

Adolescent girls' access to contraceptive information and services in South Africa: What is going wrong? (2)*

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2.4 Policies

2.4.1 National Youth Policy (NYP)¹²⁶

Various policies have been developed to serve as developmental guides for South Africa's youth.¹²⁷ The current *National Youth Policy (NYP)*, which builds upon previous policies, seeks to address policy gaps and challenges that remained with a view to recommending new measures that will be beneficial to youth development.¹²⁸ Objectives of the *NYP* include the integration of youth development into the mainstream of government policies, curbing the marginalisation of young people and strengthening the capacities of young people to personally take charge of their well-being, so that, ultimately, they can realise their potential.¹²⁹

Although defining youth as young people in the age group of 14 to 35,¹³⁰ the *NYP* recognises that young people, a non-homogenous group, have different needs thereby bringing to the fore the necessity to design diverse solutions to meet their needs.¹³¹ Recognising the precarious situation of female persons

* See 2015 *THRHR* 363 for Part 1.

126 *National youth policy 2009–2014*, available at <http://bit.ly/1M8f5F1> (accessed on 6 April 2013).

127 Youth policies that have been developed include the *National youth policy (NYP)* 2000 and the *National youth development policy framework (NYDPF)* 2002. Although the 2000 *NYP* was not adopted by the South African government, it served as a guide for subsequent policy developments. The *NYDPF* covered a five-year period from 2002 to 2007.

128 Paras 2 and 3 *NYP*.

129 Para 6.

130 This is more encompassing unlike the African Youth Charter which sets the age of 15 years as the starting point for those protected under it. The widening of the scope of children protected in the Youth Policy is a progressive step, because there is a definite recognition that this group specifically is in need of youth and adolescent-friendly health services, including those relating to contraception. Also, this provision is not out of place as s 134 of the Children's Act already provides access to contraception from the age of 12. This is apart from the Choice on Termination of Pregnancy Act which recognises the right to abortion of all women irrespective of their age.

131 Para 12 *NYP*.

generally, the policy acknowledges that based upon the impact of gender stereotyping and disease, especially HIV and AIDS,¹³² priority and immediate attention should be accorded to addressing the needs of young women.¹³³

Taking note of the various health challenges of South African youth, including those affecting their reproductive and sexual health, the policy similarly acknowledges, despite relevant stakeholders' efforts to address identified challenges, that campaigns for sexuality education have not led to the desired outcomes,¹³⁴ giving rise to a need to improve access to youth-friendly health-related services and information and to ensure that sexuality education forms part of a life skills curriculum from an early age in order to prevent risky sexual behaviour which exposes adolescents and youths to HIV and STIs.¹³⁵

2 4 2 *National policy on HIV and AIDS for learners and educators in public schools and students and educators in further education and training institutions*

This policy¹³⁶ was adopted in 1999¹³⁷ with the primary purpose of providing a framework or guideline that may be used by the various provinces and schools to develop strategies that will be embraced by learners in order to adopt behaviours, knowledge, skills, values and attitudes which will protect them from HIV infection.¹³⁸

The policy acknowledges the high HIV infection rates in the country and recognises that both students and educators already infected with the virus will gradually constitute part of the population in the various educational institutions. Ensuring non-discrimination and equality among learners, the policy seeks to increase students' knowledge about HIV and AIDS and introduces general precautions that will be adopted in order to ensure the safety of both learners and their educators in the schools.¹³⁹

To achieve its aim of increasing students' knowledge about HIV and AIDS, the policy advocates the compulsory teaching of Life Skills and HIV/AIDS in both primary and secondary schools and its integration into the Life Orientation (LO) curriculum in a scientific and age appropriate manner that will be easily understandable by students.¹⁴⁰

132 Para 12.1.

133 Including female youths residing in rural areas. Other special target groups are youths with disabilities, unemployed youths and school aged but out of school youths, among others.

134 Para 14.3.

135 Para 14.3.1.

136 *National policy on HIV and AIDS for learners and educators in public schools and students and educators in further education and training institutions* (1999) available at <http://bit.ly/18STwvO> (accessed on 16 August 2013).

137 It should be noted that before the Life Skills and HIV/AIDS education programme based on the contents of the above policy (fn 136) was introduced, previous HIV and AIDS education programmes such as the *First AIDS kit* aimed at educating students on sexuality had already been introduced in schools.

138 *National policy on HIV and AIDS for learners and educators* (fn 136).

139 Department of Basic Education *Draft integrated strategy on HIV and AIDS: 2011–2015* (2010) 32, available at <http://bit.ly/1CAemwr> (accessed on 15 August 2013).

140 Initially, in 1999, learners in grades 4–9 were set apart as the primary group to begin the implementation of the programme with. However, in 2005, the teaching of preventive life

The contents of life skills and HIV/AIDS education as merged into the Life Orientation programme, are based on four focus areas: personal well-being, citizenship education, recreation and physical activity and careers and career choices. Under the personal well-being topic, the issues to be discussed include teenage pregnancy, STI and HIV, including ways they are transmitted and appropriate prevention methods, alcohol and substance abuse, sexuality, decision-making, adoption of skills to resist peer pressure, the promotion of personal, community, and environmental health.¹⁴¹ The expected outcomes from imparting life skills and HIV/AIDS education include the ability of students to demonstrate a clear understanding of sexuality, gender, STIs, and HIV and AIDS. Additionally, students are to comprehend and realise the reasons for delaying sexual intercourse or practising abstinence, including how to deal with pressures to engage in sexual relations.¹⁴²

In addition, in order to further curb high HIV infection rates the policy advises that strict adherence to universal precautions be undertaken in schools and, apart from the sexuality and life skills education that is being provided by educators, that parents, as stakeholders, are to support the drive to reduce infection rates by imparting to their children sexuality education and guidance regarding sexual abstinence. Already sexually-active adolescents are to be counselled to practice safe sex.¹⁴³ The specific provision of the involvement of parents as stakeholders in the provision of SRH information to their children as a means of supplementing life skills and HIV/AIDS education received in the school is a positive approach.

2.4.3 *National contraception and fertility planning policy and service delivery guidelines 2012*

In a bid to ensure that the contraception policy in operation in South Africa is up to date so as to reflect changes which have occurred over the last decade in the field of reproductive and contraceptive technology, and in order to ensure compliance with other related national and international policies/frameworks, the *National contraception and fertility planning policy and service delivery guidelines*¹⁴⁴ were adopted.¹⁴⁵ The revised policy, which replaced previous policies and guidelines on contraception,¹⁴⁶ aims at the reprioritisation of contraception

skills and HIV/AIDS sexuality education was extended to pupils in grades R–3 and 10–12. See Mpangana “Implementation of the life skills HIV and AIDs program in Manyeleti circuit schools” (Thesis US 2012) 11.

141 See George *The life orientation project: Implementation, delivery and engagement with the life orientation programme in South African schools* (2013) 4; Mpangana (fn 140) 13; Department of Education *National curriculum statement grades 10–12: Life orientation* (2003) available at <http://bit.ly/1GmJL6R> (accessed on 23 September 2013); paras 2.10 and 3 *National policy on HIV and AIDS for learners and educators* (fn 136 above).

142 Peltzer and Promtussananon “HIV education in South Africa: Teacher knowledge about HIV/AIDS: Teacher attitude about and control of HIV education” 2003 *Social Behaviour and Personality* 350.

143 Para 2.6.5 *National policy on HIV and AIDS for learners and educators* (fn 136 above).

144 *National contraception and fertility planning policy and service delivery guidelines*, available at <http://bit.ly/1B5ZIAG> (accessed on 3 May 2013).

145 “Introduction” *National contraception and fertility planning policy and service delivery guidelines*.

146 *The national contraception policy guidelines within a reproductive health framework 2001* and the *National contraception service delivery guidelines 2003*.

and fertility planning services in the country and places great emphasis on the need for dual protection through the prevention of unwanted pregnancy and the planning for a healthy pregnancy,¹⁴⁷ so as to achieve the goal of providing comprehensive quality contraception and fertility management services to South Africans as part of a broader SRH package.¹⁴⁸

Based upon the SRH and rights framework,¹⁴⁹ the guiding principles for the revised contraception policy and guidelines embrace the provision of strong and visible stewardship for the promotion of SRH and rights, the provision of integrated services at the district level, the adoption of a human rights approach in the provision of contraception and fertility planning services, as well as inter-sectoral collaboration to ensure effective provision of services, among others.¹⁵⁰

Objectives of the policy include:¹⁵¹

- (a) Ensuring that contraception and fertility choices are expanded and actively promoted to enable clients to meet their reproductive intentions throughout their reproductive life.¹⁵²
- (b) Ensuring that contraceptive and fertility planning services are integrated into other health services as needed.
- (c) Training and building the capacity of health care providers so that they acquire appropriate knowledge, attitude and skills to provide holistic, quality contraceptive and fertility planning services in accordance with their scope of practice and level of care.
- (d) Ensuring that the delivery of contraceptive and fertility planning services is backed by necessary regulatory, legislative and institutional framework for all levels of care.
- (e) Adopting appropriate evidence guided communication methods that will assist in increasing the level of public awareness on contraceptive and fertility planning rights, choices and services.
- (f) Setting up appropriate monitoring and evaluation mechanisms to observe effectiveness of the policy and the development of a research agenda to inform subsequent policy formulation and programme planning based on future recommendations.

In addition to the above, the revised policy contains service delivery guidelines which explain and provide a list of the type of contraceptive and fertility-planning services that are available at various health service points, including appropriate health care providers who are empowered to deliver contraception and family planning services.¹⁵³ To ensure effectiveness in contraceptive service

147 "Foreword" *National contraception and fertility planning policy and service delivery guidelines*.

148 *Idem* para 3.2.1.

149 The sexual and reproductive health and rights framework was adopted by the Department of Health in 2011 as *Sexual and reproductive health and rights: Fulfilling our commitments*, available at <http://bit.ly/1ALD1Y2> (accessed on 3 May 2013).

150 Para 3.1 *National contraception and fertility planning policy and service delivery guidelines*.

151 Para 3.2.2.

152 Expanding the current range of contraceptive methods available to include IUDs, single-rod progesterone implants, combined oestrogen and progestogen injections, etc.

153 Para 4.1 *National contraception and fertility planning policy and service delivery guidelines*.

delivery and quality of care, areas in the health systems which need improvement are identified and the necessary steps to be taken to improve them are recommended.¹⁵⁴

The policy specifically seeks to address the problems encountered by adolescents in their bid to access contraception and protect their reproductive health. While acknowledging that abstinence is the ideal, on a practical level the policy recognises that the majority of young people are sexually active and that pregnancy and HIV can have dire consequences for their lives and futures. The policy, therefore, advocates the provision of adolescent-friendly contraceptive services that are structured in ways that mitigate the barriers to access.¹⁵⁵

2.4.3 Integrated school health policy 2012

Recognising that support for school health services is a major way of strengthening the South African Department of Health's efforts of re-engineering and strengthening primary health care service delivery, the *Integrated school health policy (ISHP)*¹⁵⁶ was adopted to reinstate health care programmes in public schools and to ensure that schools become inclusive centres of learning, care and support that assist in the protection and realisation of the educational rights of all children,¹⁵⁷ by addressing the immediate health problems of learners as well as implementing interventions which will assist in the promotion of their health and well-being from childhood to adulthood. In order to achieve these goals, the *ISHP* aims to build on existing school health services by making sure that the departments of Health, Basic Education and Social Development collaborate so as to ensure that the health education and health care services reach every learner in all schools, irrespective of age or grade levels.¹⁵⁸

By adopting strategies which advocate health promotion, health education and the provision of essential health care services in schools, the *ISHP* seeks to achieve the objectives of providing preventive and promotion services that address the health needs of school-going children through the provision of support. This is aimed at facilitating learning by identifying existing barriers to learning and also enables learners to access health services, thus supporting the school community's bid to create safe and secure environments for teaching and learning.¹⁵⁹ At a minimum, according to the *ISHP*, health education, which is to be integrated into the school curriculum and Life Orientation programme, should address fully issues relating to SRH, menstruation, contraception, STIs, including HIV and AIDS, male circumcision, teenage pregnancy, termination of pregnancy, prevention of mother to child transmission, mental health, drug and substance abuse, depression and anxiety, among others.¹⁶⁰ Health care services to be provided according to the policy in school clinics by school health nurses include counselling on sexual rights, provision of dual protection and hormonal contraception for sexually active learners and screening for STIs. In order not to fall

154 Paras 5.1 and 5.2.

155 Para 6.1.2.

156 *Integrated school health policy* (2012) available at <http://bit.ly/1BKrtcZ> (accessed on 18 September 2013).

157 "Foreword" *Integrated school health policy* (fn 156).

158 *Idem* foreword, introduction and para 2.5.

159 Para 2.4.

160 Para 2.6.

foul of the law by infringing the human rights of the learners, the consent of learners to these services has to be obtained.¹⁶¹

The objectives behind the adoption of the *ISHP* are certainly laudable. However, in relation to the provisions in the policy on health education, there is a tendency to confuse and duplicate efforts. This may lead to a situation where educators do not know which programme to adopt or to teach as the life skills and HIV/AIDS education programme which has been integrated into the Life Orientation curriculum already exists. It is therefore recommended that the Department of Education, in collaboration with other departments, merges all the programmes into a single policy to be taught uniformly in all schools.¹⁶²

2.5 Conclusion

An overview has been presented of the laws and policies that support the Constitution in ensuring that adolescent girls have access to contraceptive information and services in South Africa. Building on the foundation laid in the Constitution, the Children's Act reaffirms the paramountcy of the best interests of children, recognises their right to access contraceptive services and information, their right to consent to medical treatment, to confidentiality and also to participate in issues affecting them according to their level of maturity and understanding.¹⁶³

Laws and policies in addition to the Children's Act that are reviewed underscore South Africa's recognition of the importance of guaranteeing adolescent girls' confidentiality when they access contraceptive services, as well as the necessity of allowing them to access sexuality information and education in adolescent-friendly environments so as to enhance their willingness to access these services in the future. Also, constant monitoring mechanisms are provided for. More recent policies cite a need to strengthen the weakened contraceptive delivery service and give special attention to children's optimal health as reasons for a policy review.¹⁶⁴

From our review in the article, it is clear that by trying to pre-empt the demand for sexual and reproductive health care by female adolescents and by incorporating their right to access contraceptive services and information in various statutes and policies, South Africa makes a genuine effort to improve the sexual and reproductive health of young people, as well as combat the spread of HIV

161 Where necessary, the school health nurse is to refer such learner to a health facility where he or she should receive the service. For learners younger than 14 years, the consent of their parents is to be obtained, learners older than 14 years can personally give consent. See *ibid* and para 2.7.

162 The success of teaching sex education has been varied. While relative success has been achieved in some schools with students reported as adopting healthier sexual lifestyles and increased contraceptive use, in other schools it has been stated that the information provided was neither adequate nor comprehensive. See Smith and Harrison "Teachers' attitudes towards adolescent sexuality and life skills education in rural South Africa" 2013 13(1) *Sex Education* 69; Selesho and Modise "Strategy (ies) in dealing with HIV/AIDS in our schools: Changing the lenses" 2012 *J of Human Ecology* 184–187; and Willan *A review of teenage pregnancy in South Africa: Experiences of schooling, and knowledge and access to sexual & reproductive health services* (2013) available at <http://bit.ly/1zZUjJa> (accessed on 18 September 2013).

163 Ss 13(1)(a) and (d), 13(2), 129(2), 134(1) and 134(3) of the Children's Act.

164 *Integrated school health policy* (fn 156) 6.

and other STIs affecting adolescents. Ngwena correctly remarks that South Africa exhibits an understanding of the nature of human rights, and emphasises that understanding by inserting concrete provisions that recognise, respect and protect all rights, inclusive of socio-economic rights, in its Bill of Rights, rather than issuing mere directive principles, as is the case in other African countries.¹⁶⁵

However, in spite of the existence of progressive laws and policies which assure adolescent girls unfettered access to confidential SRH care information and services, including the right to make autonomous reproductive health care decisions,¹⁶⁶ South Africa still records a very high rate of teenage pregnancies. Research reveals that about 30 per cent of 19 year olds are not only teenage mothers, either as a result of their ineffective use of contraception or non-utilisation of available contraceptive services,¹⁶⁷ but that South African adolescent girls also constitute a larger percentage of adolescents infected with HIV.¹⁶⁸

What, then, is going wrong? In order to answer this question, we turn to the factors that impede adolescent girls' access to contraceptive information and services in the section below.

3 IMPEDIMENTS TO ADOLESCENT GIRLS' ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES: WHAT IS GOING WRONG?

3.1 Introduction

In view of the negative outcomes associated with adolescent sexuality¹⁶⁹ and in fulfilment of the mandate that state parties are to provide without discrimination, access to adequate SRH information and services for adolescents within their jurisdictions through formal and informal channels,¹⁷⁰ South Africa has put in place a comprehensive sexual and reproductive health policy package. This health policy package has been lauded as one of the most progressive in the world.¹⁷¹ Moreover, in order to ensure adequate access to contraceptive services

165 Such as Nigeria. See Ngwena (fn 50) 38.

166 Ss 12(2) and 27(1)(a) Constitution of the Republic of South Africa, 1996; s 134 Children's Act; s 5(1), (2) and (3) Choice on Termination of Pregnancy Act.

167 Mudhovozi *et al* "Adolescent sexuality and culture: South African mothers' perspective" 2012 *African Sociological R* 119; Mothiba and Maputle "Factors contributing to teenage pregnancy in the Capricorn district of the Limpopo Province" 2012 *Curatonia* 1; Ramathuba *et al* "Knowledge, attitudes and practice of secondary school girls towards contraception in Limpopo Province" (2012) available at <http://bit.ly/18SU9pg> (accessed on 27 October 2013) (fn 128 above) 1–2.

168 UNFPA *HIV prevention: Fact sheet* (2012) available at <http://bit.ly/1wXuuRD> (accessed on 28 October 2013).

169 "Over quarter of South African school girls HIV positive: Minister" (2013) available at <http://ab.co/1FcRfWc> (accessed on 15 August 2013); Kanku and Mash "Attitudes, perceptions and understanding amongst teenagers regarding teenage pregnancy, sexuality and contraception in Taung" 2010 *South African Family Practice* 564; Ahmed *et al* "HIV education in South African schools: The dilemma and conflicts of educators" 2009 *Scandinavian J of Public Health* 48.

170 Para 13 General comment 3 CRC Committee; para 26 General comment 4 CRC Committee; para 18 General recommendation 24 Convention on the Elimination of Discrimination against Women (CEDAW) Committee.

171 Maharaj and Rogan *Reproductive health and emergency contraception in South Africa: Policy context and emerging challenges* (2007) 3 available at <http://bit.ly/1DP1bTD> (accessed on 23 August 2013).

for women (and adolescent girls), contraceptives are provided free of charge at public health facilities via primary health care centres and district hospitals.¹⁷² Because of the provisioning of free contraceptive services at public health facilities, South Africa has one of the highest contraceptive prevalence rates – 60 per cent – in comparison to other countries in the region.¹⁷³

Furthermore, because of an appreciation that a successful SRH campaign must be supported by confidential health services in view of the sensitive nature of adolescent sexuality matters in African societies, South Africa has introduced various adolescent-friendly health care centres where SRH information, drugs and services are provided to adolescents.¹⁷⁴

Though the above steps are certainly praiseworthy, and though they have indeed resulted in increased adolescent contraceptive use,¹⁷⁵ it would appear that adolescents girls in South Africa have access to these services merely “on paper”,¹⁷⁶ as the legal framework guaranteeing adolescent girls’ access to contraceptive information and services has not adequately translated into full access and protection from STIs, HIV infections or unintended pregnancies.¹⁷⁷ Various impediments still prevent adolescent girls in South Africa from accessing contraceptive information and services. These impediments are briefly examined below.

3.2 Barriers caused by law

South Africa, like other African countries, has a specific age of consent to sexual activities: the Criminal Law (Sexual Offences and Related Matters) Amendment Act¹⁷⁸ makes it a criminal offence for adolescents between the ages of 12 and 15 years to engage in consensual sexual activities.¹⁷⁹ The provisions of the Act are based upon the presumption that adolescents below the age of 16 are incapable

172 *National contraception and fertility planning policy* (fn 114) 36–37; Maharaj and Rogan (fn 171) 13.

173 Unfortunately, despite the high contraceptive use, the country experiences a huge number of teenage pregnancies. See UNFPA “Country indicators – South Africa” in *The state of the world’s midwifery 2011* available at <http://bit.ly/1M9G8BJ> (accessed on 24 June 2013); The World Bank *Data on adolescent fertility rate* available at <http://bit.ly/1Ep0Dyj> (accessed on 24 June 2013); UNFPA South Africa *Sexual and reproductive health* available at <http://bit.ly/18leNgx> (accessed on 24 June 2013).

174 MIET Africa *Literature review: Youth-friendly health services* (2011) 14–15 available at <http://bit.ly/1M8g7Rc> (accessed on 14 September 2013); Ashton *et al Evolution of the national adolescent-friendly clinic initiative in South Africa* (2009) 15 31–41.

175 Tylee *et al* “Youth-friendly primary-care services: How are we doing and what more needs to be done?” 2007 *The Lancet* 1565–1573; Ashton *et al* (fn 174) 44.

176 Maharaj and Rogan (fn 171) 9.

177 For example, according to findings in the *South African national HIV communications survey* (2012), HIV prevalence has remained high among adolescent girls who have a prevalence ratio that is 2.7 times higher than among males of the same age. In the same vein, while the country in the last few decades has recorded a decline in teenage fertility, according to Willan, the rates are still as high as around 30% of 15–19 year olds reporting having ever being pregnant. See Willan (fn 162) 7; *Key findings of the third South African national HIV communication survey* (2012) available at <http://bit.ly/1Eikp9y> (accessed on 18 September 2013); *National contraception and fertility planning policy* (fn 114) 18.

178 Act 32 of 2007.

179 Ss 1, 15(1), 16(1) and 15(1) Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007; Ngwena *Sexual health and human rights in the African Region* (2011) 119 available at <http://bit.ly/1CAfRL5> (accessed on 9 October 2013).

of consenting to sexual relations. This ignores the fact that, in many instances, sexual activities among adolescents occur not as a result of coercion, but as a matter of choice.¹⁸⁰

The Criminal Law (Sexual Offences and Related Matters) Amendment Act aims to protect adolescents in South Africa from sexual abuse and exploitation,¹⁸¹ but the fact that the Act not only criminalises consensual sexual activities between adolescents within the specific age group, but also compels compulsory reporting to an enforcement officer, has the potential to produce undesirable consequences.¹⁸² Understanding the potential negative effect of these provisions, in *Teddy Bear Clinic for Abused Children v Minister of Justice and Constitutional Development*¹⁸³ the Constitutional Court noted, while it is normal during adolescence for children to engage in some form of sexual activity, that what is important is to ensure that they are appropriately supported by adults in order to make healthy choices.¹⁸⁴ According to the court, if children are not made to feel safe in discussing their sexual experiences with adults, they will not only be denied the benefit of guidance which is particularly important at that stage of their lives, but children charged under the provisions of the legislation will feel a 'mixture of shame, embarrassment, anger, and regret' which will prevent them from seeking help on sexual issues, thereby contributing to an increase in adolescent risky behaviour and negative outcomes.¹⁸⁵ The Constitutional Court, therefore, confirmed the High Court's decision on the unconstitutionality of sections 15 and 16 of the Act to the extent that they impose criminal liability on children under the age of 16 years who engage in consensual sexual relations. The court ordered that Parliament correct the defects in the Act in light of its judgment.¹⁸⁶

It should be pointed out that provisions of the Criminal Law (Sexual Offences and Related Matters) Amendment Act are also such that they effectively bar adolescent girls from attempting to access contraceptive services. In order to access contraceptive information and services, the adolescent seeking such services would have had to admit that she was engaging in sexual activities that necessitated her using contraceptives. She would, therefore, have had to admit to committing a criminal act as even consensual sexual activities between adolescents was illegal before the Constitutional Court's decision. Moreover, the health care provider that she consulted would have been compelled to report her engagement in such activities to an enforcement officer. The Constitutional Court's judgment, therefore, has made it possible for adolescent girls to access contraceptive information and services in private, without fear of prosecution.

180 Perumal "Misguided reform: Regulating consensual sexual activity between adolescents in South African law from a gender perspective" 2013 *Agenda* 2; Mothiba and Maputle (fn 176); Biddlecom *et al* *Protecting the next generation in sub-Saharan Africa: Learning from adolescents to prevent HIV and unintended pregnancy* (2007) 13 available at <http://bit.ly/1w6geuA> (accessed on 9 May 2013).

181 Preamble, Criminal Law (Sexual Offences and Related Matters) Amendment Act 2007.

182 Perumal (fn 180) 3; McQuoid-Mason "Mandatory reporting of sexual abuse under the Sexual Offences Act and the 'best interests of the child'" 2011 *SA J of Bioethics and Law* 74–78.

183 *Teddy Bear Clinic* (fn 41).

184 *Idem* para 45.

185 Paras 47–89.

186 Para 117(1) and (2).

3.3 Socio-cultural barriers

Another major obstacle which prevents adolescent girls from accessing contraceptive services in South Africa is rooted in social-cultural beliefs which entrench patriarchy and encourage gender inequality. Whereas adolescent boys are encouraged to engage in sexual relations in order to prove their sexual prowess, adolescent girls are advised to either shun pre-marital sex or discouraged from using contraceptives due to the cultural importance attached to female fertility and myths which associate contraceptive use with promiscuity and infertility. The results are adolescent girls engagement in unprotected sex and high pregnancy rates mentioned above.¹⁸⁷

Cultural beliefs prevent young women from accessing information about SRH from their parents and adults since it is believed that discussions relating to sexuality are offensive and culturally inappropriate, especially for adolescent girls.¹⁸⁸ Adolescent girls, therefore, will not seek contraceptive advice and information from adults. Recently, a study conducted among mothers drawn from the VhaVenda ethnic group, who are of different educational backgrounds and have adolescent daughters aged between 12 and 19 years, revealed that the participants not only refused to view adolescent sexuality as an inevitable phase of development, but also regarded sexuality communication as inciting in adolescents sexual ideas and as encouraging disrespect.¹⁸⁹ In the same study, although it was acknowledged that female adolescents were involved in sexual activities, the majority of participants still expressed conservative attitudes towards the use of contraceptive by female adolescents.¹⁹⁰ The views expressed ranged from:¹⁹¹

“I will never encourage her to use contraceptives because they are not good especially for young people.’ I would discourage her to even think about using contraceptives and I will tell her that they are bad”

to:

“If she wants to use contraceptives, she can use them but it would be without my approval and my knowledge because if she asked me I will not allow it.”

The lack of communication (as a result of socio-cultural beliefs) on family planning and contraceptive use between adolescent girls’ and their parents is a major stumbling block. Adolescent girls are either afraid of the negative reactions which their questions might evoke or believe that they may become the object of

187 Varga “How gender roles influence sexual and reproductive health among South African adolescents” 2003 *Studies in Family Planning* 160–172; Enuameh *et al* “Perceived facilitators and barriers to interventions aimed at reducing unintended pregnancies among adolescents in low and middle income (developing) countries: A systematic review of qualitative evidence” 2012 *Joanna Briggs Institute (JBI) Library of Systematic Reviews* 3351 3354; Lee-Rife *The educational trajectories of pregnant adolescents in South Africa* (2005) 1, available at <http://bit.ly/1B60Xua> (accessed on 12 November 2013).

188 Mudhovozi *et al* “Adolescent sexuality and culture: South African mothers’ perspective” 2012 *African Sociological R* 127–128; Ramathuba *et al* “Knowledge, attitudes and practice of secondary school girls towards contraception in Limpopo Province” (2012) available at <http://bit.ly/18SU9pg> (accessed on 27 October 2013); Ngwena *et al* “Accessing termination of pregnancy by minors in the Free State: Identifying barriers and possible interventions” (2005) 20, available at <http://bit.ly/1EikGcq> (accessed on 29 October 2013).

189 Mudhovozi *et al* (fn 188) 127–128.

190 *Idem* 128–130.

191 *Idem* 130–131.

ridicule and embarrassment in the family. In the words of a female adolescent who participated in a study on the factors that impact on the use of contraceptives among youths in the northern Tshwane area,¹⁹²

“it’s not always easy to discuss sexuality issues and contraception with your parents . . . my mother is more approachable than my father . . . but I don’t just have the guts to start these topics with my parents as they always think that we are children who do not have sexual needs . . . and must be obedient as long as you are dependent on them”.

Here, the negative effect of parental non-communication as a result of cultural beliefs on adolescents is revealed, as girls will prefer to have unprotected sex rather than visit health centres to access contraceptives and risk the information getting back to their parents.

Another factor which prevents adolescent girls’ use of contraceptive information and services is the negative attitudes displayed by health care providers. Health care providers are either high-handed in their attitude towards girls as they forcefully impose a particular type of contraceptive that they perceive to be the most reliable on adolescents, or they embarrass the girls by asking unwanted questions which reflect their bias against providing contraceptives to young girls. Consequently, adolescent girls become ashamed and reluctant to go back to access further services.¹⁹³ Additionally, in small communities health care providers who fail to respect adolescent girls’ confidentiality contribute towards stigmatising girls who seek contraceptive information and services, making such girls reluctant to come back.

Further, misconceptions about contraception and its effects are major barriers which prevent adolescent girls from using contraceptives. Studies reveal, although South African adolescents acknowledge that they have access to contraceptive information and services, that they still prefer not to use contraceptives as a result of these misconceptions. For example, some adolescent girls admitted to limiting their contraceptive use to when partners visit, and that others admitted to resorting to taking half the dose of contraception in order to reduce weight gain, thereby decreasing the effectiveness of the contraceptive method and increasing the chances of an unintended pregnancy.¹⁹⁴

3 4 Religious barriers

In Africa, as in other regions in the world, apart from cultural beliefs and traditions which affect adolescents’ contraceptive use, the religious beliefs of adolescent girls influence their uptake of contraception. Through educational seminars that

192 Maja “Factors impacting on contraceptive use among youth in Northern Tshwane: Part 2” 2007 *Health SA Gesondheid* 43 44. See also Lebeso *et al* “Teenagers’ experiences of sexual health dialogue in the rural villages of the Vhembe District, Limpopo Province” 2011 *Health SA Gesondheid* 7.

193 Wood and Jewkes “Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa” 2006 *Reproductive Health Matters* 111 113; Hughes and McCauley “Improving the fit: Adolescents’ needs and future programs for sexual and reproductive health in developing countries” 1998 *Studies in Family Planning* 234–235.

194 Panday *et al* *Teenage pregnancy in South Africa with a specific focus on school-going learners* (2009) 12, available at <http://bit.ly/1DYn4Cs> (accessed on 27 October 2013). See Mothiba and Maputle (fn 176) 4; Partners in Sexual Health *A review of teenage pregnancy in South Africa: Experiences of schooling, and knowledge and access to sexual & reproductive health services* (2013) 26–27.

encourage adolescent girls to adopt healthier SRH life styles, religion may be advantageous and assist in educating adolescents on the benefits of delaying sexual activities.¹⁹⁵ However, the negative effects of religion as a barrier to contraceptive use can be gleaned from Mash *et al* who explain that the majority of religious communities not only associate the use of condoms and contraceptives with immoral and sinful behaviour,¹⁹⁶ but also preach that the use of contraceptives “punctures and spoils the eggs”,¹⁹⁷ thereby contributing to unfounded beliefs that the use of family planning methods could result in future infertility, thereby scaring away adolescent girls from using them.

3 5 Economic barriers

There exist vast socio-economic disparities in African societies which ultimately result in female adolescents getting involved in dangerous sexual activities.¹⁹⁸ According to Brooks,¹⁹⁹ adolescent girls who live in poverty not only tend to be more susceptible to engaging in risky sexual behaviour than their wealthier counterparts but, as a result of their lack of economic empowerment, these girls are unable to negotiate safer sex, such as condom use.²⁰⁰

The incidence of transactional sex is high among South African adolescent girls, as noted by Potgieter *et al* who explain that the 2009 *National HIV prevalence, incidence, behaviour and communication survey* specially identified an increase in inter-generational sex as a factor which significantly contributes to adolescent girls’ risk of contracting HIV. This increase is because older men in relationships with young girls give the girls gifts in exchange for sex, causing girls in such relationships to be unable to control or dictate that safe sexual practices are adopted.²⁰¹

3 6 Demographic barriers

Although the results of the 2003 South African Demographic Health Survey reveal that the proportion of adolescents (15 to 19 year olds) who had given birth

195 Mbokane *The utilisation of contraceptives by women who requested termination of pregnancy services in the Gert Sibande District (Mpumalanga)* (Thesis Unisa 2004) 39.

196 Mash *et al* “Why don’t you just use a condom?”: Understanding the motivational tensions in the minds of South African women” 2010 *African J of Primary Health Care and Family Medicine* 79–82.

197 Wood and Jewkes (fn 193) 111.

198 As a result of the injustice of the apartheid era, massive inequities in income and health status exist in South Africa with the population divided into haves and have-nots. The existence of a large number of poor people which invariably includes adolescent girls from poor households, fuels the practice of inter-generational sex or sex in exchange of cash.

199 Brook “South African adolescents: Pathways to risky sexual behaviour” 2006 *AIDS Education and Prevention* 259–272.

200 *Idem* 261–262. See also Luke and Kurz “Cross-generational and transactional sexual relations in sub-Saharan Africa: Prevalence of behavior and implications for negotiating safer sexual practices” (2002) 3–5, available at <http://bit.ly/1DYnaKv> (accessed on 22 October 2013).

201 In fact, in the survey it was noted that the percentage of young women with older sexual partners (more than five years) had increased from 18.5% in 2005 to 27.6% in 2008; Potgieter *et al* “Taxi ‘sugar daddies’ and taxi queens: Male taxi driver attitudes regarding transactional relationships in the Western Cape, South Africa” 2012 *J of Social Aspects of HIV/AIDS* 193 195.

had been reduced from 35 per cent in 1998 to 27 per cent in 2002,²⁰² data generated from the same survey show that there are more teenage mothers in rural areas and that there was a greater possibility of condoms being used at first sexual intercourse in urban areas, than in rural areas of the country.²⁰³ Despite the fact that mobile clinics have been introduced to assist in ensuring health care delivery (including contraceptive services) to women and adolescent girls residing in rural communities,²⁰⁴ these remote rural areas are still greatly under-served.²⁰⁵

4 OVERVIEW OF SOME OF THE CONSEQUENCES

The barriers discussed in the previous section not only prevent adolescent girls from accessing contraceptive information and services, but also contribute to their SRH vulnerability, thereby, in many cases resulting in disastrous consequences, such as unwanted pregnancies, STI and HIV infection, and the loss of their economic and developmental potential.

Although South Africa has one of the lowest total birth rates in the region and significantly higher contraceptive prevalence rates than its neighbours,²⁰⁶ there is still a high teenage birth rate: around 30 per cent of 15 to 19 year old adolescent girls report that they are either pregnant or that they have previously given birth.²⁰⁷ Ramulumo and Pitsoe observe that this figure is high, despite awareness-raising campaigns on sex education, the teaching of life orientation at schools,²⁰⁸ and regardless of the fact that the country has adopted a reproductive health policy which furthers its commitment towards the protection of the reproductive health of adolescent girls by providing access to contraceptive services and information.²⁰⁹ Giving birth at a young age predisposes women to reproductive health problems later in life, such as an elevated risk of death during childbirth and vesico-vaginal fistula (VVF).²¹⁰

202 Department of Health and Medical Research Council (MRC) *South Africa demographic and health survey* (2003) 161 available at <http://bit.ly/1B5XZpm> (accessed on 3 November 2013).

203 *Idem* 160–161. See also Jewkes *et al* (fn 193) 678.

204 “Mobile clinics bring health care to South Africa countryside” (2013) available at <http://bit.ly/1Ep1NDa> (accessed on 14 March 2014).

205 Peer and Morojele “Factors associated with contraceptive use in a rural area in Western Cape Province” 2013 *SAMJ* 406–412; McQuoid-Mason (fn 182) 406–412.

206 WHO *The state of the world's midwifery* (fn 26) 132–133.

207 According to the WHO, the adolescent birth rate in the country stands at 54 for every 1000 live births among girls aged 15–19 years. Also, research reveals that Mpumalanga, Northern Cape, Limpopo and the Eastern Cape Provinces are worst hit by the high levels of adolescent pregnancies. See Willan (fn 162) 7; Ramulumo and Pitsoe “Teenage pregnancy in South African schools: Challenges, trends and policy issues” 2013 *Mediterranean J of Social Sciences* 756; Statistics South Africa *General household survey* (2012) 18, available at <http://bit.ly/1B9NiRF> (accessed on 9 November 2013); WHO *The state of the world's midwifery* (fn 26) 133.

208 Ramulumo and Pitsoe (fn 207) 756.

209 The recent *National contraception and fertility planning policy and service delivery guidelines* (2012) adopt a rights-based approach to contraception and fertility planning by promoting expanded choice through contraceptive availability and accessibility to all people, women and female adolescents, especially. See paras 3.1 3.2.

210 Vesico-vaginal fistula is a condition which causes continuous involuntary discharge of urine into the vaginal vault and is often caused by prolonged labour and childbirth which press the unborn child tightly against the immature pelvis. See Panday *et al* (fn 194) 47.

Many adolescent girls who get pregnant because of their failure to use contraceptives have abortions.²¹¹ Although abortion is legal in South Africa,²¹² many adolescent girls undergo unsafe and illegal abortion procedures instead of approaching public hospitals due to the social stigma attached to the termination of pregnancy.²¹³ Noting the extent of the stigma attached to abortion in South Africa, Trueman states that the conscientious objection exception is used extensively by health care providers to prevent adolescent girls who get pregnant from accessing legal abortion services. According to her, it is not only health care providers who stigmatise adolescents, but also security guards, receptionists and even maintenance workers in health care facilities.²¹⁴ As a result, the number of terminations of pregnancies performed in the public sector decreases annually,²¹⁵ as adolescent girls who get pregnant resort to back-street abortionists and become susceptible to contracting STIs, HIV, or sustaining injury to their reproductive organs which may result in future infertility and the occurrence of maternal deaths.²¹⁶

Despite the constitutional provisions on the right to education and equality,²¹⁷ and the provisions of the South African Schools Act²¹⁸ which mandate compulsory school attendance by all children irrespective of sex,²¹⁹ evidence reveals that, in the majority of cases, adolescent mothers are unable to return to school. Echoing Chigona and Chetty's opinion that adolescents who get pregnant are those who were already impoverished before becoming pregnant, Willan explains that approximately only one-third of teenage mothers return to school

211 Ratlabala *et al* (fn 30) 29.

212 This is despite the fact that South Africa is one of the few countries in Africa where the procurement of abortion upon a woman or adolescent girl's request is legal.

213 "Unsafe abortion in South Africa: A preventable pandemic" (2012) available at <http://bit.ly/1B9QxZj> (accessed on 9 November 2013); MacPhail *et al* "Contraception use and pregnancy among 15–24 year old South African women: A nationally representative cross-sectional survey" 2007 *BMC Medicine* available at <http://bit.ly/1Ep26xU> (accessed on 26 June 2013).

214 IPAS "Is the door to safe abortion services slowly closing in South Africa?" (2013) available at <http://bit.ly/1G0lChJ> (accessed on 12 November 2013).

215 Day *et al* (fn 27) 178–179.

216 Ratlabala *et al* (fn 30) 29. According to reports, maternal mortality rates in South Africa has an increased maternal mortality ratio of 300 deaths per 100 000 live births. Also, confidential enquiries into the causes of maternal deaths showed that of the 4 867 maternal deaths recorded between 2008 and 2010, 186 of them related to miscarriage in public health care facilities. It has been emphasised that 44 of the 186 maternal deaths involved complications from unsafe abortion. See Department of Health *Saving mothers 2008–2010: Fifth report on the confidential enquiries into maternal deaths in South Africa* (2012) 4 available at <http://bit.ly/1Eildew> (accessed on 11 November 2013); South Africa NGO Pulse "Unsafe abortion in South Africa: A preventable pandemic" (2012) <http://bit.ly/1B9QxZj> (11 November 2013); WHO *Trends in maternal mortality: 1990 to 2010* (2012) 1 22 available at <http://bit.ly/1NjM10D> (accessed on 7 November 2013); CIA *The world fact book* (2013) available at <http://1.usa.gov/18yjCgH> (accessed on 7 November 2013).

217 Ss 9(3) and 29(1) Constitution of the Republic of South Africa, 1996.

218 Schools Act 84 of 1996.

219 Willan suggests that the situation is such that seeks to ensure completion of schooling despite delay instead of an outright drop out from school. See Willan (fn 162) 34; Bhana *et al* "South African teachers' responses to teenage pregnancy and teenage mothers in schools" 2010 *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care* 872.

following childbirth.²²⁰ Some girls are unable to cope with their schoolwork because of the stress involved in caring for a child, others drop out of school because they cannot provide for their child's needs without working.²²¹ Other reasons for not returning to school include the problem of stigmatisation, as teenagers are shunned by their peers, and are exposed to harsh treatment and insufficient support from their schools and teachers.²²² Therefore, instead of acquiring a good education that will enable them to escape poverty, in most instances pregnant adolescents become further impoverished, thereby losing their chances of improving their economic status later in life.

5 CONCLUSION

Indubitably, South Africa has in place a legislative and policy framework that guarantees adolescent girls' right to access contraceptive information and services, thereby giving effect to the country's international human rights law obligations. However, our investigation reveals that several obstacles continue to hamper adolescent girls' access to contraceptive information and services. As a result of these obstacles, adolescent girls, on the whole, do not make use of available contraceptive services and, therefore, continue to experience the negative consequences associated with contraceptive non-use.

Not only are the rights of adolescent girls in South Africa frequently limited by a belief that children are too unwise or imprudent to take decisions on issues affecting their lives,²²³ but adolescent girls in South Africa are especially vulnerable because of socio-cultural and religious beliefs which encourage their subordination to their male counterparts. They are denied access to contraceptive information and services as a result of parochial and out-dated beliefs, causing numerous negative SRH outcomes and ill health.

As shown, hindering adolescent girls' access to factual and comprehensive contraceptive information and services has the potential to cause great harm to them and their communities. Moreover, the achievement of good SRH outcomes for adolescent girls is dependent not only on the ratification of human rights instruments and the adoption of legislation by government, but also on the readiness of parents and other gate-keepers to undergo attitudinal change and encourage young people's access to contraceptive information and services.

220 Willan (fn 162) 34 and 44.

221 See, generally, Willan (fn 162) 44–45; Bhana *et al* (fn 219) 877; Luffman *South Africa's school-age mothers struggle to stay in education* (2013) available at <http://bit.ly/1B9QM6q> (accessed on 15 November 2013).

222 Willan (fn 162) 45–48.

223 Durojaye "Realising access to contraception for adolescents in Nigeria" (Thesis University of Free State 2010) 37–38; Adjetey (fn 19) 1353; Izugbara "The socio-cultural context of adolescents' notions of sex and sexuality in rural South-Eastern Nigeria" 2005 *Sexualities* 600–617.