

# Abortion, Reproductive Rights and the Possibilities of Reproductive Justice in South African Courts

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## Abstract

Women's ability to control their reproductive destiny and choose to terminate unwanted and unsupported pregnancies is a core measure of their substantive freedom and equality. Arguing for a substantive recognition of reproductive autonomy within integrated and mutually reinforcing reproductive rights, this article reviews developments in international law (CEDAW and CESCRC) and national jurisdictions, with a particular emphasis on South Africa. Although there has been significant progress at international level, a clear recognition of the right to abortion on request remains remarkably circumscribed. The article draws on evolving international norms and domestic jurisprudence to identify two approaches to defining reproductive autonomy within a constellation of reproductive rights. The first identifies inclusive, but negative, ideas of *reproductive choice* that do not dismantle the gender-, race- and class-bound norms, attitudes and structural social and economic barriers that impede women's reproductive autonomy and abortion choices. The second speaks to *reproductive justice*, and a relationship between autonomy and equality that enables the normative and practical centring of vulnerable and disadvantaged women, within a commitment to the structural transformation of society. Turning to South Africa, the article suggests that the courts have, at best, adopted an inclusive 'reproductive choice' approach, based on extant dignity and (negative) freedom jurisprudence, that secures legal protection, but have not developed a more transformative understanding of reproductive rights as 'reproductive justice'. To develop this more transformative approach, the article analyses

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the Treatment Action Campaign's Constitutional Court victory on treatment for poor, HIV-positive women to reduce perinatal HIV transmission, not because this case addresses reproductive autonomy, but because it erases it. It uses this case as a basis for re-imagining the jurisprudence, within a 'reproductive choice' approach (that aligns with current jurisprudence) and a 'reproductive justice' approach (that pushes its boundaries). Finally, the article reflects on the politics and possibilities of reproductive rights as transformative tools of reproductive justice in securing better implementation of abortion legislation across all vectors of disadvantage and difference.

**Keywords:**

Abortion, Autonomy, Equality, Reproductive rights, Reproductive justice, Transformative jurisprudence

## *1. Introduction*

Women's ability to control their reproductive destiny and choose to terminate unwanted and unsupported pregnancies is a core measure of substantive freedom and equality in society. In the 1990s, this began to gain international recognition in terms of human rights as reproductive rights. Notably, in 1994, the International Conference on Population Development in Cairo (ICPD) placed human rights, autonomy and gender equality at the centre of women's sexual and reproductive health,<sup>1</sup> and the 1995 Fourth World Conference on Women in Beijing (Beijing) reaffirmed these commitments: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."<sup>2</sup> Reproductive rights, of course, are not new rights, but constitute a bundle of human rights, recognised in national and international law,<sup>3</sup> that are interpreted and re-interpreted to support and enhance women's reproductive freedom, equality and health. These include rights to privacy, freedom and security of the person,

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<sup>1</sup> The Cairo Programme of Action affirmed 'the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health...the right of all to make decisions concerning reproduction free of discrimination, coercion and violence.' UN, 'Report of the International Conference on Population Development: Cairo Programme of Action' (1994) A/Conf.171/13 [7.3].

<sup>2</sup> UN, 'Report of the Fourth World Conference on Women: Beijing Platform for Action' (1995) A/Conf.177/20 [96].

<sup>3</sup> *ibid* [95], [223].

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dignity, non-discrimination and equality, life and social rights, particularly the right to health.

Inspired by these developments, the 1996 South African Constitution explicitly includes rights to reproductive health, freedom and autonomy (reproductive decision-making and bodily integrity) alongside equality, dignity and privacy in its text. These provisions and international texts provide a basis for conceptualising reproductive rights as integrated and mutually reinforcing, linking a substantive idea of reproductive autonomy and self-determination to equality and health rights, in a manner that resonates with feminist writings on reproductive freedom as both individual and social.<sup>4</sup> Asserting individual reproductive autonomy affirms women’s personhood, moral agency, bodily integrity and self-determination, and is foundational to their ability to participate equally in society. However, the meaningful exercise of that autonomy requires that unequal gendered social and economic relations be addressed, requiring positive action to eliminate such inequalities and, particularly, to provide reproductive healthcare and other social services. In this sense, freedom and autonomy rights are indivisible from equality and social rights.

Although the interpretation of reproductive rights by international human rights treaty bodies has evolved significantly over the past 25 years, international standards have emphasised equality and reproductive healthcare rights, generally motivated by public health and harm reduction concerns, and often failed to affirm reproductive autonomy within a fully integrated understanding of mutually reinforcing reproductive rights. South African jurisprudence is also limited in its development of reproductive rights, either defining reproductive autonomy in narrow terms or glossing over autonomy in favour of programmatic healthcare arguments. Against the backdrop of international developments, and mindful of how politics shape possibilities, this article explores South African case-law to consider how to move through and beyond dominant international arguments, and narrow domestic interpretations, to centre a positive, substantive idea of women’s reproductive autonomy at the heart of a constellation of reproductive rights.

Section 2 briefly discusses international law developments to suggest that, until very recently, equality and public health rights have enjoyed far greater recognition than autonomy and self-determination. Drawing on these developments and comparative law, Section 3 poses two ways of defining autonomy and centring it within reproductive rights. The first identifies inclusive, but negative, ideas of reproductive choice that do not dismantle the gender-, race- and class-bound norms, attitudes and

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<sup>4</sup> Rosalind Pollack Petchesky, *Abortion and Women’s Choice* (Northeastern University 1990) 6-7.

structural social and economic barriers that impede women's reproductive autonomy and abortion choices. The second speaks to reproductive justice, and a relationship between autonomy and equality that enables the normative and practical centring of vulnerable and disadvantaged women, within a commitment to the structural transformation of society.

Section 4 considers the positive framework of South Africa's 1996 Constitution and the Choice on Termination of Pregnancy Act 92 of 1996 (CTOPA) and judicial interpretations of reproductive rights.<sup>5</sup> Acknowledging the constraints imposed by the nature of the cases, I suggest that courts have adopted an inclusive 'reproductive choice' approach, based on extant dignity and (negative) freedom jurisprudence, that secures legal protection, but does not develop a more transformative understanding of reproductive rights as 'reproductive justice'. Section 5 then analyses the Treatment Action Campaign's Constitutional Court victory in securing treatment for poor, HIV-positive women to reduce perinatal HIV transmission,<sup>6</sup> not because this case addresses reproductive autonomy, but because it erases it. I shift from the forensic to the normative to imagine two ways of deciding the matter. This allows me to illustrate the difference between a 'reproductive choice' approach (that aligns with current jurisprudence) and a 'reproductive justice' approach (that pushes its boundaries). Drawing on this analysis of *TAC*, Section 6 reflects on the politics and possibilities of reproductive rights as transformative tools of reproductive justice in securing better implementation of the CTOPA across all vectors of disadvantage and difference.

## ***2. Abortion and Reproductive Rights in International Human Rights Law***

Reproductive rights refer to a range of rights relating to reproduction and reproductive health throughout women's life cycle, including sex education and contraception, the ability and decision to have (or not have) children, ante-natal and obstetric care and the right to give birth safely, and the reproductive needs and interests of women outside of, and beyond, pregnancy and child-birth. This article considers reproductive rights

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<sup>5</sup> *Christian Lawyers Association v Minister of Health I* 1998 (4) SA 1113 (South African High Court); *Christian Lawyers Association v Minister of Health II* 2005 (1) SA 509 (South African High Court); *AB v Minister of Social Development* 2017 (3) SA 570 (South African Constitutional Court).

<sup>6</sup> *Minister of Health v Treatment Action Campaign* 2001 (5) SA 721 (South African Constitutional Court).

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through the lens of abortion, arguably the most contentious issue and one that has enjoyed limited positive and substantive recognition in international human rights law. As this section argues, the right to abortion is rarely seen as an independent right to autonomy and self-determination, but rather as an aspect of equality and reproductive healthcare rights, most often justified by public health and harm reduction concerns. This can reproduce the very stereotypes of motherhood and gendered reproduction that we seek to dismantle. It is only very recently that we have seen the conceptual development of abortion as reproductive autonomy, although with little movement away from a negative (do no harm) approach, focusing on decriminalisation, towards a positive recognition of women’s unfettered right to choose. Indeed, abortion remains a key battleground over women’s bodies and lives, where a simple recognition of women’s right to choose abortion, unencumbered by conditions and procedures, and the state’s duty to facilitate this abortion choice, remains remarkably circumscribed.

### *A. The Compromise of the ICPD and Beijing: Laying the Foundation*

Although the ICPD is credited with centring rights within reproductive healthcare and shifting the focus of family planning from ‘population control’ to ‘empowering women and promoting individual choice . . . within comprehensive reproductive healthcare services’;<sup>7</sup> women’s substantive right to choose safe, legal abortion was not endorsed in its 1994 Programme of Action. Rather, it required that abortion was safe, where legal, and the health impact of unsafe abortion was addressed.<sup>8</sup> In Marge Berer’s words, this ‘great compromise’ left women’s autonomy unresolved, as abortion (or ‘unwanted pregnancies’) were seen as something to be prevented, rather than a right to choose abortion as a normal, legitimate part of reproductive health services.<sup>9</sup> The Beijing Platform for Action went a step further to call for a review of laws that criminalised abortion, but similarly failed to centre rights to freely choose an abortion.<sup>10</sup> Recently, the ICPD/Beijing framework was endorsed in the 2015 Sustainable Development Goals’ commitment to gender equality,

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<sup>7</sup> Adrienne Germain and Rachel Kyte, *The Cairo Consensus: The Right Agenda for the Right Time* (International Women’s Health Coalition 1995).

<sup>8</sup> Cairo Programme of Action (n 1) [7.6] read with [8.25].

<sup>9</sup> “The Cairo “Compromise” on Abortion and its Consequences for Making Abortion Safe and Legal’ in Laurie Reichenbach and Mindy Jane Roseman (eds), *Reproductive Health and Human Rights: The Way Forward* (UPP 2009).

<sup>10</sup> Beijing Platform for Action (n 2) [106 (k)].

including ‘sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the [ICPD] and the Beijing Platform for Action’.<sup>11</sup> However, the primary focus on ‘maternal mortality’ reinforces, rather than disrupts, dominant public health narratives on abortion that can decentre autonomy.

Alongside these global agreements, reproductive rights have been elaborated in the interpretation and enforcement of international human rights documents, especially the Convention on All Forms of Discrimination against Women (CEDAW) and the International Covenant on Economic, Social and Cultural Rights (ICESCR). The CEDAW Committee has developed the conceptual framework of equality and non-discrimination to hold states accountable for abortion-related violations and to develop recommendations for the expansion and implementation of abortion laws and reproductive healthcare services.<sup>12</sup> Little has been said of reproductive autonomy. Under the ICESCR, a comprehensive, multi-dimensional right to health has been developed to place reproductive autonomy within a constellation of individual and programmatic rights, but with some hesitation around endorsing abortion as an unencumbered and positive choice.

### *B. Abortion and CEDAW: Reducing Harm, Reproducing Stereotypes?*

The CEDAW Committee’s approach to abortion has developed from endorsing the Beijing mandate to decriminalise abortion ‘where possible’, in its 1999 General Recommendation No. 24 on the right to health,<sup>13</sup> to a general call *not merely for the review, but for the repeal*, of all laws criminalising abortion in its 2017 General Recommendation No. 35 on gender-based violence against women (on the basis that the criminalisation

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<sup>11</sup> ‘Sustainable Development Goal (SDG)-Goal 5: Achieve gender equality and empower all women and girls’ UNGA (2015) A/RES/70/1 [5.6]. See also reducing maternal mortality to less than 70 per 100 000 births by 2030 in ‘SDG-Goal 3: Ensure healthy lives and promote well-being for all at all ages’ *ibid* [3.1].

<sup>12</sup> Rebecca Cook and Mahmoud Fathalla, ‘Advancing Reproductive Rights Beyond Cairo and Beijing’ (1996) 22 *International Family Planning Perspectives* 115; Centre for Reproductive Rights and UNFPA, ‘ICPD and Human Rights: 20 Years of Advancing Reproductive Rights Through UN Treaty Bodies and Legal Reform’ (2013) <[https://www.unfpa.org/sites/default/files/pub-pdf/icpd\\_and\\_human\\_rights\\_20\\_years.pdf](https://www.unfpa.org/sites/default/files/pub-pdf/icpd_and_human_rights_20_years.pdf)> accessed 20 April 2019; Andrew Byrnes, ‘Article 1’ in Marsha Freeman, Christine Chinkin and Beate Rudolf (eds), *CEDAW: A Commentary* (OUP 2012); Rebecca Cook and Veronica Undurruga, ‘Article 12’ in Marsha Freeman, Christine Chinkin and Beate Rudolf (eds), *CEDAW: A Commentary* (OUP 2012).

<sup>13</sup> CEDAW Committee, ‘General Recommendation No. 24: women and health’ (1999) CEDAW/C/GC/24.

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of abortion may amount to torture and cruel, degrading and inhumane punishment).<sup>14</sup> Moreover, the interpretation of CEDAW’s equality and health provisions in particular cases has led to calls for full decriminalisation, abortion law reform, albeit on limited grounds, and reproductive health care services. This is exemplified by the 2011 case of *LC v Peru*, in which a young girl who became pregnant as a result of sexual abuse, and had attempted suicide, was denied an abortion necessary to allow her to undergo surgery to prevent disability arising from her injuries.<sup>15</sup> The law allowed termination that was the ‘only way to save the life of the mother or to avoid serious and permanent harm to her health’, but no procedures, protocols or services existed to implement the provision.<sup>16</sup> The CEDAW Committee found multiple violations of women’s rights, including article 2 (contravening right not to be discriminated against and to be protected by law by denying effective legal remedy), article 5 (violating duty to eliminate patterns and practices based on stereotypes of motherhood and reproductive functions) and article 12 (discrimination in health care services by not providing necessary reproductive health service).<sup>17</sup> The Committee recommended a review of laws to ‘establish a mechanism for effective access to therapeutic abortion under conditions that protect women’s physical and mental health’ and with a view to ‘decriminalizing abortion when the pregnancy results from rape or sexual abuse’,<sup>18</sup> in addition to the provision of comprehensive reproductive health services in line with CEDAW requirements.<sup>19</sup> Three years later, the CEDAW Committee submitted a statement on sexual and reproductive health and rights to the 2014 ICPD Review in which it recognised that the right to autonomy lay at the heart of sexual and reproductive rights. It suggested that, as a result of the harm of unsafe abortion, ‘states should legalise abortion at least in cases of rape, incest, threats to life and/or health or severe foetal impairment’, and that states should provide ‘access to quality post-abortion care, especially in case of complications arising from

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<sup>14</sup> CEDAW Committee, ‘General Recommendation No. 35 on gender-based violence against women’ (2017) CEDAW/C/GC/35 [18], [29(c)], [9(i)].

<sup>15</sup> *LC v Peru* (2011) CEDAW/C/50/22/2009; *Alyne da Silva Pimental Teixeira (deceased) v Brazil* (2011) CEDAW/C/49/D/17 a failure to treat an avoidable maternal death violates Articles 2 and 12 of CEDAW and women’s rights to equality and non-discrimination require their lives to be prioritised over foetal life; CEDAW Committee, ‘Report of the inquiry concerning the Philippines of the CEDAW Committee under article 8 of OP-CEDAW’ (2015) CEDAW/C/OP.8/PHI/1 denying access to contraception is a violation of articles 2, 5, 10(h), 12, 16(1)(e) of CEDAW.

<sup>16</sup> *ibid* [2.5].

<sup>17</sup> *ibid* [8.6]-[8.9].

<sup>18</sup> *ibid* [9.2 (a)], [9.2(c)].

<sup>19</sup> *ibid* [9.2 (b)] and [9.2(d)] citing General Recommendation No. 24 (n 13).

unsafe abortions.’<sup>20</sup> This echoes the 2003 Protocol to the African Charter on the Rights of Women in Africa, the first international document to recognise the need to legalise abortion to ‘protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus’.<sup>21</sup>

Whilst showing unquestionable progress in women’s international human rights, by limiting abortion to specific grounds and prioritising a harm reduction approach, these interpretations ultimately fail to acknowledge women’s autonomy, moral agency and bodily integrity and reproduce the very stereotypes that CEDAW commits to overcoming. Indeed, the grounds deemed acceptable by the CEDAW Committee and Women’s Protocol represent another compromise, allowing abortion only where women can be seen to be ‘morally blameless’, either because they had ‘no choice’ in falling pregnant (by rape and sexual assault) or because of the need to save women’s lives or prevent serious damage to their health.<sup>22</sup> These grounds allow the perpetuation of discourses of abortion as a result of tragic circumstances or harm reduction, not individual choice, in which women are ‘forced’ to terminate pregnancies and where the myths of motherhood and women as natural nurturers of children can remain intact.<sup>23</sup> There is, as yet, no acknowledgment under CEDAW that abortion on request and access to relevant medical procedures, without conditions, are necessary to take women’s autonomy seriously and to affirm not only their personhood and self-determination, but also their equality.

It is only a 2017 Discussion Paper of the UN Human Rights Council’s Working Group on the Issue of Discrimination against Women in Law

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<sup>20</sup> CEDAW Committee ‘Statement of the Committee on the Elimination of Discrimination Against Women on sexual and reproductive health and rights: Beyond 2014 ICPD Review’ (2014)

<<https://www.ohchr.org/Documents/HRBodies/CEDAW/Statements/SRHR26Feb2014.pdf>> accessed 20 April 2019. See also CEDAW Committee, ‘Report of the inquiry concerning the UK and Northern Ireland of the CEDAW Committee under article 8 OP-CEDAW’ (2017) CEDAW/C/OP.8/GBR/1 the criminalisation of abortion and failure to establish a comprehensive and safe legal framework in Northern Ireland, that addresses the problems of vulnerable women, is a violation of articles 1, 2, 5, 12, 14 and 16(1)(e) of CEDAW.

<sup>21</sup> Article 14(2)(c) (adopted 11 July 2003, entered into force 25 November 2005) AHG/Res. 240 (XXXI).

<sup>22</sup> In recent study of six countries, public health emerged as the dominant justification for abortion law reform. Wendy Chavkin et al, ‘Implementing and Expanding Safe Abortion Care: An International Comparative Case of Six Countries’ (2018) 143 *International Journal of Gynaecological Obstetrics* 3.

<sup>23</sup> Catherine Albertyn, ‘Claiming and Defending Abortion Rights in South Africa’ (2015) 22 *Revista Direito GV* 429, 432-33.



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and in Practice that has registered a clear call for abortion on request, and thus for women’s unfettered autonomy, in the first trimester of pregnancy.<sup>24</sup> Although not repeated in its 2018 Human Rights Council Report, this nevertheless reiterates that: ‘The right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, involving intimate matters of physical and psychological integrity, and is a precondition for the enjoyment of other rights.’<sup>25</sup> This represents important progress in developing women’s autonomy within a package of mutually reinforcing reproductive rights, especially if read alongside the emerging jurisprudence of the CESCRC.

### *C. CESCRC and the Right to Reproductive Health*

The CESCRC has developed a more complex understanding of reproductive rights through the right to health. Its initial focus on public health and safe abortion in the context of high levels of maternal mortality, especially in the developing world (harm reduction),<sup>26</sup> has advanced to recognise women’s rights to decision-making and bodily integrity and their intersection with equality, non-discrimination and reproductive healthcare services. This is particularly apparent in its 2016 General Comment No. 22 on the right to sexual and reproductive health,<sup>27</sup> which defines the right as constituted by freedoms (including the right to make decisions about one’s body) and entitlements (including unhindered access to services). By recognising the relationship between autonomy, equality and social rights; the CESCRC notes that the right to health is indivisible from, and interdependent with, a range of other rights, including ‘the physical and mental integrity of individuals and their autonomy, such as: the rights to life, liberty and security of the person; freedom from torture and other cruel, inhuman or degrading punishment; privacy and respect for family life; and non-discrimination and equality’.<sup>28</sup> Denial of abortion can amount

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<sup>24</sup> UN Working Group on the issue of discrimination against women in law and in practice (UN Working Group), ‘Women’s Autonomy, Equality and Reproductive Health in International Human Rights: Between Recognition, Backlash and Regressive Trends’ (2017) <<https://www.ohchr.org/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf>> accessed 20 April 2019.

<sup>25</sup> UN Working Group, ‘Reasserting equality, countering rollbacks’ (2018) A/HRC/38/46 [35].

<sup>26</sup> UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, ‘The right to health and the reduction of maternal mortality’ (2006) A/61/338 [7], [12].

<sup>27</sup> CESCRC, ‘General comment No. 22: on the right to sexual and reproductive health’ (2016) E/C.12/GC/22.

<sup>28</sup> *ibid* [10].

to a violation of all of these rights.<sup>29</sup> Further, the CESCR moves toward a contextual understanding of autonomy by locating health rights within a substantive understanding of gender equality<sup>30</sup> and with due regard to intersectionality.<sup>31</sup> Based on this, the CESCR calls for respect for women's rights to make autonomous decisions and protection from unsafe abortions, thus requiring full decriminalisation of abortion, liberalisation of restrictive laws and the provision of safe abortion services.<sup>32</sup>

This centring of autonomy develops the 2011 Report of the Special Rapporteur on Health,<sup>33</sup> which had defined the criminalisation of abortion as interfering with women's freedom to 'make personal decisions without interference from the state',<sup>34</sup> thus 'restricting women's control over her body, possibly subjecting her to unnecessary health risks'<sup>35</sup> and resulting in coerced pregnancies.<sup>36</sup> Moreover, General Comment No. 22 is developed and endorsed by the 2018 Guttmacher-Lancet Report on sexual and reproductive health and rights, which documents an 'emerging consensus' on these issues, in which bodily integrity and personal autonomy – and the right to make decisions that govern one's body, free of stigma, discrimination and coercion – are said to be essential to gender equality and women's well-being and economic development.<sup>37</sup>

What is disappointing is that neither the CESCR and the Guttmacher-Lancet Report endorse abortion on request, limiting their recommendations to decriminalisation and liberalisation or 'expanding grounds',<sup>38</sup> while emphasising programmatic ways of saving women's lives via safe abortions.<sup>39</sup>

### *D. A 'New Compromise' Over Negative Freedom?*

Intense political, religious and cultural contestations around women's abortion rights mean that global frameworks are often the result of

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<sup>29</sup> *ibid.*

<sup>30</sup> *ibid* [24]-[26].

<sup>31</sup> *ibid* [30].

<sup>32</sup> *ibid* [28].

<sup>33</sup> UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 'Criminalisation of sexual and reproductive health rights' (2011) A/66/254 [21], [65(h)].

<sup>34</sup> *ibid* [1.5].

<sup>35</sup> *ibid* [27], [65(h)].

<sup>36</sup> *ibid* [21].

<sup>37</sup> Ann M Starrs et al, 'Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-Lancet Commission' (2018) 391 *Lancet* 2642.

<sup>38</sup> *ibid* 2644-5.

<sup>39</sup> *ibid.*

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complex strategies and political compromises. Whilst human rights bodies may have some room for manoeuvre, they are subject to differing mandates and politics. As a result, public health and harm reduction narratives (saving women’s lives) are often powerful mediators of progress and drive calls for decriminalisation and ‘expanding grounds’. And indeed, high global levels of maternal mortality (25 million women are estimated to undergo unsafe abortion annually),<sup>40</sup> mean any extension of abortion rights is significant for women’s lives and health. Yet, by sticking to negative, ‘hands off’ ideas of freedom and failing to talk in detail about how to enable and facilitate abortion on request, these international texts omit a key normative and policy basis for helping women determine their lives in line with their own circumstances, priorities, needs and aspirations. As set out above, perpetuating ideas of abortion on limited grounds, or decriminalisation without providing meaningful choice and full access and services, reproduces deeply patriarchal gendered norms and power relations about women’s place in the family, society and nation - as mothers, care-givers and home-makers required to ‘make do’ in the face of often overwhelming social and economic odds. Such approaches might broaden the ambit of rights and legal protections, but they are not necessarily inclusive of *all* women nor transformative of underlying norms and practices. As I argue in the next section, this prioritises a narrower idea of reproductive choice over reproductive justice.

### *3. Reproductive Rights and Reproductive Justice*

Abortion rights are inevitably contested in law and politics. Their interpretation ranges from a narrow focus on individual choice, free from state interference, to a wider understanding of the manner in which reproductive autonomy might be positive, contextual and relational. Further, we might focus on reproductive choice/autonomy alone (often limiting debate to the restrictions placed on choice) or we might explore the relationships between autonomy, equality and social rights (opening up discussion on positive measures to facilitate meaningful choice). Underpinning these interpretations are a variety of ideas of women, gender and sexuality, spanning paternalistic, protective and oppressive ideas of motherhood and dependency to those that centre women’s autonomy and personhood, even as they recognise practical constraints.

This section distinguishes two ‘models’ of abortion choice: a largely negative idea of reproductive choice, dominant in international and

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<sup>40</sup> *ibid.*

comparative law, and a substantive idea of choice that aligns with a wider ‘reproductive justice’ approach. While the former can extend powerful normative and legal protection to some women, it can be inattentive to the varying contexts and needs of different women’s lives. A more transformative idea of reproductive justice asserts mutually supportive forms of substantive autonomy, equality and social rights that aim to disrupt traditional gendered norms and dismantle structural barriers to inequality, thus seeking to address the needs of all women.

### *A. Reproductive Choice Based on Negative Freedom*

Reproductive autonomy and self-determination lie at the centre of reproductive rights, founded in rights to privacy, freedom and security of the person and/or dignity. How this is interpreted – and balanced against public health, medical, doctors’ and foetal interests – depends on history, context, politics and legal culture.<sup>41</sup> However, negative ideas of reproductive freedom have been dominant in decriminalising abortion in national jurisprudence and international law.<sup>42</sup> Perhaps best known is US jurisprudence where the 1971 case of *Roe v Wade* established privacy as the core right underpinning women’s abortion rights.<sup>43</sup> As summed up in *Thornburg v American College of Obstetricians and Gynaecologists*:<sup>44</sup> ‘Few decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman’s decision – with the guidance of her physician and within the limits specified in *Roe* –

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<sup>41</sup> Riva Siegel, ‘The Constitutionalisation of Abortion’ in Rebecca Cook et al (eds), *Abortion Law in Transnational Perspective* (PENN 2014) 13. Ruth Rabio-Marin, ‘Abortion in Portugal: New Trends in European Constitutionalism’ in Rebecca Cook et al (eds), *Abortion Law in Transnational Perspective* (PENN 2014) 36; Rachel Rebouche, ‘A Functionalist Approach to Comparative Abortion Law’ in Rebecca Cook et al (eds), *Abortion Law in Transnational Perspective* (PENN 2014) 98. Countries such as Nepal and Colombia have drawn on all three core elements of reproductive rights: dignity and freedom (as self-determination or free development of the individual), equality and health to define the parameters of abortion. Melissa Upreti, ‘Towards Transformative Equality in Nepal. The Lakshmi Dhikta Decision’ in Rebecca Cook et al (eds), *Abortion Law in Transnational Perspective* (PENN 2014) 279.

<sup>42</sup> ‘General Recommendation No. 35’ (n 14) [9(i)], [18], [29(c)] the criminalisation of abortion may amount to torture and cruel, degrading and inhumane punishment; Committee Against Torture, ‘Concluding Observations: Nicaragua’ (2009) CAT/C/NIC/CO/1 [16]; Human Rights Committee, ‘General Comment no. 36 on the right to life (2018) CCPR/C/GC/36 [8] restrictions on abortion should not ‘jeopardise their lives, subject them to physical or mental pain of suffering . . . discriminate against them or arbitrarily interfere with their privacy’.

<sup>43</sup> *Roe v Wade*, 410 US 113 (1973) (US Supreme Court).

<sup>44</sup> 476 US 747 (1986) (US Supreme Court).

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whether to end her pregnancy. A woman's right to make that choice freely is fundamental.’<sup>45</sup> The Canadian Supreme Court relied on procedural rather than substantive rights to freedom and security of the person to decriminalise abortion.<sup>46</sup> Concluding that the state could not impose (procedural) burdens that interfered with women’s physical and psychological integrity, the Court noted: ‘Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman’s body and thus an infringement of security of the person.’<sup>47</sup>

In the US, abortion has generated political and legal battles around appropriate limits to women’s private choices. Thus, the trimester system of *Roe*,<sup>48</sup> as amended by the viability standard of *Casey*,<sup>49</sup> has seen US jurisprudence focus on the extent to which privacy rights can be limited by states’ interests in protecting women’s health or in the ‘potentiality of human life’.<sup>50</sup> While the courts have required clear evidence to demonstrate that conditions imposed on abortion are necessary for women’s health,<sup>51</sup> in practice, this has often resulted in court-endorsed procedures such as waiting periods, referral processes and notification requirements, that act as significant barriers to access.<sup>52</sup> Further, the influence of negative, libertarian ideas has meant that, while state interference in the form of criminalisation and unfair procedures can be prevented, there is no concomitant positive obligation to fund and provide abortion services.<sup>53</sup> In a different context, the Canadian approach, with no further regulation or litigation, has seen widespread acceptance of abortion

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<sup>45</sup> *ibid* 772 (per Blackmun J).

<sup>46</sup> *R v Morgentaler* [1988] 1 SCR 30 (Canadian Supreme Court).

<sup>47</sup> *ibid* 32-33 (per Dickson J).

<sup>48</sup> *Roe* (n 43) 150, 163-66.

<sup>49</sup> *Planned Parenthood of Southeastern Pa. v. Casey*, 505 US 833 (1992) 879 (US Supreme Court).

<sup>50</sup> The state may regulate in the interests of women’s health or foetal life after viability, but may only do so prior to viability if this does not pose an ‘undue burden’ on women’s fundamental right in that it did not have ‘the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable foetus’ (*ibid* [873], [876]-[878]).

<sup>51</sup> *Whole Woman's Health v. Hellerstedt*, 579 US\_\_ (2016).

<sup>52</sup> *Planned Parenthood* (n 49).

<sup>53</sup> Robin West ‘From Choice to Reproductive Justice: De-Constitutionalising Abortion Rights’ (2009) 118 *Yale Law Journal* 1394, 1422-3.

as a private medical procedure between doctor and patient,<sup>54</sup> within its publicly funded universal health care system.<sup>55</sup>

These jurisdictions exemplify the strength and limits of negative concepts of freedom. The rhetorical power of a private sphere of decisional autonomy where women are free to make decisions about their destiny, taking into account their needs and priorities, cannot be underestimated in affirming women's personhood and citizenship. However, the translation of this into meaningful choice and access is, at the very least, dependent upon the extent to which abortion is contested, the nature of the health system that delivers the services and the position of women in relation to this. Thus while it is important to emphasise that abortion should be a private choice of medical procedure; it is rarely enough to hold states to account and secure abortion on request for all women. First, decriminalisation, on its own, does not necessarily lead to a meaningful recognition of reproductive autonomy, especially where laws place conditions and procedures on women seeking abortion. Second, a 'hands off' approach to abortion can fail to account for how women's 'choices', and their ability to act on them are constrained by interpersonal and structural factors, and the multiple, intersecting inequalities that shape women's reproductive lives as a whole. As a result, insufficient attention is paid to inequalities amongst women,<sup>56</sup> and how these affect, and are affected by, lack of abortion access.<sup>57</sup> Overall, a negative approach fails to see that the meaningful exercise of reproductive autonomy should be facilitated by positive state actions. Finally, the constraints of a negative approach to freedom have meant that equality is posed as an alternative framework for abortion rights.<sup>58</sup> As I argue below, a different approach to

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<sup>54</sup> Anne Kingston, 'How Canada's growing anti-abortion movement plans to swing the next federal election' (*MacLeans*, 12 September 2019) <<https://www.macleans.ca/politics/how-canadas-growing-anti-abortion-movement-plans-to-swing-the-next-federal-election/>> accessed 20 April 2019.

<sup>55</sup> Although access to abortion in Canada is uneven across provinces; *ibid.*

<sup>56</sup> Jael Silliman et al, *Undivided Rights: Women of Color Organize for Reproductive Justice* (South End Press 2004); SisterSong 'What is Reproductive Justice' <<https://www.sistersong.net/reproductive-justice/>> accessed 20 April 2019; West (n 53) 1422-23.

<sup>57</sup> As noted by the UN Special Rapporteur on extreme poverty and human rights, 'Country Mission to the United States of America' (2017) A/HRC/38/33/Add.1 [35]: 'Low-income women who would like to exercise their constitutional, privacy-derived right to access abortion services face legal and practical obstacles, such as mandatory waiting periods and long driving distances to clinics. This lack of access to abortion services traps many women in cycles of poverty.'

<sup>58</sup> Nadine Taub, 'Why Afford Constitutional Protection to Reproduction?' in Betty Taylor (eds), *Feminist Jurisprudence, Women and Law: Critical Essays, Research Agenda and Bibliography* (Littleton 1999) 1.

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freedom allows a mutually reinforcing relationship with equality that can enable more transformative outcomes.

### *B. Reproductive Justice*

It is widely understood that decisions to terminate pregnancies are part of a broad set of reproductive choices around ‘the right to have, or not to have, children, and to be afforded the means and information to do so’.<sup>59</sup> As Loretta Ross reminds us, questions of reproductive autonomy lie not only in effective access to, and choice in, contraception, ante-natal and obstetric care, abortion, and so on; but also in understanding the barriers to bearing and raising children experienced by marginalised women, including the criminalisation of reproduction, coerced pregnancy or sterilisation, the stigmatising of teenage mothers, the effects of environmental degradation on fertility, and access to reproductive technology. More broadly she points to the problems of raising children when economic means and social support are inadequate or absent. Thus, reproductive autonomy must be contextually understood, both in interpersonal and structural terms: women’s reproductive choices should be located within ‘a broader analysis of the racial, economic, cultural and structural constraints on [women’s] power’.<sup>60</sup> Important too is Jennifer Nedelsky’s understanding of relational autonomy, namely that individual autonomy is made possible by constructive relationships, and undermined by destructive ones, not only in ‘intimate [and family] relationships . . . [but also in] more distant relationships . . . and social structural relationships such as gender, economic relations and forms of governmental power’.<sup>61</sup> This contextual and relational interpretation recognizes that autonomy differs markedly across groups of women, despite a common vulnerability to gendered subordination. Thus a history of racialised sexual subordination and population control in the US, coupled with a complex and particular socialisation about sexuality and child-bearing, means the experience of black women is often distinctly different to that of white women.<sup>62</sup> In South Africa, racialized poverty and inequality, histories and experiences of population control and abortion access, HIV vulnerability

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<sup>59</sup> Cairo Programme of Action (n 1).

<sup>60</sup> SisterSong (n 56).

<sup>61</sup> Jennifer Nedelsky, *Laws Relations: A Relational Theory of Self, Autonomy and Law* (OUP 2011) 4.

<sup>62</sup> Silliman et al (n 56) xix-xxi. See Sonia Correa and Rosalind Petchesky, ‘Reproductive and Sexual Rights: A Feminist Perspective’ in Gita Sen, Adrienne Germain and Lincoln Chen (eds), *Population Policies Reconsidered: Health Empowerment and Rights* (Harvard Center for Population and Development Studies & International Women’s Health Coalition 1994) 107.

and epidemic levels of gender-based violence affect women differently across race, class, sexuality and so forth. This places intersectionality, as a recognition of interlocking mechanisms of subordination and oppression, at the centre of analysis, focusing attention on women pushed to the margins of society by combinations of race, class, sexuality, disability, poverty, migrancy, rural location and many other bases of oppression, for whom the reality is often one of no, or extremely limited, choice in their reproductive lives as a whole.

Under these circumstances, the achievement of substantive reproductive autonomy for women lies in negative *and* positive state action. Not only must the state refrain from criminalising women, or imposing procedural and substantive burdens on their exercise of choice; it must actively work to enable reproductive autonomy, not only in the provision of accessible and safe abortion on request within comprehensive reproductive healthcare services, but also in social and economic policies and programmes that enable women to make meaningful choices about whether ‘to have, or not have, children’. The core aspiration of reproductive justice is to ensure that everyone, especially those who are poor and marginalized, have the social, political and economic power and resources to make healthy decisions about their gender, bodies and sexualities. Thus, not only is the exercise of autonomy and self-determination indivisible from women’s equality and social rights, especially health; struggles around reproductive autonomy are indivisible from broader social and economic struggles for equality and justice.<sup>63</sup>

### *C. A Bundle of Mutually Reinforcing Reproductive Rights*

A reproductive justice approach suggests that we give substance to one of the original intentions of reproductive rights, namely, that they be viewed contextually, substantively and cumulatively – as mutually reinforcing and complementary reproductive rights. At the heart of this is a substantive and positive idea of freedom or autonomy, that is contextually understood, and that affirms women’s moral agency and bodily integrity by underpinning abortion on request.

This idea of substantive freedom is bound up with substantive equality, both as social equality (recognition) and economic equality (distributive). As feminist scholars have argued, women’s rights to abortion are an instance of substantive equality in which the ability to decide when and whether to have children is a measure of the extent to which women are

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<sup>63</sup> SisterSong (n 56).



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free of stigma and stereotype (especially in relation to motherhood), are able to participate in society and the economy and develop to their full human potential in positive social relationships. Here substantive equality speaks to the conditions that are necessary for the exercise of meaningful reproductive autonomy. However, the use of equality rights, on their own, to justify abortion can run the risk of reinforcing discourses of victimhood, motherhood and disadvantage, identified by Wendy Brown as the ‘paradox of rights’, namely that rights operate to reinscribe traditional notions of gender and sexuality even as they provide protection and some access to resources and benefits.<sup>64</sup> While this is not inevitable, a transformative approach to reproductive rights is strengthened by an independent assertion of reproductive autonomy within a nuanced understanding of substantive equality.<sup>65</sup>

Finally, as detailed by the CESCRC, the right to health encompasses freedom rights and programmatic rights. ‘Freedom rights’ overlap with autonomy rights, while programmatic rights demand positive action for comprehensive and effective health care services for abortion. Properly read, the CESCRC General Recommendation No. 22 proposes an integrated and mutually supportive relationship between freedom, equality and health rights.

In jurisprudential terms, a reproductive justice approach encompasses five principles to engage reproductive rights cumulatively and collaboratively: First, a substantive and positive understanding of women’s reproductive autonomy within their particular contexts. Second, this idea of freedom is inextricably related to a substantive idea of equality, that emphasises the unequal conditions in which reproductive autonomy is exercised and allows us to unpack and remedy the complex fault-lines of inequality that structure the choices of different women. Third, socio-economic rights, and especially the right to health, should be interpreted with due regard to affirming autonomy and addressing the inequalities that shape women’s access to reproductive healthcare services. Fourth, a substantive, contextual and intersectional analysis of all rights will sustain a jurisprudence that places disadvantaged women at the centre. Fifth, remedies must recognise the negative and positive obligations of government to facilitate abortion rights and develop the legal, social and economic conditions that enable reproductive justice. With these two models in mind, I evaluate South African jurisprudence to suggest that it

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<sup>64</sup> Wendy Brown, ‘Suffering Rights as Paradoxes’ (2000) 7 *Constellations* 230, 230-1.

<sup>65</sup> For an example of the relationship between self-determination and equality, *Lakshmi Dhikta v. Nepal* (2009) WO-0757, 2067 (Supreme Court of Nepal) See ‘Lakshmi Dhikta Case Summary and Translated Excerpts’ <<https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi%20Dhikta%20-%20English%20translation.pdf>> accessed 20 April 2019.

generally aligns with an inclusive reproductive choice perspective and propose how it might be changed.

#### 4. *Constitutional Rights and Abortion Law in South Africa*

The 1996 South African Constitution<sup>66</sup> is celebrated as a powerful statement on gender equality and women's rights, including rights against unfair discrimination based on sex, gender and sexual orientation and rights to dignity, privacy, life and freedom and security of the person.<sup>67</sup> The latter specifies in section 12(2) that 'everyone has the right to bodily and psychological integrity, which includes the right (a) to make decisions concerning reproduction [and] (b) to security in and control over their body'. Section 27 of the Constitution further guarantees the right of access to healthcare services, including reproductive healthcare. Both provisions drew on the global framework of reproductive rights established in the ICPD.<sup>68</sup>

Parallel to the development of this Constitution, the South African Parliament enacted the CTOPA in 1996 to provide abortion on request up to twelve weeks of pregnancy and on broadly specified grounds, in consultation with a medical practitioner, between thirteen and twenty weeks.<sup>69</sup> By including social and economic grounds, the enumerated

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<sup>66</sup> The 1996 Constitution replaced the 'Interim Constitution' (The Constitution of the Republic of South Africa Act 200 of 1993) which was the product of the negotiated settlement of 1993 and gave rise to the first democratic elections in 1994.

<sup>67</sup> Sections 9, 10, 11 and 14.

<sup>68</sup> Catherine Albertyn, 'Women and Constitution-Making in South Africa' in Helen Irving (ed), *Constitutions and Gender* (Edward-Elgar 2017) 47, 66-72.

<sup>69</sup> The relevant sections read as follows:

2. (1) A pregnancy may be terminated-

(a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;

(b) 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-

(i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman ...

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grounds were intended to be sufficiently open-ended to effectively allow abortion on request, in private consultation with one’s doctor. Justified by a dominant public health narrative, as well as feminist arguments on substantive equality, reproductive choice and bodily integrity,<sup>70</sup> the CTOPA sought to widen access to safe, legal abortion. By conferring rights to choose whether to terminate a pregnancy, the Constitution and CTOPA affirm women’s moral autonomy, personhood and bodily integrity. Rather than being subjects of medical and legal decisions by others,<sup>71</sup> women are formally ascribed agency as citizens and rights-bearers. Rather than stigmatizing women as immoral and criminal, South African law decriminalised abortion and entrenched substantive abortion rights, ahead of the global curve, and at the optimistic birth of a Constitution that envisaged an inclusive, non-racial and non-sexist democracy, based of equality, dignity, freedom and social justice.<sup>72</sup> It has been argued that such moments are potentially transformative, pointing to the possibilities of disrupting oppressive gendered relations and according women greater practical control over their lives.<sup>73</sup> Indeed, as access expanded and maternal mortality and morbidity declined in the first decade of the CTOPA, many women were able to do just that.<sup>74</sup>

Over the past 22 years, the CTOPA has withstood attempts to strike it down in the courts and to dilute its provisions in Parliament, as the Constitution has been mobilised to support reproductive rights.<sup>75</sup> As discussed below, the courts have generally followed a more traditional reproductive choice approach, often influenced by politics, the legal strategies of lawyers and amici, judicial reasoning and precedent, and the ‘optics’ of a particular case (how is the matter characterised and will the applicant induce judicial concern?).

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(c) 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-

- (i) would endanger the woman's life;
- (ii) would result in a severe malformation of the foetus; or
- (iii) would pose a risk of injury to the foetus.

<sup>70</sup> Albertyn, ‘Claiming and Defending’ (n 23) 433-39.

<sup>71</sup> The Abortion and Sterilisation Act 2 of 1975 allowed abortion under extremely restrictive circumstances, subject to the scrutiny and consent of medical practitioners, hospital officials and magistrates.

<sup>72</sup> Preamble, Section 1 Constitution of South Africa, 1996.

<sup>73</sup> Albertyn, ‘Women and Constitution-Making’ (n 68).

<sup>74</sup> Abortion-related morbidity and mortality decreased by 91% between 1997 and 2002. Rachel Jewkes and Helen Rees, ‘Dramatic Decline in Abortion Mortality Due to the Choice in Termination of Pregnancy Act’ (2005) 95 South African Medical Journal 250.

<sup>75</sup> Albertyn, ‘Claiming and Defending’ (n 23) 441-3.

## A. Defending the CTOPA in the High Court

Two constitutional challenges to the CTOPA by anti-abortion groups elicited a consciously narrow, defensive response from the state and feminist groups that affirmed the core right to reproductive autonomy but did not engage the detail of, or develop, abortion rights. Here the strategic choice was to minimise evidence and argument in defence of the newly won law in order to avoid a ‘show trial’ on abortion, resulting in narrower ‘reproductive choice’ arguments.

### 1. Abortion as unconstitutional? *Christian Lawyers Association v Minister of Health I*

The Christian Lawyers Association (CLA) attacked the foundation of the abortion right by claiming that the CTOPA violated section 11 of the Constitution: the right to life. The CLA argued that section 11 was held ‘from the moment of conception’ and protected the right to life of ‘unborn children’.<sup>76</sup> The Minister of Health raised an ‘exception’ for the claim to be dismissed as having no basis in law: Section 11 could not be interpreted to include a foetus as a constitutional rights-bearer, especially in light of constitutional rights that supported women’s right to choose abortion. The judge agreed. In the absence of an express inclusion of foetal rights, and in view of the Constitution’s explicit reference to the right to make decisions concerning reproduction and to security in and control over one’s body in section 12(2), as well as rights to equality, dignity, privacy and healthcare, the Constitution clearly granted women the right to choose to terminate pregnancies.<sup>77</sup> The judge found support in comparative law, citing US (*Roe v Wade*) and Canadian (*Tremblay v Daigle*)<sup>78</sup> cases as precedent for his conclusion that a foetus does not enjoy a constitutional right to life.<sup>79</sup>

Given the ideological framing of the claim, the matter turned on the question of foetal rights and says little about women’s rights, beyond asserting them as a constitutional basis for reproductive choice, and nothing about any balance that might need to be struck between women’s rights and the state’s interests in protecting potential life. It is a powerful, but abstract, endorsement of women’s reproductive rights.

<sup>76</sup> *Christian Lawyers Association I* (n 5) 1117-18.

<sup>77</sup> *ibid* 1122-23.

<sup>78</sup> (1989) 62 DLR (4<sup>th</sup>) 634 (Canadian Supreme Court).

<sup>79</sup> *Christian Lawyers Association I* (n 5) 1125-26.

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**2. Defending adolescent autonomy: *Christian Lawyers Association v Minister of Health II***

Six years later in 2004, the CLA challenged the CTOPA’s provisions that allowed adolescent girls to choose abortion without the consent of, or consultation with, their parents.<sup>80</sup> The CLA argued that, in fact, girls below eighteen were incapable of taking informed decisions on abortion, and should be subject to parental consent or control, undergo mandatory counselling and submit to a period of reflection before acting on their decision. In the absence of this, the CTOPA violated the state’s constitutional obligation, in section 28, to act in the best interests of the child. Again, the Minister objected, alleging that the claim had no basis in law.

The court concluded that ‘[t]he cornerstone of the regulation of the termination of pregnancy of a girl and indeed of any woman under the Act is . . . her “informed consent”. No woman, 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.’<sup>81</sup> This meant that girls who had the emotional and intellectual capacity to consent, as determined by a medical practitioner, could do so regardless of their age. This was supported in common law and the Constitution. The court accordingly dismissed the claim as having no basis in law.

This case provided an opportunity to elaborate the principles underlying the right to terminate pregnancies in the CTOPA. Here the court found that the ‘fundamental right to individual self-determination . . . lies at the very heart and base of the constitutional right to termination of pregnancy’.<sup>82</sup> This right is not only supported by the section 12(2); but also by section 27(1)(a) providing for access to reproductive healthcare; the rights to dignity and privacy in sections 10 and 14. In support of its conclusions, the court again draws on US and Canadian case-law. In the former, it highlights the right of privacy, bound up with dignity and autonomy, as a right to be free from government intrusion.<sup>83</sup> The Court draws on Canadian jurisprudence to emphasise the link between decisional autonomy, free from state interference, and physical and psychological integrity. It concludes that South Africa’s Constitution is even more explicit in protecting abortion rights than US and Canadian jurisprudence, thus hinting at, but not engaging in, further development of the rights.<sup>84</sup>

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<sup>80</sup> Sections 5(2) and (3) of the CTOPA read with the definition of ‘woman’ in section 1.

<sup>81</sup> *Christian Lawyers Association II* (n 5) 514.

<sup>82</sup> *ibid* 519.

<sup>83</sup> The court cites Blackmun J in *Thornburg* (n 44).

<sup>84</sup> *Christian Lawyers Association II* (n 5) 527-8.

In *Christian Lawyers Association II*, the section 12(2) right is necessarily asserted in principled and relatively abstract terms to defend the legislation under the preliminary procedure of an exception. It is a crucial recognition of woman's autonomy and personhood as a constitutional basis for abortion, but it remains a negative protection of a sphere of personal autonomy where the state cannot interfere, either by criminalising women's decisions to terminate a pregnancy, or by imposing undue psychological and emotional burdens on the exercise of that decision. Finally, it recognises the presence of a bundle of rights defending abortion in the Constitution, but does not spell out their content and relationship, beyond listing intersecting rights of freedom, dignity, privacy and healthcare that support personal autonomy.

### *B. Developing Section 12(2) in the Constitutional Court: Reproductive Autonomy and Surrogacy in AB v Minister of Social Development*

In 2016, the Constitutional Court finally addressed the right to 'physical and psychological integrity', in particular the right to 'make decisions concerning reproduction' in section 12(2)(a). The question facing the court in *AB v Minister of Social Development* was whether a legal provision that prohibits surrogacy, if there is no biological or genetic link between the commissioning parent/s and the child, violates the commissioning parent/s' right to reproductive autonomy.

In its first interrogation of freedom since 1996,<sup>85</sup> the Court agrees that the exercise of autonomy is a 'necessary, but socially embedded, part of the value of freedom',<sup>86</sup> which broadly protects 'morally autonomous human beings [and their ability] independently . . . to form opinions and act on them'.<sup>87</sup> 'The value recognises . . . our capacity to assess our own socially-rooted situations, and make decisions on this basis. By exercising this capacity, we define our natures, give meaning and coherence to our lives, and take responsibility for the kind of people that we are.'<sup>88</sup> In this sense, people are not abstract, atomised individuals: 'to be autonomous is to be socially and politically connected, rather than an agent of unfettered individual choice'.<sup>89</sup> This recognition of autonomy in the context of one's

<sup>85</sup> *Ferreira v Levin* 1996 (1) SA 984 (South African Constitutional Court).

<sup>86</sup> *AB* (n 5) [51].

<sup>87</sup> *ibid* [50] citing O'Regan J in *NM v Smith* 2007 (5) SA 250 (South African Constitutional Court) [145].

<sup>88</sup> *ibid* [52].

<sup>89</sup> *ibid* [51].

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social situation and community signifies a step towards a contextual and intersectional understanding of freedom. However, its implications remain undeveloped as the judges split on the detail of section 12(2).

Drawing on the Court’s 1996 interpretation of section 11 of the Interim Constitution, whose provisions were limited to detention without trial, torture, and cruel and degrading punishment, the majority Nkabinde judgment finds the *primary* meaning of section 12 still to be the negative protection of physical integrity.<sup>90</sup> This, together with an incorrect understanding that the two *CLA* judgments and comparative jurisprudence prioritise ‘bodily integrity’ in protecting women’s abortion rights,<sup>91</sup> leads Nkabinde J to conclude that section 12(2)(a) *only* protects reproductive decision-making that affects ‘bodily integrity’ and cannot be extended to ‘psychological integrity’. As the applicant’s body would not be physically affected by the anticipated pregnancy, the decision to have a child via the surrogacy agreement could not be viewed as constitutionally protected reproductive autonomy.<sup>92</sup>

Although the majority endorse women’s rights to abortion and bodily integrity as a core meaning of section 12(2)(a) and signal respect for women’s right to make abortion decisions; their interpretation remains a narrow, abstract and negative protection of the right. First, the equation of reproductive autonomy with physical integrity excludes a wider set of actors that might seek protection under this right, including men, infertile parents and women who suffer psychological or social, but not physical, harm as a result of state (in)activity.<sup>93</sup> This flies in the face of the understanding that reproductive autonomy encompasses the right to have *and* not to have children. Second, limiting reproductive autonomy to protecting bodily integrity fails to understand the complex nature of reproductive decisions. Whilst women’s claims to bodily integrity are a critical part of autonomy, to equate the two is to fail to see the personal, social and economic context in which women exercise autonomy and the multiple psychological, social and economic effects of denying women such autonomy.<sup>94</sup> As Petchesky notes: ‘abortion has to do with women’s

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<sup>90</sup> *ibid* [77]; [309].

<sup>91</sup> As stated in the first and minority judgment, the second and majority judgment misreads comparative law as equating violations of reproductive freedom with the denial of physical integrity only, whereas the foreign cases cited include psychological and emotional harm within their understanding of freedom. *ibid* [78]; [80].

<sup>92</sup> *ibid* [309]-[315].

<sup>93</sup> See the minority judgment *ibid* [79].

<sup>94</sup> In contrast, *H v Fetal Assessment Centre* 2015 (2) SA 193 (South African Constitutional Court) [59] ‘having regard to the fundamental right of everyone to make decisions concerning reproduction . . . the harm may simply be seen as an infringement of the right of the parents to exercise a free and informed choice in relation to these interests’.

sexual and moral autonomy as much as their physical integrity',<sup>95</sup> and it is in the cumulative violation of women's autonomy that the harm lies.

In the end, the judgment straitjackets a complex idea of reproductive autonomy into a classic liberal idea of abstract physical integrity. The inattentiveness to the context and nature of reproductive autonomy is further highlighted by the finding in the equality analysis that it is not the applicant's infertility that disqualified her from surrogacy, but her choice not to exercise other legal options available to her. Echoing the libertarian ideas of abstract free choice articulated in the much criticised judgment of *Volks v Robinson*,<sup>96</sup> Justice Nkabinde suggests that:

*the parent still has available options afforded by the law: a single parent has the choice to enter into a permanent relationship with a fertile parent, thereby qualifying the parent for surrogacy. If the infertile commissioning parents, or parent, decide not to use the available legal options, they have to live with the choices they make.*<sup>97</sup>

It is disappointing that the powerful tug of a narrow libertarian idea of freedom has influenced the Court's interpretation of autonomy in section 12(2)(a). While some might attribute this to the apparently privileged nature of the applicant and her claim,<sup>98</sup> it is nevertheless out of kilter with the extant jurisprudence, which has endorsed a wider approach to individual autonomy and self-determination within mutually reinforcing individual rights to dignity, privacy and equality (as a right to equal dignity).<sup>99</sup> As initially developed in sexual orientation discrimination cases; privacy, dignity and equality protect a sphere of personal autonomy that includes 'intensely significant aspects of one's personal life'<sup>100</sup> such as choices of intimate partners,<sup>101</sup> teenage sexuality<sup>102</sup> and decisions around

<sup>95</sup> Petchesky (n 4) 398.

<sup>96</sup> 2005 (5) BCLR 446 (South African Constitutional Court).

<sup>97</sup> *AB* (n 5) [302].

<sup>98</sup> See Marius Pieterse, "Finding for the Applicant": Individual Equality Plaintiffs and Group-based Disadvantage' (2008) 24 South African Journal on Human Rights 397.

<sup>99</sup> See Henk Botha 'Human Dignity in Comparative Perspective' 2009 20 Stellenbosch Law Review 171, 204.

<sup>100</sup> *S v Jordan* 2002 (6) SA 642 (South African Constitutional Court) per O'Regan and Sachs JJ [76].

<sup>101</sup> *National Coalition for Gay and Lesbian Equality v Minister of Justice* (1999) 1 SA 6 (South African Constitutional Court).

<sup>102</sup> See *Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development* 2014 (2) SA 168 (South African Constitutional Court) [64] 'Privacy fosters human dignity insofar as it is premised on, and protects, an individual's entitlement to "a sphere of private intimacy and autonomy". I am therefore of the view that, to the extent that



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health status,<sup>103</sup> but does not extend, for example, to decisions on sex work.<sup>104</sup> In all cases, however, this idea of autonomy is a right to left alone, and mostly concerns the obligations of the state to refrain from interference by way of punitive laws.

The minority Khampepe judgment is more in line with this jurisprudence, finding that ‘reproductive decision-making’ protects autonomy more broadly, where the harm is constituted by infringements on the exercise of free choice that have personal and social effects and involve *both* bodily and psychological integrity.<sup>105</sup> Thus, if the state puts legal barriers in the way of reproductive decisions that result in psychological – but not bodily – harm, the right is still violated.<sup>106</sup> Reproductive decision-making includes decisions to have a child by means of surrogacy,<sup>107</sup> and with sufficient evidence of psychological harm to the applicant and others similarly situated, Khampepe J concludes that the provision is an unjustifiable violation of her right to reproductive decision-making.<sup>108</sup> The minority judgment’s idea of decisional autonomy could form the basis for further development. Although it still speaks to the negative protection of autonomy – the state should not legislate to place obstacles in the way of a reproductive decisions – and is not yet precedent for a more positive protection of autonomy and freedom; it does not exclude this. Moreover, by introducing the idea of a ‘socially embedded’ value of freedom, there is ground for future substantive development. In thinking how that might be done, I return to an earlier case, *Minister of Health v Treatment Action Campaign*,<sup>109</sup> and the idea of reproductive justice.

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they encroach on the right to privacy, sections 15 and 16 constitute a related limitation of adolescents’ dignity rights.’

<sup>103</sup> In *NM* (n 87) [40] in explaining why the non-consensual disclosure of confidential medical information, including the HIV status of the applicants, can found a claim for damages, Madala J states as follows: ‘Private and confidential medical information contains highly sensitive and personal information about individuals. *The personal and intimate nature of an individual’s health information, unlike other forms of documentation, reflects delicate decisions and choices relating to issues pertaining to bodily and psychological integrity and personal autonomy.*’ (emphasis added)

<sup>104</sup> *Jordan* (n 100) [93].

<sup>105</sup> *ibid* [78].

<sup>106</sup> *ibid* [70]-[72].

<sup>107</sup> *ibid* [74]-[75].

<sup>108</sup> *ibid* [82]-[97], [214].

<sup>109</sup> *TAC* (n 6).

## ***5. Re-Interpreting Minister of Health v TAC: From Reproductive Choice to Reproductive Justice?***

The much celebrated case of *Minister of Health v Treatment Action Campaign (TAC)* successfully challenged the Mbeki government's denialism on HIV/AIDS and the state's recalcitrance in providing antiretroviral therapy (nevirapine) to women in public hospitals to reduce the risk of perinatal HIV transmission.<sup>110</sup> A little-told story of this case is the marginalisation of reproductive autonomy and the agency of poor, black HIV positive women, as a constitutional basis for accessing this treatment.<sup>111</sup> After briefly describing the case, I reflect on two perspectives on how the case could have centred women's reproductive autonomy, within an integrated bundle of reproductive rights, and how this might have affected its normative and practical outcomes.

The case was launched on a number of grounds, leading with the 'rights of women and their babies to access health care services, including reproductive health care (section 27)',<sup>112</sup> children's rights to basic healthcare services (section 28),<sup>113</sup> followed by unfair discrimination against poor, black women (section 9),<sup>114</sup> the constitutional right to life of babies (section 11)<sup>115</sup> and 'the right of the women concerned to make choices and decisions concerning reproduction' (section 12).<sup>116</sup> The Constitutional Court case focused only on section 27: (i) the reasonableness of government's limited roll-out of a programme to prevent perinatal transmission, and (ii) whether section 27 required government to provide 'an effective, comprehensive and progressive programme for the prevention of mother-to-child transmission of HIV throughout the country'.<sup>117</sup> After evaluating the voluminous evidence, the Court found

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<sup>110</sup> Mark Heywood, 'Preventing Mother-to-Child HIV Transmission in South Africa: Background Strategies and Outcomes of the Treatment Action Campaign Case Against the Minister of Health' (2003) 19 *South African Journal on Human Rights* 278.

<sup>111</sup> Catherine Albertyn and Shamim Meer, 'Citizens or Mothers? The Marginalization of Women's Reproductive Rights in the Struggle for Access to Health Care for HIV-Positive Pregnant Women in South Africa' in Maitrayee Mukhopadhyay and Shamim Meer, (eds) *Gender, Rights and Development: A Global Sourcebook* (KIT 2009) 27; Catherine Albertyn, 'Gendered Transformation in South African Jurisprudence: Poor Women and the Constitutional Court' (2011) 3 *Stellenbosch Law Review* 591.

<sup>112</sup> *Treatment Action Campaign v Minister of Health* (Transvaal Provincial Division) Applicants' Founding affidavit, August 2001 [268]; [269] (on file with author).

<sup>113</sup> *ibid* [270].

<sup>114</sup> *ibid* [271]-[272].

<sup>115</sup> *ibid* [273].

<sup>116</sup> *ibid* [264].

<sup>117</sup> *TAC* (n 6) [4]-[5]; [18].

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government’s inaction to be unreasonable and unconstitutional on several grounds. It concluded that section 27 ‘require[d] the government to devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their new-born children to have access to health services to combat mother-to-child transmission of HIV’.<sup>118</sup> It had failed to do so by ‘exclud[ing] those who could reasonably be included where such treatment [wa]s medically indicated to combat mother-to-child transmission of HIV’.<sup>119</sup> The Court ordered government to remove all restrictions and make nevirapine available where medically indicated, and to take reasonable measures to expand the programme.<sup>120</sup>

At one level, the exclusive focus on health rights and health systems and policy is unsurprising given the complexity of the case and the plethora of evidence on issues such as feasibility, efficacy and safety, as well as the ability of the health system to administer the programme effectively (capacity, budget, human resources, etc.). However, underlying these more technical issues, was the normative and legal characterisation of the case as ultimately directed at enabling the public health system to save the lives of infants, rather than to enhance the reproductive choices of women to give birth to healthy children. Absent in the Constitutional Court judgment is any meaningful reference to the reproductive autonomy of women in public hospitals, beyond a single mention of the capacity of hospitals to provide ‘counselling . . . to the mother to enable her to take an informed decision as to whether or not to accept the treatment recommended’ and reference to ‘the rights of pregnant women and their new-born children to have access to health services’ in the order.<sup>121</sup>

Of course, one must be mindful of the politics of the *TAC* case, where its characterisation as a campaign to ‘save babies’ was strategically identified as most likely to win judicial sympathy. However, this meant that the judgment, while undoubtedly laudable, ends up casting poor women as victims and dependants, their autonomy subordinated to the overriding goal of treatment to save the lives of their children. In rendering the subjectivity of women invisible, the jurisprudence that decisional autonomy is central to self-determination is set to one side, and women are indirectly stigmatized as vessels of reproduction rather than as rights-bearing citizens.<sup>122</sup> This approach reinforces, rather than undermines, ‘the ethical and legal inequalities inherent in a societal structure that places more value on a women’s reproductive capacity than her . . . individual

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<sup>118</sup> *ibid* [135].

<sup>119</sup> *ibid* [125].

<sup>120</sup> *ibid* [135].

<sup>121</sup> *ibid* [69]; [135].

<sup>122</sup> Albertyn, ‘Gendered Transformation’ (n 111) 599.

wellbeing'.<sup>123</sup> The notion of empowering women to make reproductive decisions to give birth to healthy children is absent in the judgment.

### A. *TAC Re-Imagined*

In imagining how the *TAC* case could have centred the section 12(2)(a) right to reproductive decision-making within the rights of access to reproductive healthcare and equality, I briefly outline two approaches. First, I draw on existing jurisprudence on autonomy to delineate a 'reproductive choice' perspective, followed by an alternative 'reproductive justice' perspective which seeks to capture the complexities of women's place in society (especially around race and class in South Africa), their differing ability to exercise meaningful choice and act in accordance with their decisions, and the multiple and intersecting social, economic and political inequalities that differentially structure women's autonomy and self-determination.

In a *reproductive choice* approach, the Court's dominant approach to decisional autonomy and dignity supports the argument that women's right to choose to take ante-retroviral drugs to ensure the birth of a healthy infant is a decision that lies within an individual sphere of decisional autonomy, protected by 'reproductive decision-making' rights in section 12(2)(a). Moreover, the particular facts of the *TAC* case could sustain the development of 'reproductive decision-making' in section 12(2)(a) to include the ability to parent with safety, and to be given the choices that are necessary to prevent further risks of transmission via breastfeeding. First, the obstacles to accessing treatment to prevent perinatal transmission violate women's reproductive decisions to give birth to, and parent, healthy children and, second, the absence of a comprehensive package to assist women in making decisions after birth (especially in relation to breastfeeding) similarly limits their autonomy. In both instances, the violation of the section 12(2)(a) autonomy right requires positive measures in the form of such a comprehensive package before and after birth.

While the judgment's detailed and compelling findings on access to treatment under section 27(1) would apply, the prior acknowledgment of reproductive autonomy provides a normative frame that places women's autonomy at the centre of reproductive health care, furthering the idea that women should be enabled to make real choices about their sexuality, reproduction and fertility. Rather than cast as mothers, whose primary role it is to bear and raise children, the centrality of reproductive choice sees

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<sup>123</sup> C Eyakuze et al, 'From PMTCT to a More Comprehensive AIDS Response for Women: A Much-Needed Shift' (2008) 8 *Developing World Bioethics* 33, 36 writing about the intersection of HIV and pregnancy.

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women as independent and equal agents and rights-bearing citizens, empowered to act to secure their bodily and moral autonomy and make choices on how they wish to parent. This idea of reproductive autonomy is critical to an ideological and policy context concerning HIV/AIDS that affirms ‘the rights of a woman to choose when and whether to have . . . sex, to act to protect herself from HIV, to choose whether to have children, and to be entitled to treatment in her own right’.<sup>124</sup>

Such arguments do not require additional evidence and can be made on the basis of what was available in the case and evaluated in the judgment. What they offer is a development of section 12(2), consistent with the Court’s broad jurisprudence on autonomy, its positioning as the leading right at play, and the recasting of the section 27(1) argument to recognise that it is primarily a women-centred right of access to reproductive decision-making that is violated, rather than a general right to health. Here, I suggest that the Court work with both autonomy and health rights, rather than section 27(1) alone. By maintaining a strategic consistency with the jurisprudence, whilst also developing the meaning of reproductive decision-making, and highlighting the positive obligations that flow from it, this approach has some prospects of success.

As with the CTOPA judgments, it retains the normative power of affirming women’s autonomy and does not explicitly adopt an intersectional approach that centres poor, black women. Such a *reproductive justice* approach requires a more detailed exposition of the specific nature and context of women’s reproductive choices in the public health sector. This would start with a recognition of the gendered and intersectional nature of the HIV epidemic, and the manner in which women’s decision-making is contextual, relational and constrained.

By 2000, it was apparent that the HIV epidemic was literally and metaphorically playing out on the bodies of poor, black women. The complex mix of poverty and gendered inequalities that drove the epidemic<sup>125</sup> meant that young, poor and black women were most at risk of being infected and affected by HIV.<sup>126</sup> These women also bore the burden of blame in society, as they become the scapegoats for a range of social ills from HIV/AIDS to teenage pregnancies to abortion.<sup>127</sup> Underlying this

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<sup>124</sup> Marion Stevens, ‘Sacrificing the Woman for the Child’ (2008) 28 *Rhodes Journalism Review* 60, 60-61 criticises HIV policy for its focus on women as ‘vessels of reproduction’.

<sup>125</sup> See Mark Hunter, *Love in the Time of AIDS: Inequality, Gender and Rights in South Africa* (Indiana University Press 2010) 24-28.

<sup>126</sup> *ibid.*

<sup>127</sup> See Suzanne Leclerc-Madlala, ‘Virginity Testing: Managing Sexuality in a Maturing HIV/AIDS Epidemic’ (2001) 15 *Medical Anthropology Quarterly* 533; Saadhna Panday et al, ‘Teenage Pregnancy in South Africa: With a Specific Focus on School-going Learners’ (2009) 26-28 <<https://hivhealthclearinghouse.unesco.org/library/documents/teenage-pregnancy-south-africa-specific-focus-school-going-learners>> accessed 20 April 2018.

attribution of blame are gendered stereotypes which deepen and reinforce women's unequal position in our society:<sup>128</sup> women are alternatively viewed as promiscuous and responsible for what happens to them (as if their sexual and reproductive choices are unfettered), objectified (and rendered vulnerable to violence) and patronised as victims and dependents (with little or no agency). Either way, their autonomy and equality are undermined, and the personal, social and economic circumstances in which they seek to exercise reproductive decision-making are misunderstood or ignored.

By surfacing these conditions and constraints, content is given to sections 12(2) and 27(1) with reference to the particular needs of poor black women, in a manner that challenges the lure of libertarian freedom in our law. Section 12(2) is nudged toward a contextual and substantive understanding of reproductive autonomy, including the idea that women make 'relational' decisions with due regard to their positions within a series of relationships and collectives, made up of children, family, community (including religious communities) and the state.<sup>129</sup> Section 27(1)(a) is understood with reference to the multiple intersecting barriers that structure women's ability to access reproductive healthcare services. In both instances, the right is 'socially embedded' within a specific understanding of the power relations that influence its exercise.<sup>130</sup>

The particular facts in *TAC* advance a broader understanding of reproductive autonomy and justice to include the ongoing obligations of the state to support women's decision to have children and to parent them in a safe environment. Both approaches set out above envisage the reciprocal and mutually reinforcing nature of rights to freedom, equality and socio-economic benefits (here the right to reproductive health care). Although space has not allowed the development of equality under section 9, a substantive and contextual approach would clearly strengthen a woman-centred interpretation. As with abortion, reproductive autonomy is simultaneously and necessarily an individual right and a social need. As *TAC* illustrates, to attend to the social need without affirming woman's individual rights is to subordinate women's autonomy to the needs of others and to reinforce their inequality. A reproductive justice approach explicitly seeks to shift power and resources towards women marginalised by race, class etc. The *TAC* remedies went some way to achieving this in practical terms, by opening access to treatment to prevent perinatal

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<sup>128</sup> David Everatt, 'The Underserving Poor: Poverty and the Politics of Service Delivery in the Poorest Nodes of South Africa' (2008) 35 *Politikon* 293, 315-16.

<sup>129</sup> See Rosalind Petchesky, 'Comparing Across and Within Differences' in Rosalind Petchesky & Karen Judd (eds), *Negotiating Rights: Women's Perspectives across Countries and Cultures* (Zed 1998) 295, 302-3.

<sup>130</sup> This was noted, but not developed, in *AB* (n 5) [50]-[51].

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transmission and mandating the state to develop a comprehensive package. However, while the remedies directed resources towards the needs of women, the judgment completely failed to address the power relations underpinning the issue. In centring women’s reproductive autonomy, both the above approaches shift power towards women in a normative and practical sense. However, it is in the specificity of the reproductive justice approach that the possibilities of greater transformation lie.

### *6. Conclusion: Reproductive Justice and Implementing the CTOPA*

Choices in law and politics are always made in context, and transformative outcomes are not always possible. In many instances, compromises are made, politics intervene, and progress is incremental, extending rights and legal protection, without fundamentally disrupting gendered norms and unequal power relations. Like international and comparative law, the idea of reproductive autonomy in South African jurisprudence is limited to a negative protection of individual choices against state incursions. This protects an important core of reproductive decision-making enshrined in the CTOPA, which is likely to withstand further attack in courts or in Parliament,<sup>131</sup> and attests to the powerful defensive role of rights when laws are in place.

However, an urgent contemporary need is to address the stagnation, if not decline, in abortion service provision and access,<sup>132</sup> especially across race, class, geographic location<sup>133</sup> and other vectors of disadvantage. This is attributed to a combination of state inaction (such as failure to provide information, designate and staff clinics, enable medical abortion, procure

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<sup>131</sup> A recent attempt to impose restrictions by means of a Private Members Bill was rejected by Parliament, *inter alia* because of its incursions on the choices of poor women. See Tamar Kahn, ‘Emotional Argument by Anti-Abortion ACDP MP Doesn’t Sway Parliament’ (*Business Live*, 27 March 2018) <<https://www.businesslive.co.za/bd/national/2018-03-27-emotional-argument-by-anti-abortion-acdp-mp-doesnt-sway-parliament/>> accessed 20 April 2018.

<sup>132</sup> For example, by 2016, 505 of 3880 public health facilities were designated to provide abortion services, and only 264 did so. Amnesty International, ‘Barriers to Safe and Legal Abortion in South Africa’ (2017) 12-4 <<https://www.amnesty.org/download/Documents/AFR5354232017ENGLISH.PDF>> accessed 21 April 2019.

<sup>133</sup> *ibid* 13; speaks of uneven access across provinces and rural areas. See Karen Trueman and Makgoale Magwentshu, ‘Abortion in a Progressive Legal Environment: The Need for Vigilance in Protecting and Promoting Access to Safe Abortion Services in South Africa’ (2013) 103 *American Journal of Public Health* 397.

drugs and regulate conscientious objection),<sup>134</sup> inadequate formal rules,<sup>135</sup> the operation of powerful informal rules and practices, especially around stigma and conscientious objection.<sup>136</sup> These factors have also exacerbated high rates of unsafe and illegal abortion.<sup>137</sup> Overcoming these problems requires political *and* legal engagement, thus providing opportunities for building on emerging ideas of reproductive justice<sup>138</sup> and seeking transformative outcomes. This article suggests that one way to do this is to develop and reconstruct mutually reinforcing reproductive rights that resonate with the original, more radical, aspirations of the early 1990s and some recent international developments. Underpinned by an idea of reproductive justice, and the need to centre those on the margins, this requires interpretations of abortion rights that connect a contextual, relational and intersectional understanding of women's autonomy and self-determination, with substantive equality and social rights. Overall, these should be based on normative claims and practical remedies that seek to dislodge and dismantle systemic inequalities.

The re-imagined *TAC* provides some guidance to transformative litigation on implementation. Thus, evidence of the multiple limitations and barriers to exercising choice in terms of the CTOPA could ground a conceptual development of section 12(2) of the Constitution (within a bundle of rights) to recognise the contextual and constrained nature of women's choices, solidify normative standards of self-determination and reproductive autonomy, and mandate positive action by the state to enable meaningful reproductive decision-making, regardless of race, class, geographical location etc. This would link directly to section 27(1)(a)'s guarantee of access to reproductive health care services, where evidence of implementation failure might show not only a failure of progressive realisation, but a regression in the delivery of reproductive health care services to women using in public sector clinics and hospitals, especially in rural areas. This requires due attention to the dynamic context in which

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<sup>134</sup> Amnesty International (n 132); Jane Harries et al, 'Conscientious Objection and its Impact on Abortion Service Provision in South Africa: A Qualitative Study' (2014) 11(1) *Reproductive Health* 16.

<sup>135</sup> National Guidelines to implement the CTOPA are only being developed in 2018: National Department of Health, 'National Guideline for Implementation of the Choice on Termination of Pregnancy Act' (2018) (draft on file with author).

<sup>136</sup> See Harries et al (n 134).

<sup>137</sup> Rachel Jewkes et al, 'Why are Women Still Aborting Outside Designated Facilities in Metropolitan South Africa' (2005) 12 *British Journal of Obstetrics and Gynaecology* 1236; Rebecca Hodes, 'The Culture of Illegal Abortion in South Africa' (2016) 42 *Journal of Southern African Studies* 79.

<sup>138</sup> See, for example, the reproductive justice approach of the Sexual and Reproductive Justice Coalition in South Africa <<https://srjc.org.za/>> accessed 20 April 2019.



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abortion services are provided or refused, the complexity of reasons for lack of access, and the different kinds of barriers faced by different women.

In addition, the section 9 right to equality would emphasise not only that a failure in implementation discriminates against women in general, by continuing to stigmatise them for seeking abortions and by disadvantaging them in the social and economic consequences of unwanted pregnancies; but also that these burdens fall disproportionately on particular groups of women defined intersectionally by race, class, age, geographic location etc. Finally, detailed normative, practical and structural remedies can be devised to mandate government to put in place procedures, policies, protocols, facilities and budgets to fulfil their legal and constitutional obligations to provide safe and accessible abortion services.

Whether this is possible, in the end, will depend on politics. As many have pointed out, successful rights strategies need to be embedded in wider political struggles for social justice.<sup>139</sup> Indeed, the ‘reproductive justice’ approach highlights the primary importance of politics in securing rights. Here *TAC* serves as an example of a case that was embedded in a wider mobilisation around the right to accessible and affordable treatment for poor people living with HIV/AIDS.<sup>140</sup> Whilst the stigma and secrecy that attach to abortion in South Africa make a similar mobilisation difficult, it remains important that litigation is firmly embedded within a broader politics that emphasises the particular needs and interests of marginalized women and communities,<sup>141</sup> and develops human rights approaches that address ‘the structural and social conditions influencing women’s abortion decisions and health outcomes, including poverty, weak health and social systems, and stigma’.<sup>142</sup> Of course, the reality of litigation and judicial practice will always tend to more conventional interpretations and compromises. Reproductive justice approaches might not always appear the most strategic in this context. However, even if only in a ‘radical outlier’ role, a more transformative and integrated embrace of reproductive rights should be engaged politically and legally as part of wider feminist struggles for reproductive justice.

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<sup>139</sup> Stuart Scheingold, *The Politics of Rights* (2<sup>nd</sup> ed, University of Michigan Press, 2004) 203-20.

<sup>140</sup> Mark Heywood, ‘South Africa’s Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health’ (2009) 1 *Journal on Human Rights Practice* 14.

<sup>141</sup> Zakiya Luna and Kristin Lukar, ‘Reproductive Justice’ (2013) 9 *Annual Review of Law and Social Science* 327; Sarah London, ‘Reproductive Justice: Developing a Lawyering Model’ (2011) 13 *Berkeley Journal of African American Law and Policy* 71.

<sup>142</sup> Elizabeth Mosley et al, ‘Abortion Attitudes Among South Africans: Findings from the 2013 Social Attitudes Survey’ (2017) *Culture, Health & Sexuality* 1058.