University of KwaZulu-Natal

Conscientious objection to termination of pregnancy in South Africa: Analysing the legislative framework governing the rights of patients and healthcare providers.

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ABSTRACT

The termination of pregnancy (TOP), underpinned by international, constitutional and statutory laws, is an essential medical service available to girls and women in South Africa. Health practitioners involved in TOP provision possess the constitutional right to conscientiously object to such services, but this can conflict with the patient's right to access reproductive healthcare. Therefore, this doctrinal study, through an examination of relevant legal doctrines and other contextual literature, aimed to scrutinise the legislative framework governing the rights of both patients and practitioners concerning TOP and conscientious objection (CO) within the public healthcare sector in South Africa. The findings show that CO primarily relies on the objecting provider's responsibility to refer patients to an alternative and willing provider. However, when considering this duty against the grim backdrop of a dysfunctional and critically under-resourced public healthcare system, undefined or non-existent referral pathways, public health laws incongruent with socio-economic realities, and a lack of policy monitoring structures, it becomes evident that this regulatory mechanism is inadequate to safeguard the rights of the patient. Since CO has the potential to undermine health rights, and social and reproductive justice, targeted advocacy is imperative at legislative, political, social, and health system levels to establish a realistic rights equilibrium within this normative gap. This is a critical starting point in ensuring that girls and women are not unreasonably impeded in their pursuit of TOP care.

Key words: *Termination of pregnancy, conscientious objection, public health system, rights equilibrium.*

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LIST OF ABBREVIATIONS

ASA:	Abortion and Sterilisation Act
CEDAW:	Convention on the Elimination of All forms of Racial Discrimination
CTOP Act:	Choice on Termination of Pregnancy Act
HPCSA:	Health Professions Council of South Africa
ICCPR:	International Covenant on Civil and Political Rights
ICERD:	International Convention on the Rights of Persons with Disabilities
ICESCR:	International Covenant on Economic, Social and Cultural Rights
ICRPD:	International Convention on the Rights of Persons with Disabilities
NDOH:	National Department of Health
NHA:	National Health Act
SACRRF:	South African Charter of Religious Rights and Freedoms
TOP:	Termination of Pregnancy
UDHR:	Universal Declaration of Human Rights
UN:	United Nations
WHO:	World Health Organisation

OPERATIONAL DEFINITIONS

Termination of pregnancy: The separation and expulsion of the contents of the uterus of a pregnant female, by medical intervention such as medications or surgical procedures. It encompasses a voluntary intervention to end an unwanted, unplanned, mistimed or medically incompatible pregnancy. The terms ‘abortion’ and ‘termination of pregnancy’ are used interchangeably in this dissertation.

Designated healthcare facility: A healthcare facility or clinic officially authorised to offer termination of pregnancy services, based on adherence to legal and medical standards, ensuring the safe and proper administration of these procedures.

Healthcare provider: In accordance with the Choice on Termination of Pregnancy Act, a medical practitioner is defined as any persons registered under the Medical, Dental and Supplementary Health Services Act,1974 (Act No. 56 of 1974). In the context of this study, the term healthcare provider is used specifically to denote those medical practitioners explicitly involved in abortion service provision viz. medical doctors, registered nurses and midwives (who have completed the prescribed training course).

LIST OF APPENDICES

CHAPTER ONE: INTRODUCTION AND CONTEXT OF THE STUDY

1.1 INTRODUCTION

The right of girls and women to receive a safe and legal termination of pregnancy is recognised as a fundamental human right in South Africa. Simultaneously, the right of the healthcare provider to refuse to participate in the provision of such services is also a protected human right. This introductory chapter establishes the context for the argument that the rights of healthcare providers to conscientiously object to providing safe and legal termination of pregnancy services present a significant threat to reproductive health rights and justice for girls and women seeking this essential service, specifically within the public health sector of South Africa.

1.2 BACKGROUND OF THE STUDY

From time immemorial, the prevailing rhetoric on termination of pregnancy (TOP), commonly known as abortion, has been highly contentious and globally divisive. Even at the coalface of gender equality, civic advocacy, women's agency, reproductive autonomy and efforts toward the progressive realisation of human rights-based approaches in social and legal contexts, the policies and practices governing access to safe abortion services remain relentlessly challenging. Despite being an ancient, intractable and universal practice[1] that is sought by women of all ages, in all places, and at different stages of life[2], abortion has always faced substantial socio-political disapproval, hostility and resistance.

Historically, resistance and subsequent restrictions on abortion were imposed for three main reasons: (i) they were dangerous to perform and abortionists were responsible for many deaths. Thus, legally penalising the practice was

[1] A Guillaume & C Rossier 'Abortion around the world: An overview of legislation, measures, trends and consequences' (2018) 73(2) *Population,* 217-306.
[2] A Kero, U Hogberg, L Jacobsson & A Lalos 'Legal abortion is a painful necessity' (2001) 53(11) *Social Science & Medicine*, 1481-1490.

framed in a public health interest to protect women[3]. (ii) Abortion was perceived to be sinful and represented a moral transgression against the norms, values and expectations of society. Therefore, criminalising the act served as a deterrent or punishment[4]. (iii) Restrictions against abortion were seen as an attempt to protect human life in some or all circumstances[5]. Although most, if not all, of these perceptions have been debunked, they persist as the ideological basis that shapes the present abortion narrative.

TOP in the modern world is paradoxical. With advancements in medical knowledge, technology and equipment and innovations in the realm of pharmacology, it is neither difficult nor dangerous to end a pregnancy. Yet, it is still not realised as a routine component of healthcare and remains highly contested and controlled[6]. Even in places where abortion is legalised, it is still decidedly stigmatised and occupies a central position in political agendas[7]. In fact, a conspicuous lack of political dedication to assuage the spectrum of social, legal, systemic and contextual impediments to access safe abortions persist in both international and local settings[8].Consequently, unsafe abortion, defined as a method of "pregnancy termination either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both[9]", continues to be a viable and prevalent alternative for acquiring services in spite of being a leading cause of maternal mortality globally[10]. Unsafe abortion is regarded as a preventable[11] yet neglected[12] public

[3] M Berer 'Abortion Law and Policy around the World' (2017) 19(1) *Health and Human Rights Journal*, 13-27.
[4] Ibid 3.
[5] Ibid 3.
[6] A Furedi. London, UK: Palgrave Macmillan, 2016.
[7] Ibid 6.
[8] M.F Fathalla 'Safe abortion: the public health rationale' (2020) 63 *Best Practice & Research Clinical Obstetrics & Gynaecology*, 2-12.
[9] World Health Organization. Preventing unsafe abortion. Available at: https://www.who.int/reproductivehealth/topics/unsafe_abortion/hrpwork/en/.
[10] R.M Olson & S Kamurari 'Barriers to safe abortion access: Uterine rupture as a complication of unsafe abortion in a Ugandan girl' (2017*) BMJ Case Report*s, 1-4.
[11] J Harries, D Cooper, A Strebel & C.J Colvin 'Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study' (2014) 11(16) *Reproductive Health,* 1-7.
[12] M Gebremedhin, A Semahegn, T Usmael & G Tesfaye 'Unsafe abortion and associated factors among reproductive aged women in sub-Saharan Africa: A protocol for a systematic review and meta-analysis' (2018) 7(130) *Systematic Reviews*, 2-5.

health crisis. The burden of unsafe abortion and its related maternal mortality rates are higher in Africa than in any other developing region[13]. It is estimated that 99% of abortions in Africa are unsafe[14]. This prevalence is ascribed to poverty, social inequity and repudiation of women's human rights[15].

Traditionally, lack of access to safe TOP has been synonymous with restrictive abortion laws. Despite the global mandate on liberalising abortion and expediating access to it, the policies governing the practice of abortion, in many parts of the world, range from anachronistic to unreservedly draconian. To date, there are still some countries that totally prohibit abortion despite compelling circumstances[16]. Even the way that TOP is confronted as a human right, remains globally dichotomous. On one hand, landmark cases such as *Manuela v El Salvador*[17]*, Lakshmi v Nepal*[18]*, June Medical Services v Russo*[19] *and PAK* and *Salim Mohammed v Attorney General and Three Others (Malindi High Court Petition Number E009 of 2020)*[20] underscore the imperative of challenging and redefining legal standards and frameworks to align with human rights norms and values. On the other hand, in some places, socio-political conservatism in the context of TOP appears to take precedence over empirical evidence. For example, the Georgia House Bill (HB 481) in the United States was passed in 2019. Under the Living Infants Fairness and Equality Bill, abortion is banned upon the detection of embryonic cardiac activity, as early as 6 weeks of gestation[21]. The sponsors and supporters of this bill assert that

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[13] I Shah & E Ahman 'Unsafe abortion: global and regional incidence, trends, consequences and challenges' (2009) *Journal of Obstetrics and Gynaecology Canada*, 1149-1158.
[14] Ibid 12.
[15] L.U Rehstrom Loi, U Gemzell-Danielson, E Faxelid & M Klingberg-Alvin 'Healthcare providers' perceptions of and attitudes towards induced abortions in Sub-Saharan Africa and South East Asia: a systematic literature review of qualitative and quantitative data' (2015) 15(139) *BMC Public Health.*
[16] Countries where abortion is illegal in 2023 Available at: https://worldpopulationreview.com/country-rankings/countries-where-abortion-is-illegal.
[17] *Manuela v El Salvador*, Case No. (13.069), (2018).
[18] *Laksmi v. Nepal*, 2009 SCC OnLine SC 801.
[19] *June Medical Services v. Russo*, 591 U.S. (2020).
[20] *PAK and Salim Mohammed v Attorney General and Three Others*, Malindi High Court Petition Number E009 of 2020.
[21] D.P Evans & S Narasimhan 'A narrative analysis of anti-abortion testimony and legislative debate related to Georgia's fetal heartbeat abortion ban' (2020) 28(1) *Sexual and Reproductive Health Matters*, 215-230.

detecting of a heartbeat is a medically sound indicator of life, foetal viability and distinct personhood[22] while scientists and medical experts argue that the rhythm specified in abortion bans is actually the electrical activity detected in a rudimentary group of cells and, is by no means a fully developed cardiovascular system or a marker of foetal life[23].

South Africa's TOP laws have been internationally lauded for their robust and progressive framework in the context of women's rights and public health interests[24], and have been complimented for their protection of reproductive rights[25], and is amongst the top-ranking countries globally with the most liberal laws in this regard[26]. The Choice on Termination of Pregnancy (CTOP) Act 92 of 1996[27], together with the overarching constitutional obligations stipulated in the Bill of Rights[28], creates a conducive legislative climate to actualise liberal abortion policies that espouse sexual and reproductive health and rights for girls and women. Within this framework, girls and women are permitted to seek and obtain safe and legal TOPs at designated healthcare facilities offering services, under a broad range of criteria, provided that it is commensurate with the trimester-based approach sanctioned by the law. In South African law, the incorporation of personal choice as a criterion for accessing abortion is a central element of sexual and reproductive health and rights, distinguishing it in the context of safe TOP access. This notable characteristic arises from acknowledging that choosing abortion entails an active decision to end a pregnancy, in contrast to the comparatively passive act of letting it continue to term due to circumstances or regulatory limitations[29]. This differs from

[22] Ibid 21.
[23] A Rogers 'Heartbeat bill gets the science of fetal heartbeat all wrong' (2019) Available at: http://www.google.com/amp/s/www.wired.com/story.
[24] R Jacobs 'Why aren't women getting safe abortions?' (2014) 104(12) *South African Medical Journal*, 857-858.
[25] L.B Pizzarossa & E Durojaye 'International human rights norms and the South African Choice on Termination of Pregnancy Act: An argument for vigilance and modernisation' (2019) 35(1) *South African Journal of Human Rights*, 50-69.
[26] R Kaswa & P Yogeswaran 'Abortion reforms in South Africa: an overview of the Choice on Termination of Pregnancy Act' (2020) 62(1) *South African Family Practice*, 5240.
[27] The Choice on Termination of Pregnancy Act 92 of 1996, Republic of South Africa.
[28] The Bill of Rights of the Constitution of the Republic of South Africa (1996).
[29] J.M.J.J Mavuso, M.T Chiweshe & C.I Macleod '"Choice" in women's abortion decision-making narratives: Introducing a supportability approach' (2020) 59 *Psychology in Society*, 20-40.

legislative frameworks in other parts of the world, that sometimes require women to apply to have an abortion within the narrow parameters of the law[30], or countries that permit abortion in very specific circumstances that does not include the provision of personal choice, or where abortion services fall within the scope of criminal law thereby aligning their legislative frameworks with penal codes[31].

However, regardless of the fact that liberal TOP laws have been in force since 1996 in South Africa, many serious barriers to accessing safe abortion persist[32], making the realisation of these rights somewhat unattainable, particularly for the poorest, most marginalised and geographically isolated girls and women[33]. Seeking a TOP in the public health sector is incumbered by numerous systemic impediments, including long waiting lines to access care, deficiencies in designated spaces and equipment to provide services, staff shortages, inadequacies in knowledge of abortion service protocols, and provider unwillingness to render abortion services[34].

One of the recalcitrant barriers to safe TOP access in South Africa is healthcare providers' right to conscientiously object to delivering legal abortion service. Conscientious objection denotes a refusal to perform an action that is legally recognised and professionally accepted because it is perceived by an individual as being deeply immoral[35]. It is rooted in the right to freedom of thought, conscience and belief – one of the keystones of democracy[36] - and is a constitutionally protected right. While South African girls and women are at liberty to exercise their constitutional and statutory rights to access safe and

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[30] Ibid 29.
[31] 'The State of Abortion Rights Around the World' Available at: https://time.com/6173229/countries-abortion-illegal-restrictions/.
[32] J Harries, C Gerdts, M Momberg & D.G Foster 'An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa.' (2015) 12(21) BMC *Reproductive Health*.
[33]Ibid 32.
[34] M.E Teffo & L.C Rispel '"I am alone": Factors influencing the provision of termination of pregnancy service in two South African provinces.' (2017) 10(1) *Global Health Action*, 1347369.
[35]P Benn. 'Conscience and health care ethics' (2007). In principles of health care ethics: Second edition, ed Richard Ashcroft, Angus Dawson, Helen Draper and J. McMillan. London: Wiley.
[36] *S v Makwanyane and Another* 1995 (3) SA 391 at para 330.

legal abortions, healthcare professionals involved in TOP service provision are concurrently permitted to not participate in providing the service if it conflicts with their personal, moral, ethical, religious or other convictions[37]. Except for cases of medical emergency that pose imminent risk to a pregnant person's life or severe injury to her health, state-employed healthcare professionals may invoke their right to conscientious objection with the proviso that they refer the patient to another healthcare practitioner who is prepared to terminate the pregnancy[38]. Often, this results in girls and women, who have sought TOP services at healthcare facilities specifically designated for this purpose, being denied the intended service. As a result, they must shoulder the socio-economic burden of seeking services elsewhere, in addition to enduring the delays and other social and psychological consequences. In this paradigm, the onus of accessing health services is transferred to the abortion-seeking patient while the objecting healthcare provider is essentially absolved from further responsibilities other than making the requisite referral.

The practice of conscientious objection to TOP service provision is gaining traction globally[39]. Although it has been identified as a major obstruction to access in the context of sexual and reproductive healthcare service provision[40], and is deemed as a growing threat to safe abortion access[41], healthcare providers' right to conscientious objection is widely endorsed within international, regional and domestic legislative frameworks. Only a few countries world-wide have made substantial efforts to limit or restrict healthcare

[37] J Kassner & D Lefkowitz 'Conscientious objection' (2012) *Encyclopedia of Applied Ethics* (2nd edition), 594-601.
[38] Section 36 of South African Constitution. The statute of limitations prescribes that conscientious objection is not an absolute right in instances of medical emergency.
[39] J Bateman 'How conscientious objection laws create backdoor abortion bans in Europe' (2023) Available at: https://www.iwmf.org/reporting/how-conscientious-objection-laws-create-back-door-abortion-bans-in-europe.
[40] M Cook 'Conscientious objection is indefensible says WHO' 2022. Available at: https://bioedge.org/bioethics-d75/conscientious-objection/conscientious-objection-is-indefensible-says-who/ss.
[41] M Magwentshu, R Chingwende, A Jim, J van Rooyen, H Hajiyiannis, N Naidoo, N Orr, J Menzel & E Pearson 'Definitions, perspectives, and reasons for conscientious objection among healthcare workers, facility managers, and staff in South Africa: a qualitative study' (2023) 31(1) *Sexual and Reproductive Health Matters*: 2184291.

provider conscientious objection in the context of abortion, in support of professional responsibility and public health interests[42].

Public healthcare is a critical component of the wider healthcare domain. The over-arching objective of the public healthcare system is to promote greater health and well-being in a sustainable manner, while synchronously strengthening integrated public health services, reducing inequalities[43], and ensuring the public's access to quality health services[44]. Similarly, public health law is essential in ensuring population-level health, specifically through government institutions[45]. Healthcare professionals hold a position of great moral and intellectual influence over their sometimes helpless and vulnerable patients[46]. While they have the right to freedom of conscience which entitles them to act in accordance with their beliefs, healthcare practitioners also have the professional and ethical responsibility to respect the beliefs and opinions of their patients even if contrary to their own. They cannot force any patient or colleague to subscribe to any belief, opinion or religious practice. Moreover, healthcare providers are also mandated to fulfil their professional obligations and to promulgate the realisation of the right of access to health[47].

In South Africa, conscientious objection to abortion service provision remains largely unregulated[48]. The country is yet to take any proactive steps to address this pervasive socio-legal problem, and has not developed sufficient analytical frameworks for balancing competing constitutional rights in the context of

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[42] Sweden, Finland and Iceland are some of the few countries that do not permit healthcare provider conscientious objection to abortion.
[43] World Health Organisation (WHO) Regional Office for Europe. Public Health Services, Geneva (2019) Available: https://www.eur.who.int/en/health-topic/health-systems/public-health-services/public-health-services.
[44]US Department of Health and Human Services. *Public health in America.* Washington (D.C.): US Department of Health and Human Services; 1994.
[45] P Dhavan & K.S Reddy 'Public health professionals' (2017) *International Encyclopedia of Public Health* (second edition) 210-216.
[46] A Shahvisi "Conscientious objection: a morally insupportable misuse of authority" (2018) 13(2) *Sage Journals*, 82.
[47] Doctors and Patients' Rights and Responsibilities. South African Medical Association. Available at: https://www.samedical.org/links/responsibilities.
[48] J Harries, D Cooper, A Strebel & C.J Colvin 'Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study' (2014) 11(16) *Reproductive Health*. Https://doi.org/10.1186/1742-4755-11-16.

conscientious objection and legal TOP access. Furthermore, much of the established legal precedents regarding healthcare providers' conscientious objection to offering TOP services is situated within the realm of international law. The cases of *Pinchon and Sajous v France*[49], along with *Grimmark v Sweden*[50], underscore that healthcare providers must prioritise their ethical responsibility over personal convictions, emphasising that obstructing access to reproductive healthcare infringes upon human rights. Since South Africa has not yet set precedent in the context of healthcare provider conscientious objection to TOP, an opportunity exists within the legal landscape for these two sets of constitutional rights to be tested against each other, potentially paving the way for judicial review and the establishment of a legal precedent.

While evidence-based practices have become an integral element of many disciplines such as medicine and economics, the movement to create better laws informed by reality is lagging behind in the domain of jurisprudence[51]. Evidence-based law, particularly in the context of public health law, is desperately needed in South Africa. In order to effectively honour and fulfil sexual and reproductive health rights, the first step is careful analysis of the current laws against social contexts in order to advance their modification through policies, regulations, and even other laws that are consonant with human rights[52]. Though it is a given that abortion laws are not easily or frequently changed, and that decades or even a century can pass before meaningful reform occurs[53], deliberate and focused efforts must be made to campaign for transformative jurisprudence.

[49] *Pichon and Sajous v France* (2001), App no. 49853/99, Eur, Cr, H.R. 2001- X.
[50] *Ellinor Grimmark v Sweden* (2020), App no. 43726/17 (ECtHR).
[51] J.R Rachlinski 'Evidence-based law' (2011) 96(4) *Cornell Law Review*, 901-903.
[52] S Gruskin, J Cottingham, A.M Hilber 'Using human rights to improve maternal and neonatal health, history, connections and a proposed practical approach' (2008) Bulletin of the World Health Organisation.
[53] P Skuster 'How laws fail the promise of medical abortion: a global look' (2017) 18(379) *Georgetown Journal of Gender and the Law,* 379-394.

1.3 PROBLEM STATEMENT

Theoretically, there is no hierarchy of rights in the South African Constitution[54]. Yet, in the context of conscientious objection and access to legal TOP services, it is usually the vulnerable abortion seeker that is disproportionately disadvantaged, and the realisation of their health rights obstructed[55].

Both the Constitution and the CTOP Act, which are the primary legal instruments that govern the practice of abortion for patients and practitioners, do not explicitly lay out provisions on how conscientious objection can be invoked, nor do they provide directives on the necessary protocols to ensure that the practice does not obstruct reproductive justice. Consequently, a general lack of understanding regarding the circumstances in which healthcare providers in public healthcare facilities are entitled to exercise their right to conscientious objection persists, leading to ad hoc interpretations and applications of the practice[56], making it susceptible to misinterpretation and even abuse[57]. Because it can be devoid of any genuine moral convictions rooted in freedom of thought, conscience, and belief, conscientious objection may be used as a panoptic loophole for non-provision of care. Research suggests that it can be leveraged as a way to reduce workloads[58], or even as an excuse not to do work at all[59]. This is mainly because the notion of conscientious objection has no actual rational benchmark for an objecting practitioner to decisively demonstrate the genuineness and logic of their

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[54] D Moseneke 'The right to differ religiously' Available at: https://www.pressrecorder.com/south-africa/the-sunday-independent/20101031/281930244355390.

[55] C Fiala & J.H Arthur 'There is no defense for "conscientious objection" in reproductive health' (2017) 216(11) *European Journal of Obstetrics and Gynaecology and Reproductive Biology*, 254-258.

[56] J Harries, K Stinson & P Orner 'Health care providers attitudes toward termination of pregnancy: a qualitative study in South Africa' (2009) 18(9) *BMC Public Health,* 296.

[57] C Fiala & J.H Arthur '"Dishonourable disobedience"- Why refusal to treat in reproductive healthcare is not conscientious objection' (2014) 1 *Woman- Psychosomatic Gynaecology and Obstetrics*, 12-23.

[58] M Favier, J.M.S Greensberg & M.Stevens "Safe abortions in South Africa: "we have wonderful laws but we don't have people to implement those laws" (2018) 143(4) *International Journal of Gynaecology*, 38-44.

[59] J Savalescu & U Schuklenk 'Doctors have no right to refuse medical assistance in dying, abortion or contraception' (2017) 31(3) *Bioethics*, 162-170.

objections[60]. Permitting conscientious objection lies solely on initially trusting the word of the objector *prima facie*. This doesn't leave much room to challenge objector's justifications as they are largely unverifiable, forcing us to almost unconditionally accept them[61].

At present, there is a dearth of existing literature investigating the evidence of mandatory referrals concerning conscientious objection to TOP in South Africa. There is limited information regarding the nature of these referrals, such as whether they are verbal or written, and even their occurrence remains uncertain. The extant literature also fails to clarify how and whether an objecting provider is aware of the precise location of the next closest non-objecting provider given that practitioners may resign from their posts, take time off, or otherwise become unavailable. It is therefore debatable whether a meaningful reference is made or whether it is just a mere tick-the -box exercise. Effective referral is an integral component of delivering high-quality healthcare. The necessity for referral, its appropriateness, timing, and the choice of the recipient for the referral are largely contingent on the practitioner initiating the referral[62]. While state parties, as duty bearers, are tasked with embracing the responsibility for providing the essential infrastructure that allows women to have timely referrals to alternative providers[63], Tongue asserts that depending on compulsory referral mechanisms fails to achieve a satisfactory equilibrium between abortion access and freedom of conscience. Referrals, according to Tongue, fall short of addressing the broader concerns related to the excessive and improper use of conscientious objection, and they are also incapable of guaranteeing access[64]. McQuoid-Mason suggests that a conscientiously objecting healthcare practitioner who neglects or declines to refer a patient to a willing provider may be interpreted as preventing lawful termination or obstructing access to a

[60] N Ben-Moshe 'Conscientious objection in medicine: making it public' (2021) 33(3) *HEC Forum*, 269-289.
[61] Ibid 55.
[62] E.B Anyanwu, O Abedi Harrison & E.A Onohwakpor 'The practice of medical referral: ethical concerns' (2015) 3(1*) American Journal of Public Health Research*, 31-35.
[63] General Comment No 2 on Article 14 of the Maputo Protocol, para 26.
[64] Z.L Tongue 'On conscientious objection to abortion: Questioning mandatory referral as compromise in the international human rights framework.' (2022) 22(4) *Medical Law International*, 349-371.

facility[65], though this construal has not yet been legally tested in a court of law. Failing to appropriately refer a patient could also potentially result in the healthcare provider being held legally responsible under delictual liability.

While some commentators claim that referring a patient to a participating provider or facility is an appropriate compromise that retains the autonomy of the objecting practitioner and does not undermine reproductive justice[66], research demonstrates that healthcare providers' invocation of conscientious objection compromises women's access to legal abortions in both a direct (by restricting access) and indirect (by way of augmenting pre-existing barriers to access) manner[67]. The fundamental issue with conscientious objection in the sphere of healthcare is that it always has an impact on someone else's health or access to care because non-participation interrupts health service delivery[68]. Although the underlying theoretical supposition is that the refusing healthcare provider has an obligation to minimise disruptions in delivery of care and not obstruct a patient's rights to access healthcare and autonomous decision-making[69], this is seldom practised. And, while the need for cognitive, cultural, and religious pluralism in a democratic society is acknowledged, it needs to be contextually appropriate and not infringe upon the rights of others, particularly in the perspective of access to healthcare.

The author hereof aligns with the views of Fiala and Arthur who assert that conscientious objection to TOP undermines scientific evidence and is, in effect, a dereliction of a healthcare practitioner's fiduciary obligations to their patient[70]. It is submitted that recognition of conscientious objection in law falsely equates

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[65] D.J McQuoid-Mason 'State doctors, freedom of conscience and termination of pregnancy revisited' (2010) 3(2) *South African Journal of Bioethics*, 75-77.
[66] L.M Kohm 'From Eisebstadt to Plan B: A discussion of conscientious objection to emergency contraception' 33(3) *William Mitchell Law Review*, 787-805.
[67] J.M Davis, C.M Haining & L.A Keogh 'A narrative literature review of the impact of conscientious objection by health professionals on women's access to abortion worldwide' (2022) 17(9) *Global Public Health*: 2190-2205.
[68] N Berlinger 'Conscientious clauses, healthcare providers and parents' (2022) The Hastings Center. Available at: https://www.thehastingscenter.org/briefingbook/conscience-clauses-health-care-providers-and-parents/.
[69] Ibid 68.
[70] Ibid 55.

patient and provider rights[71]. Contending that a constitutional right is detrimental represents a contentious viewpoint that may encounter scepticism and provocation in both legal and philosophical discussions. This is because constitutional rights are classically designed to guarantee a fair and equitable society. However, when examining conscientious objection to TOP within the South African context, it is imperative to deliberate the adverse consequences associated with the exercise of this constitutional right. Neglecting to do so equates to disregarding significant socio-legal issues. Constitutional rights offer a stable foundation for legal and political systems. Despite their resilient and enduring nature, it is crucial to recognise the necessity for adaptation, on-going interpretation, and possible amendments. This is essential to ensuring that constitutional frameworks remain effective and aligned with evolving contextual realities and societal values. Thus, the law should be continually reviewed and reformed in accordance with modern scientific and legal standards to remain responsive to human rights obligations[72].

1.4 RATIONALE FOR THE STUDY

South Africa has one of the highest levels of income inequality globally[73]. This has a direct bearing on access to healthcare as it results in a two-tiered and unequal system of health service provision that is divided along socio-economic lines[74]. Utilised by the majority of citizens, the public health sector, which is characteristically overburdened and underserviced[75], is beset by innate systemic, administrative, financial and human-resource problems. Private healthcare, patently having better facilities, quality care, and shorter wait times[76], is, on the other hand, accessed by affluent, educated, and skilled

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[71] N Philipsen 'Do conscience clauses violate patients' rights?' (2018) 14(6) *The Journal for Nurse Practitioners*, 448-449.
[72] L.O Gastin & J Kraemer 'Foundations in public health law' (2017) *International Encyclopedia of Public Health* (second edition), 192-198.
[73] R Burger & C Christian 'Access to healthcare in post-apartheid South Africa: availability, affordability, acceptability' (2020) 15(1) *Health, Economics, Policy and Law,* 43-55.
[74] M Young 'Private vs Public Healthcare in South Africa' (2016*) Honors Theses* 2741 Available at: https://scholarworks.wmich.edu/honors_theses/2741.
[75] B Malakoane, J.C Heunis, P Chikobvu, N.G Kigozi & W.H Kruger 'Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening' (2020) 20(58) *BMC Health Services Research*, 2-14.
[76] Ibid 74.

individuals who can afford the exorbitant costs of care, or are members of medical aid schemes[77]. Thus, access to quality healthcare services in South Africa is primarily shaped by the socio-economic status of individuals rather than their actual need for care[78]. Race also plays a significant role in sculpting the healthcare system dynamics within the nation. Studies confirm that White and Indian individuals primarily access the advantages of private healthcare, while the vast majority of Black individuals depend on the public sector for their healthcare needs[79].

Much of these disparities have to do with the historical context of the country. Apartheid era urban planning and infrastructural allocation resulted in a fragmented and discriminatory health service system with extreme variances in the quality and accessibility of services depending on racial group and place of residence[80]. Despite the country's political watershed in 1994, the relics of past injustices endure, and are expressly apparent in the context of access to quality healthcare services. Thus, despite the fact that the public health sector forms the cornerstone of the current national healthcare system and plays a vital role in the socio-economic welfare of the country, it is a model that is rampant with deficiencies and is at imminent risk of implosion[81].

Analogously, in the context of abortion, the realities of seeking care in public and private health settings are deeply disparate. For girls and women of privileged socio-economic status especially in urbanised areas, securing abortion services in private institutions or facilities – Marie Stopes clinics, for instance – is almost always guaranteed. This is not the case for females who cannot afford private care and are therefore reliant on the state for provision of

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[77] R Marten, D McIntyre, C Travassos, W Reddy & S Vega 'An assessment of progress toward universal health coverage in Brazil, Russia, India, China and South Africa (BRICS) (2014) 384 *The Lancet*, 2164-2171.
[78] R Lalloo, M.J Smith, N.G Myburgh, G.C Solanki 'Access to healthcare in South Africa-the influence of race and class' 94 *South African Medical Journal*, 639-642.
[79] J Hartwig & J Strum 'Testing the Grossman model of medical spending determinants with macroeconomic panel data' (2019) 19(8) *European Journal of Health Economics*, 1067-1086.
[80] P Maharaj & J Cleland 'Integration of sexual and reproductive health services in KwaZulu-Natal, South Africa' (2005) 20(5) *Health Policy and Planning*, 310-318.
[81] M Edmeston 'Beyond band-aids: reflections on public and private healthcare in South Africa' Available at: https://admin.hsf.org.za.

services[82]. In theory, females who use the state as their service provider can obtain abortions free of charge, compared with women who access abortion care in the private sector which incurs costs, that can sometimes run into thousands of rands[83]. Disturbingly, many state-designated abortion facilities fail their mandate of abortion service provision. In 2016, the National Department of Health (NDoH) confirmed with Amnesty International that, of the 13% of government facilities that were designated to provide TOP services, only 3.8 % were actually doing so[84].

Against the contextual backdrop of the phenomenological realities of the South African public healthcare system, relying on the mechanism of referral and the general limitation clause of the Constitution to sanction conscientious objection by a healthcare provider is not an effective way of regulating non-participation in TOP services. Taking into account the existing demands on the public health care system, and the fragmented and dysfunctional manner in which it operates[85], this dissertation endeavors to demonstrate that permitting state-employed healthcare practitioners involved in TOP service provision to invoke their right to conscientious objection is an obstruction of public health justice, as the system simply does not have the capacity nor effective regulatory frameworks and infrastructure to cope with a multitude of referrals that is contiguous with the current model of conscientious objection.

1.5 CONCEPTUAL FRAMEWORK

1.5.1 Reproductive justice as an overarching framework

Reproductive justice is a state of complete physical, mental, spiritual, social, political, and economic well-being of women and girls, and is premised upon

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[82] K.A Trueman & M Magwentshu 'Abortion in a progressive legal environment: the need for vigilance in protecting and promoting access to safe abortion services in South Africa' (2013) 10(3) *American Journal of Public Health*, 397-399.

[83] Women's legal center. Accessing abortions in Gauteng. Available at: wlce.co.za/wp-content/uploads/2022/05/WLC.Abortion-Booklet-Gauteng.pdf.

[84] 'Women are still being denied access to safe, legal abortion in SA' (2019) The Daily Maverick. Available at: https://www.dailymaverick.co.za/article/2019-05-28-women-are-still-being-denied-access-to-safe-legal-abortion-in-SA.

[85] Ibid 75.

the full achievement and protection of women's human rights[86]. The core components of reproductive justice include comprehensive sex education, affordable contraception, freedom from sexual violence, and equitable access to safe abortion services[87]. The right to have or not have a child, and the right to parent a child in a healthy and safe environment also falls under the rubric of reproductive justice[88]. Further, it recognises that a woman's ability to determine her own reproductive destiny is not simply a matter of choice or access but is determined by a range of environmental and community-based factors[89]. An intersecting system of oppressions, including racism, classism, sexism and heterosexism, plays a significant role in reproductive health and well-being[90]. Geo-political, cultural, age-related, and other power dynamics affect reproductive health and choices[91], making reproductive justice a complex and multidimensional concept.

Reproductive justice also entails identifying and addressing social injustices and obstacles such as stigmatisation, barriers to accessing information, resource scarcity, and transportation constraints[92]. Any impediment, restriction, or ban on reproductive autonomy disproportionately impacts women, particularly women of colour, those with disabilities, and those who are economically disadvantaged[93]. Reproductive justice as a conceptual framework holds great promise for directing research that can contribute to social change.

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[86] L Ross 'What is reproductive justice?' in Reproductive justice briefing book: A primer on reproductive justice and social change. Available at https://www.law.berkeley.edu/php-programs/courses/fileDl.php?fiD=4051.

[87] O Ahmed & C.M Gamble 'Reproductive justice: what it means and why it matters (now more than ever) (2017) Black Women's Health Imperative Available at: https://www.publichealthpost.org/viewpoint/reproductivejustice.

[88] M Stevens 'Challenge for achieving sexual and reproductive justice in South Africa' (2019) Sexual and Reproductive Health Matters. Available at: https://srjc.org.za/2019/05/06/challenges-for-achieving-sexual-and-reproductive-justice-in-south-africa/.

[89] K Norlock 'Feminist Ethics' (2019) Standford Encyclopedia of Philosophy. Available at: https://plato.standford.edu/entries/feminism-ethics.

[90] A.A Eaton & D.P Stephens 'Reproductive justice special issue introduction: reproductive justice moving the margins to the center in social issues research' (2020) 76(4) *Journal of Social Issues, 208-218.*

[91] Women and Girls: Closing the gender gap. United Nations. Available at: https://www.un.org/en/un75/women-girls-closing-gender-gaps.

[92] Ibid 91.

[93] K.S Ramirez 'Reproductive justice must be considered in the scientific community' (2022) 7 *Nature Microbiology*, 352-353.

It can foster nuanced and critical viewpoints to address reproductive issues and the pernicious social inequities underpinning them[94]. Reproductive health policies, the impact of welfare policies on marginalised groups, barriers to sex education in schools, and new restrictions on contraception and abortion are some examples of where the reproductive justice framework is applied[95]. Accordingly, this study uses the perspectives of both reproductive justice and feminist ethics to explore conscientious objection in the context of abortion law in South Africa and to construct a narrative that highlights how it contributes to reproductive and public healthcare inconsistencies and injustices. Winning and preserving legal protections, expanding reproductive health services in every community, and ending inequality and discrimination are essential to realise reproductive justice[96]. Since South Africa is far from achieving this goal, a concerted effort is necessary to facilitate effective and meaningful reform of policies and practices in a manner that respects and promotes reproductive justice[97].

1.5.2 Feminist ethics as a lens of reproductive justice

Feminist ethics is an approach that is commonly used in social research to criticise and correct perceptions about gender that perpetuate oppressive social orders or practices. These practices are harmful to people, specifically women and girls who have historically been subordinated within gendered parameters such a sexuality and gender identity[98]. The primary objective of feminist ethics as a conceptual framework is to illustrate how cultural and social conventions have produced a gender gap concerning ethical issues and how this gap contributes to neglecting or under-valuing women's lived experiences[99].

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[94] T Morrison 'Reproductive justice: a radical framework for researching sexual and reproductive issues in psychology' (2021) 15(6) *Social and Personality Psychology Compass,* e12605.
[95] J.L Liddell 'Reproductive justice and the social work profession: common grounds and trends' (2018) 34(1) *Journal of Women and Social Work*, 99-115.
[96] Reproductive justice is every woman's right. National Organization for Women. Available at: https://now.org/resource/reproductive-justice-is-every-womans-right/.
[97] S Nayyar & D Moerane 'Our bodies, ourselves -towards reproductive justice in South Africa. Op Ed. The Daily Maverick. (2019) Available at: https://www.dailymaverick.co.za/article/2019-12-04-our-bodies-our-selves-towards-reproductive-justice-in-south-africa.
[98] Ibid 89.
[99] S.Z Hmway 'An introduction to feminist ethics' (2019) 10(1) *Yadanabon University Research Journal*, 1-4.

Globally, girls and women have less access to education and healthcare, lack economic autonomy, and are under-represented in decision making at all levels[100]. Issues that are unique to the female experience such as pregnancy and abortion, and the socio-political contexts in which these topics are framed, falls within the scope of the feminist ethics framework.

1.6 RESEARCH QUESTIONS

1.6.1 Main research question

How do healthcare providers' rights to conscientious objection in South Africa's public health sector affect the rights of girls and women to terminate their pregnancies?

1.6.2 Research sub-questions

1.6.2.1 What is the legal framework for termination of pregnancy in South Africa?

1.6.2.2 What rights do healthcare practitioners have in relation to conscientious objection in South Africa, and how does this impact the access of women and girls to safe and legal termination of pregnancies?

1.6.2.3 What obstacles do South African girls and women face when seeking safe and legal abortions within the public healthcare system?

1.6.2.4 What policy regulation improvements are needed in South Africa to address conscientious objection in the provision of termination of pregnancy services?

1.6.3 Research Methodology

This dissertation was completed using a doctrinal method. This is a form of secondary research which involves the compilation and synthesis of information, primarily legal doctrines, principles and other legal texts, from the existing corpus of literature in order to answer the research question. Contrasted to traditional primary research in which a researcher generates data first-hand, secondary research is based upon already published information

[100] Ibid 91.

obtained from other scholars' work. It entails the review, re-analysis, and interpretation of primary sources[101]. A thorough review of literature was conducted using relevant journal articles, doctrines, statutes, textbooks, online articles, and meta-analyses from various search engines on the internet as well as the UKZN institutional repository and library, and used to construct the legislative framework for abortion seeking patients and healthcare practitioners, and the argument associated with the need to balance rights.

1.7 ETHICAL CONSIDERATIONS

Unlike in the qualitative and quantitative research methodologies that have specific ethical requisites such as informed consent, confidentiality, and voluntary participation, the ethical considerations of desk-top research are limited since no human participation is involved. Permission to proceed with this study was sought from the UKZN research ethics committee. The works of other researchers used in this dissertation has been duly acknowledged, and the referencing style conformed with that prescribed by the discipline.

1.8 STRUCTURE OF THE DISSERTATION

STRUCTURE OF THE DISSERTATION	
CHAPTER 1:	The research topic, background, and rationale are outlined in this chapter, together with additional elements that help to frame and shape the study, including the problem statement, conceptual framework and research questions and methodology.
CHAPTER 2:	This chapter delineates the rights of South African females in the context of TOP. It highlights the rights enshrined in international and regional human rights instruments, and discusses the constitutional, statutory and soft law provisions.

[101] M.D Pradeep 'Legal research-descriptive analysis on doctrinal methodology' (2019) 4(2) *International Journal of Management, Technology and Social Sciences* 95-103.

CHAPTER 3:	This chapter delineates the rights of healthcare providers involved in TOP service provision in the public health sector of South Africa and discusses in detail the right to conscientious objection.
CHAPTER 4:	A discussion of the barriers to access safe and legal TOP in the public health sector of South Africa is presented in this chapter.
CHAPTER 5:	The central themes of the study are recapitulated together with recommendations that arise from the analysis of conscientious objection to TOP in South Africa.

1.9 CONCLUSION

This chapter delineated the landscape of abortion accessibility within South Africa. With a commitment to fostering fairness, equality, and the preservation of human rights, the legislative framework safeguards the rights of both conscientious objectors and individuals seeking abortion services. However, challenges arise from the practicalities of the public health system, rendering the exercise of conscientious objection problematic. Otherwise, the process would follow a linear trajectory, where abortion access could be readily ensured simply through appropriate and timely referrals. The following chapter provides an examination of the legislative frameworks governing the rights of individuals seeking TOP in South Africa.

CHAPTER TWO: LEGISLATIVE FRAMEWORK ON TERMINATION OF PREGNANCY RIGHTS

2.1 INTRODUCTION

This chapter outlines the legal structure governing the rights of individuals seeking TOP in South Africa and underscores the pertinent global, regional and domestic instruments that constitute this framework.

2.2 PATIENT RIGHTS

Patient rights are a branch of human rights. Establishing a framework of clearly defined patient rights, derived from a core set of ethical principles including respect for autonomy, beneficence, non-maleficence and justice, helps standardise care across health profession disciplines and enables patients to have uniform expectations during their receiving of care[102]. Not only do patient rights protect against discrimination and abuse, but they also promote ethical practices in the healthcare arena[103]. In light of healthcare being a joint initiative between patient and provider, respecting patient rights is paramount to developing trust between patient and practitioner and plays a significant role in positive health outcomes[104]. Patients' awareness of their health rights is critical as it establishes a benchmark for effective patient-practitioner communication[105]. Additionally, it has the potential to increase dignity of patients by fostering participation in their healthcare decisions. Conversely, lack of respect for patient rights may lead to poor therapeutic relationships and

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[102] Olejarczyk JP, Young M. Patient Rights and Ethics. (2022). In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2023 Jan. Available from: https://www.ncbi.nlm.nih.gov/books/NBK538279/.

[103] E.M Nejad, J Begjani, G. Abotalebi, A Salari & S.R Ehsani. 'Nurses awareness of patients' rights in a teaching hospital' (2011) 4 *Journal of Medical Ethics and History of Medicine, 2.*

[104] Patient rights and the essential role of nurses available at: https://online.hpu.edu/blog/patient-rights/.

[105] A.M Thema & G.O Sumbane, 'Patients' awareness of the Patients' Rights Charter in selected hospitals of Limpopo province, South Africa' (2021) 1(1) *IJQHC Communications*, Available at: https://doi.org/10.1093/ijcoms/lyab016.

standards of care in a healthcare setting[106]. Without due consideration and comprehension of patient rights, healthcare teams may, at times, gravitate towards practices that exhibit overt paternalism, such as disregarding the patient's autonomy or making clinical decisions on the patient's behalf[107]. Since the introduction of the Human Rights Act by the United Nations (UN) in 1948, legislations on patients' rights have been prioritised and passed globally[108].

2.3 SEXUAL AND REPRODUCTIVE HEALTH RIGHTS, POLICY AND PATIENT RIGHTS

Reproductive healthcare is characterised by a constellation of methods, techniques and services that contribute to health and well-being through solving and preventing sexual and other reproductive health problems[109]. In many places, reproductive health is elusive because of factors such as inadequate knowledge about human sexuality, poor quality reproductive related health information and services, high-risk sexual behaviour, discriminatory sexual practices, negative social attitudes towards girls and women, and the limited power they have over their own sexual and reproductive lives[110]. Therefore, guaranteeing universal access to sexual and reproductive healthcare has been prioritised in the United Nations Sustainable Development Goals (SDGs). Reproductive health issues are recognised as a leading cause of illness and death for girls and women living in developing countries. Typically, marginalised and underserved populations in these countries are most susceptible to having their sexual and reproductive health rights violated[111]. Examples of these violations include denial of access to services that only women require, sub-

[106] M Nematollahi, M Fesharaki, & S Toufighi. 'Comparison of patient rights laws in Iran with Patient Rights Charter and survey of physicians of Shiraz University of Medical Sciences about patient rights' *Teb va Tazkieh.* 2000, 36:59–62.
[107] J.P Olejarczyk & M Young 'Patient rights and ethics' (2022) StatPearls. Treasure Island (FL) Available at: https://www.ncbi.nih.gov/books/NBK538279.
[108] WHO. Mental health, human rights and legislation. WHO's framework. World Health Organization, 2005.
[109] International Conference on Population and Development, Chapter VII, Section A, Paragraph 72.
[110] Sexual and reproductive health rights. Continental Policy Framework. Available at: https://au.int/sites/default/files/documents/30921-doc-srhr_english_0.pdf.
[111] L Rodriguez 'What is SRHR? Everything to know about sexual and reproductive health and rights' (2021) Available at: https://www.globalcitizen.org/en/content/sexual-reproductive-health-rights-srhr-explained/.

standard services, and regulating women's access to services by mandating third party authorisations[112]. The realisation of sexual and reproductive health rights hinges on access to safe abortion services, treatment of the complications of unsafe abortions, access to a range of modern contraceptives, antenatal and postnatal care, comprehensive sexuality education, and prevention and treatment of sexually transmitted infections[113]. Since sexual and reproductive health is linked to a range of human rights, including the right to life, the right to health, the right to be free from discrimination and degrading or inhuman treatment, the importance of guaranteeing these rights cannot be emphasised enough.

2.4 SUMMARY OF THE LEGISLATIVE FRAMEWORK REGULATING TOP RIGHTS IN SOUTH AFRICA

Abortion rights in South Africa are fortified through diverse mechanisms within the law. This comprehensive legislative framework incorporates international, regional, and domestic instruments comprising various human rights provisions, each contributing to the scope of sexual and reproductive health rights. An overview of this framework is illustrated in Table 2.1.

[112] Ibid 110.
[113] Ibid 111.

Table 2.1: A synopsis of the legislative framework governing TOP rights in South Africa

Legislative Framework Component	Legislative Instrument
International law	▪ Universal Declaration of Human Rights (UDHR)[114] ▪ International Covenant on Economic, Social and Cultural Rights (ICESCR)[115] ▪ International Covenant on Civil and Political Rights (ICCPR)[116] ▪ Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[117] ▪ International Convention on the Elimination of All forms of Racial Discrimination (ICERD)[118] ▪ International Convention on the Rights of Persons with Disabilities (ICRPD)[119] ▪ United Nations Convention on the Rights of the Child (UNCRC)[120] ▪ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)[121]

[114] Universal Declaration of Human Rights (1948).
[115] International Covenant on Economic, Social and Cultural Rights (1966).
[116] International Covenant on Civil and Political Rights (1966).
[117] United Nations. (1979). Convention on the Elimination of All Forms of Discrimination Against Women.
[118] United Nations. (1965). International Convention on the Elimination of All Forms of Racial Discrimination.
[119] United Nations. (1965). International Convention on the Elimination of All Forms of Racial Discrimination.
[120] United Nations. (1989). Convention on the Rights of the Child. Adopted 20 November 1989, entered into force 2 September 1990.
[121] United Nations. (1984). Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.

Regional Human Rights Instruments	▪ The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa[122] (The African Charter) ▪ The Beijing Declaration[123]
The Constitution of the Republic of South Africa	▪ Chapter 2: The Bill of Rights
South African Statutory Law	▪ The CTOP Act ▪ The National Health Act[124] (NHA)
South African Clinical Practice Guidelines	▪ Health Professions Council of South Africa (HPCSA) Booklet 8: General Guidelines for Reproductive Health ▪ National Clinical Guideline for Implementation of the Choice on Termination of Pregnancy Act 2020
Rights Charter	▪ South African Patient Rights Charter
Other soft law	▪ Batho Pele Principles

2.5 INTERNATIONAL AND REGIONAL TREATIES AND CONVENTIONS

International and regional treaties, together with conventions, are binding agreements that aim to advance societal stability, sustainability, prosperity, and peace[125]. Treaties are also meant to entrench and expand human rights. This is achieved by first defining and clarifying the scope of human rights and then protecting and promoting them and, in addition, by creating specific protections for marginalised and vulnerable groups[126]. Treaties as a source of rights only binds countries that explicitly accept them[127]. This can be done by definitive

[122] African Union, Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa AHG/Res.240 (XXXI) (2003).
[123] Beijing Declaration and the Platform for Action (1995) A/CONF.117/20.
[124] National Health Act, 2003 (Act No. 61 of 2003).
[125] International Treaties Available at: https://www.europewatchdog.info/en/international-treaties/.
[126] Expansion of the concepts of human rights: impact on rights, promotion and protection' (2018) Available at: https://www.europarl.europa.eu/RegData/etudes/STUD/2018/603865/EXPO_STU(2018)603865_EN.pdf.
[127] Ibid 126.

signature, ratification, acceptance, approval, or accession[128]. Simply signing a treaty does not make a state party to it unless legal measures are posited to action it. It does, however, indicate the state's commitment to take steps to realise its provisions at a later stage[129]. In the African context, regional instruments protect and promote universal human rights while integrating the values and virtues of African traditions[130]. These systems are sensitive to regional customs, cultures, and practices[131]. In instances where domestic mechanisms fail to uphold the law, or when they themselves violate the law, redress can be sought within regional legal frameworks.

2.5.1 Impact of International Legal Instruments on Global Abortion Policy

Regional and international treaties recognise abortion as a fundamental human right. They acknowledge that denial of abortion care violates a range of human rights, including violations of the rights to autonomy, bodily integrity, privacy, confidentiality, and freedom from discrimination and cruel, inhuman, or degrading treatment. Further, they affirm that specific protections for abortion as an inalienable right are a global imperative[132]. Treaty bodies explicitly implore states to decriminalise abortion and guarantee safe provision of comprehensive reproductive health services including abortion. They also denounce absolute bans on abortion as being incompatible with international human rights norms and urge states to eradicate punitive measures for girls and women who undergo abortions as well as for the healthcare providers who deliver such services[133]. These increasingly progressive standards play a critical role in

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[128] Understanding International Law. 2010 Treaty Event. Available at: https://treaties.un.org/doc/source/events/2010/press_kit/fact_sheet_5_english.pdf.

[129] Ibid 128.

[130] A rough guide to the regional human rights systems. Available at: https://www.universal-rights.org/human-rights-rough-guides/a-rough-guide-to-the-regional-human-rights-systems/

[131] Regional human rights mechanisms. Available at: https://www.right-to-education.org/page/regional-human-rights-mechanisms.

[132] J.B Fine, K Mayall & L Sepulveda 'The role of international human rights norms in the liberalization of abortion laws globally' (2017) 19(1) *Health and Human Rights Journal*, 69-80.

[133] CESCR, General Comment No. 14. UN Doc. E/C.12/2000/4. *The Right to the Highest Attainable Standard of Health.* 2016 para. 40.Committee against Torture, Concluding Observations on Nicaragua. UN Doc. CAT/C/NIC/CO/1. 2009 para. 16.HRC, Concluding Observations on El Salvador. UN Doc. CCPR/C/SLV/CO/6. 2010 para. 59(b).

advancing abortion law and policy reform by transforming national-level jurisprudence[134].

2.5.2 International Instruments: Provisions that are relevant to TOP access

The comprehensive set of rights that make up abortion rights outlined in various international and regional frameworks is catalogued in the appendices section. In this chapter, the focus will be on the discussion of the right to the highest attainable standard of health, as well as some of the key provisions included within these instruments. South Africa's Constitution recognises the significance of adhering to principles of international law and giving due regard to *opinio juris*. Section 39(1)(b) of the South African Constitution addresses the interpretation of the Bill of Rights by stipulating that when a court, tribunal, or forum interprets the Bill of Rights, it is obligated to take into account international law. Consequently, international law constitutes an integral component of South Africa's domestic legal framework, provided it aligns with the Constitution and other Acts of Parliament[135]. Therefore, South Africa must strive to uphold all provisions in these instruments.

Ensuring the right to the highest attainable standard of health, which includes sexual and reproductive health rights, acknowledges the legal responsibility of states to allocate their maximum available resources for healthcare. This commitment aims to guarantee access to timely, acceptable, and affordable healthcare. At its core, this right requisite the establishment of an effective and integrated health system that addresses both medical care and the fundamental determinants of health, which is responsive to national and local priorities, ensuring accessibility for all[136]. An important element of this right is a multidimensional strategy for progressive social change as it is not only concerned with what a healthcare system does (e.g., providing access to essential medicines), but also how it does it viz. with transparency and in a

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[134] Ibid 132.
[135] Constitution of the Republic of South Africa (1996), Section 39(1)(b). Also, Section 232.
[136] P Hunt & G Backman 'Health systems and the right to the highest attainable standard of health' (2008) 10(1) *Health and Human Rights*, 81-92.

participatory manner[137]. While all international and regional instruments include provisions for the right to access healthcare, only a few explicitly address the right to the highest attainable standard of healthcare. The distinction between the right to access healthcare and the right to the highest attainable standard of healthcare lies in the fact that the latter extends beyond mere access. Unlike the basic provision of access, the right to the highest attainable standard of healthcare underscores the quality and standard of healthcare individuals are entitled to receive. It also signifies a commitment to consider medical advancements, adopt best practices, and the evolving understanding of health as an elemental right[138].The IESCR recognises that everyone has the right to the highest attainable standard of physical and mental health[139]. Similarly, the UNCRC also provides the right to the highest attainable standard of health and medical care[140]. The ICRPD further safeguards this right for persons with disabilities[141]. The right to the highest attainable standard of healthcare validates the provision of high quality, safe and accessible abortion services.

Other notable provisions in the context of TOP access, embedded within international and regional frameworks include provisions in the CEDAW which obliges states to take appropriate measures to abolish or modify existing laws, regulations, customs and practices that discriminate against women[142]. This can be interpreted as taking all measures to allay the egregious barriers that prevent and obstruct women from accessing and receiving safe abortion services. Article 14(2) of CEDAW also establishes the duty of states to eliminate discrimination against rural women. Since rural women face some of the steepest barriers to abortion access[143], this article is particularly apt. The African Charter is one of the only instruments to explicitly mention the word abortion. Article 14 of this instrument deals with the right to reproductive autonomy[144], the

[137] Ibid 136.
[138] Ibid 136.
[139] Article 12(1).
[140] Article 24.
[141] Article 25.
[142] Article 2(b)-(f).
[143] Ibid 111.
[144] Article 14.1(a).

right to determine whether to have children or not[145], and protects reproductive rights by authorising medical abortions in certain circumstances[146]. It also addresses the curbing of discriminatory practices which endanger the health and well-being of women[147], and calls for the elimination of harmful medical practices and the protection of women vulnerable to harmful practices and intolerance[148]. Frequently, the stigma surrounding abortion and difficulties in access lead women to turn to illicit providers, a situation linked to the provisions outlined in this clause. The Beijing Declaration commits to the design, implementation and monitoring of policies that bolster empowerment and advancement of women[149]. This is directly linked to the development of more effective policies and procedures related to TOP healthcare.

2.6 EXAMPLES OF HOW INTERNATIONAL LEGAL INSTRUMENTS FACILITATED LEGISLATIVE REFORM IN THE CONTEXT OF ABORTION

2.6.1 *Mellet v Ireland*

International treaties, as exemplified in the case of *Mellet v Ireland*[150], have positively influenced abortion rights. Until 2018, the Republic of Ireland criminalised almost all abortions, citing the equal right to life for both the mother and unborn baby under Article 40.3.3 of the Irish Constitution. This meant that the state was compelled to protect and vindicate those rights as far as possible even in the context of medical emergencies necessitating abortion. Amanda Mellet's case, where she was denied a therapeutic abortion due to a fatal congenital condition, and therefore had to travel to another country to obtain one, led to a legal challenge. The court found Ireland's abortion laws violated the ICCPR, resulting in a ruling of discrimination and inhuman and degrading treatment[151]. This case played a critical role in legalising abortion in Ireland in

[145] Article 14.1(b).
[146] Article 14.2(c).
[147] Article 2.1(b).
[148] Article 5.
[149] Article 19.
[150] *Mellet v Ireland* CCPR/C/116/D/2324/2013.
[151] HRC, Communication No. 2324/2013. UN Doc. CCPR/C/116/D/2324/2013. *Mellet v. Ireland.* 2016 para. 8.

cases of severe foetal abnormality and in other instances that pose a significant risk to the life, health, or well-being of a pregnant women.

2.6.2 *K. L v Peru*

The ICCPR played an instrumental role in achieving justice in the case of *K.L v Peru*[152]. Advised to have a therapeutic abortion as continued pregnancy would be a risk to the physical and mental health of K.L, and pose significant threat to the life of her baby due to severe foetal anomalies, K.L was denied by a public hospital director, citing Peruvian law. Despite provisions for medical abortion in Article 119 of the Criminal Code, K.L suffered severe mental health consequences. The United Nations Human Rights Committee found that the misinterpretation of the Peruvian Criminal Code led to violations of K. L's rights under ICCPR, including the right to life and protection from cruel, inhuman and treatment, and special protection of her rights as a minor. In 2015, K.L received reparations from the state[153].

2.6.3 *L.C v Peru*

A 13-year-old Peruvian girl, L.C, became pregnant as a result of sexual abuse. After a suicide attempt, she survived and needed surgery to reduce the risk of losing full limb functionality. Upon learning of her pregnancy, doctors declined surgery. L.C sought a therapeutic abortion, citing the risk to her life and recovery, but it was denied. She then miscarried and was able to obtain the operation but delayed care left her paralyzed from the neck down. A complaint was submitted to the UN Committee on Elimination of Discrimination Against Women on the grounds that denial of abortion in L. C's case violated a range of her human rights specified in the CEDAW. This was verified, and the state was ordered to pay compensations. It was also recommended that the state revise its abortion law, particularly with an intention to establish effective mechanisms for accessing therapeutic abortion and decriminalising abortion in cases of pregnancy resulting from sexual abuse[154].

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[152] *KL v Peru* (2003) 1153/2003.
[153] Ibid 152.
[154] *L.C v Peru* (2009) 22/2009.

2.7 THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA: SUPPORT FOR THE RIGHT TO TERMINATE A PREGNANCY

The South African Constitution, as the supreme law, serves as the ultimate reference for all legal matters, including situations where statutory law may overlook certain elements. Chapter 1 of the South African Constitution focuses on upholding the democratic values of human dignity, promoting equality, and advancing the rights and freedoms of individuals as founding principles. Chapter 2, The Bill of Rights, is a fundamental pillar of democracy in South Africa. Although the Constitution does not explicitly reference the right to abortion, it is guaranteed through a combination of other provisions, most notably the right to equality, the right to life, the right to freedom and security of the person, and the right to healthcare.

2.7.1 The right to equality and non-discrimination[155]

The right to equality is grounded on the principle that everyone has the right to equal benefit and protection of the law and is entitled to equal enjoyment of the full suite of rights and freedoms provided by the South African legislature. It also contains provisions that protect against unfair discrimination in the form of any distinction, exclusion or restriction made (whether directly or indirectly) against anyone on grounds of race, religion, culture, age, gender, sex, sexual orientation, disability, language, birth, HIV status, socio-economic status, pregnancy, conscience and belief[156]. Regarding abortion, women's ability to choose to terminate unwanted and unsupported pregnancies, as well as their ability to control their reproductive destiny, is a key measure of their substantive right to freedom and equality[157]. Equality is directly linked with the right to autonomy; meaningful autonomy can exist only if inequities in gender, social and economic relations are addressed[158]. In many instances, women have

[155] Section 9.
[156] Equality Courts. Department of Justice and Constitutional Development, Republic of South Africa. Available at: https://www.justice.gov.za/equcact/eqc-main.html.
[157] C Albertyn 'Abortion, reproductive rights and the possibilities of reproductive justice in South African Courts' (2019) 1 *University of Oxford Human Rights Hub Journal*, 88-118.
[158] Ibid 157.

limited personal agency to make reproductive choices because of social constructs that affirm that they have a reproductive obligation. Patriarchal ideologies often place family and spousal decisions in the hands of a man[159]. Moreover, the right to equality and non-discrimination implies that the state must recognise and provide for the differences and specific needs of groups of people who are generally faced with greater health challenges and vulnerabilities[160]. For example, in many places, indigenous women receive fewer reproductive health services[161], which is contrary to the spirit of equality and non-discrimination. Reproductive sovereignty is a prerequisite for sexual and social equality of women. The social and economic consequences of pregnancy include the possibility of losing a job or promotion, limited or no maternity leave, and interruptions in career or education which have a significant impact on women's ability to participate as equal citizens[162].

2.7.2 Human dignity[163]

The right to human dignity is premised on acknowledging the intrinsic worth of all people. It underscores the imperative that individuals should be regarded as deserving of care and respect. The right to human dignity lays the foundation for many other rights entrenched in the Bill of Rights and cannot be fully realised if other socio-economic rights are not realised[164]. Chaskalson infers that the right to human dignity means that people are protected against being devalued or being treated in a humiliating or degrading manner. The right to freedom and security of the person is a *sine qua non* of an individual being able to pursue their own conception of a worthwhile life[165]. Freedom is an essential aspect of self-agency. In relation to TOP, the right to freedom justifies a voluntary choice on whether to continue a pregnancy. The concept of the right to human dignity

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[159] M Manian 'The irrational women: informed consent and abortion decision-making' (2009) 26 *Duke Journal of Gender Law* & Policy, 224.
[160] World Health Organisation. The Right to Health. Fact Sheet No 31.
[161] Ibid 128.
[162] M O'Sullivan 'Reproductive Rights' (2011) in S Woolman et al. (eds) 37 Constitutional Law of South Africa 2, 2.
[163] Section 10.
[164] J van den Berg 'Human Rights Day: your right to human dignity' (2018) Available at: https://www.phfirms.co.za/nvr/NewsResources/NewsArticle.aspx?ArticleID=2352.
[165] J Griffin 'On human rights' (2008) Oxford: Oxford University Press. Available at: https://doi.org/10.1093/acprof:oso/9780199238781.001.0001.

suggests that approaching an individual's decision to terminate their pregnancy should be done with sensitivity, acknowledging the complex and personal nature of such a choice. Additionally, it emphasises the importance of respecting the individual's decision without subjecting them to stigma or discrimination.

2.7.3 Freedom from torture, cruel, degrading and inhuman treatment[166]

Human rights bodies have obliged states to impose measures that ensure that women are not subjected to cruel, inhuman or degrading treatment in the process of seeking reproductive healthcare, particularly abortion. Cruel, inhuman or degrading treatment or punishment applies to treatment that is less severe than torture but still involves humiliation and even abuse. It includes acts that result in mental suffering, cause fear, anguish or a sense of inferiority, or debase a person[167]. This right mandates the state to ensure that the rights guaranteed under domestic law are practically available[168]. The right to be free from cruel, degrading, and inhuman treatment and punishment is one of the few non-derogable rights enshrined in the Constitution. This means that the right is absolute and inviolable, and cannot be restricted or suspended under any circumstance due to its paramount significance[169].In the context of abortion, this right recognises that deprivations of self-agency in reproductive rights can lead to pain and suffering. It also acknowledges that women who are obstructed in their efforts to obtain safe, legal and available medical services suffer from pain that is tantamount to inhuman and degrading treatment[170]. This right can be understood as the responsibility of healthcare providers to carry out TOP services in adherence to established medical standards, with the goal of reducing physical, psychological, and emotional distress. It also signifies that individuals have the autonomy to make reproductive choices independently, free from undue pressure, including pressures to continue an unwanted

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[166] Section 12(1)(e).
[167] Queensland Human Rights Commission. 'Right to protection from torture, cruel, inhuman or degrading treatment.' Available at: https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-protection-from-torture-and-cruel-inhuman-treatment.
[168] A Zureick 'Engendering suffering: denial of abortion as a form of cruel, inhuman or degrading treatment' (2015) 38(99) *Fordham International Law Journal*, 99-140.
[169] Human Rights Definitions. 2011. Available at: https: www.helpage.org/silo/files/humanrights-definitins.doc.
[170] Ibid 131.

pregnancy. Moreover, it reinforces the necessity to eradicate stigmatising and discriminatory practices associated with abortion.

2.7.4 The right to bodily and psychological integrity[171]

Bodily integrity pertains to the right to make decisions concerning one's own body without interference and coercion. The right to bodily security safeguards against unwarranted disruptions of bodily integrity, while the right to control over the body pertains to the capacity to make independent and autonomous decisions about one's own body[172]. It applies to a wide range of decisions including sexuality, control over fertility, and organ donation. It protects against situations of involuntary social constructs such as forced marriage and enforced contraception[173]. It also includes not being subjected to medical or scientific experiments unless the person has given their full, free and informed consent[174].

2.7.5 The right to life[175]

South African law primarily adopts the single-entity approach to pregnancy. This means that pregnant women are considered as single entities thus making the unborn non-entities in terms of law.[176] An unborn baby does not have legal status and a human right to life until birth.[177] The common law rule of being born alive denies the unborn legal status and the title of person. As such, unless legislation is developed through judicial precedent or trumps this common law position, any law that applies to a person does not apply to the unborn.[178] The problem with the state beginning able to recognise foetuses and potential life under the law is the fact that abortion would be illegal, leading to a rise in the

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[171] Section 12(2).
[172] I Currie & J De Waal. The Bill of Rights Handbook. Cape Town. Juta. 2005: 287.
[173] Technical Committee 4. Memorandum. (1996) Freedom and Security of the person,1 -4.
[174] Queensland Human Rights Commission. 'Right to protection from torture, cruel, inhuman or degrading treatment.' Available at: https://www.qhrc.qld.gov.au/your-rights/human-rights-law/right-to-protection-from-torture-and-cruel-inhuman-treatment.
[175] Section 11.
[176] Boezaart "Child law, the child and South African private law" in Boezaart (ed) Child Law in South Africa (ed Boezaart) (2009).
[177] N Moosa 'An argument for fetal protection within a framework of legal abortion in South Africa' (2016) 35 *Medicine and the Law* 605, 606.
[178] Botha Statutory Interpretation: An Introduction for Students (2012), 43.

already alarming statistics of unsafe abortion. Rape, incest and poverty would then not be justifiable grounds for terminating pregnancy, thus eroding women's reproductive rights. As Warren[179] aptly explains, extending rights to foetuses deprives pregnant women of the rights to personal autonomy, physical integrity and sometimes the right to life itself and that there is only room for one person with rights inside a single human skin. Various cases demonstrate the point that foetal life is not recognised under South African law. One example is the case instituted by the Christian Lawyers Association of South Africa against the Minister of health claiming that the CTOP Act was unconstitutional. In *Christian Lawyers Association of South Africa and Others v Minister of Health and Others*[180]*,* the association sought to strike down the CTOP Act in its entirety on the grounds that it violated the right to life enshrined in Section 11 of the Constitution (everyone has the right to life). Thus, termination of pregnancy was in fact violating this right. The court maintained that the Constitution does not make provision to grant legal personality and protection to the unborn child; the term "everyone" refers to people or persons who hold rights and, in the proper interpretation of Section 11, the word "everyone" could not include the unborn child. To confer legal status upon a foetus would impinge on the rights to life, human dignity, and privacy, and would further make decisions on reproduction and bodily control, and on the beliefs and opinions of the pregnant woman.

In *S v Mshumpa*[181]*,* a pregnant woman was shot in the abdomen with the intention of killing her unborn child. The shooter had conspired with the baby's father, who paid him to commit the crime. While the court found Mshumpa guilty of the attempted murder of the pregnant woman, it also had to deliberate on whether the intentional killing of the unborn baby amounted to the crime of murder. The court decided that it would be prudent to expand the definition of murder to include the killing of an unborn baby but did not bring it to bear on deciding this case. Similarly, in *S v Makhakha*[182], where a pregnant woman was

[179] M.A. Warren 'The moral significance of birth' (1989) 4 *Hypatia* 46, 46.
[180] *Christian Lawyers Association of South Africa and Others v Minister of Health and Others* 1998 (11) BCLR 1434 (T).
[181] *S v Mshumpa and Another* [2007] ZAECHC 23 2008 (1) SACR 126(E).
[182] *S v Makhakha* 2013 JDR 1934 (WCC).

brutally raped and murdered, the loss of a viable foetus that occurred during the commission of this crime was not considered.

However, while foetuses may not possess constitutional rights, this does not conclude the issue concerning foetal interests. If that were the case, the state would allow late terminations for any reason, even up to the moment of birth[183].

2.7.6 The right to privacy[184]

Privacy is a central attribute of personality[185]. The right to privacy embraces the right of freedom from interference and intrusion by the state and others in one's personal matters, as well as unauthorised disclosure about sensitive aspects of an individual's personal life[186]. In this way, privacy is closely related to the right to dignity. The constitutional right to privacy also encompasses the right to decide whether to have an abortion, as it protects individuals from unwarranted governmental intrusion into private affairs[187]. It also provides that individuals are allowed to make reproductive health decisions privately and that their personal information about such decisions is handled confidentially.

2.7.7 The right to access healthcare[188]

The provision of healthcare is critical to ensuring social welfare, since it not only benefits the individual alone but confers benefits to the broader community[189]. The right of access to healthcare is sometimes erroneously associated with the right to health. Section 27 of the Constitution states that everyone has the right to have access to healthcare services. This includes reproductive health services such as TOP, as well as the right not to be refused emergency medical treatment. The Constitution mandates the state to respect, promote and fulfil

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[183] D Meyerson 'Abortion: The Constitutional Issues' (1999) 116 *South African Law Journal*, 50-59.
[184] Section 14.
[185] South African Law Reform Commission. Discussion Paper 109. Project 124 (2005) 'Privacy and Data Protection'.
[186] D McQuoid-Mason. Chapter 38 'Privacy'.
[187] Roe v Wade and the right to privacy. Third Edition. Center for Reproductive Rights. Available at: www.reproductiverights.org.
[188] Section 27.
[189] P Black & K Siebritz 'Public expenditure and growth' (2011) *Public Economics, Oxford University Press*, Cape Town, 10-12.

this right (as well as all the other rights entrenched in the Bill of Rights) and take reasonable measures within its available resources to attain the progressive realisation of the right to access. This differs from the right to healthcare which obliges the state to do everything possible to provide a population with the requisite medical services irrespective of its fiscal status[190]. The right to access healthcare means that the government is not obliged to provide healthcare services at the time required by a particular citizen, but, rather, a value judgement must be the criteria to follow in deciding who gets which type of service. The state is only obliged to provide health services and facilities and make them accessible to all citizens using the resources which are at the government's disposal[191]. This makes the right to access to healthcare particularly challenging as the founding principles of equality and non-discrimination dictate that everyone should have access to healthcare services regardless of whether they can afford those services. However, poor, uninsured, black African and rural groups are still hampered by inequitable access to healthcare services[192]. Rural women and children bear the heaviest burden of lack of access to healthcare services due to low-income statuses and high travel costs[193].

Since abortion is encompassed within the ambit of healthcare services, the right to healthcare strengthens these provisions. It not only suggests that those seeking TOP are entitled to safe, legal, and non-discriminatory services but also places an obligation on the state to furnish the public with appropriate facilities, trained personnel, and essential information. This ensures that individuals can make well-informed decisions regarding their reproductive health. Furthermore, it includes the imperative of accessible post-abortion care to address

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[190] T Verulava 'Access to healthcare as a fundamental right or privilege?' (2021) 73(10) *Siriraj Medical Journal*, 721-726.

[191] E.A.O Ebi 'Enforcing the right of access to healthcare services in South Africa' (2016) Dissertation for Masters of Law at the University of South Africa.

[192] B Harris, J Goudge, J.E Ataguba, D McIntyre, N Nxumalo, S Jikwana & M Chersich 'Inequities in access to health care in South Africa' (2011) 32 Suppl(1) *Journal of Public Health Policy*, 102-123.

[193] J Goudge, S Russell, L Gilson, T Gumede, S Tollman & A Mills 'Illness-related impoverishment in rural South Africa: why does social protection work for some households and but not others?' (2009) 21(2) *Journal of International Development*, 231-251.

complications that may arise, even from unsafe or self-induced abortion practices.

2.7.8 The right to access to information[194]

The quality of democratic processes is enhanced by public participation in decision-making by well-informed citizens[195]. In the context of TOP, the right of access to information imposes a duty on the state to ensure that abortion services and information are available, accessible, (acceptable and of good quality)[196]. The right of access to information means that individuals can make autonomous and informed reproductive health decisions and have the right to seek, receive and impart information. In South Africa, however, information about TOP services remains scarce[197], and an unmet need among women for information on abortion endures[198]. With regard to access to information and its link with access to safe and legal abortions, a gap in the legislation exists.

2.8 TERMINATION OF PREGNANCY LAW IN SOUTH AFRICA: STATUTORY PROVISIONS

2.8.1 Historical context of TOP in South Africa

The CTOP Act was instituted in 1996 during a period of immense political transformation in South Africa. Prior to the instating of the CTOP, abortion was permissible in South Africa under the Abortion and Sterilisation Act (ASA) No.2 of 1975[199]. However, the ASA was restrictive and tended to favour white urban women while disadvantaging black rural women from accessing safe and legal TOP services. Thus, the objective of repealing the ASA with the CTOP Act, was

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[194] Section 32.
[195] A.S Mathews 'The darker reaches of government: access to information about public health administration in the United States, Britain and South Africa.
[196] South Africa: women and girls risk unsafe abortion after being denied legal services (2017) Available at: https://www.amnesty.org/en/latest/press-release/2017/01/south-africa-women-and-girls-risk-unsafe-abortions-after-being-denied-legal-services/.
[197] M Mudarikwa 'Current threats to safe and legal abortion in South Africa' (2021) Available at: https://www.girlsglobe.org/2021/05/05/current-threats-to-safe-and-legal-abortion-in-south-africa/?doing_wp_cron=1696160599.7431950569152832031250.
[198] C Morroni, L Myer & K Tibazarwa 'Knowledge of the abortion legislation among South African women: a cross-sectional study' (2006) 6(7): *Reproductive Health.*
[199] The Abortion and Sterilization Act No.2 of 1975, Section 3, Government Gazette, 478 (1975).

to expand the legal grounds for TOP in a way that promoted access for all South African women.

2.8.2 The ASA: Grounds for access to TOP

The ASA made provision for legal abortions under the following circumstances:

- Continued pregnancy posing a serious threat to maternal physical health or life
- Continued pregnancy posing a serious threat to mental health of pregnant woman
- Continued pregnancy posing a serious threat to physical and/or mental health of unborn baby
- Pregnancy that resulted from rape or incest
- Pregnancy of a mentally disabled woman who would not be able to comprehend the implications of the act and bear parental responsibility

2.8.3 Summary of the legal requirements needed to fulfil TOP provision

In each of the abovementioned provisions, it was required that two medical practitioners certify in writing in their opinion, that the justification for seeking an abortion was satisfactory. Of the two medical practitioners that were needed to meet the legal criteria to authorise an abortion, one practitioner had to be practising for four years or more[200].

With regards to mental health concerns of the mother, one of the two medical practitioners had to be a psychiatrist. In the case of rape or incest, not only did two medical practitioners have to certify in writing that sexual assault/abuse had occurred, a magistrate was also required to fulfil this provision. It was also obligatory for the women alleging sexual crimes, to lodge the complaint with the police. If this was not done, a “good and acceptable” reason needed to be provided[201]. A sworn statement or affidavit also needed to be submitted to a magistrate by the woman alleging unlawful sexual intercourse[202].

[200] Sub-section 3(a).
[201] Sub-section 4(a)(i).
[202] Sub-section 4(b).

While the ASA did make allowance for abortion services, it is evident that the provisions outlaid required a woman attempting to access care, to jump through medical, legal and administrative hoops which in itself served as an impediment to accessing safe and timely medical abortions. Contextualising the abovementioned provisions to the overloaded, resource-limited, South African public healthcare system, it can be conjectured that access to abortion under the ASA for the average South African woman, would be nearly impossible. The time and resources needed to obtain the mandatory documentation etc., would not only strain the woman requiring an abortion, but also the public health and judicial systems as well. Third party authorisations, be it by one or more medical practitioner, courts, police, spouse or guardian has been identified as a regulatory barrier to safe abortion care. In instances of sexual assault, prompt abortion services should be rendered on the basis of a woman's complaint rather than requiring forensic evidence or police examinations[203].

2.8.4 Current legislation: The Choice on Termination of Pregnancy Act 1996 (CTOP Act)

The CTOP Act epitomises one of the most significant steps taken by the South African government to make reproductive rights attainable in a practical sense. The implementation of this Act led to an initial decrease in mortality and morbidity rates associated with unsafe abortions[204].Its introduction also meant that all girls and women, irrespective of their age, race, socio-economic status or geographical location can access safe and legal TOPs and obliges the state to provide safe conditions under which these rights can be exercised without fear or harm. The preamble of the CTOP Act recognises that the decision to have children is central to a woman's physical, psychological and social health, and that, universal access to reproductive healthcare includes termination of pregnancy[205]. It also extends the freedom of choice by endowing every woman

[203] World Health Organisation. Safe abortion: technical and policy guidance for health systems. Available at: https://apps.who.int/iris/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf.
[204] R Hode 'The culture of illegal abortion in South Africa' (2016) 42(1) *Journal of South African Studies*, 79-93.
[205]Ibid 27.

with the right to choose to have early, safe and legal terminations in accordance with her individual beliefs.

The CTOP Act makes provision for safe abortion under a wide range of social circumstances and uses a trimester-based approach in order to regulate its mandate. The trimester-based approach is the Act's effort to balance the compelling interests of the foetus after viability[206]. A summary of the Act is provided in Table 2.2.

Table 2.2: Summary of the trimester-based approach to abortion in CTOP Act

Timeline for pregnancy	Condition for permissible termination of pregnancy	Healthcare professional designated to perform termination of pregnancy
0-12 weeks	No conditions- available on request	Medical Doctor or registered midwife or registered nurse
13-20 weeks	Available under the following conditions only pregnancy results from/in: ▪ Rape or incest ▪ Risk of severe fetal abnormality- physical or mental ▪ Risk of injury to woman's physical or mental health ▪ Significant impact on social or economic status	Medical Doctor only
After 20 weeks	Available only if continued pregnancy would: ▪ Endanger woman's life	Medical Doctor only

[206] Ibid 162.

	▪ Result in severe malformation of fetus ▪ Pose risk of injury to fetus	

The CTOP Act allows for medical abortion under any circumstance up to 12 weeks gestation. As the name implies, a woman is free to choose what is appropriate for her personal and social circumstances. From 13-20 weeks, TOP may only be performed under specific circumstances viz pregnancy resulting from rape or incest, severe fetal anomaly, risk of endangerment to the woman's physical or mental health or significant impact on her social or economic status. After 20 weeks, the provision for TOP becomes more stringent and is only permissible if continued pregnancy poses a serious risk to the woman's life, serious risk to the life of the unborn baby or as a result of severe fetal anomaly[207]. As compared to the previous Act, the CTOP does not require the written certification of multiple healthcare practitioners. However, in sub-section 5(4), the consent of two medical practitioners or a medical practitioner and a registered mid-wife is required in the termination of pregnancy of a severely mentally disabled woman who is unable to understand or appreciate the nature or consequence of terminating her pregnancy or in a case where a woman is a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to consent to the termination of her pregnancy.

The CTOP Act defines the place where legal TOPs can take place and outlines the parameters of a state-designated abortion facility[208]. It also recommends non-mandatory and non-directive counselling pre-and-post abortion[209]. The stipulations on informed consent are defined in section 5 of the Act. Information regarding abortion and related rights are listed in the Act[210]. Section 7 pertains to notification and record keeping of abortion services rendered at public health facilities. This section makes it compulsory for the person in charge of a facility

[207] Sub section 2.
[208] Sub section 3.
[209] Sub section 4.
[210] Sub section 6.

to be notified every time a termination is provided at that facility and to collate this information and submit it to the head of the facility[211]. In theory, this means that state designated facilities should have a firm grasp of the statistical demand for termination services and therefore could use this information to extrapolate measures to optimise service provision. Section 10 of the CTOP Act deals with offences and penalties imposed by this legislation. Specifically, section 10(c) provides that any person who prevents the legal termination of pregnancy, or obstructs access at a designated facility, is liable for criminal conviction. Since the Act does not explicitly expand on the meaning of "preventing the lawful termination of pregnancy" and "obstructing access to a facility for TOP", it can be construed to encompass several elements. The implementation of restrictive abortion legislation, creating challenges for women in accessing services within the legal framework, withholding or limiting information about legal rights and pregnancy termination options, impeding women's ability to make well-informed reproductive choices, and the refusal to provide services that are legally permissible may fall within the scope of this interpretation. However, it is unknown to date, whether anyone has ever been prosecuted on this basis through the CTOP Act[212].

In the case of *Dembe v State*[213], the appellant, Ronnie Dembe, a herbalist who moonlighted as a backstreet abortionist, was convicted on six counts under the CTOP Act for contravening various sections of the Act including section 2(1)(a) and (c), section 3(1) and 10(1)(a) and (b), for unlawfully terminating the pregnancies of two female patient who sought his services. In both cases, complications arose from these illicit abortions resulting in the complainants being admitted to hospital. This is one of the few cases prosecuted in terms of the CTOP Act. Nevertheless, despite this, the prevalence of illegal abortions persists and continues to pose a significant public health hazard.

[211] Sub section 7(3).
[212] 'Global discussion on conscientious objection to abortion' No. 17 (2022) Redass Document.
[213] *Dembe v S* (CA&R 69/09) [2009] ZANCH 75; 2010 (1) SACR 360 (NCK) (30 November 2009).

The CTOP Act is silent on the matter of healthcare provider's conscientious objections to abortion service provision. This was a calculated move on the part of the government at the time when this legislature was enacted[214]. The initial draft bill of the CTOP Act recognised the right of healthcare providers to conscientiously object to abortion provision and defined the conditions under which such rights could be invoked. However, mounting pressure from opponents of the bill, and threats to challenge it before the constitutional court, led government to make a decision to prioritise access under the banner of transformative leadership instead of being held hostage to constitutional litigation and risk failing the opportunity to provide with women highly necessary relief from unsafe abortions. And so, the conscientious clause was omitted[215].

2.8.5 Criticism of the CTOP Act

McQuoid-Mason[216] maintains that although the CTOP Act has realised its purpose of being more accessible in the first and second trimester, it has failed to realise this objective after the 20th week. This stems from failure in the legislature to include rape, incest and mental illness as a ground for termination after the 20th week. This constitutes a limitation on women's reproductive choices which is unreasonable and unjustifiable because women who become pregnant by violent acts or duress who are unable to obtain a TOP before the 20th week for whatever reason, will be unable to do so thereafter according to the stipulations of the CTOP Act. This means they will have to carry the baby to term which can cause severe psychological trauma to the pregnant women.

2.9 STATUTORY PROVISIONS: THE NHA

2.9.1 The NHA upholds the state's duty to progressively ensure healthcare access, including reproductive health[217], and protect vulnerable groups like

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[214] Debates from the National Assembly (November 1996) Col 4780.
[215] Ibid 214.
[216] D.J McQuoid-Mason 'Are the restrictive provisions of section 2(1)(c) and 5(5)(b) of the Choice on termination of Pregnancy Act 92 of 1996 unconstitutional? (2006) 31 *Journal for Judicial Sciences,* 121.
[217] Section 2(c)(i) National Health Act, 2003 (Act No. 61 of 2003).

women and children[218]. It mandates free primary healthcare to all citizens[219] and establishes fundamental principles of health service delivery, including patient rights to confidentiality[220], participation in health decisions[221], and informed consent[222]. Section 4(3)(a) mandates that state-funded community health centres and clinics, in accordance with specified conditions outlined in the CTOP Act, must offer women free TOP services. Unlike the majority of international frameworks and constitutional provisions, this law explicitly addresses the provision of TOP services. However, it fails to expand on or provide additional details or elaboration on any other specifications related to these services or their procurement. Section 5 of the NHA[223] mandates that no healthcare provider or healthcare facility can decline to provide emergency medical treatment to an individual. A medical emergency is defined as a 'sudden and unexpected onset of a health condition that requires immediate medical or surgical intervention, where failure to provide such interventions would result in serious impairment of bodily function or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy[224].' While the constitutional guarantee for emergency care accessibility represents an important starting point to facilitate further regulations, Burkholder et al. argue that they often fall short on delineating the scope and extent of a health emergency or emergency medical treatment, and do not explicitly define the party responsible for delivering emergency care nor the penalties imposed in situations that do not comply with the law[225]. Section 12[226] places the responsibility on the state, in collaboration with relevant provincial, district, and municipal departments, to guarantee the dissemination of adequate, appropriate, and comprehensive health-related information. This information encompasses details about healthcare services, operating schedules, visit

[218] Section 2(c)(iv).
[219] Section 4(3)(b).
[220] Section 14 (1) and (2).
[221] Section 8.
[222] Sections 7 & 8.
[223] Section 5.
[224] Medical Schemes Act No. 131 of 1998.
[225] T.W Burkholder, H.B Bergguist & L.A Wallis 'Governing access to emergency care in Africa' (2020) 10 (Suppl 1) *African Journal of Emergency Medicine*, S2-S6.
[226] Section 12 (a)-(g).

timetables, access procedures, and the rights and responsibilities of both healthcare users and providers. However, the absence of clarification on the platform for disseminating this information raises the possibility of outdated information being presented to the public. Furthermore, according to Section 44(1) of the NHA, if a public health establishment cannot provide necessary care, it must facilitate the transfer of the patient to another capable public health facility.

2.10 CLINICAL PRACTICE GUIDELINES

Clinical practice guidelines are proclamations that are intended to optimise patient care. They include best practice recommendations that are informed by a systematic review of available evidence as well as an assessment of the harms and benefits of alternative care options[227]. Clinical practice guideline also serves as a tool to direct the clinical practice of individual healthcare practitioners and healthcare organisations and also helps patients to make informed decisions[228]. The legal status of clinical practice guidelines is geographically variable. In some countries, these guidelines have a strong voluntary character whereas in other countries they have a compulsory character because they are either mandatory by law or can be used as evidence in court in cases of medical malpractice[229]. The HPCSA guidelines outline crucial directives on abortion services in South Africa, emphasising patient rights and healthcare provider obligations[230]. Notably, providers must not impose personal beliefs when advising and treating abortion seeking patients[231], and, if unwilling to perform a TOP, are obligated to refer the patient to a non-objecting colleague[232].

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[227] US Institute of Medicine. Clinical practice guidelines we can trust. Consensus report, Washington DC: National Academies Press 2011.
[228] European Science Foundation. Implementation of medical research in clinical practice. 2011. Available at https://archives.est.org/fileadmin/public_documents/publications/implem.medresearch.
[229] EnQual. The legal status of clinical practice guidelines. Available at: https://www.nivel.nl/sites/default/files/bestanden/The_legal_statusof_ClinicalPracticeGuidelines.pdf.
[230] Section 8.4 -8.9 of HPCSA Booklet 8: The General Guidelines for Reproductive Health.
[231] Section 8.5 and 8.6.
[232] Section 8.5.

The National Clinical Guidelines for the Implementation of the Choice on Termination of Pregnancy Act are currently scheduled for integration into healthcare worker training[233]. Once fully implemented, these guidelines will be one of the most comprehensive documents addressing TOP service provision in South Africa, potentially offering clearer guidance than even the Constitutional or statutory provisions. The purpose of this set of guidelines is to guarantee the provision of integrated TOP services at the lowest appropriate level of care and to ensure that patients seeking TOP can access services without undue delay while concurrently upholding their human rights with due respect, protection, and fulfilment. Section 2.3 of this guideline corresponds to Section 10 of the CTOP Act, focusing on the obstruction of access to TOP services. It specifies that denying an individual access to TOP services by a direct TOP provider is a chargeable offense. This denial includes failure to provide TOP services, failure to make an appropriate referral to a willing provider in cases of refusal to care, and obstructing other healthcare providers from offering TOP services. Additionally, if a healthcare provider, not directly engaged in performing a TOP, refuses to assist in managing the case, it also constitutes a violation of the CTOP Act. In congruence with the Constitution, this guideline reinforces that in cases of a medical emergency, healthcare providers, irrespective of their moral or religious beliefs, must provide TOP services to ensure that no adverse health consequences are suffered by the patient. In non-emergency situations, healthcare providers must express their objection in a non-judgmental and non-discriminatory manner, referring the patient to a provider or facility that will perform the service. These providers are also mandated to register themselves under the facility register for refusal to treat[234]. These provisions, in alignment with healthcare providers' constitutional rights, imply that the guiding policy does indeed accommodate conscientious objection by healthcare providers, even though the term is not explicitly mentioned in the document. The guidelines also encompass various other provisions related to

[233] M Stevens & D.N Conco 'A look at new abortion guidelines' (2021) Available at: https://www.wits.ac.za/news/latest-news/opinion/2021/2021-10/a-look-at-new-abortion-guidelines.html.

[234]National Clinical Guidelines for Implementing the Choice on Termination of Pregnancy Act 2020 , Available at: https://knowledgehub.health.gov.za/elibrary/national-clinical-guideline-implementation-choice-termination-pregnancy-act-2020.

abortion services. However, it is uncertain whether sufficient measures have been implemented to adopt and actualise these guidelines.

2.11 PATIENT RIGHTS CHARTER

In the shift towards patient-centered care, many nations have embraced patient rights charters. These charters do not usually establish new legal rights but rather reinforce the existing ones found in common and statutory laws, acting as a means to consolidate these patient rights[235]. A unique aspect of patient rights charters is the inclusion of a provision allowing patients to have their complaints investigated by an independent body, a feature not typically found in other legislative mechanisms[236]. Well-designed patient rights charters serve as a galvanising force for system improvement[237]. The South African Patient Rights Charter, established by the NDoH, delineates the rights and responsibilities of healthcare system users. In the context of sexual and reproductive health rights, this charter upholds the right to healthcare access, informed consent, confidentiality, continuity of care, as well as the right to voice concerns about healthcare services, request investigations into such concerns, and obtain a comprehensive response to the investigation[238]. There is a paucity of available literature in the published domain concerning patient grievances, subsequent investigations, and the resulting outcomes related to TOP services at public health facilities. Flood and May[239] argue that in the absence of reliable and practicable enforcement measures, a patient rights charter lacks significant impact and is akin to a 'toothless tiger'.

2.12 BATHO PELE PRINCIPLES

The Batho Pele principles are a set of guidelines aimed at enhancing and optimising public service delivery in South Africa. They underscore the importance of government institutions becoming more accountable, responsive,

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[235] C.M Flood & K May 'A patient charter of rights: how to avoid a toothless tiger and achieve system improvement' (2012) 184(14) *Canadian Medical Association Journal*, 1583-1587.
[236] Ibid 235.
[237] Ibid 235.
[238] The Patient's Rights Charter. Available at https://www.justice.gov.za/vc/docs/policy/patient%20rights%20charter.pdf.
[239] Ibid 202.

and efficient in their service to the public by codifying values such as courtesy, transparency and openness, access, customer impact and quality service[240]. In the context of abortion rights, the Batho Pele principles help bolster the need for abortion seeking patients to be treated with dignity and respect, acknowledging and meeting the expectations and needs of patients, and delivering prompt and timely TOP services.

2.13 CONCLUSION

This chapter explored the various legal mechanisms through which South Africa integrates sexual and reproductive health rights, with a particular emphasis on the legal framework for termination of pregnancy. The next chapter delves into the rights of healthcare providers involved in TOP services, with a specific focus on the right to conscientious objection.

[240] Batho Pele. Department of Social Development. Available at: https://www.dsd.gov.za/index.php/about/batho-pele.

CHAPTER THREE: HEALTHCARE PROVIDER RIGHTS TO CONSCIENTIOUS OBJECTION

3.1 INTRODUCTION

In this chapter, the rights of healthcare providers participating in abortion service provision in South Africa are explored. Emphasis is placed on the fundamental right to freedom of thought, conscience, belief, religion, and opinion, which serves as the primary legal foundation for conscientious objection. This chapter underscores how the right to conscientious objection, based on religious, ethical, or other personal grounds, is codified within international, constitutional, statutory, and soft law provisions.

3.2 CONTEXTUALISING THE RIGHTS OF THE HEALTHCARE PROVIDER IN LIGHT OF SOUTH AFRICAN PUBLIC HEALTH SYSTEM REALITIES

Just as patients possess rights within the context of healthcare service provision and delivery, healthcare providers responsible for rendering these services also enjoy legal rights, duties and responsibilities. Some of these rights are mutual, applying universally to both patients and healthcare practitioners as inherent human rights. Recognising and respecting the rights of healthcare providers within the healthcare environment is of paramount importance as it ensures the well-being, both physical and mental, of these professionals and plays a key role in the overall efficiency of the healthcare system. For healthcare providers in the public health sector of South Africa, numerous contextual challenges persist. These include work-related stressors stemming from resource shortages, poorly communicated national-level guidelines, occupational concerns regarding the risk of infection, structural deficiencies in some facilities, limited access to piped water and electricity, as well as issues related to medicine shortages and the absence of essential medical equipment, all of which significantly impact healthcare service delivery[241]. Currently, the South African public healthcare system is suffering from a crippling shortage of

[241] J.F Kelly, C.D Glinkski & C.A et al 'Reflections of public healthcare nurses during the first wave of the COVID-19 pandemic in the Eastern Cape Province South Africa' (2021) *South African Health Review*, 64-69.

healthcare workers, which further undermines access to and provision of healthcare services. This catastrophic shortage is exacerbated by the reality that a substantial proportion of healthcare workers serving in underprivileged and rural regions frequently relocate to urban areas in pursuit of improved working conditions. They may also transition to the private healthcare sector or even emigrate to more developed countries in search of higher salaries and a better quality of life[242]. Consequently, healthcare professionals in the public sector experience alarming levels of anxiety, depression, feelings of isolation, and burnout[243]. In addition to this, they also have to contend with other challenges such as burdensome workloads, poor workplace culture, limited access to training, and inadequate availability of equipment, all of which impact their operational capabilities and ability to perform effectively[244]. This challenging healthcare environment leads to an inequitable distribution of healthcare workers between the well-resourced private sector and the poorly resourced public sector, and between urban and rural areas[245], and, in turn, affects the accessibility of healthcare providers participating in abortion service provision.

Another compelling rationale for the need to uphold the rights of healthcare providers within clinical settings is the escalating trend of violence directed at these professionals. Violence against healthcare workers has been deemed as an "international emergency that undermines the foundation of healthcare systems and impacts critically on patients' health."[246] This includes verbal abuse, bullying, threats, harassment, intimidation, acts of physical and sexual abuse, robbing, stabbing and kidnapping that are directed towards healthcare

[242] 'Shortage of healthcare workers crippling global health systems says Phaahla' (2022) South African Government News Agency Available at: https://www.sanews.gov.za/south-africa/shortage-healthcare-workers-crippling-global-health-system-says-phaahla.
[243] C Bateman 'Medical intern burnout worsened by Covid-19' (2021) Available at: https://www.spotlightnsp.co.za/2021/08/12/medical-intern-burnout-worsened-by-covid-19/.
[244] A Mumbauer, M Strauss, G George, P Ngwepe, C Bezuidenhout, L de Vos and A Medina-Marino 'Employment preferences of healthcare workers in South Africa: findings from a discrete choice experiment' (2021) 16(4) *PLoS ONE*: e0250652.
[245] W.T Maphumulo & B.R Bhengu 'Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review' (2019) 42(1) *Curationis*, a1901.
[246] World Medical Association. Statement on Workplace Violence in the Health Sector. 2022.

professionals[247]. Considering these working conditions, it's understandable that state-employed healthcare providers may resort to conscientious objection as a means of seeking relief from their challenging work environment.

3.3 INTERNATIONAL AND REGIONAL INSTRUMENTS ENTRENCHING THE RIGHT TO FREEDOM OF THOUGHT, CONSCIENCE, BELIEF AND RELIGION

Although international and regional human rights instruments encompass a range of rights safeguarding and affirming the rights of healthcare providers within the framework of healthcare service provision such as the right to equality, non-discrimination, life, freedom and security of the person, and privacy, it is the right to freedom of thought, conscience, and belief that primarily pertains to conscientious objection. Specifically, Article 18 of both the UDHR and ICCPR provide that everyone has the right to freedom of thought, conscience and religion, and Article 8 of the African Charter guarantees freedom of conscience, the profession and the free practice of religion.

Freedom of thought is recognised as an individual's right to choose, cultivate, maintain, or alter a perspective, fact, or idea, regardless of others' viewpoints[248]. The ability to think freely is emblematic of an individual's identity, and autonomy, and is a fundamental expression of who they are. Infringements of such a freedom is tantamount to deprivation of personhood[249]. The right to freedom of thought, religion, conscience, belief and opinion bestows upon the individual, the right to have, adopt, change or leave a religion or belief system, to manifest and practice this religion or belief, in an individual capacity or in community with others, and to be free from discrimination or coercion on the grounds of this religion or belief[250]. Beliefs are typically conceptualised as being shaped by a

[247] South African Medical Association Interim Report on Violence Against Healthcare workers in South Africa, 2023.
[248] 'Freedom of thought increasingly violated worldwide, UN expert warns" (2021) Available: https://www.ohchr.org/en/press-releases/2021/10/freedom-thought-increasingly-violated-worldwide-un-expert-warns.
[249] C.M Halliburton 'How privacy killed Katz: a tale of cognitive freedom and the property of personhood as fourth amendment norm.' (2009) 42 *Akron Law Review*, 803-883.
[250] M.J Petersen 'Freedom of religion or belief and women's rights. Promoting Freedom of Religion or Belief and Gender Equality in the Context of the Sustainable Development Goals:

system of principles or philosophical reflections on life[251]. It is generally acknowledged that in order for a belief to be protected, it must attain a certain level of cohesion, cogency, seriousness and importance[252], though this is often difficult to quantify given the personal and subjective nature of beliefs. This is particularly applicable to the individual convictions of healthcare providers, especially in the context of TOP.

In the context of medical practise, it also entrenches the right of the healthcare provider to act in accordance with their beliefs and convictions and encompasses the right to clinical independence and professional autonomy. Professional autonomy is the process under which individual healthcare practitioners have the liberty to exercise their professional judgement in the context of patient care, without inappropriate or undue influence from external parties or individuals[253]. Professional autonomy is essential to quality health service delivery and is governed by evidence-based practices and professional rules and standards[254]. Conscientious objection is sometimes grounded primarily in religious beliefs and cultural practices[255]. This is usually based on the notion that life begins at conception, and on the sanctity of life and other pro-life beliefs[256]. Because religious supporters of abortion often equate the practice with murder, their argument for conscientious objection is based on the divine injunction against killing of human beings[257]. For example, the Catechism of the Catholic Church is unequivocal in its opposition to abortion, categorising

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Reflections from the 2019 Expert Consultation Process, Danish Institute for Human Rights, 2020.

[251] P.M Taylor 'A Commentary on the International Covenant on Civil and Political Right' (2021) Cambridge University Press, 505–507.

[252] Harris, O'Boyle, and Warbrick, Law of the European Convention on Human Rights, 4th edn (2018) at 572.

[253] World Medical Association Policy Tag: Clinical Independence. (2019) Available at: https://www.wma.net/policy-tags/clinical-independence/.

[254] Ibid 218.

[255] L Cabal, M.A Olaya & V.M Robledo 'Striking a balance: conscientious objection and reproductive healthcare from the Colombian Perspective' (2014) 16(2) *Health and Human Rights Journal*.

[256] J.K Awoonor-Williams, P Baffoe, M Aboba, P Ayivor, H Nartey, B Felker, D Van der Tak & A.A.E Biney 'Exploring conscientious objection to abortion among health providers in Ghana' (2020) 46 *International Perspectives on Sexual and Reproductive Health*, 51-59.

[257] H Takemura 'Conscientious objection, ethics of' (2022) 4 Encyclopedia of Violence, Peace and Conflict (third edition), 268-275.

it as “intentional homicide” and reaffirming that human life, from conception, must be respected and protected absolutely[258].

The UN Human Rights Committee, a body which monitors state compliance with the ICCPR, appreciates that religious attitudes can restrict women’s rights and have called on states to ensure that these attitudes, be it traditional, historical, cultural or religious, are not weaponised to justify violations of women’s right to equality before the law and the equal enjoyment of all rights outlaid in the covenant[259]. Further, the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health reiterates state obligation to eliminate barriers, including some laws and practices pertaining to conscientious objection, that make abortion services unavailable, especially to poor, displaced and young women, reinforces the stigma of abortion being an objectionable practice and interferes with the individual’s ability to be autonomous decision-makers in the context of reproductive health[260].

The case of *P and S v Poland*[261] reiterates the obligation of states to structure their health systems in a manner that harmonises the healthcare provider's right to freedom of conscience with the rights of patients to access abortion services. In this case, a Polish teenager, P, who became pregnant as a result of rape, sought a TOP but faced denials from health practitioners from multiple hospitals on the grounds of conscience. P’s Dr’s actually organised a consultation with a Catholic priest who attempted to convince P not to continue with the termination. P's personal and medical details were disclosed to the public and media, sparking a national debate. P experienced harassment from anti-abortion activists. Further, instead of being recognised as a victim of sexual abuse, authorities initiated criminal proceedings against P for alleged illicit sexual relations.

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[258] The Holy See (2000) Catechism of the Catholic Church Popular and Definitive Edition. London: Burns and Oates.
[259] UN Human Rights Committee. General Comment 28, Article 3: The equality rights between men and women. 2000.
[260] UN. Report on Special Rapporteur on the right of everyone to enjoy the highest attainable standard of physical and mental health, Interim Report. 2011. UN Doc A/66/254.
[261] *P & S v Poland*. Application no. 57375/08.

3.3.1 ARGUMENTS FOR AND AGAINST CONSCIENTIOUS OBJECTION IN THE CONTEXT OF HEALTHCARE

3.3.1.1 Arguments for conscientious objection: Conscience, morality, religion and selfhood

Conscientious objection is underpinned by two central concepts: conscience and moral integrity. Moral integrity signifies a person's ability to function in a state of moral unity between their professional and personal responsibilities and values[262]. Conscience refers to the cognitive process by which an individual can be accountable for their actions and deliberations of what is right or the good thing to do in any given situation[263].

The concept of conscience is intimately related to core belief and value systems, and to moral personhood. Advocates of conscientious objection believe that preserving the right of freedom of conscience merits strong protection, because conscience is deemed as a prerequisite for moral integrity and moral agency[264]. Deeply held moral convictions are a central aspect of an individual's moral identity, as they define who they are and what they stand for[265]. In the context of healthcare, a dichotomy exists in the framing of ethics and morality. On one hand, the well-being of the patient needs to be considered and prioritised as being of paramount importance. On the other, the ethical well-being of the practitioner is essential to their ability to practise with moral and personal integrity[266]. In the context of abortion, refusing to participate in service

[262] C Lamb 'Conscientious objections: understanding the right of conscience in health and healthcare practice' (2016) 22(1) *The New Bioethics*, 33-44.
[263] N.T Morton & K Kirkwood 'Conscience and conscientious objection of health care professionals: refocusing the issue' (2009) 21(4) *HEC Forum*, 351-364.
[264] M Neal & S Fovargue 'Conscience and agent-integrity: defense-based exemptions in the healthcare context' (2016) 24(4): *Medical Law Review*, 544-570.
[265] D.W Brock 'Conscientious refusals by physicians and pharmacists: who is obligated to do what and why?' (2008) 29 *Theoretical Medicine and Bioethics*, 187-189.
[266] V. D Lachman 'Conscientious objection in nursing: definition and criteria for acceptance' (2014) 23(3) *Ethics, Law and Policy*, 196-198.

provision is based on the belief system of the objector, and not necessarily on disagreement with the woman's choice[267].

White and Brody[268] argue that moral integrity is a core component of medical practitioners. Accordingly, upholding and respecting a practitioner's choice to conscientious objection, quality medical care can be enhanced and patient safety optimised. They go on to say that by prioritising moral conformity over moral integrity, conscientious objection is disregarded, thereby undermining the trustworthiness of the medical profession.

Since every individual brings their own personality, values and commitments into the healthcare space[269], the underlying assumption is that a practitioner who is compelled to participate in a practice that they are conscientiously opposed to disregards a fundamental aspect of their selfhood[270]. Moreover, when a healthcare provider is presented with a situation that creates a conflict or conscience or an ethical dilemma, they may suffer from moral distress[271], guilt and regret[272]. In a morally pluralistic society, the refutation of conscientious objection reduces diversity amongst healthcare professionals and threatens equality of opportunity[273]. The right to conscientious objection aims at protecting the rights of minorities[274] since it is an exception rather than a routine to circumvent professional responsibilities[275].

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[267] 'Improper use of conscientious objection to abortion' (2016) 42(4) *International Perspectives on Sexual and Reproductive Health*, 221-223.
[268] D.B White & B Brody 'Would accommodating some conscientious objections by physicians promote quality in medical care?' (2011) 305(17) *JAMA*, 1804-1805.
[269] R.J Weiner 'Conscientious objection: a Talmudic paradigm shift' (2020) 59 *Journal of Religion and Health*, 639-650.
[270] K Greenawalt 'Refusals of conscience: what are they and when should they be accommodated?' (2010) 9 *Ave Maria Law Review*, 47-49.
[271] P.C McMullen & N Philipsen 'Conscience clauses and refusal to treat: implications for nurse practitioners' (2017) 13(2) *The Journal for Nurse Practitioners*, 138-144.
[272] V Fleming, L Firth, A Luyben & B Ram-Sayer 'Conscientious objection to participating in abortion by midwives and nurses: a systematic review of reasons' (2018) 19 (31*) BMC Medical Ethics*, 2-13.
[273] U Schuklenk 'Conscientious objection in medicine: accommodation versus professionalism and the public good' (2018) 126(1) *British Medical Bulletin*, 47-56.
[274] 'Improper use of conscientious objection to abortion' (2016) 42(4) *International Perspectives on Sexual and Reproductive Health*, 221-223.
[275] Ibid 274.

3.3.1.2 Arguments against conscience objection in TOP healthcare

Opponents of conscientious objection submit powerful rebuttals for condoning the practice in the healthcare arena. First, conscientious objection has far-reaching negative effects on public health service provision, including limiting or denying of access to legitimate care, obstructing access to information and reinforcing stigmatisation of certain healthcare services[276]. This has a direct impact on a patient's health and well-being and cannot be perceived as an issue of individual rights and beliefs as it always has a social dimension to it[277]. Second, conscientious objection permits the social sanctioning of discrimination against people needing healthcare services and infringes on their freedom of conscience – to do what is right for themselves, along with a range of other fundamental human rights[278]. In this regard, Montero et al.[279] argue that if the requirement to permit conscientious objection in healthcare included the objecting practitioner to explicitly justify and explain their objections, the number of objectors would likely decrease. Undurraga and Sandler[280] add that because conscientious objection is permissible under a broad range of reasons, including religious, ethical, moral, professional or other relevant reasons, the healthcare environment suffers major setbacks as a result of ambiguities in interpreting the grounds for objection. This means that healthcare professionals can lay claim to conscientious exemptions for trivial reasons, and these will be tolerated[281]. Furthermore, the combination of vagueness in regulatory documents and inconsistencies in guidance on conscientious objection offered by different organisations or facilities make it difficult to control the practice[282]. In the context of abortion, this lack of clarity often has a bearing on healthcare

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[276] D.I.G Hakansson, P Ouis & M.E Ragnar 'Navigating the minefield: women's experiences of abortion in a country with a conscience clause- the case of Croatia' (2021) 22(1) *Journal of International Women's Studies*, 166-179.
[277] Ibid 68.
[278] Ibid 57.
[279] A Montero, M Ramirez-Pereira, P Robledo, L Casas, L Vivaldi & D Gonzalez 'Conscientious objection as structural violence in the voluntary termination of pregnancy in Chile' (2022) 3(13) *Frontiers in Psychology,* 1007025.
[280] V Undurraga & M Sandler 'The misinterpretation of conscientious objection as a new strategy for resistance to abortion decriminalisation' (2019) 27(2) *Sexual and Reproductive Health Matters*, 17-19.
[281] C Meyers & R.D Woods 'Conscientious objection? Yes, but make it genuine.' (2007) 33(5) *The American Journal of Bioethics*, 19-20.
[282] S Fovargue & M Neal '"In good conscience": conscience-based exemptions and proper medical treatment' (2015) 23(2) *Medical Law Review*, 221-241.

personnel, such as administrative staff, who are not even directly involved in TOP service provision, citing conscientious objection and refusing to assist abortion seekers at healthcare facilities[283]. In some places, conscientious objection is being invoked even by social workers and police officers who are involved in abortion cases[284]. Or, the objection by trained providers going to the extent of not only refusing to perform abortions, but also refusing to counsel or refer the patient to a non-objecting practitioner[285]. Some proponents of conscientious objection even go so far as to claim that referring an abortion seeking patient to a non-objecting provider amounts to moral culpability in the action of abortion[286]. In this regard, the case of *Greater Glasgow Health Board v Doogan and Another*[287], where the respondents contested that supervisory, managerial, and administrative responsibilities associated with abortion constituted direct participation, thereby undermining their status as conscientious objectors, serves as an example of how profoundly ingrained conscientious beliefs can permeate every facet of providing abortion services. Thus, conscientious objection represents a slippery slope of abortion non-provision as it often goes beyond merely opting out of providing care and reaches to the extent of abortion prevention through delays, dissuasion, misdirection and misinformation[288].

While some authors reject the notion of conscientious objection in healthcare in totality, Card offers a moderate position in attempt to present a solution to polarised standpoints. Card[289] asserts that a healthcare practitioner's fiduciary duty to a patient involves the obligation to provide any legal treatment that a patient requests, where that treatment is reasonably in the patient's best

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[283]Ibid 279.
[284] S.A Kung, J.D Wilkins, F.D de Leon, F Huaraz & E Pearson '" We don't want problems": reasons for denial of legal abortion based on conscientious objection in Mexico and Bolivia' (2021) 18(1) *Reproductive Health*, 44.
[285] R Rogan, K.L Kraschel & C.E Haupt 'Which legal approaches help limit harms to patients from clinicians' conscience-based refusals?' (2020) 22(3) *AMA Journal of Ethics*. E209-216.
[286] Ibid 50.
[287] *Greater Glasgow Health Board v Doogan and Another* [2014] UKSC 68. UKSC 2013/01234
[288] F de Londras, A Cleeve, M.I Rodriguez, A Farrell, M Furgalska & A.F Lavelanet 'The impact of "conscientious objection" on abortion related outcomes: a synthesis of legal and health evidence' (2023) 129(2) *Health Policy*: 104716.
[289] R.F Card 'Reasons, reasonability and establishing conscientious objector status in medicine' (2017) 43(4) *Journal of Medical Ethics*, 222-225.

interest, within the practitioner's scope of practice and consistent with distributive justice. Thus, if the practitioner wants an exemption from this duty, the burden should be on them to provide satisfactory reasons for this exemption. He goes on to say that not only must conscientious objection be rooted in sincerely held moral beliefs, but also, the beliefs supporting the objection must be consonant with pertinent medio-scientific data. His solution is to mandate objectors to convince a medical/ethical review panel of the reasonableness of their objections[290]. However, other critics of conscientious objection maintain that if conscientious objections are accommodated, irrespective of their grounds, we inadvertently end up accommodating incoherent, self-interested and discriminatory grounds that destabilises the quality of public healthcare[291]. Giubilini[292] contends that moral integrity and conscience should be omitted from healthcare decision-making as it does not enhance the progression of moral reasoning in any way because there is no credible basis for differentiating between valid and invalid exercise of conscience.

Some researchers declare that conscientious objection is a violation of medical ethics as healthcare practitioners commit to professional obligations to patients when they enter the profession[293] and undermines the patient-centred, evidence-based, preventative paradigm of health service provision[294]. Others deem it to be a form of structural and ideological violence that contravenes the exercising of health and human rights[295], an excuse to resist social and

[290] Ibid 289.
[291] C Meyers & R.D Woods 'Conscientious objection? Yes, but make it genuine.' (2007) 33(5) *The American Journal of Bioethics*, 19-20.
[292] A Giubilini 'The paradox of conscientious objection and the anemic concept of "conscience": downplaying the role of moral integrity in healthcare' (2014) 24 *Kennedy Institute of Ethics Journal*, 159-162.
[293] Ibid 57.
[294] T.A Weitz & S Berke Fogel 'The denial of abortion care information, referrals and services undermines quality care for U.S women' (2010) 20 *Women's Health Issues*, 7-11.
[295] Ibid 283.

legislative change[296] and an attempt to establish the right to religious freedom as a higher class of human rights than other rights[297].

3.3.1.3 An alternative perspective: an overview of the Swedish model that denies the right of conscientious objection to healthcare providers

In terms of global perspectives on conscientious objection to abortion, Sweden provides a notable model in prioritising patients' rights to TOP over healthcare practitioners' rights to refuse to participate in service provision. In the light of its awareness of the importance of civic duty, public service provision, equality, and non-discrimination, Sweden denies any profession the legal right to conscientious objection, irrespective of the moral convictions of the objector[298]. Given that public institutions provide the vast majority of healthcare services, public health service delivery occupies a central position in the hierarchy of rights in Sweden.

In instances where a public servant cites reasons to refuse work tasks which they are instructed to perform, the employer reserves the right to grant the individual reassignment of work tasks or deploy them to work in another part of the organisation. This employer prerogative is restricted by the availability of an alternative task where the individual's competence may be put to good use, the availability of a suitable replacement, and the effect that this change will have on the work distribution of the clinical team and the overall quality of the work environment. Governed by labour law, which supports the employer's right to decide on the composition and organisation of the workforce, special accommodations are legally optional for employers. The employee is left with three options if no accommodations are made. These are to accept penalties such as reduced pay, dismissal for refusal to perform one's duty, or resignation and seeking employment elsewhere[299].

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[296] A.R Michel, S Kung, S Lopez-Salm & S.A Naverrette 'Regulating conscientious objection to legal abortion in Argentina: taking into account its uses and consequences' (2020) 22(2) *Health and Human Rights Journal*, 271-384.
[297] Ibid 29.
[298] C Munthe 'Conscientious refusal in healthcare: the Swedish Solution' (2017) 43(4) *Journal of Medical Ethics*, 257-259.
[299] Ibid 262.

The ethos of TOP service provision is entrenched at a grassroot level. Individuals who object to performing TOPs, whether on moral, ethical, religious, personal, or other grounds, are exempt from becoming midwives, obstetricians, or gynaecologists. Abortion care is entrenched into the academic curricula for all medical students, and for those wishing to pursue careers in midwifery, obstetrics and gynaecology, abortion training is mandatory. There are no opt-out mechanisms for such training[300].

Similar to the South African Constitution, Chapter 2 of the Swedish Constitution (Instrument of Government-Regeringsformen) promotes the ideals of democracy. However, while it contains provisions on freedom of expression, freedom of religion, and protection against deprivation of personal liberty, these freedoms have built-in restrictions and limitations, especially in the context of public order and public safety. Thus, conscientious objection to abortion service provision by healthcare practitioners is not a constitutionally protected right and cannot be used as a basis for non-participation. At a regional level, the right to enact legislation that limits healthcare provider rights to conscientious objection is upheld by the European Court of Human Rights. For this reason, it is currently not feasible to adopt the Swedish model vis-à-vis into the South African context. The disparate framing of conscientious objection between the two nations, coupled with distinctions in legislative foundations, results in a discordance between the Swedish model and certain constitutional provisions within South Africa. Additionally, the considerable divergences in the healthcare systems of both countries, encompassing structural, resource, and accessibility dimensions, presently preclude South Africa from adopting a stance on conscientious objection as radical as that undertaken by Sweden.

[300] C Fiala, K.G Danielsson, O Heikinheimo, J.A Guomundsson & J Arthur 'Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive healthcare' (2016) 21(3) *The European Journal of Contraception and Reproductive Healthcare*, 201-206.

3.4 CONSTITUTIONAL RIGHTS OF HEALTHCARE PROVIDERS IN SOUTH AFRICA

From a constitutional standpoint, the range of rights previously emphasised in the context of the patient equally extends to the healthcare provider. In this section, the main emphasis will be on the right to equality, freedom of thought, conscience, religion, belief, and opinion, freedom of expression, freedom of trade, occupation, and profession, as well as the right to fair labour practices.

3.4.1 The right to equality and non-discrimination[301]

The Constitution protects that the state may not unfairly discriminate against anyone, directly or indirectly, on the grounds of religion, conscience and belief[302]. In the context of conscientious objection, this right recognises the significance of respecting diversity of beliefs, promoting tolerance and inclusivity, and preserving professional integrity.

3.4.2 Freedom of thought, religion, conscience and belief and opinion[303]

The right in question is protected by Section 15 of the Constitution. The details of this right closely align with what was previously discussed in relation to international instruments. It is important to recognise that limitations on this right may be applied when its exercise results in threats to national security, public order and morality, interference with the principles of secular education, endangerment of health and safety, and the infringement on the rights of others.

3.4.3 Freedom of expression[304]

This right facilitates the freedom to speak, express opinions, write and receive and impart ideas and information through various mediums. This includes the right of healthcare workers to express themselves in a professional manner and voice their opinions without victimisation[305]. In relation to conscientious

[301] Ibid 153.
[302] Section 9(3).
[303] Section 15.
[304] Section 16.
[305]'Doctors rights and responsibilities' South African Medical Association. Available at: https://www.samedical.org/links/responsibilities.

objection, this right allows healthcare providers to articulate their dissenting position without facing bias or fear of reprisal.

3.4.4 Freedom of trade, occupation and profession[306]

This provides that every citizen has the right to freely choose their trade, occupation and profession. In the context of health profession disciplines, it entitles a person to choose their related specialisation[307] such as nursing or midwifery. As South African law does not discriminate against individuals with conscientious beliefs in pursuing careers in the medical profession, this clause supports the right to conscientious objection amongst healthcare workers.

3.4.4 The right to fair labour practices[308]

The basic elements of this right include the right to work, the right to associate with a trade union, the right to bargain collectively, the right to withhold labour, the right to be protected (including the right to accessible, healthy and safe working conditions) and the right to develop in a professional capacity[309]. In the context of conscientious objection, fair labour practices involve acknowledging and honouring an individual's right to express and act in accordance with their conscientious beliefs within the scope of their employment. Upholding the right to fair labour practices also entails that employer, whenever possible, should provide reasonable accommodations to address conscientious objections, ensuring employees are not subjected to unfair treatment or discrimination.

3.5 STATUTORY PROVISIONS

3.5.1 The NHA

The NHA briefly addresses the rights of healthcare personnel[310]. More specifically, section 20(3)(a) requires every healthcare establishment to

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306 Section 22.
307 Ibid 271.
308 Section 23.
309 M Conradie 'The constitutional right to fair labour practices: a consideration of the influence and continued importance of the historical regulation of (un)fair labour practices pre-1997' (2016) 22(2) *Fundamina*, 163-204.
310 Section 20.

implement measures aimed at minimising harm or damage to the persons and property of healthcare professionals within that workplace. While this provision can generally be interpreted as safeguarding healthcare workers physically, it does not necessarily preclude protection from psychological harm that may arise due to unjust discrimination against individuals with conscientious viewpoints.

3.5.2 The CTOP Act

The CTOP Act does not include any provisions regarding the rights of healthcare providers to conscientiously object to providing TOP services. The inclusion of conscience clauses in the law not only serve to delineate the contours of a certain practice, but also protects healthcare providers from adverse actions by public or private actors[311]. Some conscientious clauses forbid employment discrimination, such as prohibiting demoting, firing or refusing to hire, while others prohibit denial of privileges such as licenses and grants[312]. Since there are currently no specific conscientious clauses in South African statutory law, protection of conscientious objectors is offered primarily through constitutional provisions.

3.5.3 The Promotion of Equality and Prevention of Unfair Discrimination Act

Section 6 of Chapter 2 of the Promotion of Equality and Prevention of Unfair Discrimination Act (Act No. 4 of 2000) establishes that neither the state nor any other person may be unfairly discriminated against. Furthermore, section 29 (1)(a), which deals primary with unfair labour and employment practices in certain sectors, affirms that creating artificial barriers to equal access to employment opportunities by using certain selection and recruitment procedures constitutes discriminatory practices. Given that the constitutional right to freedom of thought, conscience, and belief is safeguarded, any attempt to curtail or confine this right for healthcare practitioners involved in providing

[311] M.R Wicclair 'Justifying conscience clauses' *Hastings Center Report* (2018) 48(5): 22-25.
[312] L.D Wardle 'Conscience clauses offer little protection. Most are deficient, and many have been met with hostile judicial interpretations' (1993) 74(6) *Health Progress*, 79-83.

TOP services may be viewed as an unjust and discriminatory employment practice.

3.6 South African Charter of Religious Rights and Freedoms (SACRRF)

Section 234 of the Constitution allows for the creation of charters of rights, in alignment with Constitutional law, to be endorsed by Parliament. Accordingly, the SACRRF[313], functioning as a religious-legal document outlining the freedoms, rights, and responsibilities between the state and citizens, is incorporated into the realm of jurisprudence. This Charter strengthens pre-existing constitutional rights, including the right to freely express religious beliefs, the right of all citizens to make decisions in accordance with their convictions, and the right to abstain from certain duties or participation in activities conflicting with their religious beliefs. In particular, it specifies that individuals have the right, based on their convictions, to decline engagement in specific duties or to refrain from participating or indirectly aiding in particular activities. This includes the ability to withhold referral for specific services, such as medical or pharmaceutical services or procedures[314]. As conscientious objection frequently carries a significant religious aspect, the clauses in this charter work to reinforce the right to freedom of thought, conscience, belief, and religion. However, this raises questions, as it appears inconsistent with other constitutional provisions. For instance, the requirement to refer patients to alternative providers or provide emergency medical treatment appears to conflict with the broad stance on conscientious objection taken in this charter.

3.7 CONCLUSION

This chapter highlighted that the right of healthcare providers to conscientiously object to providing TOP services is firmly established through various legislative mechanisms. A discussion on the arguments both in favour of and against conscientious objection in healthcare was also incorporated. The subsequent chapter delves into a spectrum of obstacles, apart from conscientious objection,

[313] South African Charter of Religious Rights and Freedoms. 2010.
[314] Section 2.3.

that women encounter while attempting access to TOPs within the public health sector.

CHAPTER FOUR: BARRIERS TO ACCESSING SAFE AND LEGAL TERMINATION OF PREGNANCY

4.1 INTRODUCTION

Barriers to safe and legal TOP access are perennial and occur in almost every geographic locale, irrespective of the legal status of abortion there. Multiple barriers at legislative, regulatory, policy, public health system, resource distribution, and socio-economic levels deter access to legal TOP services in South Africa's public health sector[315]. These barriers, linked to the procurement of unsafe abortions, result in delays, negative mental health outcomes, and a propensity toward self-induced procedures[316]. This chapter delineates systemic and social barriers that obstruct access to legal TOPs in the public health sector of South Africa.

4.2 KNOWLEDGE DEFICITS AS A BARRIER TO ACCESS

Limited or inaccurate knowledge of laws and policies by both women and healthcare providers is cited as a global phenomenon. There are various reasons for these knowledge gaps, including education and literacy levels[317], socio-economic differences between urban and rural areas, and the broad and vague terms of the law which lead to uncertainty when unaccompanied by an accessible set of guidelines and regulations[318]. Furthermore, the proliferation of abortion misinformation on the internet, together with lax efforts by social media companies to abate abortion misinformation, makes it difficult for abortion seekers to find medically accurate information to inform their healthcare decisions[319].

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[315] World Health Organization. Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Geneva: 2011.
[316] J Jerman, L Frohwirth, M.L Kavanagh & N Blades 'Barriers to abortion care and their consequences for patients traveling for services: qualitative findings from five states' (2018) 49(2) *Perspectives on Sexual and Reproductive Health*, 95-102.
[317] B.D Mekonnen & C.A Wubneh 'Knowledge, attitude and associated factors towards safe abortion among private college female students in Gondor City, Northwest Ethiopia: a cross-sectional study' (2020) 4 *Advances in Preventive Medicine*: 8819012.
[318] J.N Erdman & B.R Johnson Jr 'Access to knowledge and the Global Abortion Policies Database' (2018) 142(1) *International Journal of Gynaecology and Obstetrics*, 120-124.
[319] T Leung 'The next infodemic: abortion misinformation' (2023) 25 *Journal of Medical Internet Research*, e42582.

4.2.1 Girls' and women's knowledge deficits of TOP law

The ability of girls and women to make informed reproductive decisions is fundamentally dependent on their access to information. If they are not mindful of the fact that they are legally entitled to seek and obtain safe TOPs at healthcare facilities, or of the conditions under which abortions may be provided, women are left vulnerable to making unfavourable decisions, specifically seeking out illegal abortions[320]. Incorrect or insufficient knowledge of abortion laws also contributes to the disconnect between laws and their application[321]. Swarts et al. found that, in general, women have limited knowledge of abortion laws. Their study also identified the inability of women to differentiate between myths and facts about abortion[322]. In the same vein, McLeod et al.[323] found that South African adolescents have a poor knowledge of both the legal status and specific stipulations for abortion provision included in the law, and that various misunderstandings and misinterpretations of the law were evident. This corroborates the earlier findings of Morroni et al.[324] who determined that many women, particularly those in rural areas, did not know that South African law permits legal TOP. Even amongst those who were cognisant its legal status, many were not aware of the time restrictions imposed on access.

4.2.2 TOP-related knowledge deficits of healthcare providers

Glenton et al.[325] established that there is also a general lack of knowledge about abortion legislation and availability of services among healthcare workers. In the context of consciousness objection specifically, it was found that healthcare practitioners use the principle to opt out of service provision. They are, however,

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[320] Assifi AR, Berger B, Tunçalp Ö, Khosla R, Ganatra B. Women's Awareness and Knowledge of Abortion Laws: A Systematic Review. (2016) 11(3) *PLoS One*, e0152224.

[321] World Health Organization. Safe abortion: technical and policy guidance for health systems. Geneva: 2012.

[322] J.J Swarts, C Rowe, J.E Morse, A.G Bryant & G.S Stuart 'Women's knowledge

[323] C Mcleod, L Seutlwadi, & G Steele. 'Cracks in reproductive health rights: Buffalo City learners' knowledge of abortion legislation' (2014) 19(1) *Health SA Gesondheid*, 1-10.

[324] Ibid 198.

[325] C Glenton, A.M Sorhaindo, B Gantra & S Lewin 'Implementation considerations when expanding healthcare worker roles to include safe abortion care: a five-country case study synthesis' (2017) 17(730) *BMC Public Health*, 2-13.

not always cognisant of the limits of the law or their legal obligations to ensure that women are not denied access to care. This is supported by the findings of Madziyire et al.[326] who submit that only 25% of healthcare providers are aware of all the conditions under which abortions are legal and that many providers are misinformed about one or more legal criteria for TOP provision. At times, healthcare professionals such as pharmacists, who are indirectly involved in abortion service provision, also lack clear understandings of the parameters of the law, in the sense that they, too, refuse to dispense abortion medication for moral reasons[327]. Abortion Support South Africa, a local abortion advocacy group, contacted 184 pharmacies across the country requesting misoprostol to be administered. Of these, 40% refused to dispense the medication despite being shown a prescription by a healthcare professional[328]. Apart from this being illegal, it creates yet another stratum of inaccessibility for abortion seekers. Knowledge deficiencies on abortion are also found at a grassroot level. In a study to determine medical students' knowledge of abortion during clinical training, Wheeler et al.[329] found that the majority of students desired more information about TOP during their training and felt that issues pertaining to abortion necessitate more attention in the academic curriculum.

4.2.3 Lack of credible TOP information on the internet and social media platforms

Using the internet to search for health-related information is a ubiquitous practice. Although an extensive repository of information is available online, much of the content is unregulated, potentially making it confusing, conflicting or incorrect. Online information pertaining to TOP is prone to be misleading and

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[326] M.G Madziyire, A Moore, T Riley, E Sully & T Chipato 'Knowledge and attitudes towards abortion from healthcare providers and abortion experts in Zimbabwe: a cross sectional study' (2019) 34(94) *The Pan African Journal*, 3-6.
[327] H.Z Jiang 'Pharmacists think it's illegal to dispense abortion pills: worrying consequences' (2023) Health-E-News. Available at: https://health-e.org.za/2023/05/30/difficulty-obtaining-abortion-pills-from-a-pharmacy-has-serious-consequences/.
[328] Ibid 46.
[329] S.B Wheeler, L Zullig, R Jungerwirth, B.B Reeve, G.A Buga & C Morroni 'Knowledge and attitudes of termination of pregnancy (TOP) legislation and attitudes toward TOP clinical training among medical students attending two South African universities' (2012) 14(1) *World Health and Population*, 5-18.

inaccurate[330] and, in some cases, intentionally seeks to thwart abortion access[331]. In fact, in many instances, abortion information searches are dominated by advertisements for unsafe, unregistered and illegal TOP providers. The NDoH websites do not readily offer information that can assist women to link with legal service providers in their area[332]. Often, government clinics do not have their contact details listed on the internet and, even if they do, these calls rarely get answered[333]. Social media platforms, such as TikTok, are also conduits of false abortion information. Videos purporting that women can use certain herbs to self-manage an abortion have amassed vast followings[334]. Other platforms, such as Twitter and Facebook, are used by anti-abortion activists to perpetuate abortion disinformation, including false information on abortion medication and how they work and unjustified comparisons of abortions to genocide and tragedies[335].

4.2.4 Abundance of illegal advertisements perpetuating inaccurate TOP information and the promise of immediate access

Advertisements for "safe," "pain-free," and "same-day-guaranteed" abortions, are common on public infrastructure in South Africa. These guerrilla marketing tactics exploit vulnerable women who have limited knowledge of TOPs and who cannot or have been denied access to legal services through legitimate channels. Offering only a contact number without provider details, illicit

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[330] S.R Chaiken. L Han, B.G Darney & L Han 'Factors associated with perceived trust of abortion websites: cross-sectional online survey' (2021) 23(4) *Journal of Medical Internet Research*, e25323.

[331] J Sherman 'How abortion misinformation and disinformation spread online' (2022) Available at: https://www.scientificamerican.com/article/how-abortion-misinformation -and-disinformation-spread-online/.

[332] The continued discrimination of black women in accessing sexual and reproductive health including abortion access in South Africa' (2022) Women's Legal Center Report. Available at: https://www.ohchr.org/sites/default/files/documents/issues/health/racismrightohealth/submissions/csos/2022-10-11/submission-health-GA-77-cso-womens-legal-centre-en.pdf.

[333] J van Dyk 'Need an abortion? Find clinics you can trust here' (2021) Available at: https://www.google.com/amp/s/mg.co.za/health/2021-11-24-need-an-abortion-find-clincis-you-can-trust.

[334] R Lerman 'People searching for abortion online must wade through misinformation' (2022) The Washington Post. Available at: https://www.washingtonpost.com/technology/2022/07/04/abortion-misinformation-herbal-remedies/.

[335] A Gold & O Gonzales 'Social media loses ground on abortion misinformation' (2022) Available at: https://www.axios.com/2022/10/18/abortion-misinformation-social-media-losing-ground.

providers often vanish post-procedure. These illegal abortions often lack pre-screening, fail medical hygiene standards, and even extend up to 6 months of pregnancy[336].

4.3 PROXIMITY, TRANSPORTATION AND COST

A major factor in access to safe abortion is the ability to actually get to the designated facility in order to obtain care. Because not every healthcare facility or clinic provides TOPs, women, especially those from rural areas, frequently have to travel long distances to access care[337]. This, in turn, creates an array of other distance-related barriers such as needing to arrange transportation, save money for travel expenses, arrange time off work and child-minding care, and the possibility of needing to make multiple trips to a clinic[338]. This affects a woman's ability to maintain privacy as extended periods away from work and home can necessitate disclosure to individuals whom the woman would have ordinarily preferred not to share this information with[339]. The lack of reliable transportation to healthcare facilities, especially from rural areas with poor road infrastructure, exacerbates the challenges of accessing abortion[340]. Navigating through poor road infrastructure also adds to the challenge of accessing care[341]. And, even if a woman is able to traverse the difficulties of getting to an abortion facility, it does not mean that she will be able to obtain services on that same day. Women presenting for abortions are often turned away and given another date to come back and receive care[342]. Not only does this add a significant

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[336] M Palin Backstreet abortions illegal, dingy clinics advertise "safe, pain-free procedures" (2017) Available at: https://www.google.com/amp/s/www.news.com/lifestyle/health/healthproblems/backstreet/abortions.

[337] Rural Health Information Hub. 'Healthcare access in rural communities' (2019) Available at: https://ruralhealthinfo.org/topicslhealthcare-access#barriers.

[338] E.A Pleasants, A.F Cartwright & U.D Upadhyay 'Association between distance to an abortion facility and abortion or pregnancy outcome among a prospective cohort of people seeking abortion online' (2022) 5(5) *JAMA Network Open*: e222065.

[339] R Heller, C Purcell, L Mackay, L Caird & S. T Cameron 'Barriers to accessing termination of pregnancy in a remote and rural setting: a qualitative study' (2016) 123(10) *An International Journal of Obstetrics and Gynaecology*, 1684-1691.

[340] M.A Dikotla & W Mothapo 'Accessibility barriers in health facilities of the South African public sector' (2021) University of Venda, 539-547.

[341] M Netshinombelo, M.S Maputle & D.U Ramathuba 'Women's perceived barriers to accessing post-abortion care services in selected districts in Kwa-Zulu-Natal Province, South Africa: A qualitative study (2022) 88(1) *Annals of Global Health*, 75.

[342] Ibid 340.

financial burden to accessing care, but it also means that they will once again have to endure the obstacles that come with accessing a facility. Further, the delays potentially jeopardise access to care given the time-sensitive nature of abortion. Although the norms and standards of primary health service propose that citizens should not have to travel more than five kilometers to access healthcare services[343], this is certainly not the case for abortion access in South Africa.

4.4 SHORTAGE OF EQUIPMENT, POOR INFRASTRUCTURE, LONG WAITING LINES AND LACK OF PRIVACY AT PUBLIC HEALTH FACILITIES

Public healthcare facilities in South Africa are notorious for their old and poorly maintained infrastructure[344]. In many facilities, there is a lack of basic equipment such as manual vacuum aspirators and medical technology devices like ultrasound machines that are needed for TOP service provision[345]. Defective equipment is also a problem. Facilities at times have abortion equipment that breaks or goes missing[346], meaning that service provision is delayed or not rendered at all. As a result of staff shortages and burdensome workloads, patients seeking care at public facilities are often left to wait unattended for hours on end[347]. Moreover, public facilities lack an efficient and practicable booking system and scheduled appointments resulting in patients arriving early in the morning but being sent back home without receiving care[348]. Overcrowding in waiting areas, together with a lack of physical space to render TOPs, mean that there is no privacy when healthcare practitioners are talking to abortion patients[349]. At times, this is done in earshot of other patients. Inadequate planning and design of hospitals and clinics can result in the built

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[343] M.A Dikotla. 2008. Assessment of information delivery systems used for dissemination of HIV/AIDS information by selected clinics at Ga-Molepo, Capricorn district in the Limpopo province. Unpublished Masters Dissertation. University of Limpopo: Polokwane.
[344] Ibid 74.
[345] Interview with a general practitioner working in public and private facilities, Mwanza (2017) Center for Reproductive Rights.
[346] J Harries 'Abortion services in South Africa: challenges and barriers to safe abortion care: healthcare providers' perspectives' (2010) Thesis, University of Cape Town Available at https://open.uct.ac.za/bitstream/handle/11427/10623/thesis_hsf_2010_harries_j_phd.pdf?sequence=1&isAllowed=y.
[347] Ibid 73.
[348] Ibid 73.
[349] Ibid 73.

healthcare environment being unsuitable for patient care[350]. Comprehensive abortion care warrants that facilities are sufficiently equipped to offer services with quality infrastructure to augment service delivery. This includes the provision of private rooms, clean linen, functioning equipment and medicinal resources[351]. In line with this, one of the derivatives of the right to health is that all people have the right to medical products and technologies including access to devices and procedures[352].

4.5 GESTATIONAL AGE

Advanced gestational age impedes TOP access, with second-trimester abortions being more prevalent in South Africa than in many other countries globally[353]. Accessing legal second-trimester abortions, whether through medical induction[354] or surgical procedures[355], is markedly challenging, particularly for rural South African women[356]. Factors contributing to these challenges include a lack of awareness of time-limited TOP access, a shortage of trained providers, healthcare provider refusals, and limited availability of essential medications like mifepristone[357]. Third-trimester abortions are even more difficult and stigmatized, with few facilities offering these services, primarily in urban areas[358].

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[350] M.M Quinn, P.K Henneberger, B Braun et al. 2015 'Cleaning and disinfecting environmental surfaces in healthcare: Towards an integrated framework for infection and occupational illness prevention. 43(5) *American Journal of Infection Control*, 424-434.

[351] Comprehensive abortion care in Eastern Cape and KwaZulu Natal. Available at: https://southafrica.unfpa.org/en/submission/comprehensive-abortion -care-eastern-cape-and-KwaZulu-Natal.

[352] S.P Marks & A.L Benedict 'Access to medical products, vaccines and medical technologies' in: J.M Zuniga, S.P Marks, L.O Gostin, editors. Advancing the human right to health. Oxford: Oxford University Press; 2013, 305-324.

[353] D Grossman, D Constant, N Lince, M Alblas, K Blanchard & J Harries 'Surgical and medical second trimester abortions in South Africa: a cross-sectional study' (2011) 11(224) *BMC Health Services Research*.

[354] N Kapp, L Borgatta , P Stubblefield , O Vragovic & N Moreno 'Mifepristone in second-trimester medical abortion: a randomised controlled trial' (2007) 110(1) *Obstetrics & Gynaecology*, 1304-10.

[355] World Health Organization: Safe Abortion: Technical and Policy Guidance for Health Systems. 2003, Geneva: World Health Organization.

[356] Ibid 353.

[357] Performing second and third trimester abortions: A South African obstetrician and gynaecologists experience and perspective. Available at: https://laterabortion.org/performing-second-and-third-trimester-abortions-south-african-obstetrician-and-gynaecologist.

[358] K Kimport 'Is third-trimester abortion exceptional? Two pathways to abortion after 24 weeks of pregnancy in the United States' (2022) 54(2) *Perspectives on Sexual and Reproductive Health*, 38-45.

4.6 NEGATIVE ATTITUDES AND UNWILLINGNESS TO PROVIDE TOPs

Healthcare providers' attitudes is a key element in the provision of quality, stigma-free abortion care[359]. Poor attitude and demeanour of healthcare providers discourage women from seeking and obtaining abortions through legal channels. They are often treated badly by healthcare personnel who try to daunt abortion seekers by demanding parental or partner consent, or dissuade women from seeking abortions or even blatantly refuse to serve them[360]. In many facilities, there is a scarcity of healthcare professionals willing to provide or even assist in termination of pregnancy services[361]. Although abortion-service provision is a standard component of health service delivery, some providers report that they would be more willing to provide these services if they were to receive additional incentives such as increased pay[362]. At some facilities, the demand for TOP is so high that the number of willing providers cannot meet it. This leads to disproportionate workloads for willing providers which, in turn, results in exhaustion and burn-out[363]. These providers then either become unwilling to provide the service or leave, creating greater voids within the healthcare system that affect abortion accessibility.

4.7 TOP STIGMA

Social stigma refers to the 'negative regard, inferior status and relative powerlessness' with which society collectively views people who belong to a particular group or category, or who possess a particular characteristic[364]. Abortion stigma is a complex phenomenon underpinned by a range of religious, cultural, ethnic, social, and geographical contexts and can occur at an

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[359] P.F Pebolo, A.A Grace & O.J Henry 'Healthcare providers' attitude towards abortion service provision in Gulu City, Northern Uganda' (2022) 5(1) *International Journal of Sexual and Reproductive Healthcare*, 008-015.

[360] B Wicks 'Social barrier, staff attitudes push women to use illegal abortion providers' (2022) Eye Witness News. Available at: https://ewn.co.za/2022/07/06/social-barriers-staff-attitudes-push-women-to-use-illegal-abortion-providers.

[361] S Rohrs 'The influence of norms and values on the provision of termination of pregnancy services in South Africa' (2017) 6 *International Journal of African Nursing Sciences*, 39-44.

[362] K.L Turner, A.G Hyman & M.C Gabriel 'Clarifying values and transforming attitudes to improve access to second-trimester abortions' (2008) 31 (Suppl) *Reproductive Health Matters*, 108-116.

[363] Ibid 341.

[364] G.M Herek (2009) Sexual Prejudice in T.D Nelson (Ed), Handbook of prejudice, stereotyping and discrimination (pp 441-467) New York NY US: Psychology Press.

individual, community, institutional, legislative, and mass media level[365]. It discredits individuals associated with abortion, be it the seeker, the healthcare service provider, friends and family who support the abortion patient, and even advocates of reproductive rights and autonomy such as pro-choice lobbyists[366]. It taints those who participate in abortion with disgrace, shame and disgust, thereby tarnishing social identities[367] and creating a divisive mentality that obstructs access to reproductive healthcare. Not only does abortion stigma make it more difficult for women to obtain care or ask for support when they need an abortion, but it further propagates antiquated gender expectations that are harmful to women[368]. Kumar et al.[369] theorise that abortion is highly stigmatised because it subverts popular perceptions of women, including the archetypal notion that they are ordained for motherhood and are therefore expected to instinctively nurture the vulnerable at any cost. Other sources of abortion stigma include shame about sexual practices, failure to contracept effectively, assigning the status of personhood to the foetus, and weaponising stigma as a tool to further anti-abortion efforts[370].

The broad socio-cultural barriers that impede women seeking abortions include stereotypical notions that they are uneducated, unintelligent, promiscuous, irresponsible, and selfish. These platitudes illustrate the lack of sociological understanding of the deeper realities and challenges faced by women seeking TOPs. They discount the compelling reasons for their enforced pursuit of such services. For example, an abortion seeker may be perceived as promiscuous without considering that she may in fact have been raped. Other manifestations of social stigma towards TOP include abortion seekers being susceptible to

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[365] L Hessini 'A learning agenda for abortion stigma: recommendations from Bellagio Expert Group meeting' (2014) 54(7) *Women's Health*, 617-621.
[366] A Norris, D Bessett, J.R Steinberg, M.L Kavanaugh, S De Zordo & D Becker 'Abortion stigma: a reconceptualization of constituents, causes and consequences' (2011) 21(Suppl) *Women's Health Issues*, S49-54.
[367] R.J Cook & B.M Dickens 'Reducing stigma in reproductive health' (2014) 125(1) *International Journal of Obstetrics and Gynecology,* 89-92.
[368] Abortion Stigma Planned Parenthood Available at: https://www.plannedparenthood.org/planned-parenthood-keystone/services/abortion-services/abortion-stigma.
[369] A Kumar, L Hessini & E.M Mitchell 'Conceptualizing abortion stigma' (2009) 11(6) *Culture, Health & Sexuality* 625-636.
[370] Ibid 365.

negative reactions, such as being ostracised and becoming the object of gossip and judgment by family, community members, and even healthcare professionals. Abortion stigma can even lead to suicide or murder[371]. Stigma also has a reciprocal relationship with discrimination within the healthcare setting and reflects power dynamics, privilege, and disadvantage in society[372].

[371] Ibid 368.

[372] M.A Boren, M.V Corona, O.J Odiase, A.N Wilson, M Sudhinaraset, N Diamond-Smith, J Berryman, O Tuncalp & P.A Afulani 'Strategies to reduce stigma and discrimination in sexual and reproductive healthcare settings: a mixed methods systematic review' (2022) 2(6) *PLoS Global Public Health*, e000582.

4.8 TOP STIGMA AT AN INSTITUTIONAL LEVEL

At an institutional level, abortion stigma shapes the environment in which TOP services are delivered and received and can have a direct impact on the quality of clinical care rendered[373].

4.8.1 Lack of leadership and collegial support within an institution

Ahiteye et al. highlight that the personal convictions of the management and leadership influence TOP services at some healthcare facilities. If leaders, such as heads of department or hospital administrators, oppose TOP, they may hinder staff training, limit the procurement of equipment essential for TOPs, and prevent discussions or meetings where abortion is on the agenda[374]. Similarly, Maxwell et al. note that those participating in abortion services face resistance, including hostility from non-participating colleagues and obstruction from medical managers to admit TOP patients into the wards. Scarcity of TOP providers is further exacerbated by uncooperative healthcare personnel, such as administrative clerks, affecting patient information and referrals at abortion facilities[375]. In some instances, when patients visited a particular facility for an abortion, their referral letters were thrown away, or they would be left for hours unattended to wait for access to care[376].

4.8.2 Healthcare providers' judgement and self-appointed gate keeping

Research confirms that healthcare workers, in addition to being hostile, dismissive, disrespectful, and unsympathetic[377] towards abortion seekers, also often actively discourage women from accessing services[378] because of their

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[373] A.M Sorhaindo & A.F Lavelanet 'Why does abortion stigma matter? A scoping review of hybrid analysis of qualitative evidence illustrating the role of stigma in the quality if abortion care' (2022) 311 *Social Science & Medicine*, 115271.
[374] P.A Ahiteye, B O'Brien & S.H Mayhew 'Stigmatised by association: Challenges for abortion service providers in Ghana' (2016) 16(1) *BMC Health Services Research*, 486.
[375] K.J Maxwell, L Hoggart, F Bloomer, S Rowlands & C Purcell 'Normalising abortion: what role can health professionals play?' (2021) 47(1) *BMJ Sexual and Reproductive Health*, 32-36.
[376] J Harries, K Stinson & P Orner 'Health care providers' attitudes toward termination of pregnancy: a qualitative study in South Africa' (2009) 9(296) *BMC Public Health*.
[377] M Favier, J.M.S Greenberg & M Stevens 'Safe abortion in South Africa: we have wonderful laws but we don't have people to implement those laws' (2018) 143(4) *International Journal of Gynaecology & Obstetrics*, 38-44.
[378] Z Fathallah 'Moral work and the construction of abortion networks: women's access to safe abortions in Lebanon' (2019) 21(2) *Health and Human Rights*, 21-31.

personal views that abortion is cruel, sinful, and equivalent to murder[379]. Other ways that practitioners' beliefs are imposed onto patients is during abortion counselling, when providers falsely assert that abortion is physically and psychologically harmful to the patient and that abortion causes sterility[380]. Some practitioners even go so far as to request women to show their marriage contracts or certificates as proof of their marital status before performing an abortion[381].

A study by Rohrs[382] highlights how healthcare providers' personal beliefs and judgements play out in the arena of TOP service provision. Healthcare providers can, at times, make moral judgements about which abortion patients are more deserving of service provision than others. More deserving patients were those who were unable to exercise their reproductive rights, such as the use of contraception, because of controlling husbands, thus being coerced into pregnancy. Rape was also a valid ground for TOP provision. Patients who were highly emotional, such as those who cried, expressed remorse and regret at having an abortion, or displayed vulnerability and desperation were also considered deserving of abortions. On the other hand, unworthy patients were those with 'flimsy excuses' for wanting a TOP, including those who engaged in careless behaviour, such as not using contraception, or those who already had previous abortions and had no valid reason for repeat abortions. It was also reported that even though abortion is legal, some healthcare providers are opposed to service provision because they overtly reject the provision that terminating a pregnancy is a right. Furthermore, some healthcare providers feel that TOP provision is a waste of valuable time that could be devoted to a sick person[383]. This supports earlier findings which indicate, first, that some healthcare providers inappropriately interrogate abortion seekers about their

[379] R Nandagiri 'Like a mother-daughter relationship: community health intermediaries' knowledge of and attitudes to abortion in Karnataka India' (2019) *Social Science and Medicine* 239.
[380] S Raifman, S Hajri, C Gerdts & D Foster 'Dualities between Tunisian provider beliefs and actions in abortion care' 2018 26 (52) *Reproductive Health Matters*, 159-169.
[381] Ibid 380.
[382] S Rohrs 'The influence of norms and values on the provision of termination of pregnancy services in South Africa' (2017) 6 *International Journal of African Nursing Sciences*, 39-44.
[383] Ibid 382.

choice to terminate their pregnancy and, second, attempt to persuade them to reconsider their decision[384]. In a healthcare setting, Schuklenk maintains that unprofessional judgements are tantamount to unprofessional conduct[385].

4.8.3 TOP Facility Stigma

Stigma around facilities that provide TOP services is a common occurrence. Under the pretext of freedom of speech and the right to protest, anti-abortion protestors picket outside abortion facilities and verbally harass both patients and healthcare professionals, using tactics such as filming, displaying graphic posters, distributing misleading flyers, throwing objects, and employing intimidation methods[386]. All these actions are done with the intention of evoking enough repulsion and guilt to deter women from pursuing abortions. Extreme cases necessitate heightened security measures around and at facilities, including bulletproof glass and metal detectors[387]. Anti-abortion resistance can escalate to violent acts, leading some countries to establish buffer zones or bubble zones around TOP clinics where demonstrations are prohibited[388].

4.8.4 Referral stigma

Abortion referrals should comprise a range of proactive, information-giving, and facilitative attitudes and behaviours. The quality of abortion referrals is dependent, inter alia, on how well the information provided meets the specific needs of the patient[389]. Even if healthcare practitioners cannot or will not provide TOP services, they still play an important role in equipping the abortion seeker with the knowledge and information that can assist them in obtaining care and

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[384] A Harden & J Ogden 'Young women's experiences of arranging and having abortions' (1999) 21(4) *Sociology of Health & Illness*, 426-444.
[385] Ibid 273.
[386] 'Why buffer zones around abortion clinics do not threaten the right to protest' (2018) The Conversation. Available at: https://theconversation.com/why-buffer-zones-around-abortion-clinics-do-not-threaten-the-right-to-protest-90371
[387] K Kimport, K Cockrill & T.A Weitz 'Analysing the impacts of abortion clinic structures and processes: a qualitative analysis of women's negative experience of abortion clinics' (2012) 85 *Contraception*, 204-210.
[388] 'Abortion clinic "buffer zone" bill lodged in Scottish Parliament' (2023) Available at: https://www.bbc.com/news/uk-scotland-65914694.
[389] M Zurek & J O'Donnell 'Abortion referral making in the United States: findings and recommendations from the abortion referrals learning community' (2019) 100 *Contraception*, 360-366.

have a legal and ethical duty to refer patients to other facilities or participating providers.

Studies highlight how abortion stigma and resultant barriers filter down to the abortion referral process. Homaifar et al.[390] found that few clinicians facilitated abortion beyond verbally naming a clinic, if in fact a referral was made in the first place. Some clinicians would not provide referrals based on moral or religious objections to referring the patient, while other clinicians stated that they did not know where to refer the patient for further care. Disturbingly, it was also noted that some providers deliberately misled abortion seekers by providing deceptive referrals to adoption agencies, crisis pregnancy centres or therapists instead of alternate facilities offering TOP services[391]. Another study reported that an abortion seeking patient was given a handwritten abortion referral scribbled on a pamphlet for diabetes by her doctor[392]. Desai et al.[393] observed that while some healthcare practitioners indicated that they had a moral or ethical objection to abortion referrals, others stated that their practice had a formal policy against abortion referrals. Referral stigma even goes to the extent that patients are asked by healthcare providers to self-refer to abortion providing facilities or are told that they would be referred to another facility, but no referral is made[394]. Even in cases where healthcare practitioners were willing to make abortion referrals, many of them did not know how and to whom to make those referrals[395].

These situations underscore the marginalised position that abortion holds within the healthcare system and expose the abortion referral system as being a

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[390] N Homaifar, L Freedman & V French '" She's on her own": a thematic analysis of clinicians' comments on abortion referral' (2017) 95(7) *Contraception*, 470-476.
[391] Ibid 390.
[392] J Margo, L McCloskey, G Gupta, M Zurek, S Bhakta & E Feinberg 'Women's pathways to abortion care in South Carolina: a qualitative study of obstacles and supports' (2016) 48(4) *Perspectives on Sexual and Reproductive Health*, 199-207.
[393] S Desai, R.K Jones & K Castle 'Estimating abortion provision and abortion referrals among United States obstetricians and gynaecologists in private practice' (2018) 97(4) *Contraception*, 297-302.
[394] Ibid 339.
[395] E.M Anderson, S.K Cowan, J.A Higgins, N.B Schmuhl & C.K Waulet 'Willing but unable: physicians' referral knowledge as barriers to abortion care' (2022*)* 17 *SSM Population Health*: 101002.

fictitious substitute for facilitating service provision. In the context of conscientious objection to abortion, these studies also show that mandatory referrals as a primary mechanism to regulate non-provision cannot be relied upon as an effective way of ensuring that an abortion seeking patient will receive care. Even when abortion seeking patients are angry and disappointed at the lack of abortion referrals, they have little desire to lodge formal complaints[396]. This is probably why non-referrals or poor referrals persist as a pervasive problem in TOP service provision.

4.9 CONCLUSION

Examining the barriers and challenges that South African women encounter in accessing public health TOP services reveals recurrent human rights violations without consequences. These include infringements of equality and non-discrimination, human dignity, privacy, personal security, freedom of choice, access to information, and the right to access healthcare. In instances of constitutional rights violations in South Africa, individuals can seek redress through various channels, such as the Constitutional Court, High Court, the South African Human Rights Commission, the Commission for Gender Equality, the Public Protector and even through civil society organisations. The paucity of abortion-related case law in South Africa, despite research documenting access violations, may be attributed to factors such as underreporting driven by stigma and fear of discrimination, low legal literacy, restricted access to legal services, and economic limitations. Therefore, urgent public health education, particularly in reproductive health, is imperative for South African girls and women at both school and community levels.

[396] Ibid 339.

CHAPTER FIVE: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

5.1 INTRODUCTION

The arguments brought to the fore in the previous chapters illustrate the state's failure to enact effective measures to ensure the equal upholding of conscientious objection and abortion rights. Rather than fostering a fair environment where both the rights of the healthcare provider and the abortion-seeking patient are respected, inadequate administrative, contextual, and policy measures have resulted in a system where one often outweighs the other. This failure undermines the fundamental principles of justice and equality. This final chapter consolidates the different aspects explored throughout this dissertation and offers suggestions to better regulate the practise of conscientious objection while facilitating access to safe and lawful TOPs in South Africa.

5.2 DISCUSSION

That South Africa serves as a paragon of reproductive self-determination in Africa and around the world, cannot be undervalued. However, while establishing an enabling legislative framework undoubtedly serves as the critical starting point in the progressive evolution of abortion rights, the increased bureaucracy, along with the systemic, political and socio-cultural co-morbidities, often leave South African women without abortion care.

When deliberating on a topic such as conscientious objection to TOP, and weighing and balancing the rights between such competing interests, it is important to note that, while grounded in the law, these issues are not exclusively legal. Instead, they have a distinct social, political, bioethical, economic, and philosophical dimension. Therefore, although this study concentrated on healthcare provider conscientious objection to TOP as the *primum mobile* barrier to reproductive justice, it is by no means the only issue that impedes and obstructs safe and legal TOP access in the South African public health context. It is hypothesised that if an abortion-seeker adeptly

navigated through all the logistical, administrative, infrastructural, and other barriers but then happened to encounter a conscientiously objecting provider at the facility they were able to reach, the cycle of challenges would be reinstated, prompting a renewed effort to locate a non-objecting provider. Herein lies the issue with conscientious objection- it can serve as a catalyst for circuitous inaccessibility. When legal TOP access is denied to women, they face limited options: seeking care at another facility, resorting to illegal abortion providers, or continuing with an unwanted pregnancy[397]. These alternatives undermine constitutional and CTOP Act provisions, signifying a violation of public health and justice systems.

This study aimed to analyse the legislative framework governing the rights of patients and healthcare professionals within the context of conscientious objection and termination of pregnancy in South Africa. The examination revealed that the right to TOP and conscientious objection are equally recognised at the international, regional, constitutional, statutory, and soft law levels. It is generally accepted that when two principle-shaped rights conflict, it impacts the realisation of those rights[398]. However, upon closer consideration of the probabilities, this study found that, in terms of access to safe and legal TOPs in the public health sector, abortion rights seem to be accorded a lower priority within the hierarchy of rights. In South Africa, it seems that various inconsistencies, manifesting at multiple levels, are the norm in the application of abortion law, specifically in the context of conscientious objection.

From a constitutional perspective, the various provisions that strengthen sexual and reproductive rights hold high theoretical appeal. However, as illustrated in this dissertation, it is glaringly obvious that profound and broadening gaps in the implementation and realisation of these laws continue to exist. Andrews argues that South Africa's inability to actualise the rights outlined in the Constitution is

[397] C Gerdts, T DePineres, S Hajri, D Vohra, D Greene Foster 'Denial of abortion in legal settings' (2015) 41 *Journal of Family Planning and Reproductive Health Care*, 161-163.
[398] A Barak 'Conflicting constitutional rights' (2012) Cambridge University Press. Available at: https://www.cambridge .org/core/books/abs/proportionality/conflict-constitutional-rights.

attributed to mismanagement, corruption, incompetence, indifference, and a deficiency of political will across all levels of government[399].

The CTOP Act was originally conceived as a legislative means to promote accessibility, expand the grounds for provision, combat stigma and discrimination, dismantle racial barriers obstructing abortion access and address the socio-economic inequities that impact it. Yet, despite its intent, it is still the most vulnerable South Africans, especially rural Black Africans, that continue to find it difficult, if not impossible at times, to access adequate and essential healthcare services[400], including abortion. Meel and Kaswa[401] found that while the CTOP Act certainly had an initial positive impact on overall maternal mortality, it did not affect the prevalence of illegal abortions in rural and remote parts of the country. They found that in one of the most rural parts of South Africa characterised by high levels of poverty and illiteracy and poor infrastructure, and where knowledge and understanding of legal TOP rights are low, illegal abortions were not even perceived as a serious crime by the community. This contradicts the envisioned spirit of repealing the ASA.

It is recognised that even in the presence of the most liberal and advanced abortion laws, automatic access to safe and legal TOP services is not guaranteed, as in order for the law to be successfully realised, it has to be implemented effectively[402]. The effective implementation of the rule of law embraces a social component: it must embody relevant and real social content and not merely abstract principles[403]. Many law and policy failures stem from defective policy design, including poor conception of a problem, insufficient knowledge of the implementation context, unclear and even contradictory goals,

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[399] P Andrews 'South Africa's problems lie in political negligence not its constitution' (2017) The Conversation. Available at: https://www.google.com/amp/s/theconversation.com/amp/south-africas-problems-lie-in-political-negligence.

[400] K.B Shai & O Ogunnubi 'South Africa's healthcare system and human rights: a critical African perspective' (2018) 10(1) *Journal of Economics and Behavioural Studies*, 69.

[401] B.L Meel & R.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' (2009) 1(1) *African Journal of Primary Healthcare & Family Medicine*, Article 36, 79-81.

[402] Ibid 82.

[403] G.E Adygezalova, S.A Zhinkin, I.S Kich & L.V Butko 'Effectiveness of legislation and implementation of the rule of law' (2022) 40(72) *Cuestiones Politicas*, 774-784.

and scarcity of policy tracking initiatives and mechanisms[404]. This is apparently clear in the context of abortion legislation in South Africa. Unsurprisingly, one of the key findings of the 2021 report on an investigation into the CTOP Act showed that there appears to be a little to no monitoring by the NDoH on abortion services within the various provinces of South Africa[405]. Considering that nearly 30 years have passed since the inception of the Constitution and the CTOP Act, it prompts questions about why, despite an abundance of data illustrating the challenges faced by South African women seeking abortions in the public health sector, few specific, measurable, practical, and time-bound objectives in this context have been put into action and achieved.

Abortion inaccessibility also entails an aspect of structural racism. Structural racism is the totality of ways in which societies propagate discrimination by perpetuating systems of inaccessibility to education, employment, housing, criminal justice, credit, media and healthcare[406]. It also represents the manner in which public policies, organisational practices and cultural norms work to reinforce and entrench racial inequity in such a way that "whiteness" is associated with privilege while black connotes disadvantage[407]. For example, healthcare infrastructure and services are often inequitably distributed in a way that predominantly black neighborhoods have lower-quality facilities with fewer clinicians than that of other areas[408]. Thompson et al.[409] determined that reproductive healthcare facilities are often located outside of low-income and

[404] Ibid 403.
[405] CGE Report on abortion in SA: Government's Response Plan to GBV & Femicide and CEDAW Compliance. Parliamentary Monitoring Group. 2022. Available at: https://pmg.org.za/committee-meeting/34405.
[406] Z.D Bailey, N Krieger, M Agenor, J Graves, N Linos & M.T Bassett 'Structural racism and health inequities in the USA: evidence and interventions' (2017) 389(10077) *The Lancet,* 1453-1463.
[407] The Aspen Institute '11 terms you should know to better understand structural racism' July 2016 Available at: https:www.aspeninstitute.org/blog-post/structural-racism-definition.
[408] K White, J.S Haas, D.R Williams 'Elucidating the role of race in health care disparities: the example of racial/ethnic residential segregation' (2012) 47 *Health Services Research*, 1278-1299.
[409] T.M Thompson, Y Young, T.M Bass, S Baker, O Njoku, J Norwood & M Simpson 'Racism runs through it: examining the sexual and reproductive health experiences of black women in the South' (2022) 41(2) *Health Affairs*, 195-202.

predominantly black neighborhoods. Similarly, Bearak et al.[410] espouse that spatial disparities have remained relatively unchanged over the last 20 years despite traveling distance to reproductive healthcare facilities being identified as a problem. It was also determined that healthcare facilities in predominantly black areas provide a lower quality of care in comparison with private facilities in more urbanised areas.

This dissertation primarily focused on TOP access in the public health sector of South Africa, and explored the invocation of conscientious objection in this specific setting. Though there is limited information regarding conscientious objection among healthcare providers in the private health sector, the assumption is that if a private provider objects to supplying abortion services, the socio-economic advantage of the system's users would likely facilitate the sourcing and obtaining of services from an alternative provider, presumably in a comparatively more straightforward and timely manner, all while upholding the spectrum of patient rights. In fact, distinct disparities exist in the nature and calibre of patient-provider interactions within the private and public healthcare sectors[411]. Within the public health sphere, healthcare practitioners, serving as agents of the state, possess limited discretion in initiating patient treatment, as opposed to their private healthcare counterparts. Nevertheless, they are bound by an obligation to see a patient's treatment through to completion once it has commenced. Further, this relationship is influenced by the employment contract between the practitioner and the state and the underlying principle that state-employed practitioners are vicariously liable for injuries or harm endured by their patients[412]. The patient-practitioner relationship has received limited research attention in rural areas, recognised as medically underserved regions where the primary focus shifts towards ensuring accessibility and availability of care[413]. In

[410] J.M Bearak, K.L Burke & R.K Jones 'Disparities and change over time in distance women would need to travel to have an abortion in the USA: a spatial analysis' (2017) 2(11) *Lancet Public Health*: e493-e500.
[411] M Slabbert 'Legal reflections on the doctor-patient relationship in preparation for South Africa's National Health Insurance' (2022) 15(1) *South African Journal of Bioethics and Law*, 31-35.
[412] Ibid 411.
[413] V Harbishettar, K.R Krishna, P Srinivasa & M Gowda 'The enigma of doctor-patient relationship' 2019 61(4) *Indian Journal of Psychiatry*.

these rural contexts, limited health literacy and insufficient means to access information can impede individuals from obtaining healthcare services. Under such circumstances, the emphasis is placed on the prioritisation of access and the availability of healthcare practitioners over the customary principles of therapeutic rapport[414]. Against this contextual backdrop, it becomes evident why individuals utilising the public health system often accept what they are provided, even when these provisions directly violate their constitutional or statutory rights. It is hypothesised that if private sector conscientious objectors had to treat patients as their public sector counterparts do, law suits could well be a likely outcome. In light of the evolving landscape where medicine is increasingly centred on rights *vis- a-vis* the relevant legal instruments and is becoming more litigious[415], it is probable that, users of the public health system may lack the requisite knowledge and resources to pursue legal remedies in situations where healthcare justice is impeded.

The WHO declares that conscientious objection is a barrier to access quality abortion care. Unclear, unenforced or non-existent regulatory frameworks make it impossible to standardise conscientious objection in a manner that respects, protects and fulfils abortion seekers rights and undermines organisational models for public service delivery by creating burdens on non-objecting providers and causes interpersonal workplace conflicts[416]. The International Federation of Gynaecology and Obstetrics (FIGO) recognise that the primary conscientious duty of healthcare providers at all times is to prevent harm, provide benefit and treat the patients they are responsible for. Conscientious objection is secondary to this foremost duty. Wherever the invocation of conscientious objection results in increases burden of accessibility, delays or

[414] D.E Pathman, T.C Ricketts & T.R Konrad 3rd 'How adults' access to outpatient physician services relates to the local supply of primary care physicians in the rural Southeast.' (2006) 41(1) *Health Services Research*, 79-102.
[415] V Mallardi 'The origin of informed consent' (2005) 25(5) *Acta Otohinolaryngolica Italia*, 321-327.
[416] Ibid 40.

outright non-provision, it should no longer be deemed as conscientious objection but rather as unjustified denial of health services[417].

The elements necessary for a functional healthcare system that permits conscientious objection yet ensures abortion access include clarity on who can object to which components of TOP care, enhanced accessibility by establishing direct entry and mandatory referrals into the system and assuring TOP access through direct provision or by contracting services to alternative abortion providers[418]. The current approach to allowing conscientious objection in the South African healthcare system falls short of meeting such criteria. Since a prescribed referral pathway ensuring timely access to safe and legal TOP services does not exist, this study proposes that the rights of the conscientious objector are prioritised over that of the abortion seeking patient.

While the researcher's stance strongly advocates prioritising access to healthcare and upholding women's rights, it is imperative to acknowledge South Africa's profound commitment to diversity and religious freedom. Consequently, it is conceded that for the effective preservation of religious freedoms within the framework of conscientious objection and abortion rights, more robust mechanisms must be implemented to ensure access, thereby striking a balance between competing rights. In an attempt to strike a balance between protecting the right to conscience objection, and the right to safe TOP access, some places have implemented 'institutional guarantees' as a measure of regulating the practise. This mechanism ensures that individuals can access abortion services at a specific health facility, regardless of the conscientious objection status of some providers within that facility[419]. Ensuring a sufficient number and appropriate geographic allocation of willing providers at public facilities is another element of policy regulation that can help to mitigate the negative

[417] Conscientious objection: a barrier to care. International Federation of Gynaecology and Obstetrics. Available at: https://www.figo.org/resources/figo-statements/conscientious-objection-barrier-care.
[418] W Chavkin, L Swerdlow & J Fifield 'Regulation of conscientious objection to abortion' (2017) 19(1) *Health and Human Rights Journal*, 55-68.
[419] Ibid 212.

consequences of conscientious objection in reproductive healthcare[420]. Exploring these possibilities within the framework of conscientious objection and TOP accessibility in South Africa could be beneficial.

Other practical solutions to handle human-rights based conflicts, particularly in the public sector, include using basic ethical principles such as serving public interest, transparency and accountability, integrity, legitimacy, responsiveness, efficiency, and effectiveness to minimise rights-based clashes. In these instances, the onus is on the public servant to act in the best interest of public welfare and to consolidate and uphold the Constitution and the law[421]. In order for countries to assure sexual and reproductive health rights as a standard component of healthcare, it is imperative that that the following basic criteria be satisfied[422].

1- *Equity in access* – this means that individuals that require services are empowered to access them, regardless of their socio-economic status, capacity to pay, geographic location, education, gender and ethnicity.
2- *Quality of care* – health facilities and commodities are of high quality and services are delivered in a safe, effectively, equitable, timely, integrated and patient-centered manner.
3- *Accountability* – the realisation of sexual and reproductive health rights is underpinned by human rights, and political, financial and performance accountability. Elements of ensuring accountability incorporate inclusiveness, transparency and taking into consideration rights holders views and demands during the planning and implementation of policies.

[420] ESCR Committee, General Comment No 22 on the right to sexual and reproductive health, para 14.
[421] Managing conflict of interest in the public sector' Toolkit by organisation for economic cooperation and development. Available: https://www.oecd.org/gov/ethics/49107986.pa/.
[422] 'Sexual and reproductive health and rights are an essential element of universal health coverage' International Conference on Population Development. Available at: https://www.unfpa.org/sites/default/files/pub-pdf/SRHR

South Africa has one of the highest rates of infanticide globally[423]. Though reprehensible, the act reflects deep underlying social issues. Some of the reasons for these statistics include poverty, cultural disapproval of abortion, and lack of access to safe abortion services. The failure of social welfare services to provide vital information and effective support on birth-control and family planning, especially to unmarried mothers in dire financial and socio-economic circumstances, exacerbates the problem[424]. Thus, inaccessibility of safe and legal abortion services has far-reaching and calamitous consequences. Another pervasive social problem is that of the rampant levels of teenage pregnancies in South Africa. These statistics also rank amongst the highest globally. In many of the cases, it is girls under the age of 13 who are falling pregnant[425]. Customary laws, such as the philosophy of 'inhlawulo[426]' further compound this problem as families in dire socio-economic circumstances are satisfied to accept a small amount of money (often from older men) in compensation for impregnating young girls. Thus, it becomes obvious that while abortion, on a social level represents an amalgamation of attitudes to sex, life, death, women's roles and freedoms, family values, views of personhood and humanity, and understanding of autonomy and individual agency, it is simply the answer to an urgent personal problem for a pregnant person[427].

To achieve the full recognition of TOP as a legally sanctioned practice, it must be approached like any other healthcare service. This entails employing best practices in service delivery, training healthcare providers, and developing and implementing evidence-based guidelines within the legal framework. This

[423] 'Ten shocking facts about infanticide in SA' Available at: https://www.google.amp/s/roodepoortrecord.co.za/2016/06/18/ten-shocking-facts-about-infanticide-in-sa/amp

[424] T Rapoo, K Maema & J Baloyi 'Mothers killing babies- a shame or cry for help?' Commission for Gender Equality. Available at: https://cge.org.za/mothers-killing-babies-a-shame-or-cry-for-help/

[425] 'Teenage pregnancy rife in SA' Available at: https://www.news24.com/news24/community-newspaper/express-news/teen-pregnancy-rife-in-sa-20230314.

[426] A traditional Zulu practice in which a man is expected to provide compensation to the family of a girl or woman for impregnating her.

[427] Ibid 6.

approach is essential for addressing negligent and unsafe practices associated with TOP[428].

That Deputy Minister Sibongiseni Dhlomo, at an illegal abortion awareness campaign in 2022, made a public declaration that 'there is no justification for women to correct unplanned pregnancies with illegal and unsafe abortion. Illegal abortion is not the answer[429]' shows how out of touch with reality our health officials are with the plight of South African women needing abortions and how, despite substandard medical and hygiene conditions, illegal abortions are still considered faster and easier to obtain in South Africa[430]. Research alludes that most developing countries struggle to create legislation of adequate quality and, in many cases, no significant effort is made to determine whether a problem can be dealt with effectively under current laws or whether it requires revision or enactment of new legislation[431]. There is a tendency in many African states to make declarations without any real tangible action[432]. In order to prompt meaningful legislative reform, it is critical to embrace Afrocentric realities and alternative and emerging ways of viewing, thinking and acting[433].

Since conscience distinguishes human beings from other living creatures and significantly influences human choice, it alludes to the idea that it should be lionized in terms of human rights. But, the right to freedom of conscience within the medical profession cannot be considered absolute in nature. A constitutional right may be restricted by a law of general application, provided that the limitation is reasonable and justifiable in an open and democratic society[434]. Limiting healthcare providers' rights to conscientiously object to TOP service provision is reasonable and justifiable. The restriction plays a sufficiently

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[428] Ibid 3.
[429] Deputy Minister Sibongiseni Dhlomo. Illegal abortion awareness campaign. 2022. The South African Government. Available at: https://www.gov.za/speeches/deputy-minister-sibongeseni-dhlomo-illegal-abortion-awareness-campaign-12-may-2022.
[430] Ibid 334.
[431] S Lortie 'Providing technical assistance on law drafting' (2010) 31(1) *Statute Law Review*, 1-23.
[432] Ibid 400.
[433] Ibid 387.
[434] Section 36(1) of the Constitution of the Republic of South Africa.

important role in ensuring that women are not prevented or obstructed from exercising their constitutional and legal rights regarding their reproductive decisions. This limitation is not excessive; it employs the least restrictive means by obliging healthcare professionals only to participate in TOPs in emergency cases or when no other practitioner is available. In all other cases, they are required to refer the patient[435]. Still, South Africa urgently requires more effective mechanisms to balance the rights of conscientious objection with those of safe and legal abortion access, ensuring both have a genuinely practicable place within the legal system. Citing Bilchitz[436], "to claim a freedom based on respect for diversity where one fails to respect that very diversity demonstrates a lack of reciprocity and a desire to gain the benefits of liberal societies without subscribing to its basic foundational norms."

5.3 RECOMMENDATIONS

5.3.1 Recommendations for further research in the context of conscientious objection to TOP

Advocates and scholars involved in promoting TOP rights and highlighting its importance in political agendas can contribute meaningfully to the existing literature by conducting focused investigations on conscientious objection within the field of abortion. Empirical studies on abortion serve as the foundation upon which stakeholders can build to validate the imperative for reform. Without such research, it is likely that the current situation will persist. Despite an abundance of literature covering various aspects of abortion, the ever-evolving nature of the topic necessitates ongoing revisiting, evaluation, and analysis. Engaging in focused and informed abortion research in local, regional, and global contexts provides valuable insights into whether legislative reforms are progressive and whether sufficient efforts are being made to improve healthcare and promulgate reproductive rights and justice. Attention must be directed at

[435] Ibid 65.
[436] D Bilchitz 'The tension between freedom of religion and equality in liberal Constitutionalism' (2011) *The Journal of the Helen Suzman Foundation*, 11-18.

legal provisions to ensure that they do not impede the recognition of abortion as a fundamental human right.

A comprehensive research approach, encompassing qualitative and quantitative studies, can investigate TOP refusal based on conscientious objection in state-designated clinics, especially in remote and rural areas. This aims to determine occurrence, prevalence, and individual experiences, serving as an indicator for regions with significant concentrations of conscientious objectors and assessing the effectiveness of these facilities. Limited data on women's experiences in the private health sector underscores the need for studies comparing conscientious objection between private and public sectors, offering a comprehensive perspective on abortion access in South Africa. Studies on the referral process when an objecting provider directs a patient to a willing provider is essential to understanding the effectiveness of conscientious objection frameworks in South Africa.

5.4 RECOMMENDATIONS FOR DOMESTIC LEGISLATIVE INSTRUMENTS

The two main legal instruments that oversee the practice of conscientious objection by healthcare providers involved in abortion service provision need to be revised for clarity and legislative cohesion.

5.4.1 The South African Constitution

In part, the Constitution (Section 36) limits conscientious objection to abortion, primarily through reasonableness and proportionality. While freedom of conscience does not permit denial of TOP *in extremis*, subjectivity remains an issue. Clear directives for everyday and non-emergency situations are needed. Including a dedicated section on women's rights or sexual and reproductive health, covering TOP rights and conscientious objection comprehensively, could enhance and expand constitutional provisions.

5.4.2 The CTOP Act

The CTOP Act should explicitly outline rights and obligations regarding conscientious objection by healthcare providers. A practical approach involves

incorporating a detailed section within the Act, defining the parameters for interpretation and navigation of healthcare provider conscientious objection. This statutory regulation would bolster soft law provisions. Section 10(c) addressing penalties and offences lacks clarity on acts constituting prevention and obstruction. Expanding and clarifying section 10(c) provisions is essential.

5.5 RECOMMENDATIONS FOR THE NATIONAL DEPARTMENT OF HEALTH

While current laws prohibit the exclusion of conscientious objectors from public health employment due to unconstitutionality, the NDoH can proactively monitor their quantity. Preliminary screening of healthcare professionals for views on conscientious objection can be a useful tool, identifying facilities with a high proportion of objectors and allowing the department to address potential shortages of willing abortion providers.

A well-defined and standardised protocol needs to be drafted and adopted amongst all health professions involved in abortion service provision in the public health sector. This needs to include a paper-trail of formalised, documented objection made by a health service provider as well as to whom or where a referral was made for alternative care. Implementation of an official legal document would be necessary for this. This document could provide an explicit map, detailing the time, place, circumstances, and referral process that was undertaken in the context of conscientious objection. The purpose of this is twofold. Firstly, it can show that while conscientious objection is being invoked and upheld, due diligence by the objecting provider is exercised to ensure that it is not simply a ‘pass the buck’ process but rather one that considers the circumstances of the abortion seeker. It must be incumbent on the objecting health provider to make specific alternative arrangements for the abortion patient, including liaising directly with an alternative willing facility or provider. This can help mitigate the burden of inaccessibility on the patient who is denied care. Secondly, it can serve as concrete statistical evidence that can be used by the NDoH to examine the prevalence of conscientious objection in the state sector to ensure fair distribution of healthcare providers, thereby facilitating access. To date, Italy is one of the only places to comprehensively document

rates of conscientious objection. This is because there is a legal obligation of conscientious objectors to formally declare their stance to the Ministry of Health, which then allows accurate prevalence data of this phenomenon to be captured. Paucity of official data in other countries prevents international comparisons[437].

Value clarification workshops by the NDoH targeted towards healthcare providers involved in TOP service provision, can help create a supportive environment for these professionals to explore and reconcile values and issues associated with conscientious objection by reinforcing awareness of the legal and ethical guidelines pertaining to it, and identifying support systems within the professional community to deal with associated emotional and ethical challenges.

Access to TOP services should be optimised and made readily available not only at provincial and district health facilities, but also at tertiary and academic hospitals, primary healthcare clinics and community health centres, as these are key entry points into the public healthcare system. The NDoH should set up regional, district, and satellite clinics/facilities that deal exclusively with sexual and reproductive healthcare provision, similar to the Marie Stopes Clinics that can be found in the private sector. In this way, safe and legal TOP access can almost always be guaranteed. Healthcare professionals employed at these specific facilities should be contractually bound to participate in TOP service provision.

5.6 CIVIC ADVOCACY AND WOMEN'S RIGHTS ACTIVISM – IDENTIFYING OPPORTUNITIES TO CHALLENGE HEALTHCARE PROVIDER CONSCIENTIOUS OBJECTION

Stakeholders involved in abortion research and socio-political advocacy and reform should identify instances where health provider conscientious objection obstructs TOP access and results in negative health outcomes for the abortion seeking patient so that it can be challenged legally. This will help build a

[437] T Autorino, F Mattioli & L Mencarini 'The impact of gynaecologists conscientious objection on abortion access' (2020) 87 *Social Science Research*, 102403.

repertoire of local case law that endeavors to set precedents for limiting conscientious objection to TOP by healthcare providers. Presently, there is a dearth of relevant abortion case law in South Africa. Case law plays an important role in shaping the development of the legal system as the resolution of real-world disputes, guided by the doctrine of *stare decisis*, not only contributes to the creation and refinement of legal principles but also promotes fairness in the application of the law and enhances judicial efficiency. While international law does provide some indicators of how provider conscientious objection to abortion has been dealt with, local cases will have more legislative clout. Marshalling efforts in this regard requires stakeholder partnerships as South African women, especially in rural settings, may not have the knowledge, literacy and resources to seek legal recourse.

5.7 RECOMMENDATIONS FOR REGIONAL AND INTERNATIONAL TREATY MONITORING BODIES

Treaty monitoring bodies should play a more active role in surveillance and supervision of the countries which endorse its provisions. This should not just be done in cases where complaints are submitted to the monitoring bodies. Instead, monitoring bodies can collaborate with local civic advocacy groups and other stakeholders to do ‘random spot checks’ at healthcare facilities involved in TOP provision to assess the regional realities against continental commitments.

5.8 STRENGTHS OF THE STUDY

This study lays the foundation for future research in the domain of TOP and campaigns for clarity, better regulation and potential amendments to existing laws in governing conscientious objection to abortion provision by healthcare providers in the public health sector of South Africa.

5.9 LIMITATIONS OF THE STUDY

The desk-top method of research does not generate primary data and is entirely dependent on pre-existing literature. This had an impact on the depth to which

certain topics could be analysed and discussed. In some instances, the available literature was dated.

5.10 CONCLUSION

Striking a balance between the rights of patients and healthcare practitioners in relation to abortion is intensely challenging. The ideal situation would be for patient and practitioner rights to simply coexist without competing or confounding one another. With regards to TOP and conscientious objection to its provision, this is not the case. Since rights do not exist in a vacuum, it is important to critically appraise both sets of rights in order to grasp how to better navigate the conflicts between them.

Remediating the issues linked with conscientious objection to TOP service provision in South Africa entails more than merely including conscientious clauses within existing legislature and expecting the outcome to be an all-encompassing solution to deep-seated and pervasive socio-political, socio-economic, systemic, and administrative problems. While amending legislation can be an intermediary in changing the status quo, the amendments need to translate into realistic and practicable reforms that filter down to the people most disadvantaged by the practice of conscientious objection, viz, South African girls and women. Conscientious objection currently rests at a constitutional level. Amending the constitution, clearly, is an onerous exercise. Accordingly, short-, intermediate-, and long-term goals need to be established to guide the trajectory of change in the context of conscientious objection to TOP, specifically for healthcare professionals in the public health sector.

While we may be able to draw on examples of legislative reform from a broader milieu and, by extrapolation, evaluate their potential efficacy in the South African context, it is important to understand that generic resolutions on regulating conscientious objection are inadequate. A multi-disciplinary effort between relevant stakeholders is necessary to facilitate meaningful change that is congruent with honouring and upholding sexual and reproductive health rights and justice in the country. For this to happen, targeted strategies to promote

knowledge and empowerment, a critical appreciation of the contextual realities of TOP access in the public sector and the long-term impact and consequences of conscientious objection are required at a grassroot level. Since conscientious objection applies at an individual level and not an organisational one, the state also needs to review the philosophical convictions of those they employ; the distinction between the individual and the institution becomes obscured when abortion seekers are turned away from state-designated TOP facilities on the grounds of conscientious objection.

Conscientious objection to TOP by healthcare providers is not a novel problem. It has existed since the very inception of legalised abortion. For far too long, the state has managed to evade responsibility for this urgent social problem despite the plethora of literature calling for action. If pro-choice advocates lose momentum in pioneering change, legislative complacency together with ineffective solutions will persist, and the chasm of barriers to abortion access will continue to widen.

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APPENDIX A: UKZN INSTITUTIONAL RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

Dr Nivida Ganesh (219080225)
School Of Law
Howard College

Dear Dr Nivida Ganesh,

Original application number: 00023447
Project title: Conscientious objection to termination of pregnancy in South Africa: Analysing the legislative framework governing the rights of patients and healthcare providers.

Exemption from Ethics Review

In response to your application received on 1 December 2023 , your school has indicated that the protocol has been granted **EXEMPTION FROM ETHICS REVIEW.**

Any alteration/s to the exempted research protocol, e.g., Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through an amendment/modification prior to its implementation. The original exemption number must be cited.

For any changes that could result in potential risk, an ethics application including the proposed amendments must be submitted to the relevant UKZN Research Ethics Committee. The original exemption number must be cited.

In case you have further queries, please quote the above reference number.

PLEASE NOTE:
Research data should be securely stored in the discipline/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours sincerely,

MKimble

Mr Matthew Blain Kimble
obo Academic Leader Research
School Of Law

APPENDIX B: INTERNATIONAL AND REGIONAL INSTRUMENTS: TOP RIGHTS FRAMEWORK

INTERNATIONAL INSTRUMENTS: PROVISIONS THAT ARE RELEVANT TO SAFE AND LEGAL TOP ACCESS

UDHR

Article	Synopsis of rights, commitments, protections and obligations
1	Right to human dignity
3	Right to life, liberty and security of the person
5	Protection against cruel, inhumane and degrading treatment
7	Right to equality
25	Right to medical care and necessary social services
27	27(1) Right to benefit from scientific advancement

IESCR

Article	Synopsis of rights, commitments, protections and obligations
1	1(1) Right to self-determination
2	2(1) Commitment to progressive realisation towards achieving human rights 2(2) Right to non-discrimination
3	Right to equality
12	12(1) The right to the highest attainable standard for physical and mental health
15	15(1)(b) Protects the right to benefit from scientific progression and its applications

ICCPR

Article	Synopsis of rights, commitments, protections and obligations
1	1(1) The right to self-determination
2	2(1) Freedom from discrimination
3	Right to equality

6	6(1) The right to life
7	Protects against cruel, inhumane or degrading treatment
9	9(1) The right to liberty and security of persons

CEDAW

ARTICLE	Synopsis of rights, commitments, protections and obligations
1	Protects women against discrimination & promotes fundamental political, social, economic and cultural freedoms
2	2(b-f) To take appropriate measures to modify or abolish existing laws, regulations, customs and practices that discriminate against women.
3	Freedom of equality and equal opportunity
5	5(a) To modify social and cultural behaviours in order to eliminate prejudices, unjust customary practices and gender stereotypes
10	10 (h) Access to health information including advice or information on reproductive health
12	12(1) Elimination of discrimination against women with regards to access to healthcare including reproductive health services.
14	14 (2) Elimination of discrimination against rural women (2)(b) Access to adequate healthcare facilities, information and sexual and reproductive health services
16	16(1)(d) The interest of the child is of paramount importance 16 (1)(e) Protects right for women to determine for themselves the number and spacing of children and access to information to facilitate this decision.

ICERD

Article	Synopsis of rights, commitments, protections and obligations
5e iv)	Right to public health, medical care, social security and social services

ICRPD

Article	Synopsis of rights, commitments, protections and obligations
4(2)	Commitment to progressive realisation towards social, economic and cultural rights
10	Right to life
14	Right to liberty and security of the person
15	Freedom from torture, cruel, inhuman and degrading treatment
17	Right to integrity of the person
25	Access to healthcare

UNCRC

Article	Synopsis of rights, commitments, protections and obligations
3	Best interest of the child- state must provide child with adequate care when parents or others fail to do so
24	Right to the highest attainable standard of health and medical care.

CAT

Article	Synopsis of rights, commitments, protections and obligations
16	Protection against cruel, inhuman or degrading treatment

REGIONAL INSTRUMENTS: PROVISIONS THAT ARE RELEVANT TO SAFE AND LEGAL TOP ACCESS

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

Article	Synopsis of rights, commitments, protections and obligations
2	2.1Promotes combating discrimination against women 2.1(a) Right to equality 2.1(b) Curbing discriminatory practices which endanger health and well-being of women
3	The right to human dignity
4	Protects the right to life, integrity and security of the person
5	Elimination of harmful medical practices 5(a) public awareness of harmful practices 5(c)provision of necessary health services 5(d) protection of women vulnerable to harmful practices and intolerance
8	Access to justice and equal protection before the law 8(f) reform of existing laws and practices in order to promote and protect women's rights
12	12.1(d) Commits to providing access to counselling and rehabilitation services for women who suffer sexual abuse and harassment
14	Health and reproductive rights 14.1(a) right to reproductive autonomy 14.1(b) right to determine whether to have children and the number and spacing of children 14.2(a) Right to adequate, affordable and accessible health services, especially for rural women

	14.2(c) Protects reproductive rights by authorising medical abortion in certain circumstances
19	Right to sustainable development 19(b)inclusion of women in conceptualisation, decision-making, development and implementation of policies and programmes.

Beijing Declaration

Article	Synopsis of rights, commitments, protections and obligations
8	Right to human dignity
13	Commitment towards women's empowerment and participation in the decision-making process
14	Recognises that women's rights are human rights
17	Right for all women to control all aspects of their health including their fertility
19	Commitment to design, implement and monitor policies and programmes, with full participation of women, that bolsters empowerment and advancement of women
24	Commitment to eliminate obstacles that impede empowerment and advancement of women
27	Right to primary health care
30	Access to healthcare Commitment to enhance women's sexual and reproductive health and education
31	Protection of human rights of girls and women

SOUTH AFRICAN CONSTITUTIONAL RIGHTS: PROVISIONS THAT ARE RELEVANT TO SAFE AND LEGAL TOP ACCESS

The Constitution of the Republic of South Africa, 1996

Section	Synopsis of rights, commitments, protections and obligations
9	9 (1): Guarantees that everyone is equal before the Law and has the right to equal protection and benefit of the law. 9 (3): Protects against direct or indirect unfair discrimination by the state on religious conscience belief and other grounds.
10	Right to have human dignity respected and protected
11	Protects the right to life
12	Freedom and security of the person 12 (1)(e): The right not to be treated or punished in a cruel, inhumane or degrading way. 12 (2): The right bodily and psychological integrity. 12 (2)(a): The right to make decisions concerning reproduction. 12 (2)(b): The right to security and control over one's body.
14	Entrenches the right to privacy
15	Freedom of religion, belief and opinion.
27	Section 27: The right to healthcare, food, water and social security. 27 (1)(a): The Right to healthcare services including reproductive healthcare. 27 (2): Obligation on the State to take reasonable legislative and other measures to achieve the progressive realisation of these rights. 27 (3): Protection against being refused emergency medical treatment.
28	The rights of the child 28 (1)(c): The Right to basic Nutrition, Healthcare and Social Services.

	28 (2): The best interest of the Child is of paramount importance in every matter concerning the Child.
29	The right to education
32	The right to access to information