



© 2003 Center for Reproductive Rights

www.reproductiverights.org

formerly the Center for Reproductive Law and Policy



**WOMEN'S REPRODUCTIVE
RIGHTS IN SOUTH AFRICA:**
A Shadow Report

The Center for Reproductive Law & Policy (CRLP)
Women's Health Project, South Africa

June 1998

Prepared for the Nineteenth Session of the Committee on the Elimination of All Forms of
Discrimination Against Women

TABLE OF CONTENTS

Laws and Policies Affecting Women's Reproductive Lives Implementation, Enforcement, and the Reality of Women's Reproductive Lives
--

A. Right to Health Care; Including Reproductive Health Care and Family Planning (Articles 12, 14 (2) (b), (c) and 10(h) of CEDAW)	<i>Page</i>
1. Access to Health Care	1
2. Access to Comprehensive, Quality Reproductive Health Care Services	3
3. Access to Information on Health including Reproductive Health and Family Planning	4
4. Contraception	6
5. Abortion	7
6. Sterilization	9
7. HIV/AIDS and Sexually Transmissible Infections (STIs) and Women	10
8. Adolescent Reproductive Health	13
B. Family Relations (Article 16 of CEDAW)	
1. Marriage and Common Law Marriage	13
2. Divorce and Child Custody	15
3. Early Marriage	16
4. Right to access Family Planning, including Abortion and Sterilization, without Spousal Consent	16
C. Sexual Violence Against Women (Articles 5, 6 and 16 of CEDAW)	
1. Rape and Sexual Crimes	17
2. Domestic Violence	18
3. Violence and/or Coercion in Health Services	19
D. Education and Adolescents (Article 10 of CEDAW)	
1. Access to Education	19
2. Information and Education on Sexuality and Family Planning	21
E. Employment Rights (Article 11 of CEDAW)	

1.	Maternity Leave	22
2.	Protection in Pregnancy	23

INTRODUCTION

This report is intended to supplement, or “shadow,” the report of the government of South Africa to the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW). It has been compiled and written by the Center for Reproductive Law and Policy (CRLP) and the Women’s Health Project of the Centre for Health Policy, Department of Community Health of the University of Witwatersand, South Africa (Women’s Health Project). Given the rapid pace of change in South Africa, many of the realities described in this report are in the process of being addressed in policy and programs. This should be borne in mind while reading this document. In some places in this report, the racial categories of “African,” “coloured,” “white,” and “Indian” are used.¹ These were categories of differential discrimination and privilege used during the apartheid period in South Africa which were often determinative of health status and other social status. It is for this reason that statistical information for these categories is sometimes given.

As has been expressed by CEDAW members, NGOs such as CRLP and the Women’s Health Project can play an essential role in providing credible and reliable independent information to CEDAW regarding the legal status of women, their real life situation, and the efforts made by ratifying governments to comply with the Convention on the Elimination of All Forms of Discrimination against Women (Women’s Convention) provisions. Moreover, if CEDAW’s recommendations can be firmly based in the reality of women’s lives, NGOs can use them to pressure their governments to enact or implement legal and policy changes.

Discrimination against women permeates all societies. Clearly, this discrimination requires urgent action. However, this report is focused particularly on reproductive rights, laws and policies related to such rights, and the realities affecting women’s reproductive rights in South Africa. As such, this report seeks to follow up on the December 1996 “Roundtable of Human Rights Treaty Bodies on the Human Rights Approaches to Women’s Health with a Focus on Reproductive and Sexual Health Rights” held in Glen Cove, New York, by bringing to the attention of treaty-monitoring bodies the human rights dimensions of health issues, with a particular focus on women’s reproductive and sexual health. As articulated at the 1994 International Conference on Population and Development in Cairo, as well as at the 1995 United Nations Fourth World Conference on Women in Beijing, reproductive rights consist of a number of separate human rights that “are already recognized in national laws, international laws and international human rights documents and other consensus documents,” including the

Women's Convention. We believe that reproductive rights are fundamental to women's health and equality and the States Parties' commitment to ensuring them should receive serious attention.

This shadow report links various fundamental reproductive rights issues to the relevant provision(s) of the Women's Convention. Each issue is divided into two distinct sections. The first, shaded section deals with laws and policies in South Africa relating to the issues and corresponding provisions of the Women's Convention under discussion. The information in the first section is mainly obtained from the South Africa chapter of *Women of the World: Laws and Policies Affecting Their Reproductive Lives — Anglophone Africa*, one of a series of reports in each region of the world being compiled by CRLP in collaboration with national-level NGOs. The Women's Health Project collaborated with CRLP and Lawyers for Human Rights, South Africa, on the South Africa chapter and updated it in May 1998 because of the rapid pace of legislative and policy change in South Africa. The second section focuses on the implementation and enforcement of those laws and policies — in other words, the reality of women's lives. The Women's Health Project has provided most of the information included in this section.

This report was coordinated and edited by Katherine Hall Martinez and Maryse Fontus, staff attorneys for CRLP, with the assistance of Catherine Cheng and Alison-Maria Bartolone, and by Marion Stevens, Policy Analyst for the Women's Health Project, with assistance from Meryl Federl, Information Project Officer, and Barbara Klugman, Director.

June 1998

<p style="text-align: center;">Laws and Policies Affecting Women’s Reproductive Lives Implementation, Enforcement, and the Reality of Women’s Reproductive Lives</p>

A. RIGHT TO HEALTH CARE, INCLUDING REPRODUCTIVE HEALTH CARE AND FAMILY PLANNING (ARTICLES 12, 14 (2)(B),(C) AND 10(H))

1. Access to Health Care

Laws & Policies

The government is currently engaged in a “complete transformation” of the health care delivery system.² This transformation is oriented towards the provision of primary health care services — an approach which emphasizes community participation, intersectoral collaboration, and cost-effective care, and in which preventive, promotive, curative, and rehabilitative services are integrated.³ The health system is being restructured around three levels of health authorities. At the national level, a unified Department of Health has been established. Its responsibilities include: providing overall leadership in the formulation of health policy and legislation; developing the capacity of provincial health departments to provide effective health services; and ensuring equity in the allocation of resources to the provinces.⁴

Pursuant to the Constitution, provincial health departments are responsible for providing and regulating health services in their respective provinces, within the framework of national policies and guidelines formulated by the national Department of Health.⁵ At the primary care level, the organization of provincial health systems is centered around health districts.⁶ Primary health care and hospital services in each health district are to be administered by District Health Authorities — unified, integrated health management structures at the local level.⁷ All residents of each district are to have access to district health services, provided by a team of staff specializing in various components of primary health care.⁸ District Health Authorities will be able to supplement the services provided to health system users by entering into contractual arrangements with private sector providers, thus making resources currently available within the private sector more accessible to the broader population.⁹ Services provided within the publicly funded primary health care system include certain family planning services, services for treatment of sexually transmissible infections (STIs), maternal and child health services such as antenatal care, deliveries, postnatal and neonatal care, and in some cases HIV/AIDS education and counseling.

Government commitment to increasing access to primary health care is also evidenced by the expanding range of free health services provided by government. Until 1994, health services were subject to user charges, with few exceptions.¹⁰ Services exempt from user charges in the public sector included sterilization, certain general family planning services, and

the examination of victims of rape and other assaults.¹¹ After the elections, the free health care policy was extended to include all pregnant women and children under six.

Before 1995, the conduct and practice of South African health professionals was regulated by a plethora of statutory bodies operating in the Republic and in the former “independent homelands.”¹² In 1995, the laws pursuant to which these bodies were constituted were amended so as to consolidate them into four statutory councils: the Interim National Medical and Dental Council of South Africa, the South African Interim Nursing Council, the Interim Pharmacy Council of South Africa, and the Chiropractors, Homeopaths and Allied Health Service Professions Interim Council.¹³ These councils are created for a period of two years, during which time they are required to make recommendations to the Minister of Health concerning their reconstitution, and to advise the Minister of Health about amending the legislation pursuant to which they were established so as to place “greater emphasis on professional practice, democracy, transparency, equity, accessibility and community involvement.”¹⁴

South African law provides users of the health system with certain safeguards against abuse by health care providers. More generally, the statutory councils described above may investigate complaints concerning any improper or disgraceful conduct by health providers, and may discipline persons found guilty of such misconduct.¹⁵

The government has stated that a fundamental principle of this system is that the needs and rights of users should be respected, and that individual users and communities should be empowered to participate in the governance of the health system. The National Primary Progressive Health Care Network, an NGO, has developed a Health Rights Charter which is gaining currency as a basis for promoting community accountability.

Reality

In 1994, when the African National Congress came to power, it inherited a public-sector health system characterized by fragmentation, inequitable geographical distribution of resources, inefficiency, and an over-emphasis on hospital-based care.¹⁶ In addition, the private-sector health system consumed, and continues to consume, a disproportionate share of resources in relation to the percentage of the population it served.¹⁷

The government’s 1996-97 health budget was U.S.\$4.2 billion (R17.2 billion)¹⁸ comprising 9.9% of total estimated government expenditure.¹⁹ The increasing emphasis on primary health care is reflected in the increased percentage of the budget devoted to it: from an estimated 29% of total public health expenditure in 1995-96 to a projected 36.5% in 2000-01.²⁰ Public health care is generally accessible to low-income individuals.

The private sector continues to be characterized by soaring expenditures.²¹ Its clients are most of South Africa’s middle-class and industrial workers, who have private medical insurance that enables them to have access to private medical facilities.

Health care in rural areas is generally provided by the government public health system. Traditionally, health services have been inadequate in these areas. However, since the change in government in 1994, the implementation of health services at a primary health care level in rural areas has been a priority.

Free services at the primary health care level have improved the accessibility of services. A significant portion of the capital expenditure in the health budget has been devoted to a clinic-building program. This initiative must still be matched by expenditures on health care service personnel, equipment and health systems management. In particular, additional expenditures on specialist personnel and materials are needed, since institutions that train health care workers have traditionally failed to focus on primary health care. Though this situation is now being addressed, training in communication skills and in certain areas of reproductive health continues to fall short.

2. Access to Comprehensive, Quality Reproductive Health Care Services

Laws & Policies

As of June 1, 1994, free health services were extended to children under six years of age and to all pregnant women for the period from the diagnosis of pregnancy until 42 days after termination of pregnancy, or until any complications that have developed from the pregnancy are cured or stabilized.²² A national Maternal, Child and Women's Health Directorate has been established within the Department of Health, and related directorates have been set up in a few provinces,²³ though they are usually integrated with other areas such as welfare or genetics. Other provinces cover maternal, child, and women's health under primary health care or provide these services through regional districts.

Since 1974, family planning services have been provided free of charge in government facilities.²⁴ Family planning services have now been identified as one of the services District Health Authorities are to integrate with other primary health care services in community hospitals, clinics, and community health centers.²⁵ This should substantially increase the accessibility of these services. In some provinces, there remain stand-alone family planning clinics. For example, in 1995 in Kwazulu-Natal, there were 25 family planning clinics. However, efforts are currently being made to integrate these clinics with facilities that provide a broader range of primary health care services.²⁶

In 1984, the former South African government established the Population Development Programme (PDP), with the goal of achieving a lower population growth rate by promoting "the small family norm" in the black population. The new South African government's socioeconomic development policies are articulated in the Reconstruction and Development Programme and in the White Paper on Population Policy which was passed by Cabinet and Parliament in May 1998. This takes a holistic developmental approach to population issues, promoting better macro planning and using demographic trends as indicators of improved quality of life rather than as goals in themselves.

Reality

The distribution of reproductive health services has been inadequate and inequitable.²⁷ For example, services in predominantly white areas have traditionally been of a higher quality

than services in predominantly black areas.²⁸ Many women in rural areas and informal settlements have had access to injectable contraceptives only, and rural clinics often lacked facilities for inserting intrauterine devices (IUDs).²⁹ Furthermore, barrier methods of contraception, such as condoms and diaphragms, were not widely promoted despite their potential to prevent STIs.³⁰

Since the change in government, there has been an overall shift towards greater health services equity by, for example, increasing funds to rural areas, improving systems of drug supply to rural clinics, and increasing the range of available contraceptives provided in rural clinics. In particular, a contraception policy process is underway to develop a national agreement on the appropriate range of contraceptives to make available as well as on how to improve education, counseling, and health worker-client communication about contraception. In addition, pilot programs introducing emergency contraception have been instituted. The Department of Health has also recently begun piloting the female condom, and has trained certain primary health care and family planning staff on its application.³¹ A major component of the new Department of Health's interventions against the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) has been to increase condom distribution.³²

Health providers are not subject to incentives or disincentives, nor are targets set for clinics and providers to reach. There have been allegations of provision of sterilization and of Depo-Provera being given post-partum without consent. There is no documentation on this and it is hoped that the new reproductive rights framework, which has moved away from the "population control" model, will be conducive to further efforts to train health workers in issues of gender equality and sexual and reproductive rights and will thus aid in preventing such violations of reproductive rights.

In rural areas, restrictive hours limit the access of low-income individuals to reproductive health services. It is often inconvenient for women to arrange for transportation to and from the clinics, which are only open during the day while most women are working. Some provinces are opening clinics with extended hours of operation. However, women health workers have raised the need for greater security to protect them from violence when leaving their posts in the evenings.

3. Access to Information on Health, including Reproductive Health and Family Planning

Laws & Policies

In its policy statement on the National Health System, the Department of Health identified as a basic principle of the primary health care delivery system the need to emphasize "the needs and rights of users of the system," quality of patient care, and the "caring" aspects of health care services.³³ The Choice on Termination of Pregnancy Act of 1996 (Choice Act) recognizes that both men and women "have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice."³⁴ When a woman requests a termination of pregnancy from a medical practitioner or registered midwife, the Choice Act requires that the practitioner inform the woman of her rights pursuant to this

law.³⁵ The Choice Act also places an obligation on the state to “promote the provision of non-mandatory and non-directive counseling, before and after the termination of pregnancy.”³⁶

Certain laws could be interpreted to restrict access to information on health. The Medicines Act prohibits the publication or distribution of any false or misleading advertisement concerning any medicine, including contraceptives.³⁷ Contraceptive advertisements or educational publications which contain explicit sexual content may also, pursuant to the provisions of the Films and Publications Act, 1996 (Films Act), potentially be subject to age restrictions or other restrictions relating to distribution.³⁸

Reality

The Department of Health has added a Chief Directorate on Health Promotion. The government is just gaining expertise in this area. The directorate has few staff thus far. A new university-based initiative to train Department of Health staff in health promotion is being developed with government support.

Because media work in this arena is expensive and the cumbersome procedures to obtain government contracts are complex, the health-promotion field is not attractive to media groups. As a result, the quality and quantity of media coverage of health generally and of reproductive and women’s health in particular tends to be inadequate and inappropriate. For example, a poster depicting a “handbag for women’s health” failed to explain what reproductive rights are and why they should be contained in a handbag. Moreover, the distribution networks for this information are insufficient. Some NGOs have produced excellent materials, but distribution is limited due to funding and capacity. In addition, due to high levels of illiteracy, NGO initiatives are now being planned to work with the extensive community-radio network in the country. Language is also an issue in that most materials are written in English despite the existence of 11 official languages. Government needs to address how to better utilize and build on NGO-developed materials.

Prior to the end of the apartheid period in 1994, the realization of women’s right to information on contraceptive methods and the implementation of mechanisms to ensure this right were not prioritized. Between August 1992 and March 1993, the Women’s Health Project conducted a study³⁹ of 86 women from various class and racial backgrounds in the metropolitan area of Pretoria to examine women’s experiences with contraceptive services.

Eighty-one percent of the women in the study had used contraceptives without having a full understanding of available contraceptive methods and their proper usage.⁴⁰ Many women complained that there were no appropriate or reliable channels through which to learn about their contraceptive choices. The majority of these women seemed frustrated that they did not learn about issues concerning sexuality and contraception at school, from their parents, or through their communities at large.⁴¹ Still others reported that they learned about contraceptives from trained hospital staff but only after having given birth to their first child.⁴²

Reproductive health care providers often failed to provide sufficient information to their clients. One low-income woman stated that health care providers “don’t explain. It appears as if they either don’t want to or they don’t have time to sit down with their patients and discuss this issue. They are always in a hurry whatever they do.”⁴³ One Muslim woman shared her

birth control prescription with a friend after not receiving proper instructions from her provider, and became pregnant.⁴⁴ Perhaps most disturbingly, another Muslim woman expressed confusion as to how long her sterilization would last, asking “I don’t know [if] the doctor sterilized ... me forever and [I] can’t get children any more or if I’m still going to get children or what.”⁴⁵ One third of the women were unaware of the permanence of sterilization.⁴⁶ One woman stated that when she complained about some of the side effects of taking birth control pills, her doctor “negated that they were real.”⁴⁷ Another woman added, “when we complain they don’t listen to us. They are only pleased to give you what they want and not what you want.”⁴⁸

Despite the government policy of providing free family planning services, the quality of service provision has traditionally been better in predominantly white areas than in black areas.⁴⁹ Low-income women, who are mostly African, receive contraception from practitioners in public health facilities, whereas middle-class women are serviced mostly by doctors. In fact, only half of the women in the African community inquiring about contraceptive methods are able to gain access to services at all;⁵⁰ and, not surprisingly, a number of these women find that they have little choice and their concerns are paid little attention. In many of the mobile clinics that service rural areas, barrier methods such as the condom and the diaphragm have not been promoted as contraceptives, but only as methods of disease prevention.⁵¹

4. Contraception

Laws & Policies

The Medicines and Related Substances Control Act, 1965 (Medicines Act)⁵² provides for the registration and control of medicines and medical devices, including contraceptive drugs and devices. The Medicines Act categorizes medicines and certain medical devices in a series of schedules. The preconditions for the sale or supply of medicines or devices vary according to the schedule in which the particular medicine or device is located. Parliament is expected to revise the Medicines Act in the next year.

Oral contraceptives containing only progestogen and IUDs may only be sold by a pharmacist, a trainee pharmacist, or assistant under a pharmacist’s supervision.⁵³ In the case of hormones other than those containing only progestogen and IUDs, a pharmacist may only sell them with a written prescription or oral instructions of a medical practitioner, regardless of the age of the purchaser.⁵⁴ In the case of oral contraceptives containing progestogen alone, the pharmacist must record the particulars of every sale and there are restrictions on their sale to persons under age 16, described in Section A.8 below.⁵⁵ In addition, the Medicines Act prohibits the sale of any medicine or scheduled substance unless it bears a label stating particulars prescribed by regulation.⁵⁶ The Medicines Act further grants the Minister of Health extensive powers to make regulations on matters such as: packaging; the composition, therapeutic suitability, effect, purity, or other properties of medicines; and the importation, transportation, storage, or disposal of medicines and scheduled substances.⁵⁷

Reality

In 1995, the overall contraceptive prevalence rate was 53%, with 51.7% of the population using modern methods and 1.3% using traditional methods.⁵⁸ African women most commonly use injectable contraceptives, while the oral pill is the method used most extensively among the other racial groups.⁵⁹ Between 10% and 25% of men use condoms.⁶⁰ Health care providers in the public health care sector favor injectables over other methods and thus many women are not offered a choice among contraceptive methods.⁶¹ Providers' historical preference for Depo-Provera is being addressed in training. However, some women prefer injectables because of unequal gender relations; they can use injectables without having to negotiate with their sexual partners. The availability of a range of methods in public health care depends on whether or not the facilities experience ordering problems. The issue is being addressed through the establishment of district health systems which are intended to improve efficiency in drug supply, among other things.

See also Section A.3 above regarding problems in provision of information.

5. Abortion

Laws & Policies

On November 12, 1996, South Africa enacted the Choice on Termination of Pregnancy Act, 1996 (Choice Act).⁶² This act repealed the provisions related to abortion contained in the Abortion and Sterilization Act, 1975.⁶³ Section 2(1) of the Choice Act now defines the circumstances in which pregnancies may lawfully be terminated⁶⁴ to be:

- (a) upon request of a woman⁶⁵ during the first 12 weeks of the gestation period⁶⁶ of her pregnancy;
- (b) from the 13th week 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 fetus 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; or
- (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 severe malformation of the fetus; or
 - (iii) would pose a risk of injury to the fetus.

The Choice Act sets forth three major requirements for the performance of a legal abortion. First, the informed consent of the pregnant woman is required. Second, the law states that, depending upon the stage of pregnancy, the abortion must be performed either by a

medical practitioner or a registered midwife. Finally, the Choice Act specifies the type of facilities in which such a procedure must occur.

The Choice Act requires the informed consent of the pregnant woman for the termination of her pregnancy.⁶⁷ In almost all circumstances, no consent other than that of the pregnant woman is required.⁶⁸

The Choice Act also stipulates that abortions performed at the request of a woman during the first 12 weeks of the gestation period may be carried out either by a medical practitioner or by a registered midwife who has completed the prescribed training course.⁶⁹ All other pregnancy terminations may be performed only by a medical practitioner.⁷⁰ Surgical abortions may only be performed at a facility designated by the Minister of Health for that purpose.⁷¹ Persons in charge of such facilities are required to keep records of all abortion procedures performed in their facilities, and must forward this information, while maintaining confidentiality regarding the woman's identity, to the Director-General of Health.⁷² The Choice Act provides that the identity of women who have requested or obtained a termination of pregnancy must remain confidential at all times.⁷³

Furthermore, it is an offense for any person to prevent the lawful termination of a pregnancy or to obstruct access to a facility for the termination of a pregnancy. Any person found guilty of this offense is liable to a fine or to imprisonment for a period not exceeding 10 years.⁷⁴

Reality

No research has been completed since the implementation of the Choice Act to determine the incidence of illegal and unsafe abortion. Available data on maternal mortality are out of date.

A national study to investigate the incidence of hospital-based maternal mortality has been developed and is in progress. The pilot indicates that unsafe abortion continues to be a major cause (35%) of maternal mortality. However, as the study has progressed, AIDS-related illnesses are proving to be an increasingly significant contributing factor to maternal mortality.⁷⁵

There is a history of prosecutions for performing or procuring illegal abortions in South Africa. Most cases involved prosecutions of doctors or other providers, though in some cases families reported women to the police. However, since passage of the Choice Act, a moratorium on such prosecutions has been in effect. Health officials and public health services have always treated the complications from unsafe and illegal abortions as serious obstetric cases.

There has been significant work and attention directed towards the implementation of the Choice Act. Because of inadequate training of health workers and poorly resourced clinics at the primary health care level, it was expected that the implementation would be slow. One significant issue is that few doctors are trained, and many are reluctant, to perform abortions. And though the training of midwives to perform abortions is being planned and the South African Nursing Council regulations are in the process of being amended, only doctors are presently performing abortions. Services are provided in designated clinics and hospitals, primarily in urban settings; few services are available in rural settings and at the primary health

care level. Safe abortion is more accessible to high-income women due to the availability of private health care.

Services continue to be more available for first-trimester abortions as compared with second-trimester abortions since first-trimester abortions are easier to perform. Dilation and Curettage — the most commonly used procedure for second-trimester abortions in South Africa — is seen as controversial by doctors. It is used more frequently than the Aspirotomy technique.⁷⁶

Three Christian organizations have sent a summons to the Ministry of Health, challenging the constitutionality of the Choice Act under the “right to life” clause of the Constitution. This case was heard in the Pretoria High Court on May 25 and 26, 1998. Numerous women’s legal and health NGOs have joined the government in fighting the challenge to the Choice Act. The court is expected to issue a decision shortly.

6. Sterilization

Laws & Policies

While the abortion section of the Abortion and Sterilization Act of 1975 has been repealed, the section on sterilization still remains in effect. However, new legislation specifically dealing with sterilization is being developed and will be tabled in Parliament later in 1998. The Child Care Act, 1983,⁷⁷ provides that any person over the age of 18 years is competent to consent, without the assistance of her or his guardian, to the performance of any operation upon herself or himself.⁷⁸ Thus, a mentally competent, consenting adult may freely choose sterilization as her or his preferred method of contraception.⁷⁹ Regarding the issue of spousal consent, see Section B.4 below.

Reality

Informed consent is not always obtained and there are “word of mouth” cases of coercion. No post-sterilization counseling is offered. No national-level statistics are kept on sterilization, although provinces do collect this information. The referral system for sterilization services does not operate well. There are waiting lists at many facilities and there are not enough personnel to perform the procedure.⁸⁰

A 1994 study of 2,290 women aged 15-49 in the Transkei subregion of South Africa, a former homeland comprising approximately 10% of South Africa’s total population, reveals the following breakdowns in the percentages of women using sterilization as a means of contraception: 0.0% between the ages of 15-19; 0.0% between the ages of 20-24; 2.6% between the ages of 25-29; 7.8% between the ages of 30-34; 6.3% between the ages of 35-39; 23.1% between the ages of 40-44; and 17.9% between the ages of 45-49.⁸¹

7. HIV/AIDS and Sexually Transmissible Infections (STIs) and Women

Laws & Policies

Since 1994, the new government has made AIDS a high priority within its program of socioeconomic development.⁸² The AIDS Program has been elevated to the level of a directorate within the Department of Health, and its sphere of operation has been expanded to include STIs.⁸³ The Department of Health has adopted five key approaches in a “medium term” strategy to combat the HIV and STI epidemics:

- life skills and responsible sex education programs in schools and youth centers;
- mass communication strategies to popularize methods of prevention;
- increased access to barrier methods of contraception, including male and female condoms;
- more effective and more appropriate management of STIs; and
- establishment of norms, standards, and guidelines for the care of patients suffering from AIDS.⁸⁴

Although the South African Law Commission (SALC) has recommended the passage of an “HIV and AIDS Act,” there is at present no comprehensive statute dealing with issues relating to HIV/AIDS in South Africa.⁸⁵ Rather, South African law affecting AIDS currently derives from a variety of sources, including the common law, statutory law, and ethical guidelines and practice rules prepared by the South African Medical and Dental Council (SAMDC),⁸⁶ which specify the acts or omissions that may give rise to disciplinary action by the SAMDC.⁸⁷ The most far-reaching protection that the Constitution provides to people with HIV or AIDS is contained in Section 9, which guarantees that everyone has the right to equal protection and benefit of the law, and which prohibits unfair discrimination by the state or any other person against anyone on various grounds, including disability.⁸⁸

Neither HIV nor AIDS have been declared to be a “notifiable medical condition”⁸⁹ such that health care workers are required to report cases to the local authorities, but this issue is currently under debate. Rather, medical practitioners voluntarily supply information regarding all new cases of AIDS to the Department of Health while maintaining the anonymity of the person infected with HIV.⁹⁰ There is significant debate as well as to whether AIDS will be listed as a “communicable disease” for the purposes of the Communicable Disease Regulations.

Dismissal from employment solely on the grounds of HIV infection is likely to be regarded as automatically unfair. Section 187(1)(f) of the Labor Relations Act provides that a dismissal is “automatically unfair if . . . the reason for the dismissal is . . . that the employer unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground, including, but not limited to . . . disability.”

There is no specific statutory prohibition on pre-employment testing for HIV. However, with the support of the SALC, the Department of Labour introduced the Employment Equity Bill in December 1997, which prohibits pre-employment testing for HIV, subject to exceptions. To qualify under an exception, the employer must demonstrate that testing is fair and justifiable.⁹¹

The SALC has recommended the adoption by the Minister of Education of a national policy on HIV/AIDS applicable to all public schools and requiring compliance with such policy for the registration of independent schools. The SALC recommendation provides that neither compulsory testing nor discriminatory treatment of HIV-positive students is justified; it also supports students' right to privacy, though it recognizes that special measures that are fair and justifiable in light of medical facts may be necessary.⁹² The SALC proposal has been the subject of wide commentary.

The South African Medical and Dental Council Guidelines state that “[n]o health worker may ethically refuse to treat any patient solely on the grounds that the patient is, or may be, HIV seropositive.”⁹³ The SAMDC Guidelines further state that “[n]o doctor may withhold normal standards of treatment from any patient solely on the grounds that the patient is HIV seropositive, unless such variation of treatment is determined to be in the patient’s interest.”⁹⁴ However, the duty to treat as set forth in the SAMDC Guidelines is merely an ethical duty, rather than a legal one.⁹⁵ Yet, in light of the constitutional prohibition of unfair discrimination⁹⁶ and its guarantee of a right of access to health care services,⁹⁷ it is likely that any refusal by a medical practitioner — whether in private or public sector practice — to provide care to HIV-positive persons could be challenged as a violation of the Constitution.

Testing the HIV-serostatus of a patient should only be performed with the informed consent of that patient.⁹⁸ This principle derives from the South African common law,⁹⁹ and has been confirmed by SAMDC Guidelines, which describe the types of information that must be given to patients.¹⁰⁰

South African law does not specifically prescribe measures to be taken for the prevention and control of STIs. STIs have neither been declared “communicable diseases” for the purposes of the Communicable Disease Regulations¹⁰¹ nor have they been declared “notifiable medical conditions” pursuant to the powers conferred on the Minister of Health by the Health Act, 1977.¹⁰² The control of STIs does, however, fall within the broad powers conferred on local authorities by the Health Act to render services for the prevention of communicable diseases.¹⁰³

Reality

Based on the results of the seventh national annual survey of women attending antenatal clinics, it is estimated that more than 2.4 million South Africans were HIV-positive by the end of 1996. Overall, 14.7% of women attending antenatal clinics are HIV-positive; the highest rate of infection is among the 20-24 age group. At present, the primary mode of HIV transmission in South Africa is heterosexual intercourse — a radical change from the earlier phase of the epidemic from 1982 to 1986 when HIV infection and AIDS were mainly restricted to gay men.¹⁰⁴

In South Africa, STIs constitute a grave problem due to the incidence of acute infections, which can be estimated from the 11 million STI cases treated annually. There is no national surveillance system for STIs in South Africa and therefore the only epidemiological data comes from published studies and health facility reports. Most information is on women and studies show that over half of all antenatal clinic attendees have at least one STI. More

specifically, a recent review estimated that up to 15% of contraception and antenatal clinic attendees were seropositive for syphilis, 16% harbour chlamydial infections, 8% have gonorrhoea and as many as 20-50% have other vaginal infections.¹⁰⁵ There is national consensus on the need for a syndromic approach to STIs and this was being implemented by 81% of service providers.¹⁰⁶

There is evidence of discrimination against domestic workers and creche workers with HIV. In some cases, domestic workers have been tested without their knowledge and then dismissed if they were found to be HIV positive. So far, these cases have been settled out of court.¹⁰⁷

The groundwork for the response to the epidemic has been laid through the development and adoption of the National AIDS Plan with strong political support from the Minister of Health. The AIDS plan is being implemented as one of the priority programs in the re-structuring of health services. In July 1997 a national review was carried out by provincial program workers to identify the strengths and weaknesses and to recommend practical strategies for rapid strengthening of implementation of the National AIDS Plan.

The review highlighted the needs and concerns of AIDS workers in a number of areas including:

- prioritization of AIDS programs in the face of general restructuring and competing priorities;
- overcoming discrimination against people with AIDS;
- insufficient familiarity with aspects of the AIDS policies;
- the need for strong leadership of the program, in the current period of re-structuring;
- the urgent need for NGO funding;
- the need to reorganize and strengthen provincial capacity;
- the need to strengthen ATTICS (AIDS Training and Information Centres) in light of their capacity and potential to play key support roles in various sectors;
- prioritization of district-level planning and implementation;
- the need to develop a coherent understanding of media and educational strategies including methodology, materials development, and evaluation;
- the need for a major advocacy and education effort to address discrimination against people with AIDS;
- the need for the development of national care policies and guidelines, specifically, the prioritization by management of the implementation of better care and training for health care workers; and
- the urgent need to institute improved welfare services.

Given the advanced stage of the epidemic, the slow rate of implementation of these responses is of great concern. The recommendations of the national STD/AIDS Review need to be rapidly implemented.¹⁰⁸

The issue of community care, which assumes that women have voluntary time available to shoulder the burden of caring for those who become ill, also needs to be addressed at the policy level.

8. Adolescent Reproductive Health

Laws & Policies

As described above, oral contraceptives containing only progestogen may be sold only by a pharmacist, a trainee pharmacist, or pharmacist assistant under the personal supervision of a pharmacist. These medicines may only be sold to a person under the age of 16 years if the sale is made pursuant to a prescription issued by a medical practitioner or pursuant to a written order disclosing the purpose for which the substance will be used and signed by someone whom the seller knows to be over the age of 16 years.¹⁰⁹ The public health services can provide contraceptives to teenagers from age 14 without parental consent.

Where a pregnant woman is under 18 years of age, the Choice Act requires a medical practitioner or registered midwife to advise the woman to consult with her parents, guardian, family members, or friends prior to the performance of an abortion. However, a woman may not be refused access to a termination of pregnancy because she chose not to consult with other individuals.¹¹⁰

Reality

In 1995, the teenage pregnancy rate was estimated to be 330 per 1,000 women under the age of 19 years.¹¹¹ Young people do face difficulties in terms of access to reproductive health care. There are a few youth centers operated by NGOs which offer these services, but there is debate about whether youth centers are the most appropriate facilities to provide reproductive health care. Activists in this area are in favor of youth services being linked to schools, youth clubs, or telecentres. This issue needs to be addressed more effectively as proposed in the area of intersectoral action in the White Paper on Population and Development.

The Department of Health is aware that teenagers find health services unfriendly. It is working to improve health worker-client relations including health workers' understanding of the sexual and reproductive rights of teenagers and their right to non-judgmental information and services.

B. FAMILY RELATIONS (ARTICLE 16)

1. Marriage and Common Law Marriage

Laws & Policies

To enjoy full legal recognition, marriages must be solemnized by a duly authorized marriage officer¹¹² in accordance with the provisions of the Marriage Act, 1961. Unless the parties to the marriage specified otherwise in an "antenuptial contract," parties to civil marriages contracted before November 1, 1984, were married "in community of property,"¹¹³ and wives were subject to the "marital power" of their husbands such that a wife was unable to contractually bind the joint household without her husband's consent. A husband, however,

could even alienate the marital home without his wife's consent.¹¹⁴ The Matrimonial Property Act, 1984,¹¹⁵ abolished "marital power" in respect to all marriages entered into after November 1, 1984,¹¹⁶ and, in the absence of an antenuptial contract specifying otherwise, made all marriages subject to community property principles with "accrual," whereby husband and wife are joint administrators of their estate for the duration of the marriage and share equally in the profits accrued during the marriage on its dissolution.¹¹⁷

"Marital power" was finally abolished in all civil marriages by the General Law Fourth Amendment Act, 1993.¹¹⁸ The effect of the abolition of "marital power" in civil marriages is to eliminate the restrictions on a wife's capacity to contract and to litigate.¹¹⁹ Hence, these reforms have given wives legal equality with their husbands.¹²⁰

Marriages of men and women pursuant to African customary law do not constitute legally valid marriages because they are potentially polygamous and are not solemnized by designated marriage officers according to the formalities set forth in the Marriage Act.¹²¹ In several statutes, however, customary marriages are accorded the same legal consequences as legally valid marriages for certain specific purposes,¹²² including for the purposes of maintenance.¹²³ The basic requirements for a customary marriage include:¹²⁴ payment of bridewealth by the prospective husband or his family to the family of the woman he intends to marry; consent of the bride and bridegroom; and consent of the bride's guardian, although such consent may not be "unreasonably" withheld.¹²⁵ The Black Administration Act, 1927,¹²⁶ provides that black women who are partners in customary unions and living with their husbands are legally considered to be "minors" under the guardianship of their husbands.¹²⁷

The Marriage Act makes provision for Islamic and Hindu religious leaders to be designated marriage officers for the purpose of solemnizing marriages according to "Mohammedan rites or the rites of any Indian religion."¹²⁸ Hindu marriages are legally recognized as valid marriages only if solemnized by a duly designated marriage officer in accordance with the provisions of the Marriage Act.¹²⁹ Marriages performed according to Muslim law are not valid, however, because they are "potentially polygamous,"¹³⁰ although they are afforded some limited statutory recognition similar to those afforded to customary marriages.¹³¹

Reality

The 1996 Constitution mandates equality before the law for all citizens and prohibits discrimination on the basis of gender and culture.¹³² Moreover, the constitutionally-created Commission on Gender Equality is charged with promoting gender equality and advising Parliament with regard to proposed legislation affecting women's status.¹³³ Thus, there are numerous legal changes that are expected to occur in relation to marriage and women's status. A bill dealing with marriage is to be introduced in June 1998. This bill is expected to give all married South African women majority status and allow them to own property and enter into contracts.¹³⁴

2. Divorce and Child Custody

Laws & Policies

The Divorce Act, 1979,¹³⁵ provides that a court may grant a divorce on one of two grounds — the “irretrievable break-down of marriage” and the mental illness or continuous unconsciousness of a party to the marriage.¹³⁶ When granting a divorce, a court may make an order regarding the custody of any children of the marriage.¹³⁷ In making such an order, courts must be guided primarily by the best interests of the child, taking account of all relevant circumstances.¹³⁸ Ultimately the court must decide which of the parents will better fulfill the child’s multiple needs.¹³⁹ In general, custody of young children and of daughters of any age is awarded to the mother,¹⁴⁰ while custody of older boys is awarded to the father.¹⁴¹ Where the court grants custody to one parent, the other parent retains a right of reasonable access to the children.¹⁴² The Divorce Act further provides that a court may make an order regarding the guardianship¹⁴³ of the child, including an order granting sole guardianship to either of the parents.¹⁴⁴ The Guardianship Act, 1993,¹⁴⁵ grants guardianship of minor children born of a marriage to the mother, in the absence of a court order to the contrary.¹⁴⁶ Furthermore, a court granting a decree of divorce may make any order which it considers appropriate with regard to the maintenance of a dependent child of the marriage.¹⁴⁷ Courts may order one spouse to pay maintenance to the other in accordance with a written agreement between them.¹⁴⁸ Maintenance orders are enforced by maintenance courts, pursuant to the provisions of the Maintenance Act, 1963.¹⁴⁹

In customary law marriages, the failure of either spouse to perform her or his duties in marriage may be sufficient reason for divorce.¹⁵⁰ Wives generally have sufficient reason for divorce if their husbands fail to support them or if their husbands exceed the “right of moderate chastisement.”¹⁵¹ Grounds for dissolution of customary marriages in KwaZulu-Natal are enumerated by the Natal and KwaZulu Codes.

In the absence of agreement to the contrary between the spouses’ families, customary law entitles the husband and his family to full parental rights in respect of children born of a marriage if bridewealth has been paid.¹⁵² However, despite this rule of customary law, courts apply common law principles to custody insofar as they award custody to the parent who is better able to serve the best interests of the child.¹⁵³ In customary law, the closest analogy to maintenance is *isondlo*, which is a one time payment that may be claimed by any person who has raised a child, if the parent claims custody of that child.¹⁵⁴ In fact, statutory law is now typically applied to maintenance claims.¹⁵⁵ The Natal and KwaZulu Codes provide that, upon the dissolution of a customary marriage, courts may make any order regarding maintenance of minor children which it considers “just and expedient.”¹⁵⁶

Reality

Thirty percent of African households are headed by women. The figures for Coloured, Indian, and White households is 22%, 13%, and 15% respectively. Metropolitan areas, compared to rural and urban areas, have the highest prevalence of women-headed households amongst Africans.¹⁵⁷ A new maintenance bill is due to be tabled in Parliament in the middle of 1998 which will “propose a wide range of measures to ensure payment of child support and the tracking down and bringing into line of defaulters.”¹⁵⁸ For example, if the bill is passed, employers would be required to deduct monthly payments from defaulters’ salaries.

3. Early Marriage and Motherhood

Laws & Policies

The Marriage Act requires minors — persons under the age of 21¹⁵⁹ — who have not previously contracted a valid marriage to obtain the consent of their parents or guardians as a prerequisite for marriage.¹⁶⁰ However, boys under the age of 18 years and girls under the age of 15 years may not enter a valid marriage except with the permission of the Minister of Home Affairs or other authorized officers.¹⁶¹ Customary law regimes do not specify a minimum age for first marriage, but rather require only that the spouses have reached puberty, the age of which varies from person to person.¹⁶²

Reality

Of the four racial categories, Africans marry youngest at an average of 18.9 years, while whites marry the latest at an average age of 20.9 years.¹⁶³ Just under half of African girls have had their first baby by the age of 20.¹⁶⁴ Fifteen percent of African teenage women were mothers in 1993, an increase of just under 5% from 1990. The percentages for other racial groups showed a decline over this period. In addition, research indicates that the majority of African and Coloured teenagers have children outside a “recognized formal marital union.”¹⁶⁵

4. Right to Access Family Planning, including Abortion and Sterilization, without Spousal Consent

Laws & Policies

The Child Care Act, 1983,¹⁶⁶ provides that any person over the age of 18 years is competent to consent, without the assistance of her or his guardian, to the performance of any operation upon herself or himself.¹⁶⁷ Thus, a mentally competent, consenting adult may freely choose sterilization as her or his preferred method of contraception.¹⁶⁸ Legal scholars in South Africa have differed on the issue of whether or not the sterilization of a married person requires the consent of that person’s spouse.¹⁶⁹ The argument for spousal consent is based on an alleged legally protected interest of a person in the reproductive capacity of her or his spouse.¹⁷⁰ Nevertheless, it may be argued that the provision in the Constitution which guarantees that everyone has the right to make decisions concerning reproduction and control over her or his

body¹⁷¹ removes any right which persons may previously have had to refuse consent to the sterilization of their spouses.

Reality

See discussion in Section A.6 (Sterilization) above.

C. SEXUAL VIOLENCE AGAINST WOMEN (ARTICLES 5, 6, AND 16)

1. Rape and Sexual Crimes

Laws & Policies

Rape is defined as “intentional, unlawful sexual intercourse with a woman without her consent.”¹⁷² The offense of rape requires penetration of the penis into the vagina. Non-consensual oral sex, anal sex, or insertion of foreign objects into the vagina constitute the offense of “indecent assault” rather than rape.¹⁷³ In 1993, the Prevention of Family Violence Act¹⁷⁴ was enacted, which provides that a husband may be convicted of the rape of his wife.¹⁷⁵ Sexual intercourse with a girl under 16 years of age, regardless of her consent, constitutes statutory rape.¹⁷⁶ Section 14(1) of the Sexual Offenses Act, 1957,¹⁷⁷ makes it an offense for any man to have or attempt to have sexual intercourse with a girl under 16 years of age, or to commit or attempt to commit an “immoral or indecent act” with a boy or girl under the age of 19 years, or to solicit such an act.¹⁷⁸

Prosecution in rape cases is complicated by certain rules of evidence that favor the defendant. The rule of evidence barring introduction of a victim’s earlier sexual history during a rape trial is waived if the complainant previously had a relationship with the defendant.¹⁷⁹ While the judicial process is often a harrowing experience for rape survivors,¹⁸⁰ the creation of a Sexual Offences Court in Wynberg, Western Cape, represents a promising initiative to address this problem, albeit on a limited scale. The Wynberg Sexual Offences Court, established in 1992, employs women assessors and specially trained prosecutors with lighter case loads to better prepare for cases. Separate waiting rooms are provided for the plaintiffs and defendants. Furthermore, police officers from each of the Criminal Investigation Units in the surrounding areas have been trained as police rape specialists.¹⁸¹

Reality

Government officials have been discussing violence against women more, especially due to the high crime rates. However, very little has actually changed for women in the last couple of years. In 1994, police statistics indicated that 32,107 cases of rape were reported.¹⁸² Activists in this area point out that complaints are not taken seriously by the police and the judiciary, due in part to their lack of gender sensitivity. Women are not comfortable with the facilities and procedures that they have to endure to bring complaints. As a result there are ineffective

prosecutions of offenders. Less than 8% of reported rapes result in a criminal sentence. It is estimated that for every rape reported, 35 go unreported.¹⁸³ The maximum sentence for rape in the Gauteng regional court was 10 years.

The evidentiary “cautionary rule,” which assumed that additional care had to be taken in accepting the uncorroborated testimony of a rape victim, has been abolished.¹⁸⁴ While this development has been seen as a significant victory, the rule of “hue and cry” is still acknowledged. This rule suggests that if a woman delays in reporting her rape, it is more likely that it did not happen, and that she is lying. Rape Trauma Syndrome has been recognized legally in a judgment handed down by Justice Satchwell in 1998.¹⁸⁵

2. Domestic Violence

Laws & Policies

South African criminal law does not recognize domestic violence as a specific crime, although women may charge abusive husbands or partners with the common law offense of assault¹⁸⁶ and marital rape was recently recognized as a prosecutable offense. The principal civil law remedy available to victims of domestic violence is an interdict issued pursuant to the Prevention of Family Violence Act.¹⁸⁷ The remedy is available between “a man and a woman who are or were married to each other according to any law or custom and also a man and a woman who ordinarily live or lived together as husband and wife, although not married to each other.”¹⁸⁸ In the interdict, a judge or magistrate may enjoin the alleged abuser from committing any act including, but not limited to: assaulting or threatening the complainant or a child living with one or both of the parties; entering the matrimonial home or other place where the complainant resides; or preventing the complainant or a child who ordinarily lives in the matrimonial home from entering that home.¹⁸⁹ The interdict is accompanied by a warrant for the arrest of the alleged abuser, which is suspended subject to compliance with the interdict.¹⁹⁰ A partner arrested for non-compliance with such an interdict must be brought before a judge or magistrate within 24 hours of the arrest.¹⁹¹ The penalty for failure to comply with an interdict issued pursuant to this act is a fine or imprisonment for a period not exceeding 12 months, or both the fine and imprisonment.¹⁹²

Reality

The Department of Justice recently organized a conference involving the SADC region, and discussed the issue of domestic violence. They also held a consultative workshop with NGOs working in this area and established a partnership with them.

The Prevention of Family Violence Act will be replaced by the Domestic Violence Act which Parliament is expected to pass in 1998. The pending legislation would enact several changes. First, the categories of relationships which fall under the Act have been broadened to include people who live together, gay people, young girls, and people living in institutions. The definition of domestic violence has been broadened to include financial abuse, emotional abuse, harassment, and stalking. Finally, the general legal procedure of an interdict will be changed to a more specific protection order. The costs of protection are to be borne by the state. However,

since the legislation has not been finalized, this provision could be edited out of the bill, seriously impacting the efficacy of the new law.

3. Violence and/or Coercion in Health Services

Laws & Policies

Medical practitioners are not permitted to treat patients without their consent. Violation of this rule could be regarded as a serious assault on the patient.¹⁹³ The patient's consent may only be dispensed with in very limited circumstances, including where statutory authority exists for such intervention in the interests of public health, and where a patient requires emergency treatment but is temporarily unable to provide consent due to shock, unconsciousness, or intoxication.¹⁹⁴ More generally, the statutory councils described in Section A.1 above may investigate complaints of any improper or disgraceful conduct of health professionals, and may exercise disciplinary powers in respect of persons found guilty of such misconduct.¹⁹⁵

The only exceptions to the requirement of the pregnant woman's consent to an abortion apply in the case of a woman who is either so severely mentally disabled that she is "completely incapable of understanding and appreciating the nature or consequences of a termination of her pregnancy," or who is in a state of continuous unconsciousness with no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy.¹⁹⁶ If those conditions are met, the woman's guardian, spouse, or "curator" may request and consent to the termination of her pregnancy during the first 12 weeks of the gestation period, or from the 13th up to and including the 20th week on the grounds permitted by law. However, the additional consent of two medical practitioners, or a medical practitioner and a registered midwife, is also required. In certain circumstances involving danger to the woman's health or that of the fetus, the above medical providers may authorize the procedure.¹⁹⁷

The Abortion and Sterilization Act of 1975 currently governs the sterilization of any person who for any reason is incapable of consenting to the operation.¹⁹⁸ Revised legislation governing sterilization is expected soon.

Reality

See Section A.3 above on Contraception and Section A.6 on Sterilization.

D. EDUCATION AND ADOLESCENTS (ARTICLE 10)

1. Access to Education

Laws & Policies

The educational system in South Africa is characterized by significant disparities in educational levels on the basis of both race and gender. The new South African government has demonstrated a commitment to eradicating these disparities in access to education. The

National Education Policy Act, 1996,¹⁹⁹ provides that national education policy must advance the right of every person to basic education and equal access to educational institutions,²⁰⁰ and must be directed toward “achieving equitable education opportunities and the redress of past inequality in education provision, including the promotion of gender equality and the advancement of the status of women.”²⁰¹ The government has recently begun providing free and compulsory education for all children from a “reception year” up to grade nine.²⁰²

The Ministry of Education established a gender-equity task team in October 1996. It submitted a report to the Minister in January 1998.

Reality

In 1993, 99% of white South Africans were literate, as compared to 84% of Indians, 66% of coloureds, and 54% of Africans.²⁰³ Women account for 53.4% of persons aged 16 to 24 who are not attending school and have not yet reached Standard 10 (the highest level of schooling).²⁰⁴ Black women were disadvantaged by apartheid policies of the former South African government, which sought to exclude black children from educational opportunities that would allow them to engage in higher education and higher-skilled careers, and by socioeconomic pressures which resulted in many girls having to leave school prematurely.²⁰⁵

Girls who reach secondary school drop out at a far lower rate than boys. For every 100 African girls who started Sub A in 1983, 51 reached Standard 10 in 1994. The comparative figure for African boys was 35. Various reasons have been given for this phenomenon. Educated girls can command a higher *lobola* price. In addition, the only two professions in which women can earn money while studying are teaching and nursing and they require a matric certificate. In contrast, boys who leave school early are likely to find it much easier to find jobs that do not require a matric.²⁰⁶ Nevertheless, in a recent article entitled “Bound in Poverty, Joyce Tells Her Story” a woman testified that girls were instructed to sell firewood which in turn would fund their brother’s education.²⁰⁷

While school fees and uniforms are a barrier for some children, they are not the most significant factors which impinge on access to education. More importantly, there are not enough classrooms and teachers are stretched too thinly. As a result, children do not have an enabling environment in which to be taught and they choose to leave school. There is also a significant shortage of textbooks, and cash-strapped provincial governments are having to decrease spending on textbooks; this is occurring simultaneously with the change in curriculum to outcomes-based education. Lack of transportation in rural areas and peripheral areas is one of the greatest obstacles affecting school attendance. In addition, pupils already suffering from malnutrition frequently walk long distances, which affects their concentration in school. Transport subsidies have been cut by various provincial departments of education.

Perhaps the most important issue in terms of access to education is the reality that if girls become pregnant while at school, they leave. There is no legal provision requiring them to leave. However, in practice pregnant girls are ostracized and usually choose to leave, and in some cases the community will not let them return to school. Little or no attention is paid to the father who is commonly a teacher or fellow school pupil and is not subjected to ostracism.²⁰⁸

2. Information and Education on Sexuality and Family Planning

Laws & Policies

Issues of adolescent health, including reproductive health, fall within the responsibilities of the Maternal, Child and Women's Health Directorate of the Department of Health.²⁰⁹ The Child Care Act, 1983 (Act No. 74 of 1983), provides that persons 14 years or younger require the assistance of their parent or guardian to obtain medical treatment.²¹⁰ In effect, this means that children under the age of 15 years cannot legally have access to contraceptive measures without the consent of their parent or guardian.²¹¹

The Department of Health has set the goal of providing all health workers with training in the field of adolescent health by the year 1998.²¹²

Education of adolescents on issues of STIs and HIV/AIDS is one of the key strategies of the Department of Health's HIV/AIDS and STD Programme.²¹³ Education on these issues will form part of a broader program that will encompass matters such as nutrition, substance abuse, and environmental awareness.²¹⁴

Reality

The legal impediments described above, combined with social norms, have meant that adolescents have typically not been provided with access to the full range of reproductive health services, including education and counseling about sexuality and adolescent health. Few centers exist that specialize in adolescent health, and these have largely been confined to the main cities.²¹⁵ Resource shortages for such services in rural areas must be addressed. Health services are working to improve accessibility of health services to adolescents.

Sexuality education programs in schools are new and are still to be implemented. In 1994-95, the Planned Parenthood Association of South Africa (PPASA) trained over 1,500 primary and secondary school teachers on sexuality and life skills, with an emphasis on influencing adolescent attitudes toward gender.²¹⁶ In 1997, the government awarded PPASA a contract to train 10,000 high school teachers (two per secondary school) in five provinces in life skills and sexuality education.²¹⁷ Trained teachers must still implement the training into school curricula. Follow-up evaluation on the effectiveness of the training will be needed.²¹⁸ The training was found to be more acceptable in rural areas than in urban areas. This was due primarily to the enthusiasm of teachers in rural areas about receiving materials and training.²¹⁹ Sexuality education is still resisted by some teachers and government officials who, despite evidence to the contrary, maintain that high school students are not sexually active.²²⁰ Despite underlying government support, in school systems resistant to the program teachers may find it particularly difficult to implement the program in class.²²¹

The Department of Health is aware that many young women experience health services as hostile to their needs and it is working to build health worker openness and communication skills. In some provinces the Department of Health is exploring options for specific youth-orientated services.

E. EMPLOYMENT RIGHTS (ARTICLE 11)

1. Maternity Leave

Laws & Policies

The Basic Conditions of Employment Act (BCEA)²²² entered into effect on March 21, 1998, though the sections dealing with maternity leave and other conditions of employment are only due to be implemented in the latter half of 1998.²²³

The new BCEA has increased compulsory unpaid maternity leave from 3 to 4 months. The Unemployment Insurance Act, 1966 (UIF Act),²²⁴ entitles women who adopt a child under two years of age to maternity leave.²²⁵ However, a woman is eligible to receive paid leave only if she has contributed to the Unemployment Insurance Fund (UIF). At present, domestic workers do not contribute to the UIF, but it is anticipated that when the provisions on maternity leave of the BCEA commence in September and October 1998, the UIF Act will have been amended so that domestic workers will contribute to the Unemployment Insurance Fund.²²⁶

If a woman earns under a certain amount a year and has contributed to the UIF for a specified period of time, she qualifies to be paid 45% of her salary by the UIF. However, the length of time for which she will receive this amount will depend on how long she has been contributing to the UIF. The maximum period a woman can receive payments from the UIF is six months. Her employer is under no obligation to supplement the 45%.

A woman is not allowed to claim unemployment benefits and maternity leave during the same three-year period. This disadvantages a woman who takes maternity leave and subsequently becomes unemployed.²²⁷

Reality

As described above, existing legislation falls short in providing adequate paid leave for all women workers. The Department of Labour is presently reviewing sections 34 and 37 of the UIF Act that deal with maternity pay. Footnote 7 of the Basic Conditions of Employment Act provides that “[l]egislative amendments will also be proposed to Cabinet to improve these benefits and to provide that the payment to an employee of maternity benefits doesn’t adversely affect her right to unemployment benefits.”

Certain sector-specific policies currently in effect discriminate against women of childbearing age. For example, the Department of Education has a regulation that stipulates that a woman employee can only take two paid maternity leaves during her period of employment with the Department.

2. Protection in Pregnancy

Laws & Policies

The Labour Relations Act provides that every employee has the right not to be unfairly dismissed.²²⁸ Dismissals are “automatically unfair” in certain circumstances, such as where the

reason for the dismissal is the employee's pregnancy, intended pregnancy, or any related reason, or where the dismissal occurred because the employer "unfairly discriminated against an employee, directly or indirectly, on any arbitrary ground," including, *inter alia*, gender, sexual orientation, marital status, or "family responsibility."²²⁹

The BCEA stipulates that special protection should be given to pregnant employees engaged in night work, and that pregnant women and nursing mothers who normally engage in work that might place their health at risk should be offered suitable alternative work without loss of salary.²³⁰

The Occupational Health and Safety Act (OHSA) requires employers to provide and maintain a healthy and safe work environment. In addition, workers have a right to information about the hazards or potential hazards of their work, though the right to information on reproductive health hazards is not specifically mentioned. OHSA does contain specific clauses protecting women from reproductive hazards, though the effect of these provisions is to cause employment discrimination against women because all women are restricted from working in certain jobs.²³¹ Equality of protection for both men and women with respect to reproductive health hazards has yet to be achieved.

Reality

Women workers are often subject to environmental hazards, but there is little awareness of reproductive hazards from pesticides, fertilizers, and chemicals used in various industries. The employers of most companies seldom provide information voluntarily and most workers are unaware of their right to information under the law.²³²

The provisions of the OHSA and BCEA protecting women's but not men's reproductive capacity have resulted in women's exclusion from many jobs, notwithstanding anti-discrimination legislation. The employer's obligation to provide a healthy and safe workplace is achieved by excluding women altogether, rather than by requiring employers to hire women and to protect them if pregnancy occurs. Implementation of existing law reinforces gender stereotypes and fails to provide equality of protection for women and men by failing to require employers to safeguard the reproductive capacity of both sexes, to ensure the provision of accurate information on hazards to all workers, and to permit women to make informed choices about jobs and childbearing.

There are very few government inspectors to monitor compliance with occupational safety laws requiring the protection of pregnant workers.

ENDNOTES

¹ "African" refers to descendants of black African peoples who migrated in a southerly direction from Central Africa. "Coloured" refers to people of mixed parentage, mainly descendants of the indigenous Khoikhoi people, the Malayan slaves (introduced by the Dutch East India Company), and the white settlers. "White" refers to descendants of European settlers, mainly Dutch, British, German, French, Portuguese, Greek, Italian, and Jewish. "Indian" refers to descendants of Asian immigrants, mainly from India. See DEP'T OF HEALTH, HEALTH TRENDS IN SOUTH AFRICA, 1995-6 (March 1997).

-
- ² S. Afr. NAT'L CONGRESS, THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME ¶2.12.5.2 (1994) [hereinafter RECONSTRUCTION AND DEVELOPMENT PROGRAMME 1994].
- ³ *Id.* ¶2.12.5.8.
- ⁴ DEP'T OF HEALTH [S. Afr.], TOWARDS A NATIONAL HEALTH SYSTEM 7-10 (1995) [hereinafter TOWARDS A NATIONAL HEALTH SYSTEM].
- ⁵ S. Afr. CONST. §§ 104(1), 125(2), *read with* S. Afr. CONST. sched. 4. TOWARDS A NATIONAL HEALTH SYSTEM, *supra* note 4, at 15.
- ⁶ TOWARDS A NATIONAL HEALTH SYSTEM, *supra* note 4, at 15.
- ⁷ Dep't of Health [S. Afr.], *Restructuring of the National Health System for Universal Primary Health Care*, para. ¶4.3.2 (1996) (visited Feb. 19, 1997) <<http://www.aztec.co.za/biz/dgreen/nhpart1.htm>> [hereinafter *Restructuring of the National Health System*].
- ⁸ *Id.* ¶4.3.5.1.
- ⁹ *Id.* ¶4.3.4.
- ¹⁰ SOUTH AFRICAN HEALTH REVIEW 1995 165 (Health Systems Trust: Durban & Henry J Kaiser Family Foundation, 1995).
- ¹¹ *Id.* at 194.
- ¹² *Id.* at 195.
- ¹³ These amendments were effected by: the MEDICAL, DENTAL AND SUPPLEMENTARY HEALTH SERVICE PROFESSIONS AMENDMENT ACT NO. 18 OF 1995; NURSING AMENDMENT ACT NO. 5 OF 1995; PHARMACY AMENDMENT ACT NO. 6 OF 1995; and the CHIROPRACTORS, HOMEOPATHS AND ALLIED HEALTH SERVICE PROFESSIONS AMENDMENT ACT NO. 40 OF 1995.
- ¹⁴ MEDICAL, DENTAL AND SUPPLEMENTARY HEALTH SERVICE PROFESSIONS AMENDMENT ACT NO. 18 OF 1995, § 4; NURSING AMENDMENT ACT NO. 5 OF 1995, § 4; PHARMACY AMENDMENT ACT NO. 6 OF 1995, § 4; and CHIROPRACTORS, HOMEOPATHS AND ALLIED HEALTH SERVICE PROFESSIONS AMENDMENT ACT NO. 40 OF 1995, § 4.
- ¹⁵ *See, e.g.*, §§ 41 and 42 of the Medical, Dental and Supplementary Health Service Professions Act No. 56 of 1974.
- ¹⁶ RECONSTRUCTION AND DEVELOPMENT PROGRAM 1994, *supra* note 2, at ¶ 2.12.1; *see also Restructuring of the National Health System*, *supra* note 7, at ¶ 2.
- ¹⁷ Private-sector employment accounts for 59% of physicians, 93% of dentists, 89% of pharmacists, and 60% of supplementary health personnel. However, only an estimated 23% of South Africans have regular access to private-sector health care. *Restructuring of the National Health System*, *supra* note 7, ¶ 2.2.
- ¹⁸ One U.S. dollar is worth approximately 5.00 South African Rands, although this exchange rate continues to fluctuate. Business Report, THE STAR, May 13, 1998.
- ¹⁹ SOUTH AFRICAN HEALTH REVIEW 1996 76 (Health Systems Trust: Durban, & Henry J. Kaiser Family Foundation, 1996).
- ²⁰ *Restructuring of the National Health System*, *supra* note 7, ¶ 5.
- ²¹ *Id.* ¶2.4.
- ²² Services provided to pregnant women pursuant to this policy include all available health services, and are not limited to services for conditions related to the pregnancy. GOVERNMENT GAZETTE NOTICE 657(1994), *as reproduced in* SOUTH AFRICAN HEALTH REVIEW 1996, *supra* note 17.
- ²³ *Id.* at 182.
- ²⁴ Women's Health Project, *Women's Health Conference Policy on Contraception* (1994).
- ²⁵ TOWARDS A NATIONAL HEALTH SYSTEM, *supra* note 4, at 18-19.
- ²⁶ Telephone interview with Dr. David Harrison, Health Systems Trust, Durban (Feb. 2, 1997).
- ²⁷ *Women's Health Conf. Policy*, *supra* note 24.
- ²⁸ *Id.*
- ²⁹ *Id.*
- ³⁰ *Id.*
- ³¹ SOUTH AFRICAN HEALTH REVIEW 1996, *supra* note 17, at 169.
- ³² *Id.*

-
- ³³ *Restructuring of the National Health System*, supra note 7, at ¶ 4.1.
- ³⁴ THE CHOICE ON TERMINATION OF PREGNANCY ACT NO. 92 OF 1996 (1996) [hereinafter CHOICE ACT].
- ³⁵ *Id.* § 6.
- ³⁶ *Id.* § 4.
- ³⁷ MEDICINES AND RELATED SUBSTANCES CONTROL ACT NO. 101 OF 1965, § 20.
- ³⁸ FILMS AND PUBLICATIONS ACT NO. 65 OF 1996.
- ³⁹ WOMEN'S HEALTH PROJECT, WHEN IS YES REALLY YES?: THE EXPERIENCES OF CONTRACEPTION AND CONTRACEPTIVE SERVICES AMONGST GROUPS OF SOUTH AFRICAN WOMEN 6 (1993).
- ⁴⁰ *Id.* at 30.
- ⁴¹ *Id.* at 54.
- ⁴² *Id.* at 30.
- ⁴³ *Id.* at 50.
- ⁴⁴ *Id.* at 51.
- ⁴⁵ *Id.* at 52.
- ⁴⁶ *Id.* at 54.
- ⁴⁷ *Id.*
- ⁴⁸ *Id.* at 44.
- ⁴⁹ *Women's Health Conference Policy*, supra note 24.
- ⁵⁰ *Id.*
- ⁵¹ *Id.*
- ⁵² MEDICINES AND RELATED SUBSTANCES CONTROL ACT NO. 101 OF 1965.
- ⁵³ *Id.*, § 22A.
- ⁵⁴ *Id.*
- ⁵⁵ *Id.*
- ⁵⁶ *Id.* § 18(1).
- ⁵⁷ *Id.* § 35(1).
- ⁵⁸ MINISTRY OF WELFARE AND POPULATION DEVELOPMENT, A GREEN PAPER FOR PUBLIC DISCUSSION: POPULATION POLICY FOR SOUTH AFRICA 7-8 (Apr. 1995) [hereinafter GREEN PAPER ON POPULATION POLICY].
- ⁵⁹ SOUTH AFRICAN HEALTH REVIEW 1995, supra note 10, at 11.
- ⁶⁰ *Id.* at 174.
- ⁶¹ DI COOPER AND AMY MARKS, *Community Based Distribution of Contraception: A Pilot Project in Khayelitsha Cape Town*, 30 URB. AND HEALTH 49-55 (1996).
- ⁶² CHOICE ACT.
- ⁶³ *Id.* The Abortion and Sterilization Act, 1975, severely restricted access to abortions by prescribing detailed procedural requirements which had to be met before abortions could be performed, and by limiting the grounds for legal abortions to situations where pregnancy: endangered the life of the pregnant woman or constituted a serious threat to her physical health; constituted a serious threat to the woman's mental health; posed a serious risk that the child to be born would be seriously disabled; or was the result of "illegitimate carnal intercourse" with a woman with permanent mental disability. ABORTION AND STERILIZATION ACT NO. 2 OF 1975, § 3.
- ⁶⁴ "Termination of pregnancy" is defined in § 1 of the Choice Act to mean "the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman."
- ⁶⁵ "Woman" is defined in § 1 of the Choice Act to mean "any female person of any age."
- ⁶⁶ "Gestation period" is defined in § 1 of the Choice Act to mean "the period of pregnancy of a woman calculated from the first day of the menstrual period which in relation to the pregnancy is the last."
- ⁶⁷ CHOICE ACT, supra note 34, § 5(1).
- ⁶⁸ *Id.* § 5(2).
- ⁶⁹ *Id.* § 2(2).
- ⁷⁰ *Id.*
- ⁷¹ *Id.* § 3.
- ⁷² *Id.* § 7(3).

-
- ⁷³ *Id.* § 7(5).
- ⁷⁴ *Id.* § 10(1)(c).
- ⁷⁵ Interview with Gerald Mental at Kalfong Hospital (April 24, 1998).
- ⁷⁶ TERSIA CRYWAGEN, REPRODUCTIVE CHOICES (March 1998).
- ⁷⁷ CHILD CARE ACT NO. 74 OF 1983.
- ⁷⁸ *Id.* § 39(4)(a).
- ⁷⁹ Steven Harrison, Review and Reform of South Africa Health Legislation 140 (1995). (Unpublished MM Dissertation, University of Cape Town).
- ⁸⁰ Interview with Doreen Senokoanyane, Deputy Director of Reproductive Health, Gauteng Department of Health (May 1998).
- ⁸¹ Chimere-Dan Oriji, *Contraceptive Prevalence in Rural South Africa*, 22 INT'L FAM. PLAN. PERSP. 4, 7 (1996).
- ⁸² SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 10, at 175.
- ⁸³ *Id.*
- ⁸⁴ SOUTH AFRICAN HEALTH REVIEW 1996, *supra* note 17, at 169-70.
- ⁸⁵ ASPECTS OF THE LAW RELATED TO AIDS, annex. A (S.Afr. L. Comm'n Working Paper No. 58, Project 85, 1995).
- ⁸⁶ The SAMDC was the predecessor to the Interim National Medical and Dental Council of South Africa, discussed above.
- ⁸⁷ ASPECTS OF THE LAW RELATED TO AIDS, *supra* note 85, at 33.
- ⁸⁸ S. AFR. CONST. § 9. It is still unclear whether HIV-infection would constitute disability for the purposes of this provision. *Id.* § 25.
- ⁸⁹ ASPECTS OF THE LAW RELATED TO AIDS, *supra* note 85, at 150.
- ⁹⁰ *Id.*
- ⁹¹ Media Statement by the South African Law Commission on its Investigation into Aspects of the Law Relating to AIDS, <<http://www.law.wits.ac.za/salc/media/pr85may98.html>> (visited June 2, 1998).
- ⁹² *Id.*
- ⁹³ SAMDC GUIDELINES 2, *as cited in* ASPECTS OF THE LAW RELATED TO AIDS, *supra* note 85, at 39.
- ⁹⁴ *Id.*
- ⁹⁵ ASPECTS OF THE LAW RELATED TO AIDS, *supra* note 85, at 39.
- ⁹⁶ S. AFR. CONST. § 9(3).
- ⁹⁷ *Id.* § 27(1).
- ⁹⁸ ANN STRODE, AIDS AND THE LAW: MAINTAINING THE BALANCE (A PARALEGAL MANUAL) 14 (1995).
- ⁹⁹ *Id.* at 14.
- ¹⁰⁰ SAMDC GUIDELINES 4-5, *as cited in* ASPECTS OF THE LAW RELATED TO AIDS, *supra* note 85, at 43.
- ¹⁰¹ REGULATIONS RELATING TO COMMUNICABLE DISEASES AND THE NOTIFICATION OF NOTIFIABLE MEDICAL CONDITIONS, NO. R. 2438, *reprinted in* GOVERNMENT GAZETTE NO. 11014 of October 30, 1987, annex. 1 [hereinafter REGULATIONS RELATING TO COMMUNICABLE DISEASES 1987].
- ¹⁰² HEALTH ACT NO. 63 OF 1977. *See* 21 JOUBERT (ed.), LAWS OF SOUTH AFRICA (LAWSA), ¶ 288.
- ¹⁰³ HEALTH ACT NO. 63 OF 1977, § 20(1)(d).
- ¹⁰⁴ Aspects of the Law Related to AIDS, *supra* note 85, at 13.
- ¹⁰⁵ SOUTH AFRICAN HEALTH REVIEW 1998 203 (Health Systems Trust: Durban & Henry J. Kaiser Family Foundation, 1998) (Article by Mark Colvin).
- ¹⁰⁶ SOUTH AFRICAN HEALTH REVIEW 1997 xiv-xv (Health Systems Trust: Durban & Henry J. Kaiser Family Foundation, 1997).
- ¹⁰⁷ AIDS LAW PROJECT QUARTERLY, Feb. 1998, at 3.
- ¹⁰⁸ SOUTH AFRICAN HEALTH REVIEW 1998, *supra* note 105, at 196 (Article by Liz Floyd).
- ¹⁰⁹ MEDICINES AND RELATED SUBSTANCES CONTROL ACT, § 22A(4).
- ¹¹⁰ CHOICE ACT, § 5(3).
- ¹¹¹ GREEN PAPER ON POPULATION POLICY, *supra* note 58, at 9.
- ¹¹² MARRIAGE ACT NO. 25 OF 1961, § 11(1).

¹¹³ A property regime whereby the estates of the husband and wife were merged into a joint estate, administered by the husband.

¹¹⁴ HUMAN RIGHTS WATCH WOMEN'S RIGHTS PROJECT, VIOLENCE AGAINST WOMEN IN SOUTH AFRICA: THE STATE RESPONSE TO DOMESTIC VIOLENCE AND RAPE 28 (1995). A somewhat different property regime applied in respect to civil marriages entered into between Africans, which were governed by the Black Administration Act 38 of 1927. These marriages excluded community of property, but wives were still subject to their husbands' marital power. However, the Matrimonial Property Law Amendment Act No. 3 of 1988 resulted in African marriages contracted after December 2, 1988, being subject to "community of property" and excluding marital power.

¹¹⁵ MATRIMONIAL PROPERTY ACT NO. 88 OF 1984.

¹¹⁶ *Id.* § 11.

¹¹⁷ HUMAN RIGHTS WATCH WOMEN'S RIGHTS PROJECT, *supra* note 114, at 28; JOUBERT, *supra* note 102, at 83.

¹¹⁸ GENERAL LAW FOURTH AMENDMENT ACT NO. 132 OF 1993, § 29.

¹¹⁹ MATRIMONIAL PROPERTY ACT NO. 88 OF 1984, § 12.

¹²⁰ JOUBERT, *supra* note 102, at 121.

¹²¹ *Id.* at 18.

¹²² *Id.*

¹²³ MAINTENANCE ACT NO. 23 OF 1963, § 5(6). Other examples of such limited recognition of customary unions may be found in: BLACK LAWS AMENDMENT ACT 76 OF 1963, § 31; INCOME TAX ACT 58 OF 1962 § 1; and INSOLVENCY ACT 24 OF 1936, § 21(13).

¹²⁴ LEGAL RESOURCES CENTRE, HANDBOOK OF PUBLIC INTEREST LAW 177 (year not available).

¹²⁵ Section 38(2) of both the KwaZulu Code and the Natal Code, however, require a guardian's consent only if either party is under 21 years of age.

¹²⁶ BLACK ADMINISTRATION ACT NO. 38 OF 1927.

¹²⁷ BLACK ADMINISTRATION ACT NO. 38 OF 1927, § 11(3)(b), reproduced in K. Robinson, *The Minority and Subordinate Status of African Women under Customary Law* 11(3) SOUTH AFRICAN JOURNAL ON HUMAN RIGHTS 457, 461 (1995).

¹²⁸ MARRIAGE ACT NO. 25 OF 1961, § 3(1).

¹²⁹ HUMAN RIGHTS WATCH WOMEN'S RIGHTS PROJECT, *supra* note 114, at 30.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² S. AFR. CONST., § 8.

¹³³ *Id.*, at § 119.

¹³⁴ Adrian Hadland, *The Law Catches Up with Fathers Who Won't Pay*, THE SUNDAY INDEPENDENT (May 19, 1998).

¹³⁵ DIVORCE ACT NO. 70 OF 1979.

¹³⁶ *Id.* § 3.

¹³⁷ *Id.* § 6(3).

¹³⁸ JOUBERT, *supra* note 102, at 198.

¹³⁹ *Id.* at 198.

¹⁴⁰ *Id.* at 221.

¹⁴¹ *Id.* at 198.

¹⁴² *Id.* at 222.

¹⁴³ Whereas custody involves the care and control of the child's person — including the duty to supply the child with sufficient accommodation, food, education, clothing, and health care — guardianship entails the right to administer the child's property and affairs. *Id.* at 189.

¹⁴⁴ DIVORCE ACT NO. 70 OF 1979, § 6(3).

¹⁴⁵ GUARDIANSHIP ACT NO. 192 OF 1993.

¹⁴⁶ *Id.* § 1(1).

¹⁴⁷ DIVORCE ACT NO. 70 OF 1979, § 6(3).

¹⁴⁸ *Id.* § 7(1).

-
- ¹⁴⁹ MAINTENANCE ACT NO. 23 OF 1963. Section 2 of this act provides that every magistrates court shall be a maintenance court for the purposes of this section.
- ¹⁵⁰ T. W. BENNETT, A SOURCEBOOK OF AFRICAN CUSTOMARY LAW FOR SOUTHERN AFRICA 248 (1991).
- ¹⁵¹ *Id.* at 247.
- ¹⁵² *Id.* at 289.
- ¹⁵³ *Id.* at 292.
- ¹⁵⁴ *Id.* at 278.
- ¹⁵⁵ *Id.* at 282. Section 5(6) of the Maintenance Act states that “[f]or the purposes of determining whether a black . . . is legally liable to maintain any person, he shall be deemed to be the husband of any woman associated with him in a customary union.”
- ¹⁵⁶ Natal and KwaZulu Codes §§ 53, 54.
- ¹⁵⁷ Debbie Budlender, *Profile of South African Women in THE WOMEN’S BUDGET* 45 (IDASA, Capetown, 1996).
- ¹⁵⁸ Adrian Hadland, *The Law Catches Up with Fathers Who Won’t Pay*, THE SUNDAY INDEPENDENT (May 19, 1998).
- ¹⁵⁹ AGE OF MAJORITY ACT 57 OF 1972, § 1.
- ¹⁶⁰ MARRIAGE ACT NO. 25 OF 1961, § 24(1); JOUBERT, *supra* note 102, at 32. If a minor has no parent or guardian or is for any good reason unable to obtain the consent of a parent or guardian to marry, a commissioner of child welfare may grant consent to the marriage. If a parent, guardian, or commissioner of child welfare refuses to consent to the marriage, a High Court may supply the requisite consent to the marriage if it is of the opinion that the refusal of consent was without adequate reason and was not in the interests of the minor. MARRIAGE ACT NO. 25 OF 1961, § 25.
- ¹⁶¹ *Id.* § 26(1).
- ¹⁶² BENNETT, *supra* note 150, at 174.
- ¹⁶³ SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 10, at 10.
- ¹⁶⁴ Jennifer Schindler, *Education in THE WOMEN’S BUDGET* 158 (IDASA, Capetown, 1996).
- ¹⁶⁵ SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 10, at 10.
- ¹⁶⁶ CHILD CARE ACT NO. 74 OF 1983.
- ¹⁶⁷ *Id.* § 39(4)(a).
- ¹⁶⁸ Harrison, *supra* note 79, at 140.
- ¹⁶⁹ J. C. Sonnekus, *Sterilisasie — toestemming deur nie-pasiënt-gade?*, DE REBUS 369, 373 (Aug. 1986).
- ¹⁷⁰ *Id.* at 371.
- ¹⁷¹ S. AFR. CONST. § 12(2).
- ¹⁷² HUMAN RIGHTS WATCH WOMEN’S RIGHTS PROJECT, *supra* note 114, at 89.
- ¹⁷³ *Id.*
- ¹⁷⁴ PREVENTION OF FAMILY VIOLENCE ACT NO. 133 OF 1993.
- ¹⁷⁵ *Id.* § 5.
- ¹⁷⁶ SEXUAL OFFENSES ACT NO. 23 OF 1957, § 14(1).
- ¹⁷⁷ *Id.*
- ¹⁷⁸ *Id.* § 14(1). Similarly, § 14(3) of this act makes it is an offense for any woman to have or attempt to have sexual intercourse with a boy under 16 years of age, or to commit or attempt to commit an immoral or indecent act with a boy or girl under the age of 19 years, or to solicit such an act.
- ¹⁷⁹ HUMAN RIGHTS WATCH WOMEN’S RIGHTS PROJECT, *supra* note 114, at 106.
- ¹⁸⁰ *Id.* at 103-07.
- ¹⁸¹ *Id.* at 119.
- ¹⁸² *Id.* at 51.
- ¹⁸³ SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 10, at 181.
- ¹⁸⁴ Jackson v. the State, Case No. 37/39 (1998).
- ¹⁸⁵ Holthauzen v. Roodt 1997(4) S. Africa Law Reports 766(W).
- ¹⁸⁶ HUMAN RIGHTS WATCH WOMEN’S RIGHTS PROJECT, *supra* note 114, at 62.
- ¹⁸⁷ PREVENTION OF FAMILY VIOLENCE ACT NO. 133 OF 1993.

-
- ¹⁸⁸ *Id.* § 1(2). Victims of abuse by relatives or by homosexual partners must still rely on the more expensive and complex High Court interdicts. HUMAN RIGHTS WATCH WOMEN'S RIGHTS PROJECT, *supra* note 114, at 69.
- ¹⁸⁹ PREVENTION OF FAMILY VIOLENCE ACT NO. 133 OF 1993, § 2(1).
- ¹⁹⁰ *Id.* § 2(2).
- ¹⁹¹ *Id.* § 3(2).
- ¹⁹² *Id.* § 6.
- ¹⁹³ Harrison, *supra* note 79, at 118.
- ¹⁹⁴ *Id.*
- ¹⁹⁵ *See, e.g.*, §§ 41 and 42 of the Medical, Dental and Supplementary Health Service Professions Act No. 56 of 1974.
- ¹⁹⁶ CHOICE ACT, § 5(4).
- ¹⁹⁷ *Id.* § 5(5).
- ¹⁹⁸ ABORTION AND STERILIZATION ACT NO. 2 OF 1975, § 4(1).
- ¹⁹⁹ NATIONAL EDUCATION POLICY ACT NO. 27 OF 1996.
- ²⁰⁰ *Id.* § 4(a)(ii).
- ²⁰¹ *Id.* § 4(c).
- ²⁰² REPUBLIC OF SOUTH AFRICA, WHITE PAPER ON RECONSTRUCTION AND DEVELOPMENT: GOVERNMENT'S STRATEGY FOR FUNDAMENTAL TRANSFORMATION ¶ 2 (1994).
- ²⁰³ SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 10, at 234.
- ²⁰⁴ GREEN PAPER ON POPULATION POLICY, *supra* note 58, at 9.
- ²⁰⁵ J v. M Ltd., 10 I.L.J. 755 (1989), *discussed in* A. K. WING AND E.P. DE CARVALHO *Black South African Women: Toward Equal Rights*, 8 HARVARD HUMAN RIGHTS JOURNAL 70-72 (Spring 1995).
- ²⁰⁶ Schindler, *Education*, *supra* note 164.
- ²⁰⁷ *NGO Matters*, Vol. 3(3) 2 (1998).
- ²⁰⁸ Interview with Melanie Naidoo, Young Women's Network (April 1998).
- ²⁰⁹ SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 10, at 182.
- ²¹⁰ CHILD CARE ACT NO. 74 OF 1983, § 39(4).
- ²¹¹ Harrison, *supra* note 79, at 141.
- ²¹² SOUTH AFRICAN HEALTH REVIEW 1995, *supra* note 10, at 183.
- ²¹³ DEPT OF HEALTH, THE SOUTH AFRICAN GOVERNMENT'S HIV/AIDS AND STD PROGRAMME: STRATEGY, BUSINESS AND STRUCTURE PLANS 1995-1996, at 4.
- ²¹⁴ *Id.* at 4.
- ²¹⁵ Telephone interview with Dr. David Harrison, *supra* note 26.
- ²¹⁶ PLANNED PARENTHOOD ASSOCIATION OF SOUTH AFRICA, ANNUAL REPORT 1997 15 (1998).
- ²¹⁷ *Id.*
- ²¹⁸ *Id.*
- ²¹⁹ Interview with Aloma Foster, Planned Parenthood Association (April, 1998).
- ²²⁰ ANNUAL REPORT 1997, *supra* note 216, at 16.
- ²²¹ *Id.*
- ²²² GOVERNMENT GAZETTE NO. 75 (December 5, 1997).
- ²²³ Lisa Seftel, *The BCEA*, 22 SOUTH AFRICAN LABOUR BULLETIN 70 (1998).
- ²²⁴ UNEMPLOYMENT INSURANCE ACT NO. 30 OF 1966.
- ²²⁵ MINISTRY OF LABOUR, EMPLOYMENT STANDARDS STATUTE: POLICY PROPOSALS, GENERAL NOTICE No. 156 of 1996, reprinted in GOVERNMENT GAZETTE No. 17002 of 1996, Feb. 23, 1996, at 61 [hereinafter MINISTRY OF LABOR GENERAL NOTICE NO. 156].
- ²²⁶ Interview with Ms. Fatima Bhyat, Acting Director, Minimum Standards (May 1998).
- ²²⁷ Ranjit Purshotam, *Penalties on Motherhood: The Unemployment Insurance Act*, 33 AGENDA 89 (1997).
- ²²⁸ LABOUR RELATIONS ACT NO. 66 OF 1995, § 185.
- ²²⁹ *Id.* at § 187(1).
- ²³⁰ Ministry of Labour General Notice No. 156, *supra* note 225, at 54, 61.
- ²³¹ Faiza Salie and Thembeke Gwagwa, *Occupational Hazards*, 27 AGENDA 19 (1995).

²³² *Id.* at 17-18.