

THE LIMITS OF REPRODUCTIVE RIGHTS IN IMPROVING WOMEN'S HEALTH

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INTRODUCTION

A few years ago, the front page of South Africa's leading newspaper ran a story titled, "Officials stumble upon Jo'burg hospital of horrors."¹ For an unknown period of time, individuals without medical training performed abortions in a dilapidated office building in downtown Johannesburg.² The extremely unsanitary conditions of the makeshift clinic shocked health offi-

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1. *Officials stumble upon Jo'burg hospital of horrors*, MAIL & GUARDIAN, Jan. 14, 2008, <http://www.mg.co.za/article/2008-01-14-officials-stumble-upon-joburg-hospital-of-horrors>.

2. *Id.*

cials, as did the discovery that a “steady clientele” used illegal services in a facility where there was little evidence of the necessary medical equipment or supplies.³

The news story is disturbing because of the gruesome environment it describes. But perhaps equally surprising is the context of abortion regulation in South Africa. One might expect to read this newspaper article in a country that bans abortion, where women resort to abandoned buildings to seek contraband health care. Yet abortion has been legal on broad grounds in South Africa since 1997.⁴ In fact, the Choice on Termination of Pregnancy Act (CTOPA)⁵ is heralded as one of the most progressive abortion laws in the world.⁶ The law permits unfettered access to government-funded abortion services for all women through the twelfth week of gestation, stating in its preamble that “every woman [has] the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.”⁷

Despite increased availability of legal abortions⁸ (and the inclusion of rights to reproductive health care and decision-making in South Africa’s Constitution),⁹ the number of illegal terminations in South Africa does not appear to have decreased significantly since liberalization.¹⁰ Although there have been lower rates of maternal mortality associated with illegal abortion,¹¹ indications of maternal morbidity—illness or negative health effects—remain high.¹² News stories like the one above suggest that the CTOPA has made little difference to practices on the ground.

3. *Id.*

4. *See, e.g.*, Choice on Termination of Pregnancy Act 92 of 1996 (S. Afr.) [hereinafter CTOPA].

5. *See id.*

6. *See* Audrey E. Haroz, *South Africa’s 1996 Choice on Termination of Pregnancy Act: Expanding Choice and International Human Rights to Black South African Women*, 30 VAND. J. TRANSNAT’L L. 863, 903 (1997) (describing the CTOPA as the “forefront of defining human rights”); Charles Ngwena, *An Appraisal of Abortion Laws in Southern Africa from a Reproductive Health Rights Perspective*, 32 J.L. MED. & ETHICS 708, 713 (2004) [hereinafter Ngwena, *Appraisal of Abortion Law*] (describing the CTOPA as “exemplary”).

7. CTOPA, *supra* note 4, pmb., amended by Choice on Termination of Pregnancy Amendment Act 1 of 2008 (S. Afr.).

8. Statistics show that in the first year of the CTOPA’s operation over 26,000 legal abortions were performed, which is a much higher number of recorded abortions than the legal abortions performed under the precursor to the CTOPA. *TOPS (Terminations of Pregnancy)*, HEALTH SYSTEMS TRUST, <http://indicators.hst.org.za/healthstats/47/data> (last visited Sept. 9, 2011).

9. S. AFR. CONST., 1996, ch. 2, § 12(2)(a) (“Everyone has the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction”); *id.* ch. 2, § 27(1)(a) (“Everyone has the right to have access to health care services, including reproductive health care”).

10. *See, e.g.*, Banwari L. Meel & Ram P. Kaswa, *The Impact of the Choice on Termination of Pregnancy Act of 1996 (Act 92 of 1996) on Criminal Abortions in the Mthatha Area of South Africa*, 1 AFR. J. PRIMARY HEALTH CARE & FAM. MED. 79, 79–80 (2009).

11. However, the 2005–2007 Savings Mothers Report showed a small increase in the number of avoidable deaths, which was “the first time since the introduction of [the] report that an increase, rather than a decrease, in abortion-related maternal mortality has been seen – with the evidence suggesting the increase in deaths is due to unsafe abortions.” Chris Bateman, *Abortion Practices Undermining Reformist Laws*, 101 S. AFRICAN MED. J. 302, 302 (2011).

12. *See infra* Part IV (citing Jewkes study).

The purpose of this Article is to explore this gap between law and practice, and to highlight some of the limitations of decriminalization and liberalization agendas for those advocating on behalf of reproductive rights. Organizations supporting women's rights exerted significant influence during the dismantling of apartheid, in part due to the desire of those engineering the new democracy to break with the discriminatory policies of the past and to incorporate international human rights norms into the new Constitution.¹³ Like many women's rights reform projects, proponents of the CTOPA relied on the autonomy and equality rights expressed in international documents, such as those agreed to at the International Conference on Population and Development (ICPD) in 1994 and the Fourth World Conference on Women (FWCW) in 1995.¹⁴

Advocates complemented human rights principles with legislative language embraced by the international community that responds to the perceived failures and controversies of privacy jurisprudence in the United States.¹⁵ Two areas where this is particularly clear are the CTOPA's treatment of parental involvement in minors' abortion decisions, and the refusals or conscientious objections of health care providers. Although providers must advise minors to consult with their "parents, guardian, family members or friends,"¹⁶ the CTOPA allows women of any age to obtain an abortion without permission from a parent.¹⁷ It is also silent on whether and how a medical professional may refuse care because of religious or moral beliefs.

Yet the controversies that its drafters sought to avoid are obstacles to the implementation of the CTOPA.¹⁸ Provider refusals and parental consent were some of the first issues raised in court challenges to the CTOPA and the current standard for deciding conflicts in these areas is not at all clear.¹⁹ Moreover, what reformists believed they would achieve—unencumbered access to abortion care—has been elusive. Problems endemic to the larger primary health care system, such as a lack of designated facilities and train-

13. See *infra* Part II.A.

14. See International Conference on Population and Development, Cairo, Egypt, Sept. 5–13, 1994, *Report of the International Conference on Population and Development*, chs. 2 & 4, U.N. Doc. A/CONF.171/13/Rev.1 (Sept. 13, 1994) [hereinafter ICPD], available at <http://www.unhcr.org/refworld/docid/4a54bc080.html>; Fourth World Conference on Women, Beijing, China, Sept. 4–15, 1995, *Report of the Fourth World Conference on Women*, ch. I.1, ¶¶ 2–5, 7, 16–17, U.N. Doc. A/CONF.177/20/Rev.1, Annex I (Sept. 15, 1995) [hereinafter FWCW].

15. See *infra* Part III.B (describing the U.S. influence on international reproductive rights activism).

16. CTOPA, *supra* note 4, § 5(3); see B. Bekink & M. Bekink, *Aspects of rape, statutory rape and the Choice on the Termination of Pregnancy Act 92 of 1996: Do we protect our minor women?*, 69 *TYDSKRIF VIR HEDENDAAGSE ROMEINS-HOLLANDSE REG (J. CONTEMP. ROMAN-DUTCH L.)* 14, 19–20 (2006).

17. CTOPA, *supra* note 4, § 5(2)–(3).

18. See *infra* Part IV.A–C.

19. See *infra* Part IV.A–B (describing controversy and confusion around provider refusals and parental consent).

ing for health professionals, impede the effective implementation of the law.²⁰

By describing the South African experience of abortion law reform, this Article maps the origins of transnational legislative strategies for reproductive rights. It questions how shifting focus might help address abortion care delivery in countries with diverse histories and needs. Strategies focused on liberalizing access to abortion may be well suited to a project in which the primary and most important aim is to create a rights-based framework. Yet they may not respond to implementation problems, help ensure delivery of health services, or take account of the unique context of service delivery.

Part I of this Article provides the historical context for passing the CTOPA by describing the regulation of and public reaction to abortion during apartheid. Part II explores the influence of the international campaign for gender equality on the South African constitutional drafting process, which facilitated the incorporation of reproductive rights. Part III more specifically addresses the strategies for drafting the CTOPA and shows how U.S. case law and activism influences transnational reproductive rights movements. Part IV describes obstacles to implementing the CTOPA and situates those problems in relation to the CTOPA's drafting. Part V envisions how an alternative strategy might incorporate reform of a country's primary health care system—noting, as an example, key differences and similarities in the abortion law reform strategies employed in Nepal. The Article concludes by reflecting on the importance of using moments of political transition to harness the powerful rhetoric of rights for goals aligned with the improvement of a country's health care system.

I. ABORTION LAW DURING APARTHEID

Since the CTOPA took effect on February 1, 1997, the reproductive health landscape in South Africa has changed dramatically in some ways and minimally in others.²¹ This Part will review the history and politics of abortion regulation in South Africa that laid the foundation for the enactment of the CTOPA.²²

Prior to 1975, there was no statute regulating abortion, and South Africa's abortion law was based on the Roman-Dutch common law that criminalized abortion unless the life of the mother was in danger.²³ South African courts also relied on the interpretation of England's Offences Against the Person Act of 1861 to permit abortion that preserved a pregnant woman's

20. See *infra* Part IV.C (describing implementation problems for the CTOPA).

21. See CTOPA, *supra* note 4.

22. This Article does not purport to describe the complex and rich history of South Africa. For a concise account of the dominant legal influences shaping the transition to democracy, see HEINZ KLUG, CONSTITUTING DEMOCRACY: LAW, GLOBALISM AND SOUTH AFRICA'S POLITICAL RECONSTRUCTION 29–47 (2000).

23. See Charles Ngwena, *The History and Transformation of Abortion Law in South Africa*, 30 ACTA ACADEMICA 32, 35–36 (1998) [hereinafter Ngwena, *History and Transformation*].

physical or mental health.²⁴ Judges and legal scholars disagreed about the legality of other exceptions and there was scant legislative or regulatory guidance about what constituted a threat to life or health.²⁵ By passing the Abortion and Sterilisation Bill of 1975 (1975 Act),²⁶ the apartheid government intended to clarify the application of the common law,²⁷ foreclose any discussion of legalizing abortion on request, and discourage abortions for white women.²⁸ The 1975 Act provided for abortion in extremely restricted circumstances,²⁹ permitting legal abortion only when there was a serious threat to a woman's physical or mental health, risk of serious disability of the fetus, or in instances of rape or incest.³⁰ Legal abortion required the approval of two medical practitioners, in addition to the approval of the practitioner performing the abortion and a hospital superintendent.³¹ The district surgeon and a magistrate had to certify abortion for reasons of rape or incest.³² Abortion on the ground of mental health required the assessment of a state-registered psychiatrist or approval of a magistrate.³³ Violations of the law could result in a fine of 5,000 rand and a five-year prison term.³⁴

24. R v. Bourne, [1939] 1 K.B. 687.

25. South Africa recognized an exception for mental health if continuing a pregnancy would make the woman a "mental wreck." This standard is set out in the English case, R v. Bourne, *supra* note 24. See Jeremy Sarkin, *Patriarchy and Discrimination in Apartheid South Africa's Abortion Law*, 4 BUFF. HUM. RTS. L. REV. 141, 145–47 (1998) [hereinafter Sarkin, *Patriarchy and Discrimination*].

26. Abortion and Sterilisation Act 2 of 1975 § 3 (S. Afr.), amended by Act 48 of 1982, repealed by CTOPA, Act 92 of 1996 (S. Afr.). The 1982 Amendment did not make substantive changes to the 1975 Act.

27. See Ngwena, *History and Transformation*, *supra* note 23, at 35–36. A segment of society amenable to reform of the 1975 Act was the medical profession. Even when grounds for legal abortion existed, there were not enough physicians to provide the sort of oversight that the 1975 Act required. See also Jeremy Sarkin-Hughes, *A Perspective on Abortion Legislation in South Africa's Bill of Rights Era*, 56 TYDSKRIF VIR HEDENDAAGSE ROMEINS-HOLLANDSE REG (J. CONTEMP. ROMAN-DUTCH L.) 83, 90 (1993).

28. Sarkin, *Patriarchy and Discrimination*, *supra* note 25, at 142. Although this Article does not explore all of the motivations for passing the 1975 Act, one influence, tracking the discussion of Part III of this Article, was the desire of apartheid legislators to distinguish South Africa from the several Western European and North American countries that began to liberalize abortion law in the late 1960s and early 1970s. *Id.* at 153.

29. Sarkin-Hughes, *supra* note 27, at 87.

30. Abortion and Sterilisation Act 2 of 1975 § 3 (S. Afr.), amended by Act 48 of 1982 (S. Afr.), repealed by CTOPA.

31. See *id.* §§ 3–7.

32. Haroz, *supra* note 6, at 881.

33. See Sally Guttmacher et al., *Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act*, 24 INT'L FAM. PLANNING PERSP. 191, 192 (1998). Prior to the 1975 Act, "white women procured abortions from their private practitioners using a loophole in the common law that allowed terminations if the pregnancy posed a threat to the woman's mental well-being." Jerome A. Singh et al., *South Africa a Decade After Apartheid: Realizing Health Through Human Rights*, 12 GEO. J. ON POVERTY L. & POL'Y 355, 373 (2005). The medical profession protested the lack of clarity in the law, fearing prosecution for performing an abortion that a judge might decide did not meet a common law exception. Sarkin, *Patriarchy and Discrimination*, *supra* note 25, at 147. The support of the medical profession for reform is similar to the experience of the United States where physicians feared criminal and civil liability because of the vague standards at work. See Reva B. Siegel, *Roe's Roots: The Women's Rights Claims that Engendered Roe*, 90 B.U. L. REV. 1875, 1884 (2010) [hereinafter Siegel, *Roe's Roots*]; BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING 25 (Linda Greenhouse & Reva Siegel eds., 2010). More modernly, medical associations in Northern Ireland supported clarification of the Offences Against the Person Act

Despite the threat of criminal prosecution, before and under the 1975 Act, the law had little to do with many women's abortion decisions. Gaining access to designated state hospitals, multiple doctors, psychiatrists, or courts was financially and logistically impossible for most women,³⁵ particularly "those who were poor, black and lived outside of major urban areas."³⁶ Physicians performed only about 1,000 legal abortions per year during the years of the 1975 Act's operation.³⁷ In contrast, the estimated number of annual illegal abortions was high. One study cites 250,000 illegal abortions per year under the 1975 Act,³⁸ and two others cite ranges of 100,000 to 500,000.³⁹ Though varying widely, all studies highlight the health problems associated with illegally-obtained abortions.⁴⁰ Frequently cited research conducted by the Medical Research Council (MRC) found that, in one year, over 44,000 women presented to hospitals with complications from induced terminations and more than 400 women died.⁴¹

Although differing from community to community, customary law dealt with abortion as a family matter that could result in condemnation from a member of one's community or family rather than criminal punishment.⁴² For example, abortion was prevalent in the Sotho community.⁴³ Family councils settled controversies arising from terminations or requests for terminations on a case-by-case basis.⁴⁴ The treatment of abortion under customary law, at least before the CTOPA, was similar to the treatment of many family issues. Family members and community leaders mediated conflicts between spouses, parents and children, and intervened when important is-

of 1861, as interpreted at common law, governing abortion in the region. See Rebecca J. Cook & Susannah Howard, *Accommodating Women's Differences Under the Women's Anti-discrimination Convention*, 56 EMORY L.J. 1039, 1067-69 (2007) (citing the brief filed by the Family Planning Association (FPA) and supported by the Royal College of Nursing and the Royal College of Obstetricians and Gynaecologists).

34. Abortion and Sterilisation Act 2 of 1975 § 10 (S. Afr.), amended by Act 48 of 1982 (S. Afr.), repealed by CTOPA.

35. UN INT'L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, ENGENDERING THE POLITICAL AGENDA: THE ROLE OF THE STATE, WOMEN'S ORGANIZATIONS, AND THE INTERNATIONAL COMMUNITY 179 (Tatjana Sikoska et. al. eds., 2000); Diane Cooper et al., *Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status*, 12 REPROD. HEALTH MATTERS 70, 71 (2004) [hereinafter Cooper et al., *Ten Years*].

36. UN INT'L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, *supra* note 35, at 195 (noting official statistics throughout the 1970s and 1980s demonstrate that access to legal abortions under the 1975 Act was largely determined by race and class).

37. Sarkin-Hughes, *supra* note 27, at 84; see also Guttmacher et al., *supra* note 33, at 192.

38. Barbara Klugman & Sanjani Jane Varkey, *From Policy Development to Policy Implementation: The South African Choice on Termination of Pregnancy Act*, in *ADVOCATING FOR ABORTION ACCESS: ELEVEN COUNTRY STUDIES* 252 (Barbara Klugman & Debbie Budlender eds., 2001).

39. Guttmacher et al., *supra* note 33, at 192; Sarkin-Hughes, *supra* note 27, at 83.

40. See Jeremy Sarkin, *Suggestions for a New Abortion Law for South Africa*, 9 S. AFR. J. CRIM. JUST. 125, 138 (1996) (noting the commonly known consequences of illegal abortions under the 1975 Act were disability and infertility).

41. Guttmacher et al., *supra* note 33, at 192.

42. See Ngwena, *Appraisal of Abortion Law*, *supra* note 6, at 711.

43. See Charles Ngwena, *History and Transformation*, *supra* note 23, at 35.

44. See *id.*; see also Bernard M. Dickens & Rebecca J. Cook, *Development of Commonwealth Abortion Laws*, 28 INT'L & COMP. L.Q. 424, 427 (1979).

sues (around work, inheritance, or procreation, for example) arose.⁴⁵ It was often traditional healers or midwives that performed abortions.⁴⁶

The continuing oversight of abortion decisions by community members mirrors how the colonial and apartheid governments “delegated” or left governance over family matters to the local leaders. Under the Black Administration Act of 1927, black South African leaders retained power over black communities, and colonial powers respected that power so long as it was not “repugnant to the general principles of humanity observed throughout the civilized world.”⁴⁷ Subsequent legislation allowed state courts to take notice of customary law if readily ascertainable or known with sufficient certainty, except when the court found that custom contravened public policy or offended principles of natural justice.⁴⁸

Courts during apartheid could have found the potentially less restrictive standards for abortion under certain customary laws, as compared to application of the common law, contrary to public policy. But there is evidence to suggest that the government turned a blind eye to communities skirting the 1975 Act and its common law precursor, in large part due to the white state’s desire to curb black population growth.⁴⁹ Governance of black communities by one set of customary rules and governance of white communities by “the state” was foundational to the apartheid order.⁵⁰ As a result, the customary practices that exerted significant influence, playing a central and long-standing role in local governance, sit in tension with the recognition of national state authority. Some of the most vexing questions for the post-apartheid government relate to how a new constitutional democracy should accommodate traditions that powerfully shape people’s behavior—a theme that emerges clearly in the context of the CTOPA’s implementation.

Adding to the complexity of abortion regulation, reactions to abortion cut across political lines. National surveys before the passage of the CTOPA revealed significant ambivalence about the liberalization of abortion law, with thirty-four percent of respondents against abortion in all circumstances, forty-five percent in support of the 1975 Act, and twenty-one percent in favor of broader access to legal abortion.⁵¹ Both conservative and progres-

45. See Tracy Higgins et al., *Gender Equality and Customary Marriage: Bargaining in the Shadow of Post-apartheid Legal Pluralism*, 30 *FORDHAM INT’L L.J.* 1653, 1678–79 (2007) (describing customary treatment of domestic violence, for example, as an issue resolved by family members and tribal leaders and not police).

46. Susanne M. Klausen, Keynote Address at the University of Alberta: Clandestine Abortion in South Africa during Apartheid (Jan. 3, 2008), available at [http://www.uofaweb.ualberta.ca/ojs/pdfs/U_of_A_keynotelecture_Klausen%20\(2\).Jan0308.doc](http://www.uofaweb.ualberta.ca/ojs/pdfs/U_of_A_keynotelecture_Klausen%20(2).Jan0308.doc).

47. Black Administration Act 38 of 1927 (S. Afr.); see also T.W. BENNETT, *CUSTOMARY LAW IN SOUTH AFRICA* 38 (2004).

48. Law of Evidence Amendment Act 45 of 1988 § 1(1) (S. Afr.).

49. Klausen, *supra* note 46.

50. See Marius Pieterse, *It’s a “Black Thing”: Upholding Culture and Customary Law in a Society Founded on Non-Racialism*, 17 *S. AFR. J. ON HUM. RTS.* 364, 371 (2001).

51. UN INT’L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, *supra* note 35, at 202 (citing D. Budlender & D. Everatt, *How Many For and How Many Against? Private and Public Opinion on Abortion*, 40 *AGENDA* 101, 102 (1999)). Just before the passage of the CTOPA, consultation

sive political factions opposed abortion before the CTOPA.⁵² Many anti-apartheid activists, for example, had strong religious beliefs that abortion was immoral.⁵³ Moreover, some anti-apartheid leaders viewed the feminist movement (and groups like the Abortion Reform Action Group (ARAG), a leader in organizing for the repeal of the 1975 Act during apartheid)⁵⁴ as fixated on an agenda for white, middle-class women and detached from the concerns of black South Africans.⁵⁵

This attitude reflects in part the racist family planning policies of the apartheid era.⁵⁶ The apartheid government instituted population control laws to encourage white women to bear children through tax incentives and public appeals to have “enough children to ensure [South Africa’s] continued existence as a Christian and Western country on the continent of Africa.”⁵⁷ In contrast, policies designed to “control” the black population promoted broad and free use of contraceptives.⁵⁸ Health care providers injected black women with the contraceptive drug, Depo-Provera, at times without their consent and at three times the recommended dosage.⁵⁹

Against this backdrop of opposition and skepticism from diverse quarters, one might imagine that repealing the 1975 Act and enacting new legislation would take time and popular support. However, the transition from apartheid to a representative democracy produced a crucial moment for feminist advocates: the new government’s commitment to human rights would prove pivotal in supporting historically marginalized issues like reproductive rights. The next Part describes the critical juncture at which activists exerted influence in constitution drafting and legislative reform.

on the Women’s Charter, a document drafted by the Women’s National Coalition, showed that many women were ambivalent about abortion because of their moral or ethical beliefs. *Id.*

52. *Id.* at 196.

53. Guttmacher et al., *supra* note 33, at 193; Barbara Stark, *Crazy Jane Talks with the Bishop: Abortion in China, Germany, South Africa and International Human Rights Law*, 12 TEX. J. WOMEN & L. 287, 304 (2003).

54. Guttmacher et al., *supra* note 33, at 191.

55. Penelope Andrews, *The Stepchild of National Liberation: Women and Rights in the New South Africa*, in THE POST-APARTHEID CONSTITUTIONS: PERSPECTIVES ON SOUTH AFRICA’S BASIC LAW 329 (Penelope Andrews & Stephen Ellmann eds., 2001) [hereinafter Andrews, *Stepchild*]; see also Saras Jagwanth & Christina Murray, “No Nation Can Be Free When One Half of It Is Enslaved”: *Constitutional Equality for Women in South Africa*, in THE GENDER OF CONSTITUTIONAL JURISPRUDENCE 231 (Beverly Baines & Ruth Rubio-Marin eds., 2005).

56. Kelly Blanchard et al., *Abortion Law in South Africa: Passage of a Progressive Law and Challenges for Implementation*, 139 GACETA MÉDICA DE MÉXICO 109, 110 (2003).

57. Singh et al., *supra* note 33, at 373 (citing a speech delivered by the apartheid government’s Minister of Bantu Administration and Development, M.C. Botha).

58. *Id.*

59. See Barbara Brown, *Facing the “Black Peril”: The Politics of Population Control in South Africa*, 13 J. S. AFR. STUD. 256, 267–68 (1987) (describing the apartheid government’s coercive measures targeted at black South Africans in implementing family planning policies); see also Cooper et al., *Ten Years*, *supra* note 35, at 71 (describing the broad use of contraceptive injections, which are less reversible than the birth control pill, for black, rural women).

II. THE FOUNDATIONS OF REPRODUCTIVE RIGHTS ADVOCACY

A. *Gender Equality and Drafting the South African Constitution*

Support for reproductive rights gained momentum as leaders of the anti-apartheid movement began to assemble the structure for a constitutional, representative democracy. Architects of the new legal order, who were instrumental in supporting the emergence of human rights thinking in the 1980s and 1990s, relied heavily on international human rights law to build consensus and to strengthen the legitimacy of the “government-in-waiting,” led by the African National Congress (ANC).⁶⁰ Advocates aided key members of the ANC in translating a commitment to human rights into a constitutional agenda that included gender equality and reproductive rights.⁶¹

By the start of constitutional negotiations, South African advocates, from both women’s rights and civil rights groups, had formed influential organizations in civil society.⁶² Working as a coalition, they situated themselves as part of a “well orchestrated campaign” connected to a “global feminist endeavor.”⁶³ These advocates called for explicit and extensive equality rights that would both address the segregationist legacy of apartheid and recognize all forms of discrimination as equally repugnant.⁶⁴ Human rights treaties that advocates interpreted as recognizing substantive equality, like the United Nations Convention on the Elimination of Discrimination Against Women, provided the anchor for making women’s rights central to the new constitution.⁶⁵

Substantive equality recognizes equality as a norm that can both level the playing field for men and women and justify the redistribution of resources in ways that take account of women’s historic disadvantage.⁶⁶ Although still needing “conceptualisation, concretisation and indigenisation,” this “expansive” form of equality features prominently in post-apartheid

60. Kieran McEvoy & Rachel Rebouché, *Mobilizing the Professions: Lawyers, Politics, and the Collective Legal Conscience*, in JUDGES, TRANSITION, AND HUMAN RIGHTS 300–09 (John Morison et al. eds., 2007).

61. UN INT’L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, *supra* note 35, at 202. Early in the life of the Parliament, almost thirty percent of its members were women because of an ANC quota. Arguably, the high proportion of women in government and at the table for constitutional negotiations helped make gender equality a priority for the ANC. Jagwanth & Murray, *supra* note 55, at 238.

62. Andrews, *Stepchild*, *supra* note 55, at 346; see also Yvonne Mokgoro, *Constitutional Claims for Gender Equality in South Africa: A Judicial Response*, 67 ALB. L. REV. 565, 566 (2003).

63. Penelope E. Andrews, *Striking the Rock: Confronting Gender Equality in South Africa*, 3 MICH. J. RACE & L. 307, 309, 310 (1998) [hereinafter Andrews, *Striking the Rock*].

64. Andrews, *Striking the Rock*, *supra* note 63, at 309.

65. *Id.* at 314–15; Ruth Rubio-Marín & Martha I. Morgan, *Constitutional Domestication of International Gender Norms: Categorizations, Illustrations, and Reflections from the Nearside of the Bridge*, in GENDER AND HUMAN RIGHTS 121 (Karen Knop ed., 2004).

66. Charles Ngwenya, *Assessing Abortion Services Under the Choice on Termination of Pregnancy Act: Realising Substantive Equality*, 25 J. JURID. SCI. 19, 25–26 (2000) [hereinafter Ngwenya, *Assessing Abortion*].

jurisprudence because of its perceived potential to address wealth and resource disparities among South Africans.⁶⁷

The extent to which the South African Constitution includes protections for gender equality and reflects the influence of modern human rights is a testament to the persuasiveness of the “well orchestrated campaign” of feminist activists.⁶⁸ The equality rights in Section 9 of the Constitution include “equal protection and benefit of the law”; non-discrimination on the grounds of sex, gender, sexual orientation, marital status, and pregnancy; and protection for positive action to redress past disadvantage.⁶⁹ Likewise, Section 15 requires that customary law comply with equality principles, and the Preamble recognizes “non-sexism” as a foundational principle of the Constitution and the new republic.⁷⁰

B. Constitutional Reproductive Rights in the Global Context

South African advocates participated in a global movement that linked persistent gender inequality to the state’s control of women’s reproductive capacity and childbearing decisions.⁷¹ As Rebecca Cook explains, modern momentum for liberalization comes from activism to improve women’s reproductive health and wider recognition that safe and dignified healthcare is a universal, human right.⁷² The then-recent activism around the ICPD,⁷³ as well as the FWCW, helped advocates set out an international approach to reproductive rights:⁷⁴ the “[ICPD and FWCW] and the parallel discourse around them in many ways smoothed the way for the formal adoption of similar constitutional guarantees and for the efforts to implement them in South Africa.”⁷⁵ In the United States, a human rights approach gained momentum in the years after *Roe v. Wade*. Reva Siegel explains that although health professionals first lead the charge to liberalize abortion laws, feminists shaped the discourse over abortion—restrictive laws resulted in the dignitarian harms of coerced motherhood, economic exclusion, and interpersonal dependence⁷⁶ that were violations of women’s constitutional rights.⁷⁷ On the global level, it is now common to talk about abortion as “a constella-

67. *Id.* at 25.

68. Andrews, *Striking the Rock*, *supra* note 63, at 310.

69. S. AFR. CONST., 1996, ch. 2, § 9. Helen Irving has shown that Canada and Australia, for example, incorporated constitutional language like “equal benefit” of the law to emphasize substantive equality principles. See HELEN IRVING, GENDER AND THE CONSTITUTION: EQUITY AND AGENCY IN COMPARATIVE CONSTITUTIONAL DESIGN 168–78 (2008).

70. See S. AFR. CONST., 1996, ch. 1, § 1 (founding provisions); Andrews, *Stepchild*, *supra* note 55, at 328–32 (describing the gender equality innovations of the South African Constitution).

71. See Cook & Howard, *supra* note 33, at 1045 (emphasizing the ways in which the equality principles in CEDAW, for example, should be used to support reproductive health rights).

72. Rebecca J. Cook & Bernard M. Dickens, *Human Rights Dynamics of Abortion Law Reform*, 25 HUM. RTS. Q. 1, 2–3, 12–13 (2003).

73. ICPD, *supra* note 14.

74. FWCW, *supra* note 14.

75. Andrews, *Stepchild*, *supra* note 55, at 346.

76. Siegel, *Roe’s Roots*, *supra* note 33, at 1883.

77. *Id.* at 1894.

tion of human rights, including the rights to privacy, liberty, physical integrity, non-discrimination and health.”⁷⁸

The provisions of the ICPD addressed why rights to reproductive health care and decision-making were central to women’s ability to realize their full equality.⁷⁹ Prior conventions on population and development dealt with reproductive health in terms of controlling the world’s birth rate and ensuring free parental choices about whether to have children.⁸⁰ The Mexico City population conference held in 1984, for example, focused on family planning measures as a means to alleviate poverty and to relieve pressures on environmental resources by reducing family size.⁸¹ Advocates across the world mobilized against abuses committed by states in enforcing population policies, such as laws requiring sterilization of certain populations of women or penalizing the use of contraceptives or abortion.⁸² They argued that women’s poor reproductive health, as measured through maternal morbidity and mortality rates, was a consequence of laws that stigmatized ending or prohibiting pregnancy.⁸³

The 1994 ICPD was the first global conference on population that had a high level of non-governmental organization (NGO) involvement, with the result that civil society and government representatives worked closely together to draft consensus principles.⁸⁴ This influenced the rights-based framework of the ICPD’s Programme for Action, now described as the dominant model for international law reform in the area of reproductive health.⁸⁵ Instead of concentrating on population or fertility control, the ICPD principles seek to improve individual well-being, advance women’s

78. Christina Zampas & Jamie M. Gher, *Abortion as a Human Right—International and Regional Standards*, 8 HUM. RTS. L. REV. 249, 255 (2008).

79. Cooper et al., *Ten Years*, *supra* note 35, at 71–72; UN INT’L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, *supra* note 35, at 207; Andrews, *Stepchild*, *supra* note 55, at 346.

80. FAMILY PLANNING COAL., REPORT ON U.S. REPRODUCTIVE HEALTH 17 (2009) (on file with author).

81. See Laura Reichenbach, *The Global Reproductive Health and Rights Agenda: Opportunities and Challenges for the Future*, in REPRODUCTIVE HEALTH AND HUMAN RIGHTS: THE WAY FORWARD 24–25 (Laura Reichenbach & Mindy Jane Roseman eds., 2009) (stating that the Mexico City conference focused on the effects of overpopulation on poverty levels and the environment). Note that the population control premise was and remains controversial. Research has shown that family size is not necessarily an indicator of poverty. In fact, the opposite may be true: low-income families that have more children can often better cope with economic demands. See Mindy Jane Roseman & Laura Reichenbach, *Global Reproductive Health and Rights: Reflecting on ICPD*, in REPRODUCTIVE HEALTH AND HUMAN RIGHTS: THE WAY FORWARD 10–11 (Laura Reichenbach & Mindy Jane Roseman eds., 2009).

82. Roseman & Reichenbach., *supra* note 81, at 7–8.

83. *Id.*

84. NADINE TAUB, AM. SOC’Y OF INT’L L., INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT 2 & n.4 (1994) (on file with author).

85. Highlighting support for the ICPD, however, is not intended to ignore the implementation difficulties of the ICPD or to minimize the tensions that exist between a reproductive rights focus and the “global health agenda,” many of the objectives of which are in part reflected in the United Nations Millennium Development Goals. See Roseman & Reichenbach, *supra* note 81, at 17–18 (arguing that attention has shifted over the last ten years from reproductive rights to issues such as malaria or tuberculosis as captured by the United Nations Millennium Development Goals; noting that an implementation strategy for the ICPD is underdeveloped).

empowerment, and secure gender equality globally.⁸⁶ Through collaborations of state and non-state actors, it sets out an agenda for the delivery of reproductive health services by urging reform of primary health care systems, community participation, and technical assistance from the international community.⁸⁷ The ICPD does not itself include a right to abortion but stresses the need for safe, effective, and affordable health services.⁸⁸ The omission of the right to an abortion was the result of compromise.⁸⁹ However, the presence or absence of laws allowing abortion on request or permitting specific grounds for abortion has become a marker of whether states are committed to women's reproductive rights.⁹⁰ The FWCW, for example, draws upon the wording and general intent of the ICPD to urge states to reconsider laws criminalizing abortion as a means to improve women's health.⁹¹

C. *Reproductive Rights in the South African Constitution*

These international conversations resonated in South Africa, which was in the process of drafting a new constitution.⁹² The ANC made the inclusion of reproductive health and decision-making in the Bill of Rights a priority even though some members of the Constitutional Assembly opposed including constitutional language on reproductive matters.⁹³ Members of the ANC Health Commission formed a women's commission that worked with advocates to add a statement of support for abortion rights.⁹⁴ The 1994 ANC Health Plan included the statement that “[e]very woman must have the right

86. *Id.* at 8, 10–11.

87. ICPD, *supra* note 14, ¶¶ 7.6–7.11.

88. *Id.* ¶ 8.25 (“All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women’s health, to deal with the health impact of unsafe abortion as a major public health concern In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion.”).

89. ADRIENNE GERMAIN & TERESA KIM, INT’L WOMEN’S HEALTH COAL., EXPANDING ACCESS TO SAFE ABORTION: STRATEGIES FOR ACTION 3–4, 6 (1998) available at http://www.iwhc.org/storage/iwhc/docUploads/ExpandingAccess_English.pdf?documentID=3.

90. *Id.* at 3–4.

91. “In the light of paragraph 8.25 of the Programme of Action of the International Conference on Population and Development, . . . [states should] consider reviewing laws containing punitive measures against women who have undergone illegal abortions[.]” FWCW, *supra* note 14, ¶ 106(k). Since the FWCW, several other international human rights documents have linked the violation of human rights to health, life, and equality and laws that limit abortion access. *See, e.g.*, Comm. on the Elimination of Discrimination Against Women, Rep. on its 20th & 21st Sess., Jan. 19–Feb. 5, 1999 & Jun. 7–25, 1999, ch. I.A.8, U.N. Doc. A/54/38 Rev.1 (Aug. 20, 1999) [hereinafter CEDAW], available at <http://www.un.org/womenwatch/daw/cedaw/reports/21report.pdf>. *See generally* Zampas & Gher, *supra* note 78, at 249 (“summariz[ing] pertinent developments within the United Nations, European, Inter-American and African human rights systems regarding abortion”).

92. UN INT’L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, *supra* note 35, at 197–99.

93. A 1992 draft of the Bill of Rights stated only that “[l]egislation may provide for reproductive rights and rights associated with child-birth and child-raising shall be respected.” *Id.* at 292 n.74 (citing a paper of the Constitutional Committee of the African National Congress).

94. *Id.* at 208–10.

to choose whether or not to have an early termination [of pregnancy] according to her individual beliefs.”⁹⁵ The Constitutional Assembly ultimately agreed to language securing a right to make decisions concerning reproduction (section 12(2)(a)) and a right to reproductive health care services (section 27(1)(a)).⁹⁶ With these provisions, South Africa became the first national constitution to recognize positive rights to both reproductive decision-making and reproductive health care.⁹⁷

Framing reproductive health and autonomy as matters of gender equality embedded a rights approach to securing access to reproductive health services.⁹⁸ If the role of law is to free women from coerced motherhood, which limits women’s ability to realize equality and other rights, then reform strategies will focus on legalization as the means to ensure that women can decide not to become mothers. The state’s role is partly one of non-interference in an individual’s exercise of her rights, rather than policing women’s choices through the penal or civil code.⁹⁹ But, as a positive right, it also suggests that the delivery of state services will follow. The South African movement for post-apartheid gender equality, like feminist activism elsewhere,¹⁰⁰ “envisio[n]ed the legal levers it pulls as activating a highly monolithic and state-centered form of power.”¹⁰¹ Formalizing protection for women in terms of substantive and state-centered rights¹⁰² highlights important presumptions that lie at the heart of reproductive rights reform projects.

Approached in this light, law grants women the capacity to decide whether to terminate pregnancies and does not restrict choice based on who the woman is or her reason, allowing women to reap health and other societal benefits.¹⁰³ Modern thinking about reproductive rights concerns not just women’s status as decision-makers but links rights of equality and autonomy to women’s health and well-being, self-determination, and equal citizenship.¹⁰⁴ Yet, as has been the critique of rights generally, the expres-

95. *Id.* at 200 (citing the 1994 Reconstruction and Development Programme of the African National Congress).

96. *Id.* at 211–12.

97. *See* S. AFR. CONST., 1996, ch. 2, §§ 12(2)(a), 27(1)(a); IRVING, *supra* note 69, at 199 (describing the reproductive rights provisions of the South African Constitution as “recent and rare” and “unusual, perhaps unique”).

98. *See* Ngwena, *Appraisal of Abortion Law*, *supra* note 6, at 716 (arguing that the protection of reproductive rights as an equality matter seeks to improve women’s lives).

99. *See* MICHEL FOUCAULT, SECURITY, TERRITORY, POPULATION: LECTURES AT THE COLLEGE DE FRANCE, 1977–78, at 352–55 (Michel Senellart et al. eds., Graham Burchell trans., 2007) (discussing a shift in governmental control from prevention to promotion in modern economies).

100. Andrews, *Stepchild*, *supra* note 55, at 331.

101. Janet Halley et al., *From the International to the Local in Feminist Legal Responses to Rape, Prostitution/Sex Work, and Sex Trafficking: Four Studies in Contemporary Governance Feminism*, 29 HARV. J.L. & GENDER 335, 341 (2006).

102. *Id.* at 340–42; *see also* Rubio-Marín & Morgan, *supra* note 65, at 117.

103. *See, e.g.*, Lance Gable, *Reproductive Health as a Human Right*, 60 CASE W. RES. L. REV. 957, 968 (2010) (stating that reproductive rights “apply to all humans by virtue of their humanity and that these rights can be claimed from governments, which have a legal obligation to uphold them”).

104. *See generally id.* at 969–70 (arguing that reproductive health, understood as a human rights issue, encompasses positive rights to welfare, health as well as negative rights related to autonomy and

sion of a right may become an end in itself and may be overly dependent on state recognition and enforcement.¹⁰⁵ The focus of South African advocates was to legalize abortion and replace the 1975 Act with a law that allows greater access to abortion services, which was a likely starting place.¹⁰⁶ Perhaps the South African Constitution contemplated reproductive health in broader terms. For example, the Constitution guarantees a right to “health care services” complemented by a state duty to “take reasonable legislative and other measures, within its available resources, to achieve the progressive realization” of that right.¹⁰⁷ Even though the CTOPA’s Preamble references the need for comprehensive reproductive health services, its text does not.¹⁰⁸ The provisions for the CTOPA do not mention the details of health service delivery or the means by which women already procured abortions.

The trajectory of activism in South Africa may have appeared as the only option, rather than one of many, available to those seeking to increase women’s access to safe abortion. The CTOPA, as the primary piece of legislation pursued by advocates on the heels of constitutional reform, may have “attract[ed] institutional energy and resources that would otherwise flow elsewhere.”¹⁰⁹ Indeed, it appears that the South African strategy was a self-conscious reaction to the reproductive rights activism in the United States, where pro-choice arguments are now “compound claims on dignity, liberty, and equality” that articulate the availability of abortion services in the language of rights.¹¹⁰ Part III looks closely at the values that animate reform priorities, specifically U.S.-influenced concepts of women’s reproductive rights.

III. DRAFTING LEGISLATION: AN AMERICAN ANTI-MODEL

As the conversation shifted from writing a constitution to drafting legislation, South African advocates focused on removing restrictions on how, when, and which women could decide to have abortions. This approach, as discussed above, draws from a developing consensus in human rights law about the importance of legal abortion in protecting women’s health, eradicating sexism, and improving women’s status.¹¹¹ This Part illustrates how reproductive rights reform projects, and the international principles that underpin them, transplant the American experience of abortion law and politics in interesting and indirect ways.¹¹²

the freedom to make decisions without government interference).

105. See David Kennedy, *The International Human Rights Movement: Part of the Problem?*, 15 HARV. HUM. RTS. J. 101, 109–10 (2002).

106. CTOPA, pmbl.

107. S. AFR. CONST., 1996, ch. 1, §§ 27, 27(2).

108. CTOPA, pmbl.; CTOPA.

109. See Kennedy, *supra* note 105, at 108.

110. Siegel, *Roe’s Roots*, *supra* note 33, at 1879.

111. Cook & Howard, *supra* note 33, at 1055–56.

112. Cf. Gerald L. Neuman, *Casey in the Mirror: Abortion, Abuse and the Right to Protection in the United States and Germany*, 43 AM. J. COMP. L. 273 (1995) (describing how American abortion deci-

A. What Drafters Wanted

The scope of U.S. influence in the diffusion of rights has been the subject of varied attention,¹¹³ particularly in scholarship examining how an American rights-based system of adjudication helped fortify an international human rights culture.¹¹⁴ Human rights advocacy in promoting autonomy, equality, choice, and secularism draws support from American legal traditions that promote formal equality and non-discrimination.¹¹⁵ Significant research, notably in the field of law and development, details the impact of U.S. policies in law reform projects designed to open markets in a global economy,¹¹⁶ resulting in changes to law on the books but not necessarily in transformation of localized or community practices.¹¹⁷

As noted, the ICPD marked an important conceptual change from regulating population, environment, and fertility issues to promoting rights of individual well-being and gender equality.¹¹⁸ U.S. activists and organizations promoting reproductive rights played an important role in the development of an international movement and specifically in the drafting of the ICPD and FWCW documents.¹¹⁹ In 1994, a representative of the Department of State set out the United States' position on the ICPD Programme for Action:

sions have been a subject of comparative constitutional law).

113. TAUB, *supra* note 84, at 9, 12.

114. Heinz Klug, *Model and Anti-Model: The United States Constitution and the "Rise of World Constitutionalism,"* 2000 WIS. L. REV. 597, 599; see also Duncan Kennedy, *Three Globalizations of Law and Legal Thought: 1850–2000*, in THE NEW LAW AND ECONOMIC DEVELOPMENT: A CRITICAL APPRAISAL (David M. Trubek & Alvaro Santos eds., 2006) (describing the role of U.S. constitutionalism, rights balancing, and policy analysis as the basis of modern globalization and diffusion of law).

115. See, e.g., Sally Engle Merry, *New Legal Realism and the Ethnography of Transnational Law*, 31 L. & SOC. INQUIRY 975 (2006); Richard Goldstone, *Ambiguity and America: South Africa and U.S. Foreign Policy*, 72 SOC. RES. 1 (2005) (noting the role of *Brown v. Board of Education*, for example, in inspiring racial equality advocates across the world and especially in South Africa).

116. See, e.g., David Kennedy, *The Mystery of Global Governance*, 34 OHIO N.U. L. REV. 827, 829 (2008) ("At the same time, ideas about economics and law and political affairs developed in the United States have had an enormous impact on the world in the last half century. Unfortunately, we have often been far better at exporting our main ideas than the qualifications and critical traditions with which they arose."). See also Laura Nader, *The Americanization of International Law*, in MOBILE PEOPLE, MOBILE LAW: EXPANDING LEGAL RELATIONS IN A CONTRACTING WORLD 207–08 (Franz von Benda-Beckmann et al. eds., 2005) (criticizing rule of law projects, supported and funded by American organizations and the government of the United States, for promoting regulations that support market-based democracy but may create an economic infrastructure in developing nations that can be exploited by other countries).

117. See, e.g., Ugo Mattei, *A Theory of Imperial Law: A Study on U.S. Hegemony and the Latin Resistance*, 10 IND. J. GLOBAL LEG. STUD. 383, 389–90 (2003); Francis G. Snyder, *Governing Globalization*, in TRANSNATIONAL LEGAL PROCESSES: GLOBALIZATION AND POWER DISPARITIES 65–67 (Michael Likosky ed., 2002) (highlighting the role of legal pluralism in globalization).

118. FAMILY PLANNING COAL., *supra* note 80, at 2. U.S. thinkers were also concerned with how population control policies, abortion laws included, could help protect environmental resources. Linda Greenhouse & Reva B. Siegel, *Before (and After) Roe v. Wade: New Questions about Backlash*, 120 YALE L.J. 2028, 2038 (2011).

119. Julia L. Ernst et al., *The Global Pattern of U.S. Initiatives Curtailing Women's Reproductive Rights: A Perspective on the Increasingly Anti-Choice Mosaic*, 6 U. PA. J. CONST. L. 752, 763–64, 785 (2004).

[A]dvancing the roles and rights of women is a critical common thread that must be woven through the recommendations and implementation of our goals from [the ICPD and FWCW] [Sustainable development] cannot be realized when women are denied the choices that spring from access to a full range of primary and reproductive health care services.¹²⁰

The constitutional protection of privacy in *Roe v. Wade*¹²¹ provided a catalyst for reframing procreative decisions in terms of autonomy and equality rights.¹²² *Roe* “both informed and was informed by a larger global movement to recognize reproductive health and self-determination as integral components of women’s equality.”¹²³ This role for *Roe*, however, may be more symbolic than it is a jurisprudential template. Many have noted that the decision itself did not make extensive reference to autonomy or equality rights.¹²⁴ Rather, the influence of *Roe* extended beyond its text by setting the stage for a rights approach to reproductive health issues.¹²⁵ Although the basis of *Roe* is a judicial interpretation of constitutional rights, the decision encouraged legislative changes to liberalize abortion laws across the world.¹²⁶

The CTOPA adopts a trimester approach inspired by *Roe v. Wade* because, as recounted by one South African activist, *Roe* is grounded in “the right to freedom, dignity and autonomy of the woman.”¹²⁷ Drafters also wanted to acknowledge the “changing moral attitudes of women towards developing fetal life” in the structure of the CTOPA.¹²⁸ The first proposal ARAG drafted allowed abortion for any reason in the first fourteen weeks of pregnancy, and from week fourteen to twenty-four under certain condi-

120. TAUB, *supra* note 84, at 12–13 (citing Timothy E. Wirth, Counselor, U.S. Dep’t of State, Address to Citizens of Cairo, Trusteeship Council Chamber (Mar. 30, 1994)).

121. 410 U.S. 113 (1973).

122. Ernst et al., *supra* note 119, at 755, 760.

123. *Id.* at 753.

124. Many articles have examined the constitutional foundations of *Roe v. Wade* and, relevant to the point made here, have noted that the decision does not necessarily ground the privacy rights in terms of women’s equality or autonomy. See Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375 (1985); see also Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 348–78 (1992).

125. Reed Boland & Laura Katzive, *Developments in Laws on Induced Abortion: 1998–2007*, 34 INT’L FAM. PLAN. PERSP. 110, 117 (2008) (“[Thirty-six] countries have significantly liberalized their abortion laws. . . . [since *Roe* because of] the use of human rights principles to support a woman’s right to [an] abortion.”).

126. See CTR. FOR REPROD. RIGHTS., ROE V. WADE AND THE RIGHT TO PRIVACY 54–58 (3d ed. 2003), *available at* http://reproductiverights.org/sites/crr.civicactions.net/files/documents/roeprivacy_0.pdf. See also Naomi Cahn & Anne T. Goldstein, *Roe and Its Global Impact: The Constitution, Reproductive Rights, and Feminism*, 6 U. PA. J. CONST. L. 695 (2004).

127. CTR. FOR REPROD. RIGHTS, THIRTY FACES OF ROE: INTERNATIONAL VOICES (2006) [hereinafter CTR. FOR REPROD. RIGHTS, THIRTY FACES OF ROE] (quoting Catherine Albertyn) (on file with author).

128. UN INT’L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, *supra* note 35, at 204.

tions, which included protecting the health of the woman and fetus, age, socio-economic reasons, and family size.¹²⁹

Working in coalition as the Reproductive Rights Alliance, women's rights and civil rights advocates exerted substantial influence over the legislative process. The final version of the CTOPA, for example, retains the structure and most of the substance of the ARAG draft. The influence of the Reproductive Rights Alliance was also evident in the public consultation on the new abortion law conducted by the ANC's *ad hoc* Committee on Abortion and Sterilisation.¹³⁰ Although a number of public submissions (mostly on the behalf of national and international NGOs) supported the bill,¹³¹ the majority of the submissions made to the Committee were opposed to abortion.¹³² The Committee discounted many of these because "most of [the submissions opposing abortion] were from individuals and small bodies, especially religious organizations," whereas "[t]he submissions [supporting abortion]. . . came from a broad[er] range of civil society."¹³³ Reproductive rights advocates thwarted attempts by abortion opponents to argue for legislative recognition of fetal rights. Instead, the Reproductive Rights Alliance persuaded Parliament to replace the 1975 Act with legislation expressly grounded in women's rights.¹³⁴ The Committee recommended to the Portfolio Committee of the Department of Health (the committee responsible for drafting the legislation) that the 1975 Act be repealed and that the new bill include ARAG's proposal of a right to abortion until the fourteenth week of gestation with only informed consent of the patient required.¹³⁵

Ultimately, advocates got most, but not all, of what they wanted: as amended in parliamentary debates, the final version of the CTOPA allows abortion for any reason until twelve, rather than fourteen, weeks of pregnancy.¹³⁶ The final version of the bill retained broad grounds for abortion in the second trimester (including when continued pregnancy would "significantly affect the social or economic circumstances of the woman").¹³⁷ After twenty weeks, women may elect abortion with the advice of two medical practitioners or a medical practitioner and midwife if continued pregnancy

129. At a major conference hosted by the Women's Health Project, the ARAG draft became the basis of the policy statement adopted by the delegates in 1994. *Id.* at 204–05.

130. Women's rights groups (both local and affiliates of transnational organizations that worked together in the constitution-drafting process), academics, and civil rights organizations formed the Reproductive Rights Alliance to lobby the Committee and to provide it with resources and expertise. *Id.* at 208–09.

131. *Id.* at 209.

132. *Id.*

133. *Id.* (noting "[a] significant gap in submissions from black people and community based organizations, which had difficulty in accessing Parliament").

134. *Id.*

135. *Id.* at 210.

136. *Id.* at 222.

137. CTOPA § 2(1) (stating that, from thirteen to twenty weeks of gestation, a medical practitioner in consultation with the patient must determine if there is a risk of injury to the woman's physical or mental health, severe fetal abnormality, or significant harm to the social and economic circumstances of the woman).

would endanger the woman's life, result in "a severe malformation of the fetus," or pose a risk of injury to the fetus.¹³⁸

B. What Drafters Sought to Avoid

The influence of human rights and of the United States is evident in the issues the drafters of the CTOPA decided to take off the table. As stated by a leader of the Reproductive Rights Alliance: "Reproductive rights advocates in South Africa learned from the U.S. abortion rights movement's mistakes as well as from its successes . . ."¹³⁹ Kim Lane Scheppele describes this comparative method of law reform as "knowing who you are by knowing what you are not" or the process of rejecting the practices of another country by drafting legislative language meant to preclude undesirable outcomes.¹⁴⁰ In the same vein, Heinz Klug described the United States as an "anti-model,"¹⁴¹ elaborating, "by and large United States jurisprudence has been increasingly used as a counter-example, as a source of distinction, or merely distinguished as inapposite."¹⁴²

As *Roe* inspired legislative reform in countries that liberalized abortion law, the decision also played a part in inciting opposition to abortion in the United States¹⁴³ and in other countries. Anti-abortion activism revolved around defining personhood at conception or conferring constitutional protections on the fetus.¹⁴⁴ In many ways, abortion opponents have been successful: abortion law in the United States changed significantly after *Roe*.¹⁴⁵ By the time of the CTOPA's drafting, American states had passed numerous laws that restricted the right to abortion.¹⁴⁶ Parental involvement laws, protections for health professional refusals, regulation of abortion providers and facilities, and state-mandated counseling (in some instances intended to dissuade women from abortion) are examples of laws that regulate when and how to obtain an abortion.¹⁴⁷ Underpinning legal restrictions on abor-

138. *Id.* § 2(1)(c).

139. CTR. FOR REPROD. RIGHTS, THIRTY FACES OF ROE, *supra* note 127 (quoting Catherine Albertyn).

140. Kim Lane Scheppele, *Aspirational and Aversive Constitutionalism: The Case for Studying Cross-Constitutional Influence Through Negative Models*, 1 INT'L J. CONST. L. 296, 300, 303-05 (2003).

141. Klug, *supra* note 114, at 599, 604-12 (describing a model as a "source of ideas, concepts, examples, and even specific constitutional arguments").

142. *Id.* at 607.

143. *Cf.* Greenhouse & Siegel, *supra* note 118, at 2074 (contesting that *Roe* caused "backlash" because of "bad judicial decisionmaking," which has been criticized for overreaching, preventing compromise, or nationalizing the discussion over abortion).

144. *See* Ernst et al., *supra* note 119, at 761.

145. This Article does not purport to review, in depth, the many developments in U.S. abortion and reproductive health law since *Roe* in 1973. For a more fulsome treatment of U.S. law governing abortion, see THE REPRODUCTIVE RIGHTS READER: LAW, MEDICINE, AND THE CONSTRUCTION OF MOTHERHOOD (Nancy Ehrenreich ed., 2008).

146. Ernst et al., *supra* note 119, at 771-73.

147. On a monthly basis, the Guttmacher Institute lists and summarizes various state laws that restrict abortion access, including the 36 state laws requiring parental involvement, the 46 allowing individual health care providers to refuse abortion care, the 43 allowing institutions to refuse to perform abortions,

tions is the rejection of the premise that liberalized abortion leads to improvements in women's health or equality.¹⁴⁸

The decision of the United States Supreme Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey* in 1992 upheld abortion restrictions related to parental consent, a waiting period, record keeping and reporting duties, and pro-childbirth counseling information, but struck down the requirement of spousal consent.¹⁴⁹ Although *Casey* preserved constitutional protection for abortion, the decision rejected *Roe*'s trimester framework and gave states more discretion in restricting abortion services and extending protections for fetal life.¹⁵⁰ The Court held that states could limit abortion access so long as the state does not create an "undue burden" on the woman's decision to have an abortion.¹⁵¹ Rather than overturn *Roe*, the Court's undue burden standard upholds state laws that make abortions costly and logistically difficult.¹⁵²

Challenging principles that have gained considerable support in international human rights law, American policies restricting abortion extended their influence internationally and reflected the divisiveness of the U.S. abortion debate. Although the U.S. government took a crucial role in forming the United Nations Population Fund (UNFPA) and was the largest contributor for the first decade of its existence,¹⁵³ in 2002 the United States reversed positions by de-funding UNFPA.¹⁵⁴ The Bush Administration argued that the phrases "reproductive rights" or "reproductive health services" were proxies for abortion and that any mention of the reproductive rights of adolescents would encourage underage sex.¹⁵⁵ The now-rescinded "global

the 24 requiring a waiting period and 19 requiring counseling, and the 39 prohibiting abortion after a certain point in pregnancy. See GUTTMACHER INST., STATE POLICIES IN BRIEF: AN OVERVIEW OF ABORTION LAWS 1-3 (2011), available at http://www.guttmacher.org/statecenter/spibs/spib_OAL.pdf.

148. See, e.g., James Gathii, *Exporting Culture Wars*, 13 U.C. DAVIS J. INT'L L. & POL'Y 67, 70, 79 (2006). In the American context, Robert Post and Reva Siegel characterized opposition to legalized abortion as a "vision that is intensely concerned . . . about the role of women, sex, family, and religion in American life." Robert Post & Reva Siegel, *Roe Rage: Democratic Constitutionalism and Backlash*, 42 HARV. C.R.-C.L. L. REV. 373, 377 (2007).

149. 505 U.S. 833 (1992).

150. See *id.* at 846 (summarizing holding).

151. *Id.* at 897-901.

152. See Linda J. Wharton et al., *Preserving the Core of Roe: Reflections on Planned Parenthood v. Casey*, 18 YALE J.L. & FEMINISM 317, 319-21 (2006). Whether a state could ban abortion before viability has yet to be tested in the Supreme Court, although states have attempted to pass pre-viability bans to trigger just such a review. See S.D. Initiative Petition 11 (proposed Dec. 14, 2007) (measure that would have banned all abortions in South Dakota, with exceptions for rape, incest, to save a woman's life or to avert a "substantial and irreversible" maternal health risk of impairment to "a major bodily organ or system"), available at http://ppsd.3cdn.net/6c52965874d08286b2_3ym6bhh22.pdf. As of June 2011, six states (Alabama, Idaho, Indiana, Kansas, Nebraska, and Oklahoma) passed legislation forbidding abortion after twenty weeks, which is usually before viability, unless the pregnant woman's life was in danger or there was risk of "serious physical impairment of a major bodily function." Erik Eckholm, *New Laws in 6 States Ban Abortion After 20 Weeks*, N.Y. TIMES, June 27, 2011, at A10.

153. Chad M. Gerson, *Toward an International Standard of Abortion Rights: Two Obstacles*, 5 CHI. J. INT'L L. 753, 760 (2005).

154. See Press Release, Population Action Int'l, PAI Appalled by White House Decision to Deny UNFPA Funds (July 22, 2002), available at <http://www.planetwire.org/details/2981>.

155. See Gathii, *supra* note 148, at 89.

gag rule” (or the Mexico City Policy) prohibited recipients of U.S. foreign aid, such as NGOs working for women’s rights outside of the United States, to perform abortions unless there was a threat to the woman’s life, rape, or incest; provide counseling or referral for abortion; or lobby for liberalized abortion laws.¹⁵⁶

At the same time, international women’s rights activists concentrated on translating reproductive rights into human rights on the global stage.¹⁵⁷ This activism influenced the drafters of the CTOPA, who feared transplanting or inciting the intensity of the U.S. debate on abortion policies. For example, the CTOPA promotes non-directive, non-mandatory counseling before and after a termination, which responded in part to the informed consent laws of the United States that require options counseling—information a woman must review or hear that can be intended to dissuade women from terminating a pregnancy.¹⁵⁸

South African advocates also deployed their lobbying power to defeat amendments that would have restricted access to abortion in the ways that the state laws upheld by *Casey* did. When the Portfolio Committee called for written submissions and organized public hearings on the proposed legislation,¹⁵⁹ advocates directed their energy to defeating amendments that would have conditioned abortion access on factors other than the women’s informed consent.¹⁶⁰ The Reproductive Rights Alliance argued against the inclusion of mandatory counseling for minors in the Committee’s draft and tried to diffuse public pressure for a parental involvement requirement.¹⁶¹ Certainly important to this campaign was the American experience of parental consent and notice for minors’ abortions.¹⁶² Advocates were mindful of research documenting the emotional, physical, and financial costs of requiring consent from potentially absent, unsupportive, or abusive parents.¹⁶³

156. Ernst et al., *supra* note 119, at 774–75, 786–87.

157. *Id.* at 755, 790; *see also* Gathii, *supra* note 148.

158. *See* Planned Parenthood v. Casey, 505 U.S. 833, 883 (1992) (stating that counseling information may contain information “which might cause the woman to choose childbirth over abortion”). Moreover, several states require information that is biased or wrong: “in 4 states, the written materials inaccurately portray [the] risk [to future fertility]”; 6 states “inaccurately assert a link between abortion and an increased risk of breast cancer”; “7 of the 19 states that include information on possible psychological responses to abortion describe only negative emotional responses.” *See* GUTTMACHER INST., STATE POLICIES IN BRIEF: COUNSELING AND WAITING PERIODS FOR ABORTION 1–2 (2011), available at http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf.

159. UN INT’L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, *supra* note 35, at 208–09.

160. Like the CTOPA, the ARAG draft originally proposed that minors be advised but not required to have counseling. *Id.* at 205 (citing a pamphlet from the Women’s Health Conference Policy on Abortion).

161. *Id.* at 210–11.

162. *See generally* GUTTMACHER INST., STATE POLICIES IN BRIEF: PARENTAL INVOLVEMENT IN MINORS’ ABORTIONS (2011), available at http://www.guttmacher.org/statecenter/spibs/spib_PIMA.pdf.

163. For a discussion of the varying consequences of and problems with parental involvement laws in the United States, *see generally* HELENA SILVERSTEIN, GIRLS ON THE STAND: HOW COURTS FAIL PREGNANT MINORS (2007) (studying the implementation of parental involvement laws in Alabama, Pennsylvania, and Tennessee); J. SHOSHANNA EHRlich, WHO DECIDES?: THE ABORTION RIGHTS OF TEENS (2006) (interviewing minors about their experiences navigating parental consent and notice laws).

In the same way, the CTOPA purposefully omitted conscientious objection rights for health professionals.¹⁶⁴ An earlier version of the CTOPA provided that “no person shall be under any legal duty . . . to participate in the termination of a pregnancy if he or she has a conscientious objection to the termination of the pregnancy.”¹⁶⁵ The Reproductive Rights Alliance fought to eliminate the refusal clause from the bill, in part because its members were cognizant of debates about conscientious objection in the United States and elsewhere.¹⁶⁶ The Church Amendments, passed in the 1970s, allowed hospitals or health care providers to refuse to provide abortion, contraceptive services, or sterilization.¹⁶⁷ The amendments made clear that health care providers receiving federal funds were not obligated to provide abortions if “contrary to [their] religious beliefs or moral convictions.”¹⁶⁸ Concurrently with the drafting and passage of the CTOPA, Section 245 of the Public Health Services Act of 1996 (or Coats Amendment)¹⁶⁹ brought the issue to the forefront of U.S. public attention. Section 245 created a right to non-discrimination for those health care entities that refused to offer or to require training for abortion services.¹⁷⁰ The extent to which drafters actually succeeded in neutralizing the debate on refusals, as well as parental involvement, is the focus of the next Part.

C. Early Challenges to the CTOPA

The final version of the CTOPA passed in November 1996 by a vote of 209 to 87.¹⁷¹ Advocates could have challenged the 1975 Act in court under the new Constitution, as other laws from the apartheid era were. Instead,

164. Charles Ngwena, *Conscientious Objection and Legal Abortion in South Africa: Delineating the Parameters*, 28 J. JURIDICAL SCIENCE 1, 9 (2003) [hereinafter Ngwena, *Conscientious Objection*].

165. Termination of Pregnancy Bill, 1996, Bill 80–96, § 8, available at http://us-cdn.creamermedia.co.za/assets/articles/attachments/03832_termofpergb80-1996.pdf (last visited September 6, 2011).

166. Ngwena, *Conscientious Objection*, *supra* note 164, at 8–9.

167. 42 U.S.C. §§ 300a-7(b),(c)(1),(c)(2),(d),(e) (2006).

168. See, e.g., *id.* § 300a-7(b)(1).

169. 42 U.S.C. § 238n (2006).

170. The issue of conscientious objection in the United States has been the subject of recent public debate. In late 2008, the Department of Health and Human Services (DHHS) under the Bush Administration issued a rule interpreting the federal regulation of refusals. Ensuring That Department of Health and Human Services Funds Do Not Support Coercive or Discriminatory Policies or Practices in Violation of Federal Law, 73 Fed. Reg. 78,072 (Dec. 19, 2008) (to be codified at 45 C.F.R. pt. 88). Abortion supporters criticized the regulations for including a medically inaccurate definition of abortion that “conflate[s] most modern contraceptives with abortion.” Adam Sonfield, *For the Record: Obama Administration Rescinds Most of Controversial ‘Conscience’ Regulation*, GUTTMACHER POL’Y REV., Winter 2011, at 24. However, in 2011, the DHHS rescinded and revised the 2008 regulations. While the DHHS still “supports clear and strong conscience protections for health care providers who are opposed to performing abortions,” it “rescind[ed] those parts of the 2008 Final Rule that were unclear and potentially overbroad in scope.” Regulation for the Enforcement of Federal Health Care Provider Conscience Protection Laws, 76 Fed. Reg. 9,968, 9,969 (Feb. 23, 2011) (to be codified at 45 C.F.R. pt. 88).

171. The ANC resisted pressure from members to allow a conscience vote and, instead, voted collectively. However, it has been noted that had the ANC allowed a conscience vote, rather than using the party whip, the CTOPA might not have passed in its current form (or at all). Haroz, *supra* note 6, at 886; Guttmacher et al., *supra* note 33, at 193.

advocates pressed for a statutory right to abortion, the drafting of which they could shape and would avoid court interpretation of what a right to abortion included.¹⁷² As noted, the then-recent *Casey* decision—and the concern that the Supreme Court of the United States would overturn *Roe*, which preceded the *Casey* decision—was very much on the minds of drafters of the CTOPA.¹⁷³ A lawyer involved in the drafting stated:

We were aware of how precarious it might be to use the courts to establish the right to abortion. In that sense, *Roe* was a lesson, because we had seen people consistently trying to take *Roe v. Wade* back to court and chip away at the right. We spent a lot of time trying to keep the abortion issue out of the courts, so that we could first get a law in place, and we could get women's protection through a law that we could then defend in court. So, in a sense, we were reacting to what we thought was a problem in the U.S.¹⁷⁴

Returning to the U.S. law as an “anti-model,”¹⁷⁵ Klug argues that the first court challenge to the CTOPA demonstrated the success of an approach that avoids American-associated outcomes.¹⁷⁶ For example, in the first of two cases discussed in this Part, the then Transvaal High Court dismissed the claim that Section 11 of the Constitution, which guarantees the right to life, applies at conception.¹⁷⁷ As Klug explains, the court avoided relying on a right to privacy and instead referred to common law definitions of when life begins to determine that a fetus is not a rights-bearer under the South African Constitution.¹⁷⁸

The two courts that have dismissed challenges to the constitutionality of the substance of the CTOPA in 1998 and 2004 cite to *Roe* and U.S. academics to support the legislation.¹⁷⁹ What the decisions appear to frame as an anti-model are the U.S. controversies that surround abortion. But, in essence, they reframe *Roe* as emblematic of a women's rights approach. The anti-model is what *Roe* actually said, not what it now stands for: “*Roe* was

172. See *supra* Part III.A (describing what drafters wanted to include in the CTOPA).

173. See *supra* Part III.B (describing what drafters sought to exclude from the CTOPA).

174. CTR. FOR REPROD. RIGHTS, THIRTY FACES OF ROE, *supra* note 127 (“We consciously chose the law reform route, rather than going through the courts to secure the right.”) (quoting Catherine Albertyn).

175. Klug, *supra* note 114, at 598 (describing a “source of ideas and an outsider to a growing transnational constitutional conversation”). Klug offers another example of an “anti-model” by describing how drafters of the South African Constitution created a right to just compensation but only for arbitrary deprivation in order to block courts from developing a doctrine of regulatory takings or inverse condemnation like that in the United States. *Id.* at 606–07.

176. *Id.* at 612.

177. *Christian Lawyers Ass'n of SA and Others v. Minister of Health and Others* 1998 (11) BCLR 1434 (T) at 1436 (S. Afr.) [hereinafter *Christian Lawyers I*].

178. Klug, *supra* note 114, at 612 (“[E]ven in an area of law in which the United States Supreme Court clearly led the way internationally, its recognition of a women's right to make a choice within the realm of personal privacy has been essentially ignored and framed as an alternative or anti-model.”).

179. *Christian Lawyers I*, *supra* note 177, at 1444; *Christian Lawyers' Ass'n v. National Minister of Health and Others* 2004 (10) BCLR 1086 (T) at 1099 (S. Afr.) [hereinafter *Christian Lawyers II*].

at best a transitional decision that straddled the medical and women's rights models. Women's advocacy helped establish women as constitutional rights holders who are entitled to make decisions about sex and parenting without control by the state – but *Roe* gave only confused expression to this right.”¹⁸⁰

The first case decided in 1998, *Christian Lawyers Association v. Minister of Health (Christian Lawyers I)*, cites to *Roe* to illustrate an international consensus that a fetus does not have a constitutional right to life because granting that right would infringe on women's rights to equality and security of person.¹⁸¹ Although the court analyzes the personhood rights of fetuses under South African common law, it ultimately bases its judgment on an interpretation of the South African Constitution.¹⁸² The court supports its interpretative method by noting the same analysis of the term “person” under the U.S. Constitution.¹⁸³ In particular, the court highlights, and then notes similar argumentation in *Roe*, that a right to life for a fetus would mean that all abortions—even terminations to save a woman's life—would be unconstitutional.¹⁸⁴ Such an interpretation would be stricter than permitted by the 1975 Act (and pre-*Roe* state laws), which allowed abortion for reason of threat to life.¹⁸⁵ To reiterate “the finding that the foetus is not a person and does not enjoy a constitutional right to life has been generally accepted [globally],” the court quotes an excerpt of the book *Life's Dominion* by Ronald Dworkin.¹⁸⁶

The same theme emerges in the second case challenging the constitutionality of the CTOPA decided in 2004. After reviewing South African common law on informed consent, the court in *Christian Lawyers Association v. Minister of Health (Christian Lawyers II)*, a challenge to minors' access to abortion without parental consent, quotes from *Roe* to demonstrate support for a “right [of a woman] to determine the fate of her own pregnancy.”¹⁸⁷ The Supreme Court of Appeal cites *Casey* as “affirm[ing] the essential findings of *Roe* including the principle that women have a constitutional right to determine the fate of their own pregnancy.”¹⁸⁸

180. Siegel, *Roe's Roots*, *supra* note 33, at 1897.

181. *Christian Lawyers I*, *supra* note 177, at 1444. Judge McCreath held that the drafters of the Constitution purposely excluded rights for the fetus. *Id.* at 1444; see Sujit Choudhry, *Globalization in Search of Justification: Toward a Theory of Comparative Constitutional Interpretation*, 74 *IND. L.J.* 819, 833–39, 841–46 (1999) (setting out categories of reasons on which courts rely to legitimate their use of foreign law; noting South Africa's use of foreign law is at times to promote a universalist approach).

182. *Christian Lawyers I*, *supra* note 177, at 1442–43.

183. *Id.* at 1444.

184. *Id.*

185. *Id.* at 1443–44.

186. *Id.* at 1444.

187. *Christian Lawyers II*, *supra* note 179, at 1099. Interestingly, the court again cites Ronald Dworkin's, *Life's Dominion*, for “the court's conclusion that the Constitution protects the woman's freedom to determine the fate of her own pregnancy.” *Id.* at 1100.

188. *Id.* at 1100. The decision fails to mention that, specifically related to minors' access to abortion, *Casey* upheld a parental involvement law that required the consent of a parent before a minor's abortion. The pattern of citing American caselaw as proof of an emerging consensus toward liberalization and in ways that ignore subsequent developments is not unique to the South African courts. Rachel Rebouché,

But *Christian Lawyers I* and *II* describe abortion jurisprudence from another era, which is perhaps unsurprising. The CTOPA itself took *Roe* as its model and rejected the types of regulations upheld by U.S. courts that cut against a right to abortion.¹⁸⁹ A strategy built around the rejection of law carries with it definitional limits and assumptions. Robin West has written about the unintended consequences of the *Roe* legacy, highlighting in particular what privacy and autonomy rights cannot accomplish in the United States—in West’s account, better choices for caregivers and a just social welfare system.¹⁹⁰ The assessment of costs is apt here, but not just in terms of the limits of courts’ judicial review powers and of negative rights to accomplish redistributive ends.

Roe has not been a ready platform for thinking about abortion in terms of women’s right to health care.¹⁹¹ Many scholars note how U.S. legislators increasingly ignore concerns with women’s health in the abortion context,¹⁹² unless expressed in terms of how abortion may harm women.¹⁹³ One could look at the marginalization of abortion as a health care service in the 2009 debate on American health care reform and in the subsequent Patient Protection and Affordable Care Act of 2010¹⁹⁴ as examples. Whether abortion would be included in benefit plans offered by new state health care exchanges, which individuals could purchase with the help of federal subsidies, was controversial for bills introduced in the House and the Senate, as well as the reconciliation bill approved by Congress and signed by President Obama.¹⁹⁵ The final Act excludes abortion as an essential benefit in the

Comparative Method in Rights Reform (Nov. 2011) (unpublished manuscript) (on file with author).

189. See *supra* pp. 25–26.

190. Robin West, *From Choice to Reproductive Justice: De-Constitutionalizing Abortion Rights*, 118 YALE L.J. 1394, 1409–10, 1423 (2009).

191. B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501, 507, 510–11 (2008) (noting that although *Roe* was written in the “medical model”—a negative right to non-governmental interference in a medical decision made by a physician and pregnant woman—it does not suggest that women have a positive right to receive reproductive health care).

192. See, e.g., Hilary Hammell, *Is the Right to Health a Necessary Precondition for Gender Equality?*, 35 N.Y.U. REV. L. & SOC. CHANGE 131, 166 (2011) (arguing that in passing anti-abortion legislation, legislators “are permitted to focus on the fetus, or the abstract question of ‘whether and if’ to procreate, rather than on the health implications for the woman whose body is directly and seriously affected by pregnancy and abortion”).

193. For example, in 2007, the U.S. Supreme Court upheld a federal law that barred physicians from using a particular abortion procedure popularly known as partial birth abortion and clinically described as intact dilation and extraction. The subject of the challenge was the law’s failure to include an exception for when the procedure would be necessary to protect a woman’s health. The Court held that evidence did not conclusively establish that the procedure was necessary (in comparison with other available procedures) to protect the pregnant woman’s health. *Gonzales v. Carhart*, 550 U.S. 124, 165–66 (2007). This holding has been criticized for ignoring the opinion of medical experts that testified about the safety and health benefits of the banned procedure for women and for overly emphasizing emotional harm that abortion may cause women. Priscilla J. Smith, *Responsibility for Life: How Abortion Serves Women’s Interests in Motherhood*, 17 J.L. & POL’Y 97, 141–42 (2008); see also Pamela S. Karlan, *The Law of Small Numbers: Gonzales v. Carhart, Parents Involved in Community Schools, and Some Themes from the First Full Term of the Roberts Court*, 86 N.C. L. REV. 1369, 1382–84 (2008).

194. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). The Act also prohibits plans from discriminating against any physician participant that is unwilling to provide abortion care.

195. For brief summary of the Congressional debate over abortion in health care reform, see Susan

package of health care benefits that insurance plans participating in state exchanges must cover.¹⁹⁶ State exchange plans may offer abortion coverage but must comply with segregation rules that ensure no federal money subsidizes that care.¹⁹⁷ For example, insurers must offer at least one plan that does not cover abortion,¹⁹⁸ and, for plans that cover abortion, the insurance company must collect two premiums from all of the plan's members—one for abortion benefits and one for everything else.¹⁹⁹ State insurance commissions will oversee the separate accounts into which insurance companies must deposit payments for abortion benefits.²⁰⁰

The South African experience of implementing the CTOPA demonstrates the value of imprinting the details of health care delivery on a legislative strategy for securing abortion rights. This would inevitably present challenges given the myriad of health priorities and different infrastructure needs of any country. But a legislative strategy designed to address implementation obstacles at the point of enactment might help de-stigmatize abortion services in the long run.

Advocates and legislators supporting the CTOPA succeeded in establishing abortion as a legal right. However, that effort may not incorporate the tools necessary to pursue legislation that meets the reproductive health needs of women.²⁰¹ The next Part considers how the influence of U.S. law on drafters may have limited the scope and purpose of reproductive health reform through an analysis of the shortcomings of the CTOPA's implementation. Mapping these problems reveals that some of the controversies drafters sought to avoid erupted anyway and that challenges the drafters perhaps

Cohen, *Insurance Coverage of Abortion: The Battle to Date and the Battle to Come*, GUTTMACHER POL'Y REV., Fall 2010, at 2-4. For a summary of the text of the bills debated in Congress, see KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: HEALTH CARE REFORM PROPOSALS (2009), available at http://www.kff.org/healthreform/upload/healthreform_tri_full.pdf.

196. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1303(a)(1)(A)(i), 124 Stat. 119, 168 (2010).

197. *Id.* § 1303(a)(1)(B)(i).

198. *Id.* § 1303(a)(1)(D)(i)(II).

199. *Id.* § 1303(a)(2)(B). The cost of the abortion benefit must be at least one dollar per enrollee per month. *Id.* § 1303(a)(2)(C)(ii)(III).

200. Since passage of the Patient Protection and Affordable Care Act of 2010, fifteen states have passed laws prohibiting insurance companies participating in state exchanges from offering coverage for abortion services; another fifteen have proposed such laws. Karmah Elmusa, *Map of the Day: States Banning Abortion Coverage*, MOTHER JONES, June 29, 2011, <http://www.motherjones.com/mojo/2011/06/map-state-abortion-coverage-ban>. In 2011, the House of Representatives passed the "No Taxpayer Funding for Abortion Act," which did not move forward in the Senate. The bill prevents employers from taking a tax deduction for insurance plans that include abortion coverage and prevents individuals from paying for plans that cover abortion with pretax dollars or using a flexible health spending account to pay for abortion care or claiming medical care deduction from federal taxes. No Taxpayer Funding for Abortion Act, H.R. 3, 112th Cong. (2011). More recently, the House passed the "Protect Life Act," which, among other things, amends the Patient Protection and Affordable Care Act to prohibit funds from covering any costs of any health plan that offers coverage of abortion services. The Protect Life Act H.R. 358, 112th Cong. (2011).

201. Andrews, *Striking the Rock*, *supra* note 63, at 318-19, 338; see Chad M. Gerson, *Toward an International Standard of Abortion Rights: Empirical Data from Africa*, 18 PACE INT'L L. REV. 373, 387-88 (2006) (arguing that the movement to define a right to abortion as a human right is distinctly "Western").

did not anticipate became substantial impediments to realizing the CTOPA's goals.

IV. CHALLENGES OF THE CTOPA'S IMPLEMENTATION

It is not for lack of political will that the implementation of the CTOPA has been problematic.²⁰² The ANC supported the CTOPA by publicizing widely the importance of safe abortion for all South African women.²⁰³ Yet the extent to which the CTOPA has led to improvements in women's access to reproductive health services is unclear. For example, some studies have found that legal and illegal abortion-related deaths have decreased,²⁰⁴ estimating that rates of maternal mortality decreased by almost half in the two years following the CTOPA.²⁰⁵ However, a study conducted over 2005 to 2007, the Saving Mothers Report, found an increase in avoidable, abortion-related deaths.²⁰⁶

The number of women with illness or disease resulting from abortion has *not* decreased significantly.²⁰⁷ And data on the number of illegal abortions post-passage of the CTOPA is troubling: studies in 2000 and 2009 suggest a fairly constant rate of illegal abortion—or terminations performed outside of designated facilities or by unapproved persons.²⁰⁸

Moreover, attitudes about abortion remain largely mixed or negative. There continues to be considerable social stigma associated with abortion. In *Christian Lawyers I*, petitioners argued that the majority of South Africans opposed abortion and believed in life at conception, which is a claim about public attitudes that carries some weight.²⁰⁹ In KwaZulu-Natal, for example, forty-eight percent of those surveyed said abortion was morally wrong and forty-one percent believed it was justifiable only in the case of rape; only ten percent believed it was a woman's right.²¹⁰ Arguably, because of the stigma associated with abortion, women report that they fear judg-

202. The politics of ANC President Zuma, whose conservative, religious base has pressured him to reconsider abortion or other legislation, may signal change in ANC support. See Mandy Rossouw, *Zuma's New God Squad Wants Liberal Laws to Go*, MAIL & GUARDIAN, Sept. 11, 2009, <http://mg.co.za/article/2009-09-11-zumas-new-god-squad-wants-liberal-laws-to-go> (noting that President Zuma's Christian supporters are pressing for the repeal of abortion and same-sex marriage laws).

203. See, e.g., Manto Tshabalala-Msimang, Minister of Health, Speech: The Saving Mothers Report on Confidential Enquiries into Maternal Deaths in South Africa (Sept. 19, 2006).

204. Margaret Hoffman et al., *The Status of Legal Termination of Pregnancy in South Africa*, 96 S. AFR. MED. J. 1056, 1056 (2006).

205. Cooper et al., *Ten Years*, *supra* note 35, at 75.

206. Bateman, *supra* note 11, at 302.

207. Rachel Jewkes et al., *Prevalence of Morbidity Associated with Abortion Before and After Legalisation in South Africa*, 324 BRIT. MED. J. 1252, 1252 (2002) (study revealed that there were 362 incomplete abortions per 100,000 women in 2000 as compared to 375 in 1994).

208. Rachel Jewkes et al., *The Impact of Age on the Epidemiology of Incomplete Abortions in South Africa after Legislative Change*, 112 BRIT. J. OBSTETRICS & GYNAECOLOGY 355, 356–57 (2005); Meel & Kaswa, *supra* note 10, at 79–80.

209. *Christian Lawyers I*, *supra* note 177; see also Denise Meyerson, *Abortion: The Constitutional Issues*, 116 S. AFR. L.J. 50, 53 (1999).

210. Abigail Harrison et al., *Barriers to Implementing South Africa's Termination of Pregnancy Act in Rural KwaZulu/Natal*, 15 HEALTH POL'Y & PLAN. 424, 426–28 (2000).

ment from their friends and families or disapproval from health practitioners.²¹¹ Women in turn are more likely to hide their terminations while they seek out confidential or clandestine services.²¹²

There are always anticipated difficulties in implementing or enforcing new legislation when it challenges deeply held social beliefs or practices. However, problems of reception intensify when legislative change fails to account for the practical or contextual aspects of reform. This Part situates post-enactment controversies as consequences of the legislative model pursued. First, this Part looks at the uncertain and unsatisfactory standards created by drafters' avoidance strategy—taking minors' access and conscientious objection as its primary examples—and reviews how practitioner discretion or judicial and statutory interpretation now mediate debates about the meaning and scope the CTOPA. Second, it seeks to understand the resource limitations that delay or prevent women from gaining access to abortion services. This discussion suggests that a shortcoming of the CTOPA is its incapacity to wrestle with the limitations of health care service delivery.

A. Refusals by Health Care Providers

The number of health professionals who refuse to assist women seeking abortions has hampered the realization of CTOPA rights.²¹³ These professionals include nurses, physicians, midwives, and the “peripheral staff,” like managers and hospital superintendents, that act as “gatekeepers” to health services.²¹⁴ For example, a 2002 study conducted in the Transkei region showed that only 12.5% of practitioners were willing to perform an abortion on request.²¹⁵ Several studies note that most health professionals are reluctant to assist women seeking abortions because of their moral beliefs.²¹⁶ Health workers state in surveys that their role is to “save [lives,] not take [them] away.”²¹⁷ In a study conducted in 2000, seventeen percent of women interviewed in three hospitals across Gauteng said that they understood abortion was legal but chose another method of termination (for example,

211. *Id.* at 428–30.

212. Of 673 women interviewed in Gauteng, Mpumalanga, and the Western Cape provinces between November 2001 and March 2002, thirty-three percent discussed their terminations with their sexual partner and twenty-five percent with family members, while twenty-one percent did not discuss their abortions with anyone. Diane Cooper et al., *Medical Abortion: The Possibilities for Introduction in the Public Sector in South Africa*, REPROD. HEALTH MATTERS, Nov. 2005, at 35, 38–39 [hereinafter Cooper et al., *Medical Abortion*].

213. Di McIntyre & Barbara Klugman, *The Human Face of Decentralisation and Integration of Health Services: Experience from South Africa*, REPROD. HEALTH MATTERS, May 2003, at 108, 112–13.

214. SANJANI JANE VARKEY & SHARON FONN, HOW FAR ARE WE? ASSESSING THE IMPLEMENTATION OF ABORTION SERVICES: A REVIEW OF LITERATURE AND WORK-IN-PROGRESS 8 (2000), available at <http://www.hst.org.za/uploads/files/assabort.pdf>; Blanchard et al., *supra* note 56, at 112.

215. G.A.B. Buga, *Attitudes of Medical Students to Induced Abortion*, 79 E. AFR. MED. J. 259, 262 (2002).

216. See Harrison et al., *supra* note 210, at 428–29; Sanjani Jane Varkey et al., *The Role of Advocacy in Implementing the South African Abortion Law*, REPROD. HEALTH MATTERS, Nov. 2000, at 103, 105.

217. VARKEY & FONN, *supra* note 214, at 15.

self-administered or outside of a medical facility) because they feared the reaction of medical staff.²¹⁸ Medical professionals with conscientious objections often refuse to refer women to professionals who might offer them abortion care or to provide health services to women post-termination.²¹⁹

Whether to include a refusal clause was a source of lively debate in the drafting of the CTOPA.²²⁰ A clause in an earlier draft would have allowed a health care provider to refuse to treat a patient but required a referral to a willing provider.²²¹ The government later removed language from the bill about refusal because reaching consensus proved too time-consuming and met resistance from the Reproductive Rights Alliance.²²² As a result, the standard for refusal is unclear.

Section 15 of the Constitution provides for “the right to freedom of conscience, religion, thought, belief and opinion.”²²³ Charles Ngwena notes that providers could seek protection under the Constitution, which would subject refusal rights to the limitations set out in Section 15 (rights to expression must be consistent with other constitutional rights such as rights to reproductive health and decision-making)²²⁴ and the Constitution’s general limitations clause, Section 36.²²⁵ For Ngwena, Sections 15 and 36 read together imply a balancing approach: providers would not have a right to object when a termination is necessary to save a life or prevent serious damage to a woman’s health, could not refuse to provide information regarding where a

218. Rachel Jewkes et al., *Why Are Women Still Aborting Outside Designated Facilities in Metropolitan South Africa?*, 112 BRIT. J. OBSTETRICS & GYNAECOLOGY 1236, 1240 (2005).

219. See Michelle C. Engelbrecht et al., *The Implementation of the Choice on Termination of Pregnancy Act: Some Empirical Findings*, 23 CURATIONIS 4, 6 (2000) (noting that health care workers obstruct abortion by refusing to give patients information about abortion services); Ngwena, *Appraisal of Abortion Law*, *supra* note 6, at 715.

220. Note also that the 1975 Act included a conscience clause that allowed physicians to refuse to perform an abortion. Haroz, *supra* note 6, at 881.

221. See Termination of Pregnancy Bill, 1996, Bill 80–96, § 8, available at http://us-cdn.creamermedia.co.za/assets/articles/attachments/03832_termofpergb80-1996.pdf (last visited September 6, 2011). Ngwena argues that this form of refusal may still require health professionals to act against their beliefs, potentially offending their right to freedom of religion and freedom of belief and their right to be free from unfair religious discrimination. Ngwena, *Conscientious Objection*, *supra* note 164, at 11–14.

222. Ngwena reports that Parliament left out a refusal clause because it could not find a satisfying balance between the health professional’s right to expression and the woman’s right to access health services. Records of the debate indicate that drafters believed the interpretation of the Constitution could mediate conflicts between the right to object and the right to health care. Ngwena, *Conscientious Objection*, *supra* note 164, at 14.

223. S. AFR. CONST., 1996, ch. 2, § 15(1).

224. *Id.* at § 15(3)(b) (stating that “[r]ecognition in terms of paragraph (a) must be consistent with this section and the other provisions of the Constitution”); Ngwena, *Conscientious Objection*, *supra* note 164, at 9.

225. S. AFR. CONST., 1996, ch. 2, § 36(1) provides that rights in the Bill of Rights may be limited “to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom” and taking account of factors such as the nature, importance of the right; the nature and extent of the limitation; the relation between the right and the limitation; and whether the less restrictive limitation has been applied. See Ngwena, *Conscientious Objection*, *supra* note 164, at 11.

woman may seek termination, and could object only if they were involved directly in performing the termination.²²⁶

Court decisions have not clarified the issue, although health professionals have asserted refusal rights. In a case yet resolved, a nurse refused to prepare patients for follow-up treatment after terminations and her then-director reassigned her to another department in the hospital. She sued the hospital for unfair discrimination on the grounds of religion, conscience, and belief under the Promotion of Equality and Prevention of Unfair Discrimination Act.²²⁷ Unsure whether the case presented an equality or employment issue, courts transferred the case to forums of differing jurisdiction.²²⁸

Legislation subsequent to the CTOPA could have also clarified a standard for refusals. An amendment to the Health Professions Act addresses ethical standards for medical professional conduct, such as obtaining informed consent and record keeping.²²⁹ However, it avoids the issue of conscientious objection to abortion services.²³⁰

The lack of clarity makes for questionable health policy. It increases the likelihood that health care providers will misunderstand what their legal obligations are,²³¹ which may in turn create a disincentive for medical professionals to provide abortion care.²³² A 2006 study revealed that both supportive and antagonistic physicians, nurses, and midwives were “not all that familiar with the legislation” or “unclear about the conditions under which a woman could request an abortion.”²³³ The extent to which the medical profession is unaware of the law is particularly troubling given that health professionals exercise wide discretion in determining the validity of the grounds for abortion in the second and third trimesters. They serve as the

226. Ngwena, *Conscientious Objection*, *supra* note 164, at 11–15.

227. Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (S. Afr.), amended by the Judicial Matters Amendment Act 66 of 2008 (S. Afr.).

228. The plaintiff lodged her case in the Equality Court in 2004. Her case was transferred to the Labor Court as a matter of constructive dismissal in 2005. In 2007, the Labor Appeals Court transferred the case to the Commission for Conciliation, Mediation and Arbitration. *Charles & Others v. Gauteng Dep't of Health (Kopanong Hosp.) & Others* 2007 ZALAC 18 (S. Afr.). More recently, arbitration helped reinstate a physician dismissed after participating in “protest action and campaigns against the termination of pregnancies by the Free State health department.” South African Press Association, *Anti-Abortion Doc Reinstated*, NEWS24.COM, Mar. 8, 2010, <http://www.news24.com/SouthAfrica/News/Anti-abortion-doc-reinstated-20100308> (but note that article incorrectly asserts that legislation governs health professionals' refusals in the abortion context).

229. Ethical Rules of Conduct for Practitioners Registered Under the Health Professions Act, 1974: Amendment (GN) R390/2008 (S. Afr.) available at <http://www.info.gov.za/view/DownloadFileAction?id=79654>.

230. *Id.*

231. Ferdinand Van Oosten, *The Choice on Termination of Pregnancy Act: Some Comments*, 116 S. AFR. L.J. 60, 67–68 (1999).

232. Some health professionals have reported experiencing post-traumatic stress syndrome after participating in abortion services, due in part from experiencing isolation or being denied promotion or pay as a consequence of performing terminations. Ngwena, *Conscientious Objection*, *supra* note 164, at 4.

233. Jane Harries et al., *Health Care Providers' Attitudes Towards Termination of Pregnancy: A Qualitative Study in South Africa*, 9 BMC PUBLIC HEALTH 296, 299 (2009).

judges, for example, of patients' claims of physical, mental, or socio-economic harm after twelve weeks of pregnancy.

At present, a provider has discretion to fill in the gaps of the CTOPA with his or her own interpretation of the law. Considering, as the next Parts do, that health care providers may be in need of further training and more resources, the confusion or ignorance around their professional duties, combined with opposition towards abortion generally, creates obstacles to implementation that provisions of the CTOPA do not readily address. Still unresolved is what role law should play in monitoring how providers serve as gatekeepers to legal abortion services—mirroring contemporary debates in the United States.²³⁴

B. Minors' Abortions and Parental Involvement

As with health care provider refusals, advocates did not avoid controversy by omitting parental notice or consent requirements for minors' abortions.²³⁵ During discussions over whether to include mandatory counseling for minors (and whether some form of parental consent should be required), advocates argued that any restriction on minors' choice would result in young women using underground services outside the purview of parental or public scrutiny.²³⁶ For example, the MRC study referenced in Part I showed that adolescents were the population of women most likely to present at hospitals with complications from illegal abortions before the CTOPA.²³⁷ Even though the CTOPA gives minors the right to terminate pregnancies without third-party permission, there is a significant reluctance by providers to perform abortions on minors without prior parental approval.²³⁸ Only thirteen percent of health professionals surveyed said minors should be able to make independent abortion decisions and ninety-four percent of social workers stated that the law should mandate that minors inform their parents when terminating pregnancies.²³⁹

In *Christian Lawyers II*,²⁴⁰ plaintiffs before the Supreme Court of Appeal argued that women under the age of eighteen were incapable of giving informed consent, as defined by the CTOPA, without parental involve-

234. See *supra* note 193.

235. Political parties and anti-abortion organizations introduced amendments to restrict minors' access during the 2004 and 2008 debates on the Choice on Termination of Pregnancy Amendment Act. See *infra* Part IV.C.

236. UN INT'L RESEARCH AND TRAINING INST. FOR THE ADVANCEMENT OF WOMEN, *supra* note 35, at 215, 217 (noting the drafting Committee incorporated amendments regarding parental consent offered by the Reproductive Rights Alliance and citing the to the Portfolio Committee on Health on the Termination of Pregnancy Bill by the Reproductive Rights Alliance).

237. Guttmacher, *supra* note 33, at 192 ("A closer inspection of the Medical Research Council data shows that women under the age of 20 were three times more likely to present at a hospital with incomplete abortions than were older women.")

238. Sanjani Jane Varkey, *Abortion Services in South Africa: Available Yet Not Accessible to All*, 26 INT'L FAM. PLAN PERSP. 87, 88 (2000).

239. VARKEY & FONN, *supra* note 214, at 10.

240. *Christian Lawyers II*, *supra* note 179.

ment.²⁴¹ The court held that the capacity of a minor to give informed consent should be determined by the mature minor standard developed by common law: a minor “mature enough to form an intelligent will” may seek health care without parental involvement.²⁴² Medical professionals maintain broad discretion to decide if a minor meets this standard of maturity. The court stated:

Within the context of the Act, actual capacity to give informed consent, as determined in each and every case by the medical practitioner, based on the emotional and intellectual maturity of the individual concerned and not on arbitrarily predetermined and inflexible age or fixed number of years, is the distinguishing line between those who may access the option to terminate their pregnancies unassisted on the one hand and those who require assistance on the other.²⁴³

If a minor lacks “emotional and intellectual maturity,” then a health professional should refuse to perform the abortion.²⁴⁴

However, the decision does not offer guidance to medical professionals for determining maturity. The court’s reliance on the common law would suggest that common law decisions would be informative on the point. But as Joanna Erdman notes, the mature minor standard (as developed by common law) can be just as frustrating to a minor’s agency as parental involvement laws by requiring a health professional to judge a minor’s abortion decision.²⁴⁵ Erdman describes faulty assumptions that underpin decisional oversight based on maturity.²⁴⁶ The first is that adolescents are incapable of making any important decisions about their lives independently from adults, which has been undermined by research on the cognitive development of adolescents.²⁴⁷ The second, and perhaps more significant, assumption is that third parties will *improve* the decision-making of minors.²⁴⁸ Erdman relies on extensive literature to argue that because abortion decisions are individu-

241. Bekink & Bekink, *supra* note 16, at 22 (noting constitutional challenges based on rights to family care and freedom from abuse or maltreatment).

242. *Christian Lawyers II*, *supra* note 179, at 1094; *see also* Gillick v. W. Norfolk & Wisbech Area Health Auth. [1985] 3 All E.R. 402 (H.L.) 403 (holding that medical practitioners may prescribe contraceptives to minors without parental knowledge if the minor shows “sufficient understanding and intelligence to . . . understand fully what was proposed”).

243. *Christian Lawyers II*, *supra* note 179, at 1094.

244. *Id.*

245. Joanna N. Erdman, *Moral Authority in English and American Abortion Law*, in *CONSTITUTING EQUALITY: GENDER EQUALITY AND COMPARATIVE CONSTITUTIONAL LAW* 107, 110 (Susan Williams ed., 2009).

246. *Id.* at 120–24.

247. *See, e.g.*, Elizabeth Cauffman & Laurence Steinberg, *The Cognitive and Affective Influences on Adolescent Decision-Making*, 68 *TEMP. L. REV.* 1763, 1768 (1995) (“[M]ost studies indicate that there are few, if any, differences between the cognitive processes of adults and adolescents.”).

248. *Id.* at 1768–70.

alized and context-driven, a third party rarely assesses the risks and benefits better than the individual minor can.²⁴⁹

Interestingly, *Christian Lawyers II* creates a maturity test that loosely resembles the American standard for waiver of parental involvement. Under U.S. parental involvement laws, a minor may waive notice to or consent from a parent if a court—or in three states, a physician—finds that she is either mature and well-informed or an abortion is in her best interests.²⁵⁰ The test affords courts wide discretion in determining maturity or best interests, and many state courts receive little to no guidance in determining maturity or best interests.²⁵¹ Courts can, and do, systematically deny most or all petitions heard or, conversely, grant almost all petitions.²⁵² Arguably, health professionals, like judges, could apply their discretion to the detriment of minors if they believe *most* adolescents are immature. The Supreme Court of Appeal addressed this possibility by stating blankly that medical practitioners may not deny all minors an abortion because of their age.²⁵³ It is unclear how courts would police this prohibition. Outside of an explicit age requirement, a maturity test does not curb the provider's discretion in setting too high a threshold for young women to evidence "emotional and intellectual maturity."²⁵⁴

The court could have considered other avenues for balancing the interests of minors, parents, and providers. The court highlighted minors' right to reproductive decision-making in Section 12 of the Constitution, but did not discuss how the constitutional rights of children in Section 28 (applying to persons under eighteen) might inform a mature minor standard.²⁵⁵ Section 28(2) states that "[a] child's best interests are of paramount importance in every matter," which the Constitutional Court of South Africa has interpreted as a stand-alone and enforceable provision.²⁵⁶ The right to "family

249. Erdman, *supra* note 245, at 120–24.

250. *Casey*, in upholding Pennsylvania's parental consent statute, affirmed key aspects of the U.S. Supreme Court's plurality decision in *Bellotti v. Baird*. In *Bellotti*, a plurality of the Court wrote that a parent may not have an absolute veto of their child's abortion decision. If a minor does not want to obtain parental consent—or cannot obtain parental consent—states must provide an alternative process that allows the minor to show she is mature and well-informed or it is in her best interests to waive parental consent. 443 U.S. 622, 643–44 (1979).

251. See, e.g., Rachel Rebouché, *Parental Involvement Laws and New Governance*, 34 HARV. J.L. & GENDER 175 (2011) (suggesting that the structure of parental involvement laws and the lack of training on notice or consent laws deepen court discretion).

252. See Carol Sanger, *Regulating Teenage Abortion in the United States: Politics and Policy*, 18 INT'L J.L., POL'Y & FAM. 305, 309 (2004) ("Judges tend to fall into two categories: those who grant no petitions, and those who rubber stamp most.").

253. *Christian Lawyers II*, *supra* note 179, at 1094.

254. *Id.* A 2009 report profiled by the World Health Organization highlights this problem. Nurses resisted helping patients if they believed patients did not have good reasons for their abortions. DEP'T OF REPROD. HEALTH AND RESEARCH, WORLD HEALTH ORG., WHAT HEALTH-CARE PROVIDERS SAY ON PROVIDING ABORTION CARE IN CAPE TOWN, SOUTH AFRICA: FINDINGS FROM A QUALITATIVE STUDY 3 (2009) [hereinafter, WHO Report], available at http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.18_eng.pdf.

255. *Christian Lawyers II*, *supra* note 179, at 1095–96.

256. *Minister for Welfare and Population Development v. Fitzpatrick & Others* 2000 (7) BCLR 713 (CC) at 720 (S. Afr.) (stating that section 28(2) "creates a right that is independent of those specified in

care or parental care” in Section 28(1)(b) suggests that a child’s right to parental care derives from the Constitution’s protection of the minor’s well-being rather than a parent’s right to direct the upbringing of a child.²⁵⁷ This interpretation is consistent with the decision of the Constitution’s drafters to omit references to the rights of parents or to the right to found a family.²⁵⁸ The best interest standard understood in this way could serve as a check on providers’ discretion.

Like refusals, subsequent legislative interventions related to minors’ consent to medical treatment have not necessarily clarified the standard. At the time *Christian Lawyers II* was decided, the Child Care Act governed parental consent for minors’ medical treatment and surgical procedures.²⁵⁹ Under the Act, any surgical procedure for a child under eighteen (and any medical treatment for a child younger than fourteen) needed approval of a guardian.²⁶⁰ This contradicted the CTOPA, which requires no such consent for surgical abortion.²⁶¹ In 2005, the Children’s Act replaced the Child Care Act and may have supplanted a mature minor standard, although not in straightforward ways.²⁶² Subject to the CTOPA, the Act permits a child to consent to a surgical operation if she is over the age of twelve years and “is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation.”²⁶³ The Act does not define who would make the maturity determination. The child also must be “duly assisted by his or her parent or guardian.”²⁶⁴ “Assistance” is not defined in legislation, but the Act appears to limit parental involvement in so far that a parent may not refuse to assist the minor “by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically accepted alternative choice to the medical treatment or surgical operation concerned.”²⁶⁵

The examples of refusals and parental involvement highlight how a focus on a woman’s right to abortion may be necessary but not sufficient to create the kind of access to services that drafters had in mind. These issues touch on the complex role that intermediaries play in women’s abortion

section 28(1)”; *LS v. AT & Another* 2001 (2) BCLR 152 (CC) at 162 (S. Afr.) (referring to section 28(2) as “an expansive guarantee that a child’s best interests are paramount in every matter concerning the child”).

257. S. AFR. CONST., 1996, ch. 2, § 28.

258. The South African Constitution does not explicitly protect parental rights. There is no right to found a family and no provision that confers special status on the family unit, such as in other human rights documents like the International Covenant on Civil and Political Rights or the International Covenant on Economic, Social and Cultural Rights. D. MARIANNE BLAIR & MERLE H. WEINER, *FAMILY LAW IN THE WORLD COMMUNITY: CASES, MATERIALS, AND PROBLEMS IN COMPARATIVE AND INTERNATIONAL FAMILY LAW* 1139 (2003) (quoting Justice Albie Sachs about the decision of the Constitution’s drafters to exclude a right to found a family).

259. Child Care Act 74 of 1983 (S. Afr.); Van Oosten, *supra* note 231, at 71.

260. Bekink & Bekink, *supra* note 16, at 21.

261. CTOPA, *supra* note 4, § 5.

262. Children’s Act 38 of 2005 (S. Afr.).

263. *Id.* §§ 129(1)–(3).

264. *Id.* § 129(3)(c).

265. *Id.* § 129(10).

choices. The CTOPA succeeded in ensuring that legislative language did not define the roles of third parties in relation to women, but it may not have gone far enough in resolving conflicts between women's choices and the interests of parents, providers, or others.

C. Logistical Obstacles to Health Care Services

The goal that reform strategies for additional abortion grounds presuppose is that legal abortion services, the access to which does not depend on the woman's reason for termination or characteristics like age, will result in greater access to abortion and will thus produce better health outcomes for women. As noted, arguments for the CTOPA advanced research illustrating how restrictions on legal abortion under the 1975 Act related to maternal morbidity and mortality.²⁶⁶ Some women's health outcomes under the CTOPA may look disconcertingly similar to those under the 1975 Act, because there remains a gap between those who have the necessary resources to navigate obstacles to health care and those who do not.

Implementation problems would be predictable in any country, like South Africa, where resource limitations are a substantial impediment to the delivery of health care services. A broadly applicable right to abortion requires more facilities and more health professionals to meet the increased demand of a new population of women that can now seek legal abortions. And because the CTOPA creates state responsibility to pay for abortion care in public facilities, scarce resources are stretched even farther.²⁶⁷

A decade after the CTOPA's enactment, only fifty-seven percent of health facilities authorized to perform abortions actually did so.²⁶⁸ The majority of abortions occur in or around South Africa's two largest cities, Johannesburg and Cape Town,²⁶⁹ and almost all of the designated facilities are public hospitals,²⁷⁰ which are overwhelmed with patients and face severe shortages of space and medical professionals.²⁷¹ Very few clinics provide terminations in specialized settings independent from a hospital.²⁷²

Consolidation of services in urban areas exacerbates the considerable delay in setting an appointment for an abortion.²⁷³ Given that the majority of

266. Guttmacher, *supra* note 33, at 192.

267. See National Health Act 61 of 2003 §4(3)(c) (S. Afr.) (reaffirming that terminations performed at public facilities would be at no cost to women).

268. Bateman, *supra* note 11, at 302; see also WHO REPORT, *supra* note 254, at 4 (finding that public sector facilities often did not have health professionals willing to perform abortions).

269. VARKEY & FONN, *supra* note 214, at 6; see also Elizabeth Clarke, *Abortion Services in South Africa*, HEALTH SYSTEMS TRUST, <http://www.hst.org.za/news/abortion-services-south-africa> (last visited Oct. 21, 2011).

270. Varkey, *supra* note 238, at 87. Jeremy Sarkin, writing before the passage of the CTOPA, argued that hospital care is more costly to patients, results in greater delay, and lacks the equipment and professional specialization for delivering abortion services. Sarkin, *Patriarchy and Discrimination*, *supra* note 25, at 166–69.

271. McIntyre & Klugman, *supra* note 213, at 112.

272. VARKEY & FONN, *supra* note 214, at 7.

273. Sarkin, *Patriarchy and Discrimination*, *supra* note 25, at 166–69.

South Africans live in rural areas,²⁷⁴ many women must travel considerable distances to reach approved facilities, increasing the cost and time associated with terminations.²⁷⁵ Access problems only become worse with delay because, as a pregnancy develops, the CTOPA requires additional provider oversight.²⁷⁶ The nature of a trimester framework inevitably depends on approval by providers of grounds for terminations in later pregnancy, which assumes there are available health professionals for the task.

In an attempt to address the severe shortage of health care providers and facilities, Parliament amended the CTOPA (“the Amendment”) in 2004 to allow all clinics or hospitals with twenty-four hour maternity wards to perform terminations, irrespective of whether the Minister of Health had approved the facility under the terms of the CTOPA.²⁷⁷ The Amendment also allows nurses who complete a Medical Controls Council (MCC) training course to provide abortions.²⁷⁸ The Amendment quickly came under attack. In *Doctors for Life Int’l v. Speaker of the National Assembly & Others*, petitioners challenged the process of provincial consultation for the Amendment.²⁷⁹ The Constitutional Court held that the required consultation was indeed lacking; the National Council of Provinces (NCOP) and the provincial governments had failed to hold hearings on the Amendment in each province.²⁸⁰ The Court suspended implementation of the Amendment for eighteen months so that the NCOP could facilitate adequate public consultation among the provinces.²⁸¹ Having consulted through a number of the mechanisms noted in the Court’s opinion,²⁸² the Amendment returned to Parliament in 2008 without substantive changes and passed by 266 to 52 votes.²⁸³

Amendment debates provided a window into current public discourse around abortion in South Africa. Political parties and anti-abortion organizations introduced amendments to restrict minors’ access under the CTOPA and to require mandatory counseling,²⁸⁴ as well as to codify a conscience clause for health care professionals.²⁸⁵ These proposals, although ultimately unsuccessful, took precedence over discussions of resource allocation or logistical concerns about the CTOPA’s implementation.²⁸⁶

274. Higgins et al., *supra* note 45, at 1698.

275. See Haroz, *supra* note 6, at 891–92; see also Varkey, *supra* note 238, at 87.

276. See Sarkin, *Patriarchy and Discrimination*, *supra* note 25, at 166–69.

277. Cooper et al., *Ten Years*, *supra* note 35, at 76.

278. *Id.*

279. *Doctors for Life Int’l v. Speaker of the National Assembly & Others* 2006 (12) BCLR 1399 (CC) (S. Afr.).

280. *Id.* ¶ 186.

281. *Id.* ¶ 214.

282. *Id.* ¶¶ 132, 154.

283. Choice on Termination of Pregnancy Amendment Act 1 of 2008 (S. Afr.).

284. Siyabonga Mkhwanazi, *One step closer for girls wanting abortions*, IOL, Jan. 18, 2008, <http://www.iol.co.za/news/south-africa/one-step-closer-for-girls-wanting-abortions-1.386150>.

285. Wyndham Hartley, *South Africa: MPs Pass Abortion Bill By Due Date*, ALLAFRICA.COM, Jan. 18, 2008, <http://allafrica.com/stories/200801180289.html>.

286. *Abortion Bill Passed*, HEALTH 24, Jan. 18, 2008, http://www.health24.com/news/Health_Care/1-

Whether relaxing the CTOPA's centralized approach will help support different avenues to abortion (such as through community-based clinics, where many women seek other health care) is yet to be seen. Early reports suggest that progress is slow. Citing one physician, a recent article in the *South African Medical Journal* estimates that the CTOPA is implemented at "30% of its potential efficacy."²⁸⁷ Waiting lists and medical practitioner refusals cause increased numbers of second trimester abortions, which, as noted, put further strain on personnel, space, and services.²⁸⁸ The shortage of resources has become so acute that health professionals are asking the National Health Council to dispense the drug combination of misoprostol and mifepristone so that women can self induce abortion at home with minimal medical supervision.²⁸⁹

In ways that the Amendment addressed indirectly, the CTOPA did not have to rely so heavily on approval by the national health authority, the Minister of Health, in order to designate facilities for abortion services. It did not have to restrict the type of medical professional that could perform what should be a relatively low-risk procedure. And it could have drawn from the resources already at the community level, such as traditional healers who serve in roles like midwives. It might have intervened in building the country's health care infrastructure, but with women's reproductive health as a centerpiece. The next Part presents a tentative suggestion for how to pursue reform on somewhat different terms.

V. REFLECTIONS ON AN ALTERNATIVE LEGISLATIVE STRATEGY

The dominant model of reform may embed the very problems that it seeks to circumvent, and may undermine an approach that would support women's broader reproductive health needs. Reproductive health and rights campaigns increasingly recognize that they must address problems in a country's primary health care system.²⁹⁰ The ICPD, for example, urges states to ensure better service delivery and technical assistance at the level

918,43784.asp.

287. Bateman, *supra* note 11, at 304. Supporting this, a study conducted from 2008 to 2009 found that health facilities met only a third of requests for abortion services in the Johannesburg area. J.F. Mendes, D. Basu & J.K. Basu, *Addressing the Demand for Termination of Pregnancy Services in District Health Facilities in Johannesburg*, 100 S. AFR. MED. J. 614, 614 (2010).

288. Bateman, *supra* note 11, at 304 (noting a six week waiting list for services at a major Cape Town hospital).

289. *Id.* at 302.

290. In some ways, health arguments have come full circle in abortion law reform, at least in the United States. Reva Siegel notes that feminist interventions in the late 1960s, before *Roe*, sought to reframe the discourse from "a question of public health" to concerns about women's equal citizenship. Siegel, *Roe's Roots*, *supra* note 33, at 1881-82 ("Where the ALI model rationalized liberalization as needed to protect women's health, the women's movement sought repeal of abortion laws to promote women's equal standing as citizens."). Feminists mobilized people around the message of "women fighting for themselves" rather than "rescu[ing]" the woman with a troubled pregnancy. Greenhouse & Siegel, *supra* note 118, at 2042 n.43 (quoting CHRISTINE STANSELL, *THE FEMINIST PROMISE: 1792 TO THE PRESENT* 323 (2010)).

of local and primary health care.²⁹¹ Activists and scholars alike call for strategies that incorporate abortion into agendas to improve women's health and, in particular, to reduce maternal morbidity and mortality.²⁹² How legislation might incorporate these concerns from the outset—in ways that make use of existing power structures of import to communities—may not receive sufficient attention during legislative or constitutional drafting processes.

In South Africa, for example, the CTOPA and the Amendment were divorced from efforts to reform the country's primary health care system. The government advanced a Primary Health Care Model in 1994 and the Patient Rights Charter in 1997.²⁹³ Both the Model and the Charter focused on concrete proposals to consolidate primary health care services at regional levels and to experiment with different delivery systems for preventive and promotive health services.²⁹⁴

Reproductive health care remained marginalized in these initiatives. Moreover, the government enacted policies for non-abortion reproductive health services, like guidelines regulating access to contraceptives, funding for cervical cancer screening, or provisions for antiretroviral drugs through the public health system, in a piecemeal fashion that took longer to put in place.²⁹⁵ A more recent example of the gap between health policy and abortion law is the National Health Act of 2003, which emphasizes the development of telemedicine to serve rural communities and to work with traditional healers in promoting a national health care agenda.²⁹⁶ Considering that seventy percent of women report consulting traditional healers first,²⁹⁷ and over sixty percent of rural women were unaware that pregnancy terminations were legal,²⁹⁸ proposals like those in the National Health Act would have made sense for the CTOPA. But regulations issued on training for health care providers (rural and urban) under the National Health Act do not address abortion services. The general medical curriculum for primary care health providers also does not include training and information on abortion procedures or the optional, non-directive counseling before and after a termination.²⁹⁹

The CTOPA treats all issues of access the same—creating a right for women based on non-discrimination and informed consent but not on the

291. ICPD, *supra* note 14, ch. 8.

292. R.J. Cook & C.G. Ngwena, *Women's Access to Health Care: The Legal Framework*, 94 INT'L J. GYNECOLOGY & OBSTETRICS 216, 216–17 (2006).

293. Cooper et al., *Ten Years*, *supra* note 35, at 71–72.

294. *Id.* at 72.

295. *Id.* at 73–79.

296. Andy Gray & Caron Jack, *Health Legislation and Policy*, S. AFR. HEALTH REV. 31 (2008) (citing National Health Act 61 of 2003 (S. Afr.)).

297. Meel & Kaswa, *supra* note 10, at 80.

298. Varkey, *supra* note 238, at 88 (noting that an early media campaign made people aware of the CTOPA's existence, but not how it worked or what rights it conferred). In the Northern Cape, for example, only fifty-five percent of respondents knew that abortion was legally available on request in the first trimester and only twenty-four percent understood that the CTOPA does not require parental consent for minors. VARKEY & FONN, *supra* note 214, at 12.

299. Varkey, *supra* note 238, at 87; *see also* Haroz, *supra* note 6, at 891.

particular difficulties sub-populations of women have in seeking health care. One change that shows promise is the introduction of medical abortion. In 2001, five years after the passage of the CTOPA, the MCC approved terminations induced by the combination of hormones taken in pill form for up to eight weeks of pregnancy.³⁰⁰ The advantages were set out in a 2005 study of the use of medical abortions in South Africa.³⁰¹

Some women may prefer medical to surgical abortion to avoid instrumentation of the uterus. Medical abortion could also potentially increase access in settings where providers are reluctant to provide surgical abortion services. Health care workers may be less opposed to a method of abortion that they do not have to initiate. Medical methods may require less staff input. Provision of medical abortion could increase women's options and broaden access to abortion services.³⁰²

Medical abortion could help overcome the current obstacles of stigma, confidentiality, and lack of resources; however, medical abortion is rarely used.³⁰³ Medical abortion is not available through public sector pharmacies, and health professionals do not have the training they need under the MCC's guidelines to administer it.³⁰⁴ Traditional healers or their counterparts could monitor the use of medical abortion, a strategy that might tap into the role many of those community figures play in women's reproductive decisions.³⁰⁵ Instead, women are increasingly taking drugs that induce abortion, like misoprostol without mifepristone, often without sufficient instruction on dosage, timing, or use.³⁰⁶

Of course, drafters cannot spell out every detail of a statute's implementation in the legislative text or predict all of the problems that might erupt. But the CTOPA, as modern legislation shaped by a women's rights move-

300. "Medical abortion with 200mg mifepristone orally and 800mcg misoprostol vaginally may be used up to nine weeks of pregnancy at home or in the clinic in the first trimester, and using a different regimen, at the clinic in the second trimester of pregnancy. In 2001 the South African Medicines Control Council approved a regimen of 600mg mifepristone and 400mcg misoprostol orally for medical abortions up to eight weeks of pregnancy." Cooper et al., *Medical Abortion*, *supra* note 212, at 36.

301. Of those interviewed who had medical abortions, ninety-six percent of 289 women were satisfied or very satisfied with the experience. Three South African provinces found that ninety-three percent of women had complete abortions using the mifepristone-misoprostol regimen. The "classic" regimen of medical abortion shows that on average ninety-five percent of patients complete abortions. South Africa: Mifepristone and Misoprostol for Medical Abortion: A Brief Background, NAT'L ABORTION FED'N, Feb. 27, 2006, http://www.prochoice.org/international/training/south_africa_mife.html.

302. Cooper et al., *Medical Abortion*, *supra* note 212, at 36.

303. *Id.* at 35-42.

304. *Id.* at 36.

305. This might not meet the concerns of medical abortion's cost, which is not yet free in public sector facilities, or the costs of training traditional healers. Ipas, an international reproductive health organization, estimates that the cost of medical abortion rose 75% in South Africa from 2002 to 2007. IPAS, MISOPROSTOL AND MEDICAL ABORTION IN AFRICA 2 (2009), available at http://www.ipas.org/Publications/asset_upload_file683_4512.pdf.

306. Jessica Cohen et al., *Reaching Women with Instruction on Misoprostol Use in a Latin American Country*, REPROD. HEALTH MATTERS, Nov. 2005, at 84, 85.

ment whose purpose was to advance women's health, may have missed an opportunity to make connections between legal rights and practical access.

Nepal serves as an imperfect but useful counterexample. Reform processes in countries other than South Africa share similarities in their approaches to reproductive rights reform: liberalization or decriminalization of laws governing abortion; intervention in political transition; reliance on autonomy and equality norms from international documents like the ICPD and FWCW; and predictable difficulties in implementing new laws that place a demand on already limited public resources. Nepal, however, began its campaign with a focus on creating access to health services through partnerships among the state, civil society, and international organizations.³⁰⁷

In 2002, Nepal revised its abortion law in its legal code, or *Muluki Ain*, after a twelve-year conflict and the drafting of a new constitution.³⁰⁸ Abortion is legal for any reason during the first twelve weeks of pregnancy; up to eighteen weeks if the pregnancy is the result of rape or incest; and at any time with the advice of a medical practitioner if the life, physical or mental health of the woman is at risk, or for fetal anomaly incompatible with life.³⁰⁹ For women under sixteen, a "guardian" must give consent, which can include any adult friend or family member.³¹⁰ The former law banned abortion entirely, even if the pregnancy was "the result of rape or incest or threatened the woman's life."³¹¹ Unlike South Africa, the state prosecuted women who had abortions. At one point, individuals jailed for having abortions were over one-fifth of the women's prison population.³¹²

The advocacy effort in Nepal was complex. Beginning in the 1970s, advocates and legislators lobbied for reform with the assistance of American and Western European NGOs.³¹³ Drawing strength from the global movement for reproductive rights, a then-newly established constitutional monarchy took responsibility for Nepal's "Safe Motherhood Network," which received technical assistance from the World Health Organization.³¹⁴ In addition to the democratization of Nepal's political system and growing acceptance of international law, advocates gathered empirical evidence of the number of women harmed from illegal abortion.³¹⁵ One pre-

307. Shyam Thapa, *Abortion Law in Nepal: The Road to Reform*, REPROD. HEALTH MATTERS, Nov. 2004, at 85, 86–88.

308. *Id.* at 91.

309. NEPAL RAJ PATRA (OFFICIAL GAZETTE), pt. 52, Additional issue 47, pt. 2, Sept. 26, 2002, at 22–23.

310. *Id.*

311. Thapa, *supra* note 307, at 85.

312. *Id.* at 89; *see also* Cook & Dickens, *supra* note 72, at 31–32 (noting increased support for abortion law liberalization after a fifteen-year-old rape victim was imprisoned for illegal abortion—a termination her family forced her to have).

313. Ganga Shakya et al., *Abortion Law Reform in Nepal: Women's Right to Life and Health*, REPROD. HEALTH MATTERS, Nov. 2004, at 75, 79.

314. Thapa, *supra* note 307, at 86–87. The World Health Organization launched its global Safe Motherhood Network initiative in 1987.

315. *Id.* at 88–89.

liberalization study estimates that fifty percent of maternal deaths were due to abortion-related complications.³¹⁶

The first bill introduced to decriminalize abortion failed when its sponsor's term of office ended.³¹⁷ The second attempt to change the abortion law, in 1997, was part of a larger legislative strategy to remove gender discrimination in property ownership, inheritance law, divorce and marriage laws, and in criminal statutes governing rape.³¹⁸ After five years of debate, the legislature passed the 11th Amendment Bill to the Legal Code in 2002.³¹⁹ Almost two years after passage, the legislature approved the Procedural Order necessary to give the law effect.³²⁰

Drafting policy guidelines to implement abortion access took six months.³²¹ The guidelines set out objectives for changing negative attitudes toward abortion, increasing government funding for abortion services, and reducing "health system barriers."³²² Related to the third objective, the National Safe Abortion Directive provides for the training of providers, including nurses and midwives.³²³ Much of this training occurred with the assistance of international NGOs and, like South Africa, a coalition of national advocates who successfully collaborated with government.³²⁴

Also similar to the South African experience, proponents of change relied on international human rights and research illustrating the impact of illegal abortion on women's health to make the case for liberalization. However, a key difference between Nepal and South Africa is that reformists in South Africa began with media and messaging campaigns—their focus post-enactment was to change the attitudes of people about the connection between abortion and women's rights. Conversely, Nepal's advocates pressed first for government issued guidelines on timely services, access to medical abortion, and training for physicians and nurses.³²⁵ For example, Nepal's reform movement began with calls for the training of health professionals across the country and for including abortion care as part of the primary health care curriculum.³²⁶ Moreover, advocates concen-

316. *Id.* at 89. As noted, a characteristic of Nepal's past system of abortion regulation that attracted a lot of media attention was that police frequently arrested and jailed women for abortion offenses. The due process rights of these women, who were often prosecuted under the abortion statute even if they had miscarried, gave the campaign for liberalization an added, salient human rights dimension. Shakya et al., *supra* note 313, at 76.

317. Thapa, *supra* note 307, at 90.

318. *Id.*

319. *Id.* at 90–91.

320. Shakya et al., *supra* note 313, at 79.

321. *Id.*

322. *Id.* at 80.

323. Amit Bhandari et al., *Experiences of Abortion in Nepal and Menstrual Regulation in Bangladesh: A Gender Analysis*, 16 GENDER & DEV. 257, 267 (2008) (discussing the need for expedited policy decisions to allow for the training of providers); CTR. FOR REPROD. RIGHTS, WOMEN OF THE WORLD: LAWS AND POLICIES AFFECTING THEIR REPRODUCTIVE LIVES - SOUTH ASIA 115 (2004), available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pdf_wowsa_nepal.pdf.

324. Shakya et al., *supra* note 313, at 81.

325. *See* Thapa, *supra* note 307.

326. Shakya et al., *supra* note 313, at 80.

trated on expanding services at the local level by adopting a community-centered approach.³²⁷

Contrasting legislative strategies is not to suggest that abortion access in Nepal is unencumbered. Unlike South Africa, the public health sector does not offer free abortion services. Litigation has helped secure state funding for some women with financial need. In 2009, the Supreme Court of Nepal held that the government had the duty to subsidize terminations for low-income, rural women.³²⁸ But there is still a need to expand services for many Nepalese women.³²⁹ Most legal abortion providers are in urban areas in primary health care centers or district hospitals,³³⁰ while eighty-eight percent of the population lives in rural Nepal.³³¹ Informational deficits also remain. For example, many women still believe spousal permission is required³³² or resort to illegal abortions because of negative societal attitudes towards abortion and shortages of accessible, confidential medical services.³³³

Despite these shortcomings, it would appear that abortion is accessible to a wider range of Nepalese women than South African women.³³⁴ Intuitively, this should not be the case: grounds for abortion in Nepal are not as expansive as they are in South Africa. More women qualify for legal abortion in Johannesburg than in Kathmandu, so, in theory, more South Africans should have access to abortion procedures. The priorities of legal reform shape the resulting availability of services—whether legislation defends against future attacks on women’s legal rights or whether it concentrates on reducing “system barriers.”³³⁵

CONCLUSION

The purpose of this Article is to suggest how dominant thinking around reproductive rights, perhaps effective in transplanting priorities salient in U.S. abortion jurisprudence, could include approaches tailored to health care delivery at the beginning of reform projects, when advocates have influence in times of political change. Changing a country’s health care infrastructure or attitudes about abortion does not happen quickly or easily. Negotiating new understandings of medical professional ethics and principles

327. *Id.* at 75.

328. Kathambi Kinoti, *Nepal Government Directed to Make Abortion Accessible*, AWID (July 8, 2009, 4:38 AM), <http://awid.org/Library/Nepal-government-directed-to-make-abortion-accessible/>.

329. Shakya et al., *supra* note 313, at 77.

330. Bhandari et al., *supra* note 323, at 258.

331. Shakya et al., *supra* note 313, at 75–77.

332. Bhandari et al., *supra* note 323, at 261.

333. *Id.* at 259. State officials also need more education and training on the new law: a few Nepalese women have been arrested for having abortions despite the procedure’s legalization. Shakya et al., *supra* note 313, at 82.

334. Mallika Aryal, *Health-Nepal: On Course to Achieve MDG on Maternal Health*, INTERPRESS SERV., Jan. 13, 2009, <http://ipsnews.net/news.asp?idnews=45387>.

335. Shakya et al., *supra* note 313, at 80.

of parental control, for example, are nuanced tasks for any society. Creating space in health care facilities and training medical practitioners requires substantial funding, will, and time.

Yet in moments of transition, such as the one that occurred in South Africa at the end of apartheid, reformists have a limited window to pursue change that reconfigures the institutions of governance. This Article challenges a model of reproductive rights advocacy that may prove too reactive and not sufficiently responsive to the particularities of a nation's health care system or the social context that shapes the law's implementation. South African supporters of abortion rights now spend considerable energy fighting controversies they aimed to avoid in the first place. One reason may be that the template readily available to those promoting reproductive health rights and increased access to termination services is often fixated on decriminalization and liberalization of abortion law to the exclusion of related health care issues. This critique can strengthen the assumptions that underpin modern reproductive rights movements: abortion is not the sole goal of reformers, who also pursue policies supporting pre-natal health care, access to contraceptives, and prevention and treatment of sexually transmitted infections, for example; unsafe and illegal abortion can have profoundly harmful health consequences for women; and successful implementation of a new abortion law depends not only on availability of services, but also on changing attitudes toward women's procreative roles.

Aspects of the current model, however, undermine practical strategies that could ultimately help accomplish the goal of improving women's health. There may be room for compromises or creative solutions that would not be possible or wise in countries like the United States. Perhaps one way to reconfigure the conversation is to concentrate less on what outcomes legislation should avoid and more on the particularized problems that accompany creating or restructuring health care services.