the right to termination of pregnancy or abortion in two ways, first, under section 12(2)(*a*), that is, the right to bodily and

14 See Michael Freeman, 'Child Abuse: The Search for a Solution' in Michael Freeman (ed), *Overcoming Child Abuse: A Window on a World Problem* (Dartmouth Publishing Co 2000) 9, who argues that 'we must accept that children are not property ... but individuals whose physical, sexual and psychological integrity is as important as – indeed more important than – that of the adult population.'

15 Section 12(2)*(a)* of the Constitution.

16 Susan Coetzee, 'Pregnant Minors' Sexual Rights: A Constitutional Perspective' (2012) 27 SAPL 493.

17 See, for example, Ronald Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia and Individual Freedom* (Knopf 1993) 106–107, where the author argues:
Laws that prohibit abortion or make it difficult or expensive to procure one, deprive pregnant women of a freedom or opportunity that is crucial to many of them. A woman who is forced to bear a child she does not want because she cannot have an early and safe abortion, is no longer in charge of her own body: the law has imposed a kind of slavery on her … Adoption even when it is available, does not remove the injury, for many women would suffer great emotional pain for many years if they turned a child over to others to raise and love … But once one accepts (the dictum of Brennan I quoted above) as good law, then it follows that women do have a constitutional right to privacy that in principle includes the decision not only whether to beget children, but whether to bear them.

> psychological integrity which includes the right to make decisions concerning reproduction and, secondly, under section 12(2)(*b*), that is, the right to control over one's body.[18]

Later in the judgment, the court made the following declaration:

> The specific provisions of section 12(2)(*a*) and (*b*) of our Constitution guarantee the right of every woman to determine the fate of her pregnancy. The Constitution … affords 'everyone' the right to bodily integrity including the right 'to make decisions concerning reproduction' and 'to security in and control over their body'. This is quite clearly the right to choose whether to have her pregnancy terminated or not, for short, the right to termination of pregnancy …. Cumulatively therefore the more explicit rights in section 12(2)(*a*) and (*b*) and all the other reinforcing rights provide a strong constitutional base for the right to termination of pregnancy in our law.[19]

The rights to 'control over' one's body and 'to make decisions concerning reproduction' are constitutive elements of bodily self-determination and permit competent minors to make autonomous reproductive decisions. In addition, the rights to make decisions concerning reproduction and to reproductive healthcare entitle adolescents to practise safe sexual relations, to be provided with the conditions necessary for optimal foetal survival and development,[20] and to maintain their reproductive health by having access to safe abortion services.[21] Given that unwanted pregnancies and sexually transmitted diseases threaten a child's life, survival and intellectual development (particularly by forcing the child to drop out of school), the rights to control over one's body and to make decisions on reproduction play an important role in promoting reproductive autonomy and the protection of children from the dangers associated with risky sexual practices.

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18 Paragraphs 27–28. See also Charles Ngwena, 'An Appraisal of Abortion Laws in Southern Africa from a Reproductive Health Rights Perspective' (2004) 32(4) J of L, Medicine & Ethics 715, who observes that these constitutional provisions provide for the right to choose to have an abortion and impose on the government the duty to provide abortion services.

19 Paragraphs 51–52. See also para 54 of the same case, where the court held that '[o]ur Constitution protects the right of a woman to determine the fate of her own pregnancy. It follows that the State may not unduly interfere with a woman's right to choose whether or not to undergo an abortion.'

20 Section 27(2) provides that '[t]he state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of' the right to reproductive health.'

21 See generally Rebecca Cook, 'Human Rights and Reproductive Self-determination' (1995) 44 American University LR 1002.

The Termination of Pregnancy

The Evolution of Abortion Laws in South Africa

Before 1975, South African common law permitted abortion only on the ground of necessity—the clearest example of that being the need to save the pregnant woman's life.[22] If carried out for other reasons, abortion would constitute a crime under the common law.[23] In an attempt to facilitate access to legal abortion, the apartheid government passed the Abortion and Sterilisation Act (hereinafter the Abortion Act).[24] The Abortion Act (now repealed) permitted an abortion if the pregnancy threatened the woman's life or physical or mental health, was likely to lead to severe malformation of the baby, or was a product of rape, incest or other forms of unlawful sexual intercourse with a woman.[25] To qualify for an abortion, women had to obtain approval from two independent medical practitioners, neither of whom had the authority to perform the abortion.[26] The limited grounds upon which an abortion could be legally requested and the procedural formalities to be completed before an abortion could be carried out limited women's access to abortion services under the Abortion Act. Another shortcoming of the Act was that it prohibited, implicitly, the termination of pregnancy on demand, even during the first trimester, making it difficult for pregnant women to terminate unintended pregnancies unless one of the traditional grounds for termination existed. This denied adult women, let alone minors, the right to make any decisions concerning their reproductive lives.

Under the Abortion Act, a pregnant woman could legally have an abortion only if the procedure had been approved by at least three medical practitioners. This meant that the majority of women living in the rural areas could hardly procure an abortion as most hospitals had only one or two doctors. As Mhlanga would have it

> [t]he conditions that had to be fulfilled were so stringent that only women in urban and well-resourced areas could make use of the provisions of the Act. … Some women from richer families or who could afford went overseas to procure termination of pregnancy. The Act therefore was part of the response to the need to protect the lives of the privileged (mostly white population), while neglecting the welfare of the many women

22 See John Milton, *South African Criminal Law and Procedure*. *Volume II: Common Law Crimes* (3 edn, Juta 1996) 305.

23 See Belinda van Heerden, Alfred Cockrell and Raylene Keightley (eds), Borberg's Law of Persons and the Family (2 edn, Juta 1999) 28, 44 note 28.

24 Act 2 of 1975.

25 Section 3 of the Abortion Act.

26 See s 3(1)*(a)–(e)* of the Abortion Act.

> who were in the rural areas, and who did not know of the facilities that could be available for legal abortion.[27]

Even if a black woman knew about the availability of abortion facilities, this would not help her as provincial hospitals were governed by apartheid laws which denied blacks the right to use the same facilities as their white counterparts. The result was that many black women sought assistance from backstreet abortionists and either died as a result or suffered severe morbidity.

The Abortion Act did not expressly regulate the issue of consent to termination of pregnancy by girls. It regulated termination of pregnancy by women provided at least one of the traditional grounds for such termination existed and at least three medical practitioners had confirmed that the alleged ground for termination of pregnancy existed.[28] In *G v Superintendent, Groot Schuur Hospital & Others (hereinafter G v Superintendent)*,[29] the Cape Provincial Division pointed out that

> [t]he Abortion Act does not deal expressly with the position of a minor in respect of whom a legal abortion is sought to be procured in terms of its provisions. In the normal course, under the common law, the consent of the minor's guardian would nevertheless have been required before an abortion could be carried out on the child pursuant to the provisions of the Abortion Act.[30]

With time, the termination of pregnancy by or on minors was regulated by the Child Care Act.[31] Section 39(4) of that Act provided as follows:

> *(a)* any person over the age of 18 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any operation upon himself; and
>
> *(b)* any person over the age of 14 years shall be competent to consent, without the assistance of his parent or guardian, to the performance of any medical treatment of himself or his child.

This meant that where the minor's pregnancy had to be terminated through a surgical operation, the parent or guardian had the competence to consent to the operation without necessarily having to involve the child in the decision-making process. Pregnant minors had decisional autonomy to authorise surgical operations fully conferred on them only from the day they attained the age of 18 years; however, where the pregnancy could be

27 See RE Mlanga, 'Abortion: Developments and Impact in South Africa' (2003) 67 British Medical Bulletin 116.

28 Section 3(1) of the Abortion Act.

29 1993 (2) SA 255 (C).

30 *G v Superintendent* (n 29) 262E.

31 Act 74 of 1983.

terminated by some kind of medical treatment, every child of 14 years or older had the right to consent to the proposed medical treatment, without parental consent. Further, section 39(1) of the Child Care Act authorised the attending physician to ask for ministerial consent to surgical operations on a pregnant child if the parent or guardian unreasonably refused or was unable to consent to such an operation.[32] This approach was followed in the case of *G v Superintendent*,[33] where the responsible minister authorised the performance of a surgical operation on a minor to terminate a pregnancy caused by unlawful sexual intercourse, the parent having refused to give consent to the proposed medical intervention.

Currently, the termination of pregnancy is extensively regulated by the Choice Act, which expressly states that it:

> repeals the restrictive and inaccessible provisions of the Abortion and Sterilisation Act, promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.[34]

> In addition, the Choice Act reiterates that the Constitution recognises 'the right of persons to make decisions concerning reproduction and to security in and control of their bodies'.[35] It further recognises that every person has the right to be informed of and to have access to safe [and] effective methods of fertility regulation of their choice' and that every woman has 'the right of access to appropriate health care services to ensure safe pregnancy and childbirth'.[36]

These provisions make it clear that the purpose of the Choice Act is to give effect to the child's rights to reproductive autonomy, briefly discussed above.

Another related feature of the legislation is that it creates an environment in which pregnant women may make free reproductive choices. Further, the focus on 'early, safe, legal and effective termination of pregnancy' suggests that the Choice Act was enacted to respond to the epidemic of unsafe and illegal abortions that were reported when the stringent provisions of the Abortion Act were operative.[37] The problem of unsafe abortion is discussed below, particularly as one of the practical reasons for justifying

32 Section 39(1) of the Child Care Act.
33 See (n 29).
34 Preamble of the Choice Act.
35 Preamble.
36 Preamble.
37 See generally Sally Guttmacher and others, 'Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act' (1998) 24(4) International Family Planning Perspectives 192.

the liberalisation of the abortion laws.[38] Finally, the main duty of the state under the new legal framework is to promote reproductive choice and not to restrict access to services for termination of pregnancy.[39] Below is an analysis of how the specific provisions governing women's consent to the termination of pregnancy seek to achieve these broad goals.

Grounds for the Termination of Pregnancy

In terms of the Choice Act, pregnant women may have an abortion on request in the first trimester of pregnancy:[40] section 2(1)(*a*) of the Act provides that 'a pregnancy may be terminated *upon request of a woman* during the first 12 weeks of the gestation period of her pregnancy' (emphasis added). No other conditions are attached to the woman's request to her termination of pregnancy. This provision marks a departure from the common law and the Abortion Act in that it introduces the concept of termination of pregnancy on demand. Read with sections 1(xi)[41] and 5(1)–(3) of the Choice Act, discussed below, section 2(1)(*a*) permits pregnant minors to authorise the termination of their pregnancies without having to prove the existence of any grounds. It also signifies a move away from parental rights towards the pregnant minor's right to make reproductive decisions according to her 'own beliefs'. The relevant provisions have

38 See 'Informed choice on termination of pregnancy and the rationale for minors' reproductive autonomy' above.

39 See section 27(2) of the Constitution, 1996.

40 Sections 2(1)(a) and 5 of the Choice Act read together. Section 2(1) of the Choice Act provides as follows:
A pregnancy may be terminated –
upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;
from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that –
the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or
the pregnancy resulted from rape or incest; or
the continued pregnancy would significantly affect the social or economic circumstances of the woman; or
after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy-
would endanger the woman's life;
would result in a severe malformation of the foetus; or
would pose a risk of injury to the foetus.

41 Section 1(xi) defines a 'woman' as 'any female person of any age' and section 5 provides that a pregnancy may be terminated only with the informed consent of the woman.

great resonance with child liberation ideology,[42] emphasising the autonomy and separate personhood of the child and the child-as-active-agent mantra.[43]

Moreover, from the 13th to the 20th week, an abortion may be procured if, among other grounds, 'the continued pregnancy would significantly affect the social or economic circumstances of the woman.'[44] The other grounds mentioned in section 2(1)(*b*) approximate those stated in the Abortion Act, but the additional ground of 'socio-economic circumstances' permits minors to seek an abortion on the basis that they will not be able to support the child if required to carry the pregnancy to term. If after consulting with the pregnant woman a medical practitioner is of the opinion that any of the stated grounds exists, such pregnancy may be terminated.

After the 20th week, an abortion may be performed only on the ground that the pregnancy poses a risk to the health of the mother or the foetus.[45] At this stage, the medical practitioner must, after consulting with another medical practitioner or a registered midwife, be of the opinion that any of these grounds exists. This locates decision-making outside the province of children's autonomy since two medical practitioners or one medical practitioner and a midwife should make a finding that the pregnancy poses a risk to the health of the mother or the foetus. Nonetheless, the informed consent of the pregnant woman is required before a pregnancy is terminated at each stage of the gestation period.[46]

The Rights of the Choice Act

Informed Consent to the Termination of Pregnancy

The Choice Act does not specify any age of consent and every pregnant minor qualifies as a woman for the purposes of termination of pregnancy. Section 5(1) of the Act provides that 'the termination of a pregnancy may only take place with the *informed consent* of the pregnant woman' (emphasis added). Read together, these provisions imply that every woman, regardless of their age, has the right to consent to the

42 For spirited defences of child liberation, see D Gottlieb (ed), *Children's Liberation* (Prentice-Hall 1973); Richard Farson, *Birthrights: A Bill of Rights for Children* (Penguin Books 1974) 27; John Holt, *Escape from Childhood* (EP Dutton & Co 1975); Beatrice Gross and Ronald Gross (eds), *The Children's Rights Movement* (Anchor Press 1977) 329–333; Howard Cohen, *Equal Rights for Children* (Littleneld and Adams 1980) 60–69; and Michael Freeman, 'Whither Children: Protection, Participation and Autonomy' (1993–1994) 22 Manitoba LJ 308–316.

43 See generally Philippe Ariès, *Centuries of Childhood: A Social History of Family Life* (transl Robert Baldick) (Vintage 1962) 37 and 128; Allison James and Alan Prout (eds), *Constructing and Reconstructing Childhood* (Routledge 1990) 4; Michael Freeman, 'The Sociology of Childhood' (1998) 6 Intl J of Children's Rights 433, 438; and Chris Jenks, *Childhood* (Routledge 2005) 55.

44 Section 2(1)*(b)* of the Choice Act.

45 Section 2(1)*(c)*.

46 See s 5(1) and (2) of the Children's Act.

termination of her own pregnancy.[47] More importantly, the Choice Act defines the term 'woman' to mean 'a female person of any age',[48] a broad definition that includes pregnant minors. To exercise the right to authorise an abortion, pregnant women or minors should have the capacity to give informed consent to the relevant medical procedure.

The Choice Act does not define the notion of 'informed consent', but the National Health Act (NHA) defines it as 'consent for the provision of a specified health service given by a person with legal capacity to do so and who has been [adequately] informed' about the nature, risks and benefits of the medical procedure.[49] The Transvaal High Court has already expanded on the meaning of 'informed consent' in the context of termination of pregnancies. In *Christian Lawyers Association of South Africa v Minister of Health* (hereinafter *Christian Lawyers Association II*),[50] Mojapelo J held that

> the cornerstone of the regulation of the TOP of a girl under the Act is the requirement of her informed consent. No female person, regardless of her age, may have her pregnancy terminated unless she is capable of giving her informed consent to the termination and in fact does so.[51]

He explained that informed consent included three components: knowledge, appreciation and consent.[52] Knowledge means that the woman who consents to the termination of pregnancy should have 'full knowledge of the nature and extent of the harm or risks' associated with the relevant procedure.[53]

The element of 'appreciation' implied something more than knowledge and meant that the pregnant woman 'must also comprehend and understand the nature and extent of the harm or risk.'[54] 'Consent' means that a pregnant woman must, as a matter of fact,

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47 A literal reading of the Choice Act results in an anomaly in terms of which pregnant minors of all ages who are neither severely mentally retarded nor in a state of perpetual unconsciousness are considered to be intellectually competent to give informed consent to a termination of pregnancy. In this respect, Himonga and Cooke have criticised the drafters of the Choice Act for wrongly assuming that the moment a child becomes pregnant, she thereby acquires the required capacity to understand the risks and benefits of an abortion. See Chuma Himonga and Anita Cooke, 'A Child's Autonomy with Special Reference to Reproductive Medical Decision-making in South African Law: Mere Illusion or Real Autonomy?' (2007) 15(3) International Journal of Children's Rights 333. For comparative arguments about the termination of pregnancy regime in Britain, see Jonathan Herring, 'Children's Abortion Rights' (1998) 5 Medical LR 257.

48 Section 1(xi) of the Choice Act.

49 Sections 6(1)*(a)–(d)* and 7(3) of the NHA read together.

50 2005 (1) SA 509 (T).

51 Paragraph 19.

52 Paragraph 20. Mojapelo was following the holding made by Innes CJ in *Waring & Gillow Ltd v Sherborne* 1904 Th 340 at 344.

53 Paragraph 21. The court was following *Castell v De Greef* 1994 (4) SA 408 (C) 425.

54 Paragraph 21.

'subjectively consent to the harm or risk associated with the termination of her pregnancy.'[55] Her 'consent must be comprehensive' in the sense that it must 'extend to the entire transaction, inclusive of its consequences.'[56] Mojapelo J insisted that 'valid consent can only be given by someone with the intellectual and emotional capacity for the required knowledge, appreciation and consent.'[57] The Choice Act therefore authorises every pregnant woman who has the capacity for informed consent to have an abortion regardless of her age or youthfulness.[58]

The Choice Act also extends to all pregnant minors the autonomy to make decisions regarding the termination of pregnancy provided they are capable of giving informed consent to the relevant procedure. This interpretation is supported by the fact that (i) a pregnancy may be terminated upon the request of a pregnant woman; (ii) a termination of pregnancy may take place only with the informed consent of the pregnant woman; and (iii) 'no consent other than that of the pregnant woman shall be required for' a termination of pregnancy. Even where the termination of pregnancy constitutes a very invasive surgical operation, very young and mentally competent pregnant minors may give informed consent to the relevant procedures without the parental assistance required for surgical operations in terms of the Children's Act: section 5(2) of the Choice Act provides that '[n]otwithstanding any other law ... no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.' It must be stated at the outset, therefore, that the provisions regulating consent to abortion recognise children's active participation as social actors in decisions that affect them.

There is a strong correlation between access to health-related information and the capacity for informed consent. In the context of access to health-related information, the right of access to information is protected in the NHA[59] and the Children's Act. The NHA binds healthcare providers to inform the user 'in a language that the user understands and in a manner that takes into account the user's level of literacy.'[60] The relevant information should explain the nature, potential risks, benefits and

55 Paragraph 21.

56 Paragraph 21.

57 Paragraphs 21–22. See also Sylvester Chima, 'Evaluating the Quality of Informed Consent and Contemporary Clinical Practices by Medical Doctors in South Africa: An Empirical Study' 2013, 14 (Suppl 1):S3 BMC Medical Ethics 1, 2–3, arguing that the doctrine of informed consent has the following five elements '(a) Information disclosure: provision of adequate information; (b) Competence: capacity to understand that information; (c) Voluntariness: decision making in the absence of coercion or deception; (d) Comprehension: understanding of information provided; and (e) Consent: agreement to the proposed treatment or procedure.'

58 In *Christian Lawyers Association II* (n 49) para 54, Mojapelo J would later hold that 'the Act allows all women who have the intellectual and emotional capacity for informed consent to choose whether to terminate their pregnancies or not. It does not distinguish between them on the ground of age.'

59 Act 61 of 2003.

60 Section 6(2) of the NHA. See also *Castell v De Greef* (n 52) 425 and Christian Lawyers Association II (n 49) para 21.

consequences of the proposed treatment or surgery.[61] This includes information about alternatives to the proposed intervention, the range of diagnostic procedures involved and how the child would fare if they were not to take the treatment or undergo surgery.

The NHA spells out specific guidelines concerning the nature of information to be given to users (patients) to enable them to give informed consent to such clinical procedures as medical treatment, contraception and abortion. It provides that healthcare providers have an obligation to inform users of (*a*) their health status, except where it would be against the best interests of the user; (*b*) the range of diagnostic procedures and treatment options available to the user; (*c*) the benefits, risks, costs and consequences generally associated with each option; and (*d*) the user's right to refuse health services, including an explanation of the implications, risks and obligations of such refusal.[62] Further, section 13 of the Children's Act provides that every child has the right to receive information relating to treatment, sexuality and reproduction; to their own health status, and to the causes and treatment of their health status.[63]

The statutory provisions cited above provide guidelines on the kind of information children need in order to make informed medical or reproductive decisions. They emphasise the importance of the disclosure of health-related information to the full enjoyment of healthcare rights. The right of access to information requires parents and the state to refrain from interfering with the child's access to health-related information. Access to information is a precursor not only to the child's right to freedom of expression, but also to their right to make rational decisions, particularly those in the context of adolescents' access to information concerning their (reproductive) health. Without access to adequate information, children may not make informed choices in the context of access to healthcare services.

A lack of access to information restricts the control that children have over their bodies. At common law, the duty to disclose all relevant information historically formed part of the informed consent process and that duty required medical practitioners to disclose all the material risks associated with treatment or surgery.[64] This duty arose from the fact

61 See generally *Richter & Another v Estate Hammann* 1976 (3) SA 226 (C) at 232.

62 Section 6(1) of the NHA.

63 Section 13(1) provides that
'[e]very child has the right to –
have access to information on health promotion and the prevention and treatment of ill-health and disease, sexuality and reproduction;
have access to information regarding his or her health status;
have access to information regarding the causes and treatment of his or her health status; and
confidentiality regarding his or her health status, except when maintaining such confidentiality is not in the best interests of the child'.

64 See P Carstens, 'Informed Consent in South African Medical Law with Reference to Legislative Development' <http://new.samls.co.za/node/410> accessed 5 May 2014, who observes as follows:

that many patients are laypersons in the field of medicine and doctors have the peremptory duty to disclose relevant information to all patients to enable them to make informed medical choices.

The focus on 'informed consent' emphasises the role of the child's evolving capacities in conferring reproductive autonomy on children of all ages. This embodies the realisation that children gradually attain rights to and capacities for self-determination. Parents or guardians, as fiduciaries or paternalists, have the duty to relinquish, gradually, their control of the child in order to enable the child to develop the capacity for rational autonomy. The developing competences of the child require that parents nurture their children to take responsibility for personal actions and to make autonomous decisions whenever the children acquire the capacity to make decisions in their own best interests. Similarly, most of the autonomy rights entrenched in the Bill of Rights are to be exercised by children who have the capacity for rational action. These principles are incorporated into the Choice Act, which recognises the emancipatory function of the child's developing competences.

However, the concept of 'informed consent' also allows parents to make reproductive decisions for minors who lack sufficient maturity to understand the proposed procedure for an abortion.[65] This is another way of recognising that autonomy rights are the preserve of those with the capacity for rational action. Incompetent minors should not be abandoned to their autonomy rights as this threatens their best interests and basic right to life, survival and development. To be legitimate, every violation of bodily integrity should be authorised by the child or another person with the legal authority to do so.[66] If the child is incapable of understanding the instructions given by the medical practitioner or weighing up the risks and benefits of the available options, then the consent of another person with authority over the child is required.[67] This also follows

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In this way, adequate information becomes a requisite of knowledge and appreciation, and therefore, also of informed consent. In the absence of information, real consent will be lacking. In turn, this means that the doctor, as an expert, is saddled with a legal duty to provide the patient with the necessary information to ensure knowledge and appreciation, and yet, real consent on the patient's part. The doctor's duty of disclosure is not treated as one of negligence, arising from a breach of care, but as one of consent in the contractual sense.

65 See *Christian Lawyers Association II* (n 49) para 22.

66 See also B Sneiderman and D McQuoid-Mason, 'Decision-making at the End of Life: The Termination of Life-prolonging Treatment, Euthanasia (Mercy-killing), and Assisted Suicide in Canada and South Africa' (2000) XXXIII Comparative Intl LJ of South Africa 194; see also Medical Protection Society, C*onsent to Medical Treatment in South Africa – An MPS Guide* (2 edn, MPS 2010) 1, which states as follows:

To treat competent patients without their valid consent is a violation of their constitutional rights and transgresses a fundamental principle of medical law. The basic rule is simple: no-one has the right to touch anyone else without lawful justification and if doctors do so it may well undermine patients' trust as well as violate their rights to physical integrity.

67 See, for example, *Ex parte Dixie* 1950 (4) SA 748 (W) at 751.

common-law principles which recognise that the touching of a patient who lacks the capacity to consent to treatment without the authorisation of the person who has authority over that patient violates the physical integrity of the patient.[68] Accordingly, the minor's lack of 'capacity for knowledge, appreciation and consent' limits her right to self-determination in the context of termination of pregnancies.

However, the lack of capacity for informed consent does not necessarily mean that the pregnant minor is not entitled to an abortion which is in her own best interests. It simply means that in law the minor's consenting to an abortion may be invalid for a lack of independence. In my view, it is difficult for a parent to show that early pregnancies are in the best interests of children and to deny their termination, especially if the child (though incompetent) is willing to have the pregnancy terminated. In any event, since it is the medical practitioner who, most likely in the absence of parents, determines whether the child possesses the capacity for informed consent to the termination of pregnancy, the medical practitioner may well deem the pregnant minor 'competent' and avoid having to seek parental consent to the termination. This is particularly so in the light of the focus of the Choice Act on informed choice on termination of pregnancy.

Informed Choice on Termination of Pregnancy and the Rationale for Minors' Reproductive Autonomy

There are overlaps between the twin doctrines of informed consent and informed choice in that both revolve around the individual's right to self-determination. There can never be genuine consent where an individual lacks the choice or freedom to decide whether or not to give such consent.[69] Further, both doctrines impose on physicians the duty to

68 In *Stoffberg v Elliot* 1923 CPD 148, Watermeyer J made the following remarks:
In the eyes of the law every person has certain absolute rights which the law protects. They are not dependent on statute or upon contract, but they are rights to be respected, and one of the rights is absolute security of the person … Any bodily interference with or restraint of a man's person which is not justified, or excused or consented to is wrong … [A] man by entering a hospital does not submit himself to such surgical treatment as the doctors in attendance upon him may think necessary. He remains a human being, and he retains his rights of control and disposal of his own body; he still has the right to say what operation he will submit to and any operation performed upon him without his consent is an unlawful interference with his right of security in and control of his own body and is a wrong entitling him to damages if he suffers any.
See also *Broude v McIntosh* 1998 (3) SA 60 (A) and *Sidaway v Bethlem* RHG [1985] 1 All ER 643, where Lord Scarman held that 'a doctor who operates without the consent of the patient is guilty of the civil wrong of trespass to the person; he is also guilty of the criminal offence of assault.'

69 See, for example, *Canterbury v Spence* [1972] 464 2d 772 (DC), where the US District Court of Appeal made the following remarks:
The patient's right to self-determination can be effectively exercised only if the patient possesses enough information to enable intelligent choice ... True consent to what happens to one's self is the informed exercise of choice and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. From these axiomatic considerations springs the need, and

disclose to their patients relevant facts and medical information about the latter's condition or the proposed medical intervention. Healthcare practitioners should provide useful information in an honest and understandable manner that enables the pregnant woman to have a realistic estimate of the maternal or foetal risks involved. This enables a pregnant woman to make an informed choice on whether to terminate her pregnancy. In this regard Steer *et al* argue that:

> [i]nformed choice means that the woman should be aware of the option of termination of pregnancy should she find herself unexpectedly pregnant after deciding that she was not planning to conceive. The assurance that clinicians will be non-judgmental and supportive of a decision to terminate a pregnancy is important. Open discussion of this option and provision of contact numbers to facilitate access to services reinforces that this is an option available to the woman.[70]

The idea of informed choice presupposes that a person may not 'give a valid consent without understanding the potential health consequences of their choices.'[71] They need not only be informed about their medical condition, but be given a clear understanding of the choice they are making and its implications for their health.

Informed choice means that the woman is entitled to make an independent decision, based on the information given to her, on whether or not to have a pregnancy terminated. This does not mean that the decision should necessarily be consistent with what the majority of women of her status would think is an appropriate choice, but that the choice – whether bad or good in the eyes of others – is made with full knowledge of its consequences. The choice on termination of pregnancy belongs to the pregnant woman and it must be a choice that is made by someone who has had access to all the relevant information. Macleod *et al* argue that informed choice entails:

> (1) access to sufficient information, (2) understanding the information, (3) competence to evaluate potential consequences, (4) freedom to make a choice, and (5) the ability to make and express that choice.[72]

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in turn the requirement, of a reasonable divulgence by the physician to the patient to make such a decision possible.

70 Philip Steer, Michael Gatzoulis and Philip Baker, *Heart Disease and Pregnancy* (RCOG Press 2006) 6.

71 See Rebecca Dresser, 'From Double Standard to Double Bind: Informed Choice in Abortion Law' (2008) 76 The George Washington LR 1603. See Tom Beauchamp and James Childress, *Principles of Biomedical Ethics* (5 edn, Oxford University Press 2001) 77–78.

72 Catriona Macleod, Lebogang Seutlwadi and Gary Steele, 'Knowledge of the Choice on Termination of Pregnancy Act amongst Learners in Buffalo City, South Africa' (Policy Brief, Critical Studies in Sexualities and Reproduction research programme, Rhodes University) <www.ru.ac.za/criticalstudies> 3.

Accordingly, an informed choice may not be made by someone without the capacity for rational action. Further, the capacity for rational action is decision-specific in the sense that the minor may be able to make a decision on one matter but not on another. In the context of termination of pregnancy, the minor should have the capacity to understand and analyse the available information and should then make a choice, without being forced or influenced by anyone, about whether or not to have their pregnancy terminated.

There is a rationale behind conferring on minors the right to request an abortion without parental consent. To begin with, the Choice Act disaggregates children's reproductive rights from the rights of parents and portrays children as ends in the context of termination of pregnancies. This represents a departure from the historical focus on the parental right to control or guide children in making decisions.[73] Even doctors and the state may not deny a competent pregnant minor the right to terminate her pregnancy (on demand) during the first trimester. In this way, the Choice Act departs from the notion that children need parental guidance and protection in making important decisions. However, the most alarming presumption seems to be that competent children are better protected from harm by conferring on them the autonomy to make independent decisions.

Pregnancy raises unique issues. To a larger extent, reproductive autonomy rights enable children to make decisions on intimate matters of life and to overcome the practical challenges associated with the notion of parental consent. This is particularly so if such autonomy is exercised by a mature minor in a manner that enhances the protection of the very minor's best interests and right to life, survival and development. Because of the confidential nature of sexuality and reproduction, minors tend to resort to unsafe abortion if required to seek the consent of parents, and unsafe abortion is more harmful to the child's best interests than access to safe abortion without parental consent.[74] Many

73 See, for example, John Stuart Mill, *On Liberty* (1859) J Manis (ed) (The Pennsylvania State University; 1998) 13; Robert Wolff, *In Defence of Anarchism* (University of California Press 1970) 12, stating that children are 'not fully responsible for their actions [as they] lack freedom of choice … [and] do not yet possess the power of reason in a developed form'; Gerald Dworkin, 'Paternalism' in Richard Wasserstrom (ed), *Morality and the Law* (Wadsworth Publishing Co 1971) 107, 119; Bob Franklin, 'The Case for Children's Rights: A Progress Report' in Bob Franklin (ed), *The Handbook of Children's Rights: Comparative Policy and Practice* (Routledge 1995) 3, 13 and Gerald Dworkin, 'Consent, Representation and Proxy Consent' in Willard Gaylin and Ruth Macklin (eds), *Who Speaks for the Child: The Problems of Proxy Consent* (Plenum Press 1982) 193, 205, who contends that '[parents] ought to choose for [children], not as they might want, but in terms of maximising those interests that will make it possible for them to develop life plans of their own. We ought to preserve their share of what Rawls calls "primary goods"; that is, such goods as liberty, health and opportunity, which any rational person would want to pursue whatever particular life plan he chooses.'

74 For practical reasons why minors often elect not to tell parents about pregnancy, see Women's Legal Centre, Annual Report (Wits CALS 2004) 7 and John Weeks, *Population: An Introduction to Issues and Concepts* (7 edn, Thomson Wadsworth 1999) 178–182.

children would not wish their parents to know that they engage in consensual sex while in school and would rather resort to unsafe abortion if they were required by law to seek parental consent to termination of pregnancies.[75] According to the Committee on the Rights of the Child, the:

> limited availability of contraceptives, poor reproductive health education and the requirements of *parental consent* have resulted in an increasing number of illegal abortions among girls.[76]

These factors contribute to the disproportionately high mortality of African women from unsafe abortion.[77]

In South Africa, anecdotal evidence suggests that backstreet abortions dramatically increased to between 120 000 and 250 000 annually between 1975 and 1996.[78] This increase has been attributed to the enactment of the restrictive provisions of the Abortion Act. In addition, childbirth complications and unsafe abortions have been reported as some of the major causes of maternal mortalities in the 15–19-year age group; and pregnant minors younger than 15 years are generally at five times higher risk of death than pregnant women aged 20 years and above.[79] These realities explain why the autonomy threshold envisaged in the Choice Act is more far-reaching than that contemplated in international law or the Children's Act.

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75 See Geraldine van Bueren, *The International Law on the Rights of the Child* (Martinus Nijhoff Publishers 1995) 312, who argues that '[i]n practical terms an insistence on notification could have the result of inhibiting children from seeking medical advice where sensitive issues are involved … If a child consents to parental notification, however, there is not any problem.'

76 United Nations Committee on the Rights of the Child, *Concluding Observations: Kyrgyzstan*, 24th Session, para 45, UN Doc CRC/C/15/Add.127 (2000) and CRC Committee, General Comment No 4 (2003): Adolescent Health and Development in the Context of the Convention on the Rights of the Child, 33rd Session, UN Doc CRC/GC/2003/4 (2003) para 31.

77 See Communiqué from the Action to Reduce Maternal Mortality in Africa Regional Consultation on Unsafe Abortion, 5–7 March (2003) Addis Ababa, Ethiopia; World Health Organisation (WHO), *The Prevention and Management of Unsafe Abortion: Report of a Technical Working Group* (WHO 1992); WHO, *Unsafe Abortion: Global and Regional Estimates of Incidence of and Mortality due to Unsafe Abortion with a Listing of Available Country Data* (WHO 1998) 8, where it is stated that Africa has the highest regional incidence of recourse to unsafe abortion by adolescents; Charles Ngwena, 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32(4) Human Rights Quarterly 815; Iqbal Shah and Elisabeth Åhman, 'Age Patterns of Unsafe Abortion in Developing Country Regions' (2004) 12(24) Reproductive Health Matters 9; and WHO, *Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets* (WHO 2004) 7.

78 Helen Rees and others, 'The Epidemiology of Incomplete Abortions in South Africa' (1997) 87(4) South African Medical Journal 432–437.

79 See United Nations Population Fund, *Maternal Mortality Update 2004 – Delivering into Good Hands* (United Nations Population Fund and University of Aberdeen 2004).

There is a wide scope for arguing that where a pregnant minor consents to having her pregnancy terminated, such a decision promotes her best interests and right to life regardless of whether she has the capacity for informed consent. Similarly, it is difficult to demonstrate why pregnant minors, whether competent or not, should be forced to carry their pregnancies to term: this is because early pregnancies are generally not in their best interests,80 precisely because early pregnancy threatens the child's right to life, survival and development.[81] Carrying a pregnancy to term requires sacrifices that only the pregnant woman can make and forcing her to do so undermines her freedom to determine how to use her own body.[82] For these reasons, abortion should be seen as an exception to the general rules governing consent to medical treatment because competent children are better protected by being afforded some relative degree of autonomy in this intimate sphere of life.

Limiting Parental Responsibility in the Context of Termination of Pregnancy

Section 5(3) of the Choice Act is designed to ensure that young children who wish to consult their parents on the matter benefit from parental guidance in making decisions on termination of pregnancies. It provides as follows:

> In the case of a pregnant minor, a medical practitioner or a registered midwife, as the case may be, shall advise such minor to consult with her parents, guardian, family members or friends before the pregnancy is terminated: Provided that the termination of the pregnancy shall not be denied because such minor chooses not to consult them.

If the child agrees to the involvement of their parents, the latter's views will no doubt enrich the decision-making process. Parents know the circumstances surrounding the child, their immediate needs, their socio-economic position and the various ways in which the termination or non-termination of pregnancy will negatively affect the pregnant child in the light of the latter's background, age, religion and level of education. The doctor's duty to advise the child to consult with her parents implies that

80 More importantly, children born of poor and young parents (who are children themselves) start off badly in life and have limited opportunities to enjoy fully the rights to life, healthcare services, quality education, adequate housing, food and clean water. Some have even claimed that in poor resource contexts some 'children' have the right not to be born. See, for example, Michael Freeman, 'Do Children Have the Right Not to be Born?' in Michael Freeman (ed), *The Moral Status of Children: Essays on the Rights of the Child* (Martinus Nijhoff 1997) 165.

81 The term 'development' has been defined to include the development of the intellect, through access to education and other services. See, for example, article 27 of the CRC, which refers to the child's right to 'physical, mental, spiritual, moral and social development'. See also General Comment No 5 'General measures of implementation of the Convention on the Rights of the Child (articles 4, 42 and 44, para 6)' CRC/GC/2003/5 (2003) (hereinafter CRC General Comment 5) para 12, which states that States Parties are expected 'to interpret "development" in its broadest sense as a holistic concept, embracing the child's physical, mental, spiritual, moral, psychological and social development'.

82 See the section on 'The Constitutional Basis of Reproductive Autonomy' above.

the doctor should not proceed without the participation of parents unless the doctor is satisfied that:

- the child will appreciate the advice given by the medical practitioner;
- it is not possible for them to persuade the child to inform her parents or to allow the practitioner to do so;
- the child is very likely to begin or to proceed to have illegal and unsafe abortion;
- unless the child receives treatment, her health and life are likely to be endangered; and
- the child's best interests require the medical practitioner to act without parental involvement.[83]

These conditions ensure that the doctor does not take lightly the duty to advise the child to consult with their parents about the termination of pregnancy. But the doctor's duty to encourage the child to involve their parents is not intended to protect any separate parental interests; indeed, it should be intended to enhance the child's protection both before and after the proposed abortion. This claim is supported by the fact that the termination of pregnancy 'shall not be denied because such minor chooses not to consult' with parents and that even if the pregnant minor chooses to consult with her parents, the doctor still needs *only* the consent of the minor in order to proceed with the termination of the pregnancy.[84]

In *Christian Lawyers Association II*, the Christian Lawyers Association challenged the constitutionality of section 5(1), (2) and (3) of the Choice Act, partly because its provisions permit a child to terminate her pregnancy without parental consent. The court held that 'the cornerstone of the regulation of the termination of pregnancy' is the pregnant minor's informed consent.[85] It further held that where a pregnant child who is expected to give consent to an abortion is young and immature, 'the normal common-law rules that require the consent to be given by or with the assistance of the guardian must necessarily kick in.'[86] Mojapelo J clarified these remarks by holding that:

> [y]oung and immature children do not have the capacity for real knowledge, appreciation and consent. Such young and immature children therefore would not qualify under the Act to access the rights to termination of pregnancy because they are

83 For a comparative approach, see Lord Fraser in *Gillick v West Norfolk and Wisbech Area Health Authority & Another* [1986] 1 AC 112 at 174.

84 Subsections 5(1), (2) and (3) of the Choice Act read together.

85 Paragraph 19.

86 Paragraph 22.

incapable of complying with the important jurisdictional requirement of giving informed consent.[87]

Parental responsibility remains relevant to an incompetent child's right to terminate a pregnancy.

However, it is still not in the best interests of a minor for her to be required to carry her pregnancy to term simply because the parent is refusing to permit its termination. To allow parents to refuse, for trivial reasons, an abortion on behalf of children who are incapable of giving informed consent would be to view children as the property of their parents and to frustrate the child's rights to bodily integrity and reproductive health. In *G v Superintendent*,[88] the pregnant minor's guardian had refused to grant the required consent to the termination of an unintended pregnancy allegedly conceived as a result of rape and the court permitted the abortion to proceed on the basis of ministerial consent.[89] Similarly, the Choice Act leaves room for pursuing this approach to prevent the frustration of children's constitutional right to reproductive health.[90]

Overall, parental responsibility in respect of the termination of minors' pregnancies has been severely curtailed, even where the child lacks the capacity for informed consent, because early pregnancies are inconsistent with the child's best interests and right to life, survival and development. The state has (through statutory regulation) 'broken' the hold of the public–private dichotomy on South African law and taken away from parents the power to make decisions on reproductive health matters affecting children. Consequently, pregnant minors with the capacity for informed consent have the right to procure an abortion without parental consent. This liberal approach to reproductive decision-making is intended to protect children from unintended pregnancies and unsafe abortion: the Choice Act being founded on the need to promote children's reproductive autonomy rights.

The State's Role in Limiting a Minor's Right to Terminate Her Pregnancy

The Choice Act does not leave children's exercise of reproductive autonomy entirely unregulated, though. If the child makes a choice to terminate her pregnancy in the third trimester, such a request cannot be implemented unless it is medically clear that continued pregnancy threatens the minor's life, will lead to 'severe malformation of the

87 Paragraph 22.

88 1993 (2) SA 255 (C) (n 29).

89 *G v Superintendent* (n 29) 262G–H.

90 See *Christian Lawyers Association II* (n 49) para 25. For comparative jurisprudence, see generally JL Rue, 'The Distribution of Contraceptives to Unemancipated Minors: Does a Parent Have a Constitutional Right to be Notified?' (1980–1981) 69(2) Kentucky LJ 436 and SA Bush, 'Parental Notification: A State-created Obstacle to a Minor Woman's Right to Privacy' (1982) 12(3) Golden Gate University LR 579.

foetus' or will 'pose a risk of injury to the foetus'.[91] Therefore, the limitation of a woman's right to terminate a pregnancy derives from two strands: the pregnant woman's right to life and the state's interest in preserving prenatal life. These limitations are explored in turn.

The Pregnant Minor's Right to Life

A pregnant minor's right to terminate her pregnancy is limited by her own right to life. In the early stages of pregnancy, the state's interest in preserving the pregnant minor's life is less compelling as the termination of pregnancy is less dangerous then than it is in the second and third trimesters.[92] Accordingly, the escalating risk to the mother associated with abortion in the third trimester stands as sufficient justification for limiting minors' reproductive autonomy rights. The right to life imposes on the state the positive duty to prevent the killing of its citizens.[93] As argued by Pieterse:

> 'at its core, the right to life protects human life from extinction. To kill or to condone the killing of a person therefore amounts to an infringement of the right to life.'[94]

If a pregnant minor were to seek an abortion for trivial reasons in the last trimester of her pregnancy, the state would protect the same minor from the dangers attached to her proposed course of action. Children's protection rights, including the right to life, both draw the boundaries within which children should exercise autonomy and justify state intervention when manifestations of autonomy appear to undermine the child's best interests and threaten the basic right to life. The best interests of the child therefore require the state to limit minors' autonomy rights if these rights are exercised in a manner that threatens the minor's basic right to life, survival and development.[95]

While some scholars have argued that restricting women's reproductive autonomy rights risks turning them into 'foetal incubators',[96] this argument does not justify the potential invasion of the pregnant minor's right to life for the purposes of enhancing children's reproductive autonomy. By almost denying women the freedom to terminate pregnancies in the third trimester, the Choice Act affirms the state's duty to protect pregnant minors' lives and promote their best interests: third-trimester abortions may be procured only 'if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that continued pregnancy would

91 Section 2(1)*(c)* of the Choice Act.

92 *Christian Lawyers Association II* (n 49) para 39.

93 Read together, ss 7(2) and 11 of the Constitution impose on state and non-state actors the duties to respect, protect, promote and fulfil the right to life.

94 Marius Pieterse, 'Life' in Stu Woolman, Michael Bishop and Jason Brickhill (eds), *Constitutional Law of South Africa* Vol 3 (Juta 2005) 39-1, 39-38.

95 For a detailed explanation of this approach to decision-making, see John Eekelaar, 'The Emergence of Children's Rights' (1986) 6 Oxford J of Legal Studies 170–182.

96 Christyne Neff, 'Woman, Womb and Bodily Integrity' (1991) 3 Yale J of L and Feminism 327, 350.

endanger the woman's life' – the responsibility for determining whether the conditions for an abortion exist lies with the medical practitioner, not the pregnant minor.

On the whole, the conditions attached to third-trimester abortions limit the timing of the minor's choice on termination of pregnancy and serve to expand the province of state intervention in the decision-making process. This approach recognises the role played by the pregnant child's protection rights in limiting the same child's rights to autonomy.

The State's Interest in Preserving Prenatal Life

At common law, legal subjectivity begins at birth and an unborn foetus does not have the rights of a born child.[97] Whereas the *nasciturus* fiction provides limited protection to the rights of the unborn, for the foetus it does not create the right to life.[98] However, the fact that a foetus is not entitled to the constitutional right to life does not say anything about whether the state has an interest in the protection of developing human life. Therefore, it is possible to concede that the state has an interest in regulating the termination of pregnancies without denying pregnant women the constitutional right to terminate their pregnancies.[99] In *G v Superintendent*, the Cape Provincial Division expressed the view 'that an unborn child has an interest capable of protection, in circumstances where its very existence is threatened.'[100] In *Christian Lawyers Association II*, the court held that:

> the state has an important and legitimate interest in the preservation and protection…of the potential life of the foetus. When its interest in doing so becomes sufficiently compelling, it warrants State intrusion upon the woman's privacy and self-determination.[101]

97 However, if it is to its advantage, a foetus is, in terms of the *nasciturus* fiction, deemed to have been born at the time of conception and to have all the rights provided that it is subsequently born alive. See Chuma Himonga, 'Unborn Persons' in Francois du Bois (ed), *Wille's Principles of South African Law* (Juta 2007) 161.

98 In *Christian Lawyers Association of South Africa & Others v Minister of Health & Others* (hereinafter *Christian Lawyers Association I*) 1998 (4) SA 1113 (T), the court held, at 1122I–1123B–C, that the foetus does not enjoy the right to life which is afforded to 'everyone' under s 11 of the Constitution, and that the Constitution does not limit pregnant women's rights to make decisions concerning reproduction and to security in and control over their bodies in order to protect the foetus from abortion.

99 See Woolman (n 9) 36-1, 36-4; O'Sullivan (n 8) 37-1, 37-2; Iain Currie and Johan de Waal, 'Life' in Currie and De Waal (n 13) 258, 266; Jeremy Sarkin-Hughes, 'Choice and Informed Request: The Answer to Abortion' (1990) 1 Stellenbosch Law Review 372 and Jeremy Sarkin-Hughes, 'Abortion and the Courts' in Sandra Liebenberg (ed), *The Constitution of South Africa from a Gender Perspective* (Routledge 1995) 217, 227 and 229.

100 *G v Superintendent* (n 29) at 259D–E. See also Lourens du Plessis, 'Jurisprudential Reflections on the Status of the Unborn Life' (1990) 1 Tydskrif vir die Suid-Afrikaanse Reg 44 at 51–54, where the author argues that the law must provide what he calls 'preventive protection' for the unborn child.

101 *Christian Lawyers Association II* (n 49) paras 38–39.

In constitutional language, the state's interest in preserving prenatal life may be grounded on the value of human dignity. Human dignity is one of the founding values of the Constitution[102] and it is also referred to in other important constitutional provisions that have a bearing on human rights litigation. Section 36(1) of the Constitution provides that constitutional rights may be limited only if the limitations are 'reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.' Further, section 39(1) provides that when interpreting the Bill of Rights, the courts must do so in a manner which promotes 'the values that underlie an open and democratic society based on human dignity, equality and freedom.' Section 39(2) provides that when interpreting legislation, including the Choice Act, or when developing the common and customary law, courts must 'promote the spirit, purport and objects of the Bill of Rights.' Together, these provisions imply not only that a woman's right to reproductive autonomy may be limited in a manner that is consistent with human dignity as a value, but that the courts' reading of the Choice Act and the relevant provisions of the Constitution must be consistent with the same value. It follows that even if the foetus has no constitutional right to life, the value of human dignity nevertheless operates as a constitutional control on legislation governing access to termination of pregnancy. Linking the value of human dignity to the laws regulating access to termination of pregnancy services, Meyerson argues as follows:

> It is clear that, as pregnancy progresses, the destruction of the foetus becomes a matter of increasing regret and the value of human dignity is increasingly under threat. Importantly, the foetus becomes capable of feeling pain at approximately the time at which it also becomes viable or capable of independent existence. It follows that the later in pregnancy abortion is sought, the stronger the arguments on the woman's side need to be. In fact, the Choice Act probably strikes just the right balance between the competing considerations, inasmuch as it does restrict the circumstances in which abortion may be performed in the second trimester, and virtually never allows it in the third.[103]

Generally, the state's interest in regulating the termination of pregnancy becomes progressively stronger from the 20th week of the gestation period onwards as foetal viability is roughly estimated to begin at that stage.[104] For this reason, the Choice Act begins to attach serious conditions to the woman's right to terminate her pregnancy in the third trimester. Third-trimester abortions are therefore available only when the pregnancy poses a danger to the life of the foetus or the pregnant minor.[105] Foetal life

102 Section 1 of the Constitution, 1996.

103 Meyerson (n 2) 5.

104 Jeremy Sarkin-Hughes, 'A Perspective on Abortion Legislation in South Africa's Bill of Rights Era' (1993) 51(1) Tydskrif vir Hedendaagse Romeins Hollandse Reg 89 and Camilla Pickles, 'Termination-of-pregnancy Rights and Foetal Interests in Continued Existence in South Africa: The Termination of Pregnancy Act 92 of 1996' (2012) 15(5) Potchefstroom Electronic LJ 420.

105 In terms of s 2(1)*(c)* of the Choice Act,

in the period just before birth is not very different from the life of a new-born baby and this concretises the state's interest in protecting prenatal life. At this stage, the foetus would have grown substantially and the state's interest in regulating a competent minor's right to consent to an abortion becomes even more compelling.[106] On the whole, the Choice Act appropriately balances minors' reproductive autonomy rights and the state's interest in preserving prenatal life in a manner consistent with the constitutional value of human dignity.

The Wrongs of the Choice Act

The Need to Combine 'Informed Consent' with a Specific Age of Consent

The total disregard of age as a criterion for measuring children's capacity to give informed consent to an abortion is liable to abuse in two ways. Firstly, a competent child on the verge of attaining majority would have no redress if the treating physician were to decide, for instance wrongly, that she lacked the capacity for informed consent. Therefore, conservative doctors have room to label the majority of pregnant minors 'incapable to give or refuse informed consent' to an abortion.[107] Secondly, the open-ended approach to capacity determinations enables pro-choice medical practitioners to deem incompetent children 'competent' in order that they (such children) may authorise treatment or surgery without parental involvement. Given the power imbalances between doctors and children, this approach creates room for doctors to influence young minors unduly (albeit sometimes unconsciously) to consent to or refuse termination of pregnancy services. Besides, there are no criminal or civil sanctions against doctors

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a pregnancy may be terminated … after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy–
would endanger the woman's life;
would result in a severe malformation of the foetus; or
would pose a risk of injury to the foetus.

106 See *Christian Lawyers Association II* (n 49) para 39, where the court held that
[o]nly when the foetus becomes viable, which occurs more or less at the end of the second trimester, does the State's interest in the protection of the health and welfare of the foetus become sufficiently compelling to warrant intrusion for that purpose. The State may then regulate and even prohibit abortion to protect the life of the foetus provided that it does not preclude abortion when necessary to preserve the life and health of the woman herself.
At para 52 of the same case, the court regarded the state's duty to protect 'pre-natal life as an important value in our society to regulate and limit the woman's right to choose' to terminate a pregnancy.

107 See Rachel Rebouché, 'Parental Involvement Laws and New Governance' (2011) 34 Harvard J of L and Gender 175; see also Andrew Bainham, 'Growing up in Britain: Adolescence in the Post-*Gillick* Era' in John Eekelaar and Petar Sarcevic (eds), *Parenthood in Modern Society: Legal and Social Issues for the Twenty First Century* (Martinus Nijhoff 1993) 501, 510, who argues that, regardless of the permissive nature of British healthcare law, parents and doctors are likely to deem children incompetent to give informed consent to abortion unless both consider the pregnant minor's decision to abort to be in her best interests.

who, in either good or bad faith, make incorrect determinations as to the capacity of their patients.

Without some statutorily ordained minimum age of consent, it is difficult for doctors to evaluate minors' competence unless they request the services of a psychologist or some other qualified professional. While the concept of informed consent has some advantages, as discussed below, it does not eliminate the possibilities for wrong capacity determinations. This is because the concept is inherently subjective, particularly in the light of the fact that the Choice Act does not combine it with such an objective measure as the child's age in determining the child's capacity to make legally binding choices. While there is no doubt that the use of 'chronological age' alone in protecting minors from immature decisions may be 'imprecise and perhaps even unjust in particular cases',[108] it proves to be an important guideline to the courts and the general public, particularly if it is combined with the concept of 'informed consent'.

The Choice Act forms part of parliament's experiment with legal concepts designed to limit the influence of objective age-based legislative categorisations and to increase subjective reviews of individual capabilities. Arguably, however, this leads to increased judicial openness to individual variations in competences, but it also reduces the entire decision-making process to what the sitting judge thinks about the child's capacity to make informed decisions. As Hafen and Hafen once observed:

> Individualized determinations do appear to offer greater fairness, but that promise can be more than offset by the inherent lack of reasoned generality, and, hence, the lack of neutrality, in subjective decisions. The most ardent advocates of child autonomy have still argued, if not for the removal of minority status altogether, that children should be presumed capable of legally binding action until an individualized determination shows they lack capacity. The experience of United States courts, however, reveals that customized findings of maturity are in practice not very workable.[109]

On the positive side, an open-ended approach to individual capacities recognises every child's capacity to consent to relevant medical procedures regardless of that child's age and prevents the arbitrariness associated with age-based capacity presumptions.[110] Pregnant minors as young as 12 years of age have the right to terminate their pregnancies provided they have the capacity for informed consent. However, these claims are built on the false premise that capacity is somewhere 'there' (that it can be easily determined) and that doctors are trained to determine the intellectual capacities of patients. Why not combine age (say a minimum of 15 or 16 years) and the

108 See Stevens J's holding in *Planned Parenthood v Danforth* 428 US 52, 104–105 (1976).

109 Bruce Hafen and Jonathan Hafen, 'Abandoning Children to their Autonomy: The United Nations Convention on the Rights of the Child' (1996) Harvard Intl LJ 465.

110 See *Christian Lawyers Association II* (n 49) para 23.

requirement for informed consent as twin factors to be considered in determining minors' competence to consent to an abortion?

Age limits serve as an entry point to a broad range of activities. If the minimum age of consent is neither too low to risk giving autonomy to children without the capacity for rational action nor too high to risk denying autonomy to children who have such capacity, such an age would act as a guideline as to the age at which children roughly attain the capacity for rational action. To eliminate the charge that age is rigid and arbitrary,[111] the minimum age of consent should be tied to the idea that a child still needs to possess the capacity for informed consent to an abortion. This approach is used in the Children's Act,[112] but it is arguable that the age of 12 years referred to in the Children's Act is perhaps too low for many South African children to have acquired the capacity for rational autonomy.

Rejecting age-based categorisations plays down the role parents and caregivers perform in the child's mental development as it shifts the decision-making process for determining an individual's capacity to some presumably 'objective' individual such as a medical practitioner or a judge. Where the law provides for the minimum age of consent, parents perform an important function in supervising the choices made by minors who are below or just above the stipulated age of consent. As the child grows further and further away from the minimum age of consent, they enjoy a wide discretion in making personal decisions, but the courts – as the upper guardians of all minors – retain overall jurisdiction over all minors.

By relying solely on the concept of informed consent, the Choice Act defers the process of determining whether a child has such capacity to functionaries who have very little knowledge about the child; moreover, in this process the input of those who are familiar with the child's strengths and weaknesses are side-lined. Given that medical practitioners or 'judges hardly know the children whose maturity they must judge', that 'maturity as a concept is hopelessly complex and subjective', and that so many choices, particularly those relating to reproductive autonomy and the termination of pregnancy, 'are laden with heavy personal value preferences',[113] tasking medical practitioners and judges with determining an individual's capacity may abandon children to their autonomy. This is especially so, given that doctors and judges are not trained to determine children's capacity to make particular decisions.

In general, the law governing minors' consent to medical procedures in South Africa is both piecemeal and fragmented: the age of consent to medical and surgical procedures ranges from 12 to 18 to no age at all, depending on the procedure in question. For

111 Id para 56.
112 See ss 129 and 134 of the Children's Act.
113 Hafen and Hafen (n 108) 466.

instance, a child only needs to reach the age of 12 years to exercise the right to access and use condoms.[114] Further, section 134(2)(*a*)–(*c*) of the Children's Act confers on every child who is aged 12 years or above the right to be provided with contraceptives other than condoms on request and without the consent of their parents, provided 'proper medical advice is given to the child' and there is medical certainty that the contraceptive will not cause medical harm to the child. In the context of medical treatment, every child who is over the age of 12 years may consent to their own medical treatment, provided they have sufficient maturity and mental capacity to understand the benefits, risks and social and other implications of the treatment.[115] Further, any child over the age of 12 years may consent to their own surgical operations, provided that they have sufficient maturity and mental capacity to understand the risks and benefits of such treatment and that they are duly assisted by parents or guardians.[116] This means that in the context of surgical operations the child attains genuine decisional autonomy when they reach the age of 18 years. When it comes to abortion, however, there is no age limit despite the fact that the process of terminating a pregnancy constitutes either medical treatment or a surgical operation. Therefore, in terms of the applicable law, should a child reach puberty, become sexually active and fall pregnant before they reach the age of 12 years, they are entitled to have their pregnancy terminated provided a medical practitioner thinks the child has the capacity for informed consent.

There is adequate evidence, from writings on developmental psychology, that it is unlikely that children acquire the capacity for rational action around the age of 12 years. In communitarian communities, families and society (through activities supportive of social engagement) encourage children to develop behaviours that promote group solidarity over individual identity.[117] In many African countries, the majority of children are socialised along the communitarian model of family relations and do not necessarily view autonomy as an end goal of child development. This is important in the South African context, where the majority of children feed on communitarian ideologies and view autonomy not as an end goal of human development. Indigenous African communities are built on the four principles of respect, restraint, responsibility and reciprocity.[118] Within this context, the interests of the child and those of the community

114 Section 134(1) of the Children's Act provides that 'no person may refuse *(a)* to sell condoms to a child over the age of 12 years; or *(b)* to provide a child over the age of 12 years with condoms *on request* where such condoms are provided or distributed free of charge.'

115 Section 129(2)*(a)* and *(b)* of the Children's Act.

116 Section 129(3)*(a)–(c)* of the Children's Act.

117 See JA Robinson, '"What We Have Got Here is a Failure to Communicate": The Cultural Context of Meaning' in Jaan Valsiner (ed), *Child Development within Culturally Structured Environments* Vol 2 (Ablex 1988) 137, 193.

118 For a detailed discussion of reciprocal support obligations, respect and restraint, see BA Rwezaura, 'Changing Community Obligations to the Elderly in Contemporary Africa' (1989) 4 Journal of Social Development in Africa 5; Afua Twum-Danso, 'Reciprocity, Respect and Responsibility: The 3Rs Underlying Parent Child–Child Relationships in Ghana and the Implications for Children's Rights'

are symbiotic and the child stands not as an individual but as a family member within the community. This approach to family relations is acute in Africa's communitarian societies, where women and children are socialised to submit to traditional attitudes, values and priorities largely articulated by men.[119]

Parent–child relationships are often structured by means of developmental tasks.[120] Targeted at the achievement of a specific competence at a given developmental stage,[121] these tasks or responsibilities are the products of particular cultures which stipulate the appropriate age, sequence and process of accomplishment.[122] Further, these responsibilities organise parent–child relations by either reducing the force of inter-individual difference and environmental factors or by influencing the degree to which children show dependent and independent behaviour.[123] Developmental tasks are strongly connected to children's goals and parental expectations as prescribed by cultural guidelines on how and when they should proceed.[124] Kindermann and Skinner observe that:

> the variability between different cultures in belief systems about early competencies of the child should result in actual differences in the onset, process and achievement of competencies, presumably mediated by differences in training practices stemming from these beliefs.[125]

This tends to suggest that many 'African' or black children, especially those living in intact traditional communities where they are socialised to defer to adults, are less likely

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(2009) 17 Intl J of Children's Rights 415; and Nana Apt, 'Ageing and the Changing Role of the Family and the Community: An African Perspective' (2002) 55 Intl Social Security Review 44.

119 See generally Admark Moyo, 'Reconceptualising the 'Paramountcy Principle': Beyond the Individualistic Construction of the Best Interests of the Child' (2012) 12 African Human Rights LJ 154–155.

120 See Evelyn Duval, *Family Development* (JB Lippencott 1971) 51, who defines 'family developmental tasks' [as] 'those growth responsibilities that must be accomplished by a family at a given stage in development ... if the family is to continue as a unit'; and see Robert Havighurst, *Developmental Tasks and Education* (Allyn and Bacon 1972) 2, who defines developmental tasks as 'tasks which arise at a certain period in the individual's life, successful achievement of which leads to ... success with later tasks while failure leads to individual unhappiness, disapproval by society and difficulty achieving later tasks.'

121 Developmental tasks emerge from three sources: biological changes, socio-cultural norms and individual expectations or values.

122 See Jaan Valsiner, *Culture and the Development of Children's Action: A Cultural Historical Theory of Developmental Psychology* (Wiley 1986) 207, who argues that cultural socialisation goals are 'already coded into the fixed-feature objects that surround children.'

123 Thomas Kindermann and Ellen Skinner, 'Developmental Tasks as Organisers of Children's Ecologies: Mothers' Contingencies as Children Learn to Walk, Eat and Dress' in Valsiner (n 122) 66, 71.

124 Kindermann and Skinner (n 123) 94–95.

125 Id 95.

to have acquired the capacity for rational autonomy.

The Need to Regulate Minors' Refusal to Terminate Life-Threatening Pregnancies

Problems arise where a minor is deemed competent—either wrongly or correctly—to possess the capacity for informed consent and refuses an abortion that a medical practitioner thinks is important to save the minor's life. The Choice Act promotes choice on termination of pregnancies and it does not empower doctors or the state to coerce minors into terminating their pregnancies.

Several provisions of the Choice Act would not permit medical practitioners to require a competent minor to terminate her pregnancy.[126] In the first trimester, the choice of whether or not to terminate a pregnancy necessarily belongs to the minor, not the doctor or their parent.[127] While the medical practitioner also has to consent to an abortion in the second and third trimesters, a termination of pregnancy during this period also has to be sanctioned by the pregnant woman herself, otherwise it will constitute an unlawful invasion of the woman's bodily integrity.

As the law currently stands, the focus of the Choice Act on the woman's right to have an abortion does not cater for situations where a competent minor chooses to refuse an abortion that would save her own life. The Act regulates only those situations where a pregnant minor wants to terminate her pregnancy but the medical practitioner refuses on the basis that it is risky to do so;[128] it does not prescribe the action to be taken by a medical practitioner where the minor wishes to keep a pregnancy that the attending physician reasonably believes to be a threat to the minor's life.

Given that informed consent is often dangerously equated to informed refusal, a pregnant minor appears to be entitled (under the current legal framework) to refuse an abortion even if such refusal poses a danger to the minor's life. To this end, Van Oosten argues that:

> the right to consent without the right to refuse is a legal castratus. That the girl's ultimate decision is irrational, unreasonable, unwise or dangerous makes no difference, for this

126 Sections 2(1) and 5(1) and (2) of the Choice Act read together.

127 An informed refusal is the flip side of informed consent and it can hardly be said that every pregnant child's refusal of an abortion is not in the child's best interests merely because it is irrational or unreasonable in the eyes of the doctor. See F van Oosten, 'Medical Law: South Africa' in R Blanpain and H Nys (eds), *International Encyclopaedia of Laws* (Kluwer Law International 1996) 120.

128 See 'Informed consent to the termination of pregnancy' above.

> is precisely what the doctrine of informed consent, with its underlying principle of personal autonomy and self-determination, is all about.[129]

While it is correct to say that, read literally, the Choice Act allows minors to make personal decisions on termination of pregnancies, it is difficult to sustain the argument that minors should be allowed to exercise autonomy in an objectively 'dangerous' manner. To do so would be to ignore the role played by children's protection rights – particularly the right to life – in defining the scope and limits of children's autonomy rights.

It is arguable that a child who refuses an abortion that a medical practitioner believes to be important to save the child's own life may be forced to terminate her pregnancy to promote her own best medical interests.[130] Yet, the Choice Act does not directly deal with cases where the child dangerously chooses not to terminate her pregnancy: the role of the right to life in defining the best interests of the child does not seem to permit even competent children to refuse life-saving medical procedures. Consequently, there is need for a provision in the Act which stipulates that where the minor's refusal to terminate a pregnancy which threatens the same minor's life, the Minister of Social Development or the High Court as upper guardian of all minors may authorise the termination of such a pregnancy.

Conclusion

South African law largely locates reproductive decision-making, particularly the termination of pregnancy, outside the reach of parental responsibility and state intervention. The Choice Act is unequivocal in confirming that it is designed to protect women's reproductive health rights and to enable women, including minors, to make independent decisions.

This article has shown that there are four elements that the drafters of the Choice Act got right. The first is the idea of informed consent. In conferring reproductive autonomy on children of all ages, the Act's focus on 'informed consent' emphasises the role of the child's evolving capacity. This is consistent with the idea that children gradually attain rights to and a capacity for self-determination. The developing competences of the child require that parents and the state nurture children to take responsibility for personal actions and to make autonomous decisions whenever the child acquires the capacity to make decisions in their own best interests. Secondly, the Choice Act revolves around the idea of informed choice. The Act unequivocally states that where the child possesses the capacity for informed consent, the termination of pregnancy may take place *only*

129 F van Oosten, 'The Choice on Termination of Pregnancy Act: Some Comments' (1999) 116 South African LJ 66.

130 On the primacy of the child's best interests, see s 28(2) of the Constitution, 1996 and ss 7 and 9 of the Children's Act.

with the *informed consent* of the pregnant woman and 'no consent other than that of the pregnant woman shall be required for the termination of a pregnancy.'[131] Therefore, the Act disaggregates children's reproductive rights from the rights of parents and portrays children as ends in the context of termination of pregnancy.

Thirdly, the Choice Act does not require pregnant minors to consult with their parents or guardians before an abortion may be procured. This represents a departure from the historical focus on the parental right to control or guide children in making reproductive decisions. Treating physicians have a duty only to encourage the child to involve her parents, but the termination of pregnancy may not be denied because the minor chooses not to consult her parents or guardians. Further, even if the pregnant minor chooses to consult with her parents, the doctor still needs *only* the consent of the minor in order to proceed with the termination of pregnancy. This is important because many children would not even wish their parents to know that they engage in consensual sex while in school and would rather resort to an unsafe abortion if legally required to seek parental consent to termination of pregnancy.

The fourth strength of the Choice Act is that it does not leave children's exercise of reproductive autonomy rights entirely unregulated. Minors' reproductive autonomy rights are limited by two considerations: first, the pregnant minor's right to life and, second, the state's interest in preserving prenatal life. If a pregnant minor were to seek an abortion for trivial reasons in the last trimester of her pregnancy, the state would protect the same minor from the dangers attached to her intended course of action. The pregnant minor's right to life draws the boundaries within which children should exercise autonomy and justifies state intervention when manifestations of autonomy undermine the child's best interests and threaten her basic right to life.

This article has also shown that the constitutional value of human dignity justifies the state's interest in limiting minors' freedom to order the termination of pregnancy. Generally, the state's interest in regulating the termination of pregnancy becomes progressively stronger from the end of the second trimester onwards, because foetal viability is roughly estimated to begin at that stage. For this reason, the Choice Act begins to attach serious conditions to the woman's right to terminate her pregnancy in the third trimester.

One of the wrongs of the Choice Act is that it does not provide for a minimum age of consent. Without some statutorily ordained age of consent, it is difficult for doctors to evaluate minors' competences appropriately. The total disregard of age as a criterion for measuring children's capacity to give informed consent to an abortion is liable to abuse in two ways. Firstly, a competent child on the verge of attaining majority would have no redress if the treating physician were to decide, for instance wrongly, that she lacked

131 Section 5(2) of the Termination of Pregnancy Act.

the capacity for informed consent. Therefore, conservative doctors have room to label the majority of pregnant minors 'incapable to give or refuse informed consent' to an abortion. Secondly, the open-ended approach to capacity determinations enables pro-choice medical practitioners to label incompetent children 'competent' so that they may authorise treatment or surgery without parental involvement. To resolve these challenges, it is necessary to 'partner' the doctrine of 'informed consent' with a particular age of consent in order to provide some guidance on when children are roughly expected to acquire the capacity for rational reproductive autonomy.

Another wrong of the Choice Act is that it does not directly address cases where the child dangerously chooses not to terminate her pregnancy. The Act regulates only those situations where a pregnant minor wants to terminate her pregnancy but the medical practitioner refuses on the basis that it is risky to do so.[132] It does not prescribe the action to be taken by a medical practitioner where the minor wishes to keep a pregnancy that the attending physician reasonably believes to be a threat to the minor's life. Problems arise where a minor is labelled 'competent', whether wrongly or correctly, to possess the capacity for informed consent and refuses an abortion that a medical practitioner considers to be important to saving the minor's life.

The Choice Act promotes choice on termination of pregnancy and it does not empower doctors or the state to coerce minors to terminate their pregnancies. Several provisions of the Choice Act, particularly those relating to informed consent and choice, would not permit medical practitioners to require a competent minor to terminate her pregnancy. Given that informed consent is often dangerously equated to informed refusal, a pregnant minor appears to be entitled (under the current legal framework) to refuse an abortion even if such refusal poses danger to the minor's life. The need exists for a provision to be introduced that covers situations in which a competent minor chooses to refuse an abortion that would save her own life.

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132 See 'Informed consent to the termination of pregnancy' above.

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