3 Liberal abortion law in practice: The South African example

The legal framework on abortion in South Africa is widely regarded as being radically liberal, owing to the robust reproductive rights provisions enshrined in the Constitution of the Republic of South Africa, 1996 and the Choice on Termination of Pregnancy Act. However, despite the existence of these legal protections, there is a significant divergence between the law and its implementation in practice. Healthcare professionals, including nurses, often refuse to perform or provide abortion care on the grounds of conscientious objection. While the Act does not directly address conscientious objection, the consequences of this gap in the legal framework serve as a significant obstacle to the effective implementation of a liberal abortion law.[1] Without clear laws or guidelines, healthcare providers may act based on their own interpretation of the law, leading to inconsistencies in practice.

This chapter will provide an overview of South Africa's abortion architecture, starting with an exploration of the country's reproductive rights framework, including the Constitution and the Choice on Termination of Pregnancy Act. I will then examine conscientious objection in the context of reproductive healthcare in South Africa, showing the limited regulatory framework and jurisprudence on the subject, laying the groundwork for the subsequent chapters.

1 The 1996 Constitution and reproductive rights

The South African Constitution contains several provisions that protect reproductive rights, including the right to access safe and legal abortion services. One of these provisions is section 12(2), which guarantees all individuals the right to bodily and psychological integrity. This right includes the freedom to make decisions about reproduction, control over one's body, and protection from non-consensual medical experimentation. This constitutional framework recognises the importance of reproductive

1 S Nabaneh 'Abortion and 'conscientious objection' in South Africa: The need for regulation' in E Durojaye, G Mirugi-Mukundi & C Ngwena (eds) *Advancing sexual and reproductive health and rights in Africa: Constraints and opportunities* (2021) 16-34.

choice and affirms women's right to autonomy and bodily integrity. These protections, as indicated in the Preamble, are rooted in the principles of equality, freedom, dignity, and social justice, and apply to all individuals regardless of race or gender.

In 2016, the Constitutional Court of South Africa delivered a ruling on the case of *AB v Minister of Social Development* (*AB* case),[2] which clarified the interpretation of section 12(2) of the Constitution on the right to physical and psychological integrity. AB was a single woman who had undergone 18 IVF cycles, between 2001 and 2011, in an attempt to have a child but was unsuccessful. She then entered into a surrogacy agreement, but was informed that as a single woman, she was not legally entitled to do so under section 294 of the Children's Act 38 of 2005.[3] AB, along with the Surrogacy Group and the Centre for Child Law, challenged the constitutionality of the provision, arguing that it violated her reproductive autonomy, privacy, and access to healthcare. The Minister of Social Development argued that AB's need could be met through adoption and that the provision was necessary to prevent commercial surrogacy and the creation of 'designer' babies.[4] However, the High Court declared section 294 of the Children's Act unconstitutional, as it violated AB's constitutional rights to equality, human dignity, reproductive autonomy, privacy, and healthcare.[5] This case clarified that the decision to have a child through surrogacy is not a constitutionally protected right of reproductive autonomy, but it affirmed the importance of protecting an individual's bodily and psychological integrity.

After the High Court declared section 294 of the Children's Act unconstitutional in the *AB* case, AB and the Surrogacy Group appealed to the Constitutional Court. The petitioner argued that autonomy is a key value of the Constitution and that individuals have the right to choose how they reproduce without state interference. The Minister, however, argued that section 294 of the Children's Act did not violate AB's rights and any limitations on these rights were reasonable and justifiable in an open and democratic society based on human dignity, equality, and freedom.

2 2017 (3) SA 570 (CC).

3 Section 294 reads: 'No surrogate motherhood agreement is valid unless the conception of the child contemplated in the agreement is to be effected by the use of the gametes of both commissioning parents or, if that is not possible due to biological, medical or other valid reasons, the gamete of at least one of the commissioning parents or, where the commissioning parent is a single person, the gamete of that person.'

4 *AB* case (n 2) paras 3-12.

5 As per *AB v Minister of Social Development* 2016 (2) SA 27 (GP) (High Court judgment).

The majority judgment in the *AB* case emphasised the need for a broad interpretation of section 12(2)(a) of the Constitution, despite it being part of a collection of rights relating to freedom and security of the person.[6] However, the Court's interpretation of section 12 as a negative protection of physical integrity was influenced by its previous interpretation of section 11 of the Interim Constitution in *Ferrerira v Levin NO*,[7] which was focused on detention without trial, torture, inhumane, and degrading treatment. The Court interpreted the section as a negative right, thereby asserting that bodily integrity does not extend to psychological harm, since the applicant's body would not be physically affected by the anticipated pregnancy.[8] Consequently, the decision to have a child via surrogacy would not be viewed as constitutionally protected under the right to reproductive autonomy.

The Constitutional Court's recognition of the significance of bodily and psychological integrity as crucial for women who opt for termination of pregnancy is praiseworthy.[9] However, the interpretation of the central meaning of section 12(2)(a) does not account for the intersectional context of women's reproductive decision-making. The Court's understanding of bodily integrity as a negative right, as well as its exclusion of psychological harm from its ambit, fails to consider the complexities of women's lived experiences, especially those belonging to marginalised communities. The ruling's narrow interpretation could potentially exacerbate existing disparities and perpetuate the marginalisation of certain groups, rather than promoting reproductive autonomy and equality for all women.

In terms of access to healthcare services, section 27 of the South African Constitution states that everyone has the right to access reproductive healthcare. The section further stipulates that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right. Additionally, the provision obligates the state to ensure that no one is refused emergency medical treatment.

South Africa's Constitution guarantees socio-economic rights, including the right to healthcare services, and the country has progressive jurisprudence on holding the government accountable for its obligations

6 *AB* case (n 2) para 63.

7 *Ferreira v Levin NO* 1996 (1) SA 984 (CC).

8 *Ferrerira v Levin NO* (n 7) para 76.

9 See *H v Fetal Assessment Centre* 2015 (2) SA 193 (CC) para 1; *Christian Lawyers' Association v Minister of Health* 2005 (1) SA 509 (T) at 518C-F.

towards the realisation of these rights.[10] For instance, in the *Minister of Health v Treatment Action Campaign* (*TAC* case),[11] the government was found to have failed in providing Nevirapine for people living with HIV in public hospitals. However, the judgment has been criticised for marginalising the reproductive autonomy of black women living with HIV. Catherine Albertyn argues that the judgment fails to make any meaningful reference to the reproductive autonomy of women in public hospitals, beyond a single mention of hospital capacity.[12]

Section 27(2) of the Constitution also places a positive duty on the state to progressively realise socio-economic rights based on available resources. In *Soobramoney v Minister of Health* (*Soobramoney* case),[13] the Constitutional Court held that the state has an obligation to take concrete steps in order to evaluate whether it is discharging its obligation to progressively realise socio-economic rights, including reproductive healthcare.[14] In *Government of the Republic of South Africa v Grootboom* (*Grootboom* case),[15] the Constitutional Court identified three instances of unreasonableness in relation to this obligation: when the state has not adopted any measures; when the adopted measures and policies are exclusionary or limited in scope; and when the state does not assess its policies to ensure the progressive realisation of socio-economic rights.[16] The Court further held that legislative measures are not sufficient in themselves to comply with the constitutional obligations envisaged under section 27 of the Constitution.[17] Yacoob J in asserting this approach held that:

> [T]he State is required to take reasonable legislative and other measures. Legislative measures by themselves are not likely to constitute constitutional compliance. Mere legislation is not enough. The State is obliged to act to achieve the intended result, and the legislative measures will invariably have to be supported by appropriate, well-directed policies and programmes

10 See S Liebenberg 'South Africa' in M Langford (ed) *Social rights jurisprudence: Emerging trends in international and comparative law* (2008) 75-101.

11 *Minister of Health v Treatment Action Campaign* 2001 (5) SA 721 (CC).

12 C Albertyn 'Abortion, reproductive rights and the possibilities of reproductive justice in South African courts' (2019) 1 *University of Oxford Human Rights Hub Journal* 87 at 112-113.

13 1998 (1) SA 765 (CC) on the obligation of the state to meet its obligations to progressively realise the constitutional right to housing within available resources.

14 *Soobramoney* case, para 11.

15 2001 (1) SA 46 (CC).

16 *Grootboom* case, para 67.

17 *Grootboom* case, para 42.

> implemented by the Executive. These policies and programmes must be reasonable both in their conception and their implementation. The formulation of a programme is only the first stage in meeting the State's obligations. The programme must also be reasonably implemented. An otherwise reasonable programme that is not implemented reasonably will not constitute compliance with the State's obligations.[18]

The state's obligation to progressively realise socio-economic rights, including the right to healthcare services, cannot be met by mere legislative measures. Rather, the state must implement well-designed programmes that are backed by resources and periodically review its policies to ensure their relevance and practicability. This is because the nature and context of society are constantly changing, and as such, state's policies must adapt to these changes to ensure that it is meeting its constitutional obligations.

In other words, the state has an obligation to provide reproductive healthcare services to those who cannot afford it and to ensure that access to these services is not obstructed without justifiable reasons. Any refusal of care would be viewed as unjustifiable and thus would be considered a violation of the individual's right to healthcare services, as guaranteed under section 27(1)(a) of the Constitution.

The interconnectedness of reproductive autonomy, access to healthcare, and other fundamental rights is essential in ensuring the rule of law and respect for human dignity in South Africa.[19] This notion is supported by the UN Working Group on the Issue of Discrimination against Women in Law and in Practice, which highlights the importance of a woman's right to make independent decisions regarding her body and reproductive functions.[20] This right is fundamental to achieving equality, privacy, physical and psychological integrity, and the enjoyment of other rights. Therefore, denying, or obstructing access to reproductive healthcare services, including abortion, would constitute a violation of multiple fundamental rights and guarantees of equality.

The recognition of equality to include the full and equal enjoyment of all rights and freedoms is guaranteed in section 9(1) of the Constitution. This understanding of equality recognises that in order to achieve true equality, different treatment may be necessary for certain groups who have

18 *Grootboom* case, para 42.

19 *S v Makwanyane* 1995 (3) SA 391 (CC) para 313.

20 Human Rights Council 'Report of the UN Working Group on the Issue of Discrimination against Women in Law and in Practice' A/HRC/28/46 (2018) para 38.

historically faced discrimination and marginalisation.[21] This is particularly relevant in the context of reproductive healthcare, where access and treatment may need to be tailored to the specific needs and circumstances of women, particularly those who are historically disadvantaged. In this regard, the right to equality should be interpreted in a way that recognises and addresses the systemic inequalities faced by certain groups, including women.

In both international and national legal systems, the idea of substantive equality has gained prominence. According to this principle, equality is not just about treating everyone the same, but also about addressing the larger societal context and differences among individuals. In other words, substantive equality recognises that people are not always in the same situations and therefore, treating them identically does not necessarily result in equality. Instead, General Comment 18, issued by the UN Human Rights Committee, highlights that the principle of equality may require states to take affirmative action to eliminate discriminatory conditions prohibited by the ICCPR.[22] Amartya Sen's works also supports the notion of substantive equality by arguing that human capability determination must extend beyond assessing available goods and services to examining the social arrangements that shape each person's ability.[23] This is particularly important in addressing historical and structural inequalities that may prevent certain groups from enjoying their rights and freedoms on an equal basis.

In South Africa, the Constitutional Court jurisprudential developments[24] has also embraced the concept of substantive equality, emphasising the need to address systemic discrimination and to promote transformative change given the South African social and historical context of persisting inequalities arising from the remnants of structural oppression of apartheid.[25] In *Soobramoney,* the Constitutional Court emphasised the

21 *President of the Republic of South Africa & Another v Hugo* 1997 (4) SA 1 (CC).

22 Human Rights Instruments: Volume I: Compilation of General Comments and General Recommendations adopted by Human Rights Treaty Bodies' 27 May 2008, UN Doc HRI/GEN/1/Rev.9 (Vol. I) (2008) para 8.

23 A Sen *Inequality reexamined* (1992) 23.

24 These include *President of the Republic of South Africa v Hugo* 1997 (6) BCLR 708 (CC); *National Coalition of Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) para 74.

25 C Albertyn 'Equality' in MH Cheadle et al *South African constitutional law: The Bill of Rights* (2002) 53; T Loenen 'The equality clause in the South African Constitution: Some remarks from a comparative perspective' (1997) 13 *South African Journal of Human Rights* 405. See also M Wesson 'Equality and social rights: an exploration in light of the South African Constitution' (2007) *Public Law* 748.

existence of great disparities in wealth and living conditions, which are detrimental to human dignity, freedom, and equality. These conditions persist despite the country's new constitutional order that committed to address and transform them.[26]

Moreover, gender-based inequality also exists due to women's gender roles, as pointed out by Justice Goldstone in the *Hugo* case.[27] The burden of rearing children is challenging, particularly for women without skills or financial resources, making it harder for them to compete in the labour market. This hardship is further exacerbated by the failure of fathers to contribute their share of the financial and social burden of child-rearing.[28] Women in South Africa continue to have less opportunities than men, unable to fully partake in the economy due in part to the characterisation and distinction of labour along the lines of gender in the household.[29] South Africa remains one of the most unequal societies in the world.[30] In a new World Bank report on poverty and inequality in South Africa, the authors claim the persistence of gender disparities in South Africa's labour marker are an enduring legacy of apartheid.[31] The consequences of such a cycle of gender inequality is explained by Lynn Freedman:

> Inequality – imbalances in power and access to resources – makes the control of women's reproduction by others both more possible and more likely. At the same time, such external control of reproduction and sexuality – and thus of women and their place in society – reinforces of inequality.[32]

The pursuit of equality is not limited to political rights but also extends to socio-economic status, especially in the context of historical inequalities based on race and gender. To achieve this, states must fulfil their obligations to address disparities in access to healthcare services. The Guttmacher-Lancet Commission's 2018 report emphasises the importance of reproductive rights in attaining gender equality and economic

26 *Soobramoney* (n 13) para 8.

27 *Hugo* (n 21) para 38.

28 As above.

29 *Hugo* (n 21) para 38.

30 See V Sulla & P Zikhali 'Overcoming poverty and inequality in South Africa: An assessment of drivers, constraints and opportunities' (2018) http://documents.worldbank.org/curated/en/530481521735906534/pdf/124521-REV-OUO-South-Africa-Poverty-and-Inequality-Assessment-Report-2018-FINAL-WEB.pdf (accessed 2 September 2019).

31 Sulla & Zikhali (n 30) xiv.

32 LP Freedman 'Censorship and manipulation of family planning information: An issue of human rights and women's health' in JM Mann et al (eds) *Health and human rights: A reader* (1999) 150.

development.[33] Access to safe abortion is a key aspect of women's control over their own bodies and contributes to their ability to participate equally in society. Therefore, the concept of equality centres around fairness and justice for all citizens within a liberal political system. Charles Ngwena in discussing the challenges and struggles involved in protecting and promoting equality within such a system, notes that to truly prioritise equality, it is essential to take actions to safeguard the rights of marginalised groups by dismantling unconstitutional or unnecessary barriers that hinder their access to legal rights.[34] These barriers can delay or completely prevent these individuals from exercising their rights, which only serves to maintain the current unequal system, particularly in respect to access to healthcare.

Section 27 of the Constitution aims to achieve substantive equality in relation to access to healthcare. This is because the ability to control one's own reproduction, as guaranteed in section 12(2) of the Constitution, is a fundamental aspect of human dignity. Section 10 of the Constitution reinforces this by stating that everyone has inherent dignity and the right to have it respected and protected. These principles of equality and dignity are closely intertwined, with both recognising the inherent worth and value of every human being.[35] Justice Chaskalson has aptly explained the relationship between equality and dignity, noting that substantive equality acknowledges the need to protect and promote the inherent worth and dignity of every person.[36] This understanding of substantive equality has been crucial in shaping the approach that the Constitutional Court has taken in interpreting and applying the equality clause of our Constitution. In the *Hugo* case, the Constitutional Court held that:

> At the heart of the prohibition of unfair discrimination lies a recognition that the purpose of our new constitutional and democratic order is the establishment of a society in which all human beings will be accorded equal dignity and respect regardless of their membership of particular groups. The achievement of such a society in the context of our deeply inegalitarian past

33 AM Starrs et al 'Accelerate progress – Sexual and reproductive health and rights for all: Report of the Guttmacher – Lancet Commission' (2018) 391 *Lancet* 2642.

34 C Ngwena 'Taking women's rights seriously: Using human rights to require state implementation of domestic abortion laws in African countries with reference to Uganda' (2016) 60 *Journal of African Law* 133. See also C Ngwena *What is Africanness? Contesting nativism in race, culture and sexualities* (2018) 248-250.

35 *National Coalition of Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) para 42.

36 A Chaskalson 'The third Bram Fischer lecture – Human dignity as a foundational value of our constitutional order' (2000) 16 *South African Journal on Human Rights* 203.

> will not be easy but that is the goal of the Constitution should not be forgotten or overlooked.[37]

This approach is particularly important in addressing systemic inequality and discrimination that is often hidden behind seemingly neutral laws or policies. The issue of women's control over their reproduction cannot be viewed in isolation. It is a complex matter that involves a range of social and economic relationships that exist at all levels of society. It is therefore important to move beyond a narrow focus on individual choice and rights, to a broader context of reproductive decision-making that takes into account the social, economic, and political factors that shape women's reproductive choices. To realise women's reproductive rights, it is important to recognise the vital role that health professionals play in protecting and promoting these rights, including the right to access safe and legal abortion services. Health professionals are often the gatekeepers of reproductive healthcare services and have a critical responsibility to ensure that women's reproductive rights are respected and protected.

Despite the importance of ensuring that women have access to safe and legal abortion services, healthcare workers exercise conscientious objection, finding support in the Constitution. The South African Constitution provides for the implied right to conscientious objection, as outlined in section 15(1), which guarantees everyone the right to freedom of conscience, religion, thought, belief, and opinion. However, like other constitutional rights, the right to conscientious objection is not absolute and is subject to limitations under section 36 of the Constitution. The Constitutional Court has recognised the importance of respecting diversity and treating everyone with equal concern and respect, as the essence of equality.[38] In determining the limits of the right to conscientious objection, a balancing act is required between the rights of the healthcare worker and the rights of the patient.

Section 36 imposes a duty on healthcare workers to provide medical care in case of a medical emergency and also enshrines an obligation to provide information. It is only applicable to those directly involved in the procedure, and any limitation of the right to conscientious objection must be based on a compelling and legitimate reason. The use of section 36 ensures that a balance is struck between the rights of the healthcare worker and the rights of the patient.

37 *Hugo* case (n 21) para 41.

38 *Christian Education of South Africa v Minister of Education* 2000 (10) BCLR 1051 (CC) para 42.

2 The Choice on Termination of Pregnancy Act

South Africa's Choice on Termination of Pregnancy Act 92 of 1996 is widely regarded as one of the most liberal and progressive laws on abortion. The Act was a response to the high mortality rate among South African women who were seeking unsafe, backstreet abortions.[39] It was also the result of feminist political action, which had been advocating for safe and legal abortion services for women.[40] The Act represented a significant departure from the 1975 Sterilization Act, which had strict conditions for permitting abortion and complex administrative procedures, making it difficult for women to access safe abortion services.[41]

Under the Act, abortion is available on demand up to 12 weeks of pregnancy. Beyond 12 weeks, the Act allows for abortion in certain circumstances such as if the pregnancy poses a risk to the woman's health, or in cases of rape, incest, or foetal abnormality. In addition to the provisions on the circumstances for accessing abortion, the Act also provides for non-directive counselling and information for women seeking abortion services. This is essential to ensure that women can make informed decisions about their reproductive health, free from coercion or undue influence. Furthermore, the Act ensures that all information related to the abortion, including the woman's identity, is kept confidential, thereby respecting her right to privacy.

The Act also sets out clear guidelines for the regulation and monitoring of abortion services, including the training of healthcare providers and licensing of facilities. These provisions are crucial for ensuring that women can access safe and high-quality abortion services, thereby preventing unnecessary deaths and complications from unsafe procedures.

2.1 Provision of abortion services

2.1.1 Abortion providers: Training and certification

In an effort to improve women's access to abortion services, the Choice on Termination of Pregnancy Act was amended in 2008 to allow registered

39 RE Mhlanga 'Abortion: Developments and impact in South Africa' (2003) 67 *British Medical Bulletin* 115; and R Hodes 'The culture of illegal abortion in South Africa' (2016) 42 *Journal of Southern African Studies* 79.

40 M Mbali & S Mthembu 'The politics of women's health in South Africa' (2012) 26 *Agenda: Empowering Women for Gender Equity* 9.

41 For a discussion on abortion during apartheid, see SM Klausen *Abortion under apartheid: Nationalism, sexuality, and women's reproductive rights in South Africa* (2015).

nurses with the required accreditation to perform the procedure during the first trimester.[42] This expansion of the role of nurses is seen as a significant step towards ensuring access to safe and legal termination of pregnancy care.[43] It is important to note that midwives were already authorised to provide such services since 1996.[44] As the legal scope of practice for both nurses and midwives are similar under South Africa's abortion law, the term 'nurses' used in this book encompasses midwives with the appropriate training.

Training and certification are necessary to ensure that the procedures are conducted safely and with the required level of quality.[45] The Choice on Termination of Pregnancy Act specifies that only individuals who have received the appropriate training may perform an abortion. The South African Nursing Council mandates that nurses undergo 160 hours of training, divided into 80 hours of theoretical training and 80 hours of practical training supervised by an experienced provider in a designated hospital, in order to be certified to perform abortions.[46] Without this clinical training, nurses are not authorised to perform termination of pregnancies. Midwives, on the other hand, can undergo a Midwifery Abortion Care training programme that was created as part of the National Abortion Care Programme in 1998 by the Department of Health in collaboration with various organisations, including the Planned Parenthood Association of South Africa, the Reproductive Health Research Unit of the University of the Witwatersrand, the Reproductive Rights Alliance, and Ipas South Africa.[47]

Additionally, nurse providers in the private sector are typically trained in private facilities and work in private abortion clinics. However, some nurses have also been trained in the public sector and later move to

42 The first amendment passed in 2004 was challenged on the grounds of non-adherence to the process of provincial consultation for the amendment in *Doctors for Life International v Speaker of the National Assembly* 2006 (6) SA 416 CC. The Constitutional Court suspended the implementation of the amendment for 18 months to follow due process. It was eventually returned to Parliament and the Choice on Termination of Pregnancy Amendment Act 1 of 2008 was passed.

43 WHO *Safe abortion: technical and policy guidance for health systems* 2nd ed (2012).

44 Sec 2(2) of the Act.

45 World Health Organization (WHO) 'Health worker roles in providing safe abortion care and post-abortion contraception' (2015).

46 South African Nursing Council. See also Ipas 'Learner manual: Management of termination of pregnancy, incomplete abortion and related reproductive health matters' (n.d).

47 K Dickson-Tetteh & DL Billings 'Abortion care services provided by registered midwives in South Africa' (2002) 28 *International Family Planning Perspectives* 145.

private clinics or set up their own abortion clinics. It is noteworthy that unlike nurses, doctors are not required to undergo any specific training or certification to perform abortion services.

2.1.2 Abortion procedures

In South Africa, women have the option to terminate their pregnancy using medications, surgery, or a combination of both. Medication abortions, which involve taking pills, are typically performed during the early stages of pregnancy, up to nine weeks.[48] For later-stage pregnancies, surgical procedures are often necessary.[49] Women who are less than 12 weeks pregnant can have abortions performed by both doctors and nurses who have been trained as abortion providers. However, for second-trimester abortions, only doctors are permitted to perform the procedure, with the support of nursing staff.

As the provision of abortion services has evolved globally, there has been a shift away from the legal or illegal dichotomy to a categorisation of 'safe, less safe, and least safe' procedures.[50] The World Health Organization (WHO) defines a safe abortion as one performed by a trained provider using an endorsed method.[51] A 'less safe' abortion may involve the use of a method that is not recommended, while a 'least safe' abortion involves untrained providers using dangerous methods. It is estimated that globally, 55 per cent of abortions are safe, 31 per cent are less safe, and 14 per cent are least safe.[52]

South Africa demonstrates the existence of all three categories of safe, less safe, and least safe abortions. Despite the illegality of informal abortions, the availability of black-market Misoprostol and instructions from informal abortion providers have made them relatively safe. The

48 See D Constant et al 'Assessment of completion of early medical abortion using a text questionnaire on mobile phones compared to a self-administered paper questionnaire among women attending four clinics, Cape Town, South Africa' (2015) 22 *Reproductive Health Matters* 83. For an analysis of the legal regime on medical abortion, see P Skuster 'How laws fail the promise of medical abortion: A global look' (2017) XVIII *Georgetown Journal of Gender and the Law* 379.

49 For more in-depth analysis, see D Grossman et al 'Surgical and medical second trimester abortion in South Africa: A cross-sectional study' (2011) 11 *BMC Health Services Research* 1; B Winikoff & WR Sheldon 'Use of medicines changing the face of abortion' (2012) 38 *International Perspectives on Sexual & Reproductive Health* 164.

50 B Gantra et al 'Global, regional and subregional classification of abortions by safety, 2010–14: Estimates from a Bayesian hierarchical model' (2017) 390 *Lancet* 2372.

51 See World Health Organization (WHO) 'Health worker roles in providing safe abortion care and post-abortion contraception' (2015).

52 Gantra et al (n 50) 2372.

providers also inform clients to seek help in health facilities in case of complications, ensuring access to medical care in case of a medical emergency. Additionally, there are unlicensed or undesignated private abortion clinics that provide safe abortions, meeting the criteria for safe abortion laid down by WHO. These clinics are operated by appropriately trained healthcare professionals who use appropriate methods for performing abortions.

2.1.3 The health system

The public health sector, managed by the government, bears the primary responsibility for providing abortion services in facilities that are officially 'designated'[53] and accredited by the National Department of Health. Private health facilities, upon certification, are also authorised to provide abortion services. The private sector in this context encompasses all private nurse practitioners and private abortion health facilities, such as clinics run by non-profit organisations or owned and operated by nurse providers. By making provision for both public and private healthcare providers, South Africa's abortion laws seek to ensure that women can access safe, legal, and affordable abortion services, regardless of their socio-economic status.

In South Africa, there are general inequalities in the healthcare system and uneven distribution of human resources for health across provinces, between urban and rural areas, and between the public and private sectors.[54] For instance, rural areas, which make up 43.6 per cent of the population, are served by only 12 per cent of the country's doctors and 19 per cent of nurses.[55] These inequalities have major consequences for the availability of services in the country, including abortion services. For example, a study found that the richest province, Western Cape, has 60 private hospitals, 55 public hospitals, and 1 246 doctors for a population of 4.8 million, compared to the poorest province, Limpopo, which has only

53 A facility that meets the requirements to provide termination of pregnancy services in terms of section 3 of the Choice on Termination of Pregnancy Act and certified by the Department of Health.

54 See African Institute for Health and Leadership Development 'From brain drain to brain gain: Nursing and midwifery migration trends in the South African health system' (2017) 5 & 18 https://www.who.int/workforcealliance/brain-drain-brain-gain/17-449_South_Africa_Case_Study_Nursing_and_Midwifery-2017-12-06.pdf (accessed 6 March 2019).

55 National Department of Health 'Human Resources for Health South Africa 2012/2013-2016/2017' (2011) 3.

six private hospitals, 44 public hospitals, and 882 doctors for a population of 5.7 million.[56]

Abortion services in public health facilities are provided free of charge, whereas private clinics charge fees that vary based on the gestational age and type of abortion procedure, ranging from 800 ZAR to 1 500 ZAR (approximately $55 to $100).[57] While private healthcare may provide access to safe abortions for women who can afford it, this raises concerns about unequal access to services between those who can pay and those who cannot.

2.2 The defence of abortion rights

The legalisation of abortion in South Africa has faced opposition from conservative groups who argue that it violates the constitutional right to life of the foetus. Political parties like the African Christian Democratic Party (ACDP), Pan Africanist Congress (PAC) and the New National Party (NNP) have fuelled this opposition.[58] In the case of *Christian Lawyers Association v National Minister of Health*,[59] the Act's constitutionality was challenged on these grounds. However, the Pretoria High Court rejected the argument, stating that the foetuses were not rights-bearers, and the provisions of the Bill of Rights did not envision this.[60] Despite this decision, the pro-life movement continues to be vocal in South Africa.

In 2004, the Christian Lawyers Association challenged sections 5(2) and (3) of the Act, which allow adolescent girls to choose abortion without the consent or consultation of parents.[61] The High Court dismissed the challenge, citing the constitutional rights of girls including reproductive freedom, dignity, privacy, and access to reproductive healthcare.[62]

In the same year, Doctors for Life International challenged an attempt to amend the Act, arguing that the process did not follow proper

56 D Stuckler et al 'Health care capacity and allocations among South Africa's Provinces: Infrastructure/inequality traps after the end of apartheid' (2011) 101 *American Journal of Public Health* 169.

57 These prices were obtained from observations when I visited private abortion clinics.

58 Reproductive Rights Alliance 'Media coverage on termination of pregnancy over January to August 1999' (1999) 3 *Barometer* 15.

59 *Christian Lawyers Association v National Minister of Health* 1998 (4) SA 1113 (T).

60 As above.

61 *Christian Lawyers Association v National Minister of Health* 2005 (1) SA 509 (T).

62 *Christian Lawyers* (n 61) 519.

consultation rules at the provincial level.[63] This led to the Constitutional Court suspending the implementation of the amended Act for 18 months, allowing the state to follow due process. The Choice on Termination of Pregnancy Amendment Act 1 of 2008 was eventually passed, expanding the list of medical personnel who can perform abortions during the first trimester. Registered nurses and midwives who have completed prescribed abortion training can now also perform abortions, in addition to medical practitioners.

3 South Africa's abortion architecture and conscientious objection

One notable weakness of the Choice on Termination of Pregnancy Act is the absence of a clear provision concerning conscientious objection among healthcare providers. This is a contrast to the 1975 Abortion and Sterilization Act, which granted physicians the right to decline performing abortions. Specifically, section 9 of the older Act allowed doctors to refuse to participate in abortion procedures on the grounds of their beliefs or conscience. It states:

> A medical practitioner (other than a medical practitioner referred to in section 6(1)), a nurse or any person employed in any other capacity at an institution referred to in section 5(1) shall, notwithstanding any contract or the provisions of any other law, not be obliged to participate in or assist with any abortion contemplated in section 3 or any sterilization contemplated in section 4.

This particular section allowed for conscientious objection without restrictions.

In 1995, when the Ad Hoc Select Committee on Abortion and Sterilisation was set up, there were wide public consultations and inputs were received from health workers, lawyers, government professionals, Non-Governmental Organisations (NGOs), community-based organisations and women.[64] The Women's Health Conference held in 1994 provided written input to the Committee, proposing several recommendations specifically for healthcare professionals, including the following:

> Health workers may refuse to participate in abortions if they have conscientious objection to taking part. However, women should always be referred to

63 *Doctors for Life International v Speaker of the National Assembly* 2006 (6) SA 416 (CC).

64 Choice on Termination of Pregnancy Bill – Second reading 4763.

> alternative persons or institutions who do provide abortion services. Health authorities must ensure the provision of accessible abortion services.[65]

Hence, clause 8 on conscientious objection was included in an earlier draft of the Bill, which provides as follows:

> (1) Subject to subsection (2), no person shall be under a legal duty, whether by contract or any statutory or any other legal requirement, to participate in the termination of pregnancy if he or she has a conscientious objection to termination of pregnancy.
> (2) The provisions of subsection (1) shall not affect any duty to participate in treatment which is necessary to save the life or to prevent serious injury to the health of the woman, or to alleviate pain.
> (3) Any person having an objection referred to in subsection (1) shall be obliged to refer a woman who wants her pregnancy to be terminated to a medical practitioner or a registered midwife, as the case may be, who shall terminate the pregnancy.[66]

During the second reading debate of the Choice on Termination of Pregnancy Act on 29 October 1996, the conscience clause was heavily debated among members of the Portfolio Committee on Health. The chairperson of the Portfolio Committee on Health reported the following:

> Where health workers are concerned, the committee has heeded the sentiments expressed by organisations such as *Doctors for Life*, who argued that a statutory obligation to refer a patient to another doctor would constitute complicity for some health workers opposed to abortion. We have therefore deleted the original clause 8 and wish to stress instead the importance of women's right to access information on available services.[67]

It was largely believed that the framers of the Act thought that a conscience clause was unnecessary as it was already implicitly provided for in the Constitution.[68] This amendment partially aligned with the proposal of the New National Party (NNP), the former governing Afrikaner party, which called for the removal of the clause requiring healthcare professionals with a conscientious objection to performing an abortion

65 Women's Health Policy Conference 'Policy document on abortion' (1994) 4. See also, Reproductive Rights Alliance 'Submission to the Portfolio Committee on Health on the Termination of Pregnancy Bill' (1996) (on file with author).

66 C Ngwena 'Conscientious objection and legal abortion in South Africa: Delineating the parameters' (2003) 28 *Journal for Juridical Science* 8.

67 Emphasis added. Choice on Termination of Pregnancy Bill – Second reading 4764.

68 Interview with feminist lawyer via Email dated 29 March 2019.

to refer the patient, as it was seen as a violation of their constitutional right of freedom of conscience and belief.[69] However, the party also raised concerns that the amendment did not go far enough to protect the rights of healthcare providers with conscientious objections, and that it may lead to discrimination against them in the workplace, noting that:

> The ANC threw the baby out with the bathwater and also removed the clause in the Bill which protected medical personnel of the Department of Health who are not prepared to perform these abortions.[70]

The Inkatha Freedom Party (IFP) welcomed the removal of the clause requiring healthcare professionals with a conscientious objection to refer patients for abortions, however, they expressed a preference for the Bill to explicitly state that conscientious objectors would be respected and protected.[71] The IFP made this point because they remained concerned about tolerance for plural morality:

> The Bill now requires that a woman be informed of her rights by a dissenting doctor. Why should the Gender Commission or the Constitutional Court not be confronted with instances of women claiming precedence for their right to freedom of the person over a doctor's or a midwife's right to freedom of conscience, particularly in small clinics and hospitals which are not staffed with consenting practitioners?[72]

The Democratic Party (DP), now the Democratic Alliance (DA), despite their support for the Bill, expressed concern over the removal of the conscience clause.[73] They argued that the Constitution already provides for conscientious objection, but the removal of this section from the Bill may put doctors and midwives who object to termination of pregnancies on the grounds of conscience under severe pressure. They feared that these healthcare professionals may be coerced into performing abortions against their will, which would violate their fundamental right to freedom of conscience and belief.

The African Christian Democratic Front (ACDF) strongly objected to the deletion of clause 8 on conscientious objection, arguing that:

69 Choice on Termination of Pregnancy Bill – Second reading 4769.

70 Choice on Termination of Pregnancy Bill – Second reading 4769.

71 Choice on Termination of Pregnancy Bill – Second reading 4774.

72 As above.

73 Choice on Termination of Pregnancy Bill – Second reading 4781.

> All medical doctors must be informed of their right to refuse to perform any abortion and to refuse to refer pregnant girls to abortion slaughterhouses. It is not true that *Doctors for Life* requested the deletion of clause 8 in *toto* – the committee chairperson will do well to listen attentively to this. They only asked for the deletion of clause 8(3), which required doctors to refer pregnant women to another medical practitioner.[74]

Another MP interjected:

> This bill could destroy the profession of medicine, which is founded on principles for reverence for life, by forcing nurses to be accessories to the killing of unborn child. The Choice on Termination of Pregnancy Bill mocks the oath taken by nurses … Midwives especially are health professionals, who most intimately deal with nurturing a pregnancy towards a successful outcome or birth. For nurses and midwives to be charged with assisting in or being responsible for terminating a pregnancy, I believe, will undermine the trust that women have in them, and such trust forms the cornerstone of medical and midwifery practice.[75]

The consensus was that doctors and nurses who do not wish to participate in termination of pregnancies should be protected in the proposed legislation. In the same line, another MP proposed that:

> There should be a clause in the Bill stating clearly that any health personnel who refuse to participate in terminations should not be prosecuted or discriminated against in anyway whatsoever.[76]

Various other reasons have been put forward to explain why the clause on conscientious objection was removed from Act. One reason was that this decision was made in exchange for a block vote by the ANC, backed by the Congress of South African Trade Unions, women's organisations, and the South African Communist Party.[77] Another reason was that its removal would avoid controversy and legal challenges. Patricia De Lille, speaking on behalf of the Pan Africanist Congress (PAC), also expressed concern regarding the potential impact of removing the clause, highlighting the need to protect the rights of healthcare professionals exercising conscientious objection while still ensuring access to safe and legal abortions for those who choose to undergo the procedure. She noted:

74 Choice on Termination of Pregnancy Bill – Second reading 4784.

75 Choice on Termination of Pregnancy Bill – Second reading 4787.

76 Choice on Termination of Pregnancy Bill – Second reading 4785.

77 Reproductive Rights Alliance 'The journey to reproductive choice in South Africa' (2006) (on file with author).

> The right to conscientious objection is implied in the Bill, but nobody has the right to prevent a legal abortion … The PAC does not welcome the removal of clause 8 relating to conscientious objectors and warns the ANC that this might mean a referral to the Constitutional Court with all that implies. This could further delay the implementation of the Bill.[78]

The absence of an explicit provision on conscientious objection has instead become a major obstacle to the implementation of the law in practice.

A feminist lawyer working on sexual and reproductive health and rights previously stated that the conscience clause was thought to be unnecessary when the Act was framed due to its implicit provision in the Constitution. In her words, 'there was no need for a conscience clause based on the wording of the Act. Unfortunately, this has failed with time and place'.[79] The Reproductive Rights Alliance had also made submissions to Parliamentary Hearings in June 2000, proposing that if a conscience clause is included, it should not obstruct women's access to termination of pregnancy services.[80] They further argued that where there are inadequate staff to meet the demand for services at designated public health facilities, the state may require health professionals to perform abortion as an essential component of their jobs.[81] This would make willingness to perform the abortion procedure a condition for employment. Over time, this has proven to be insufficient.

It should be noted that opponents of the Bill were in favour of the inclusion of a conscientious objection clause but were partially against the requirement for referral by an objecting medical professional. John Smyth, legal advisor to Doctors for Life, expressed this sentiment by stating:

> Those driving the South African bill successfully resisted the pleas to include such a clause saying that such a clause would 'undermine' the objects of the legislation. They rightly asserted that the Constitution *should* provide all the protection required, but also resorted to 'special pleading' in spuriously alleging that the word 'choice' in the title of the Act gave not only women but the practitioner a choice.[82]

78 Choice on Termination of Pregnancy Bill – Second reading 4811-4812.

79 Interview with feminist lawyer: via Email on 29 March 2019.

80 Reproductive Rights Alliance 'Public hearing on the implementation on the 1996 Choice on Termination of Pregnancy Act (2000) (on file with author).

81 As above.

82 J Smyth 'Moving towards improvement in South African abortion legislation' (2007) 11 (on file with author).

Despite calls from various stakeholders to include an explicit provision on conscientious objection, the Act was passed without an explicit provision on conscientious objection. Consequently, in 2004[83] and 2007 respectively[84] attempts were made to reintroduce the conscience clause in the Bill. Particularly in 2007, this move was largely supported by various groups including the Justice Alliance of South Africa (JASA), Christian Lawyers Association of South Africa (CLA), Christian Action Network (CAN), the African Christian Democratic Party, South African Medical Association (SAMA), and the Democratic Nursing Association of South Africa (DENOSA).[85] These groups argued for the inclusion of a conscience clause on two fronts.

In support of the Bill, pro-life organisations such as Doctors for Life International argued that healthcare professionals who objected to participating in abortion services were often discriminated against and threatened with disciplinary action.[86] They believed that there should be an explicit provision for healthcare workers to exercise their constitutional right to freedom of conscience, as provided in other countries. According to them, healthcare practitioners were being set up to create pro-abortion propaganda around the issue of conscientious objection.[87]

In contrast, medical bodies emphasised the importance of including an opt-out provision that would allow for the continuation of care through referral.[88] DENOSA further recommended that nurses who object to performing abortions be given the right to conscientiously object, while also providing the opportunity for nurses who are willing to undergo the necessary training.[89] By including these provisions, medical professionals

83 National Assembly Health Portfolio Committee 'Choice on Termination of Pregnancy Amendment Bill: Public hearings' (2 August 2004) https://pmg.org.za/committee-meeting/3763/ (accessed 20 May 2019).

84 See National Assembly Health Portfolio Committee 'Choice on Termination of Pregnancy Amendment Bill: Public hearings' (13 November 2007) https://pmg.org.za/committee-meeting/8601/ (accessed 20 May 2019).

85 As above.

86 Doctors for Life International 'Written submission in respect of the Choice on Termination of Pregnancy Amendment Bill 21 of 2007 to the Portfolio Committee on Health (National Assembly)' (8 November 2007) http://pmg-assets.s3-website-eu-west-1.amazonaws.com/docs/2007/071113dfl.htm (accessed 20 May 2019).

87 C Dudley 'Report of roundtable on abortion: Assessing the current situation' (2 March 2007) 3 (on file with author).

88 Comment by the South African Medical Association (SAMA) Choice on Termination of Pregnancy Amendment Bill 21 of 2007 (2007) http://pmg-assets.s3-website-eu-west-1.amazonaws.com/docs/2007/071113sama.htm (accessed 20 May 2019).

89 Submission by the Democratic Nursing Organization of South Africa (DENOSA) regarding the Choice on Termination of Pregnancy Amendment Bill 21 of 2007 (2007)

who object to performing abortions on the basis of their beliefs or conscience would not be forced to compromise their values, while still ensuring that women have access to safe and legal abortion services.

The proposed inclusion of a conscientious objection clause was not eventually added to the Bill. The decision was made by the Chair of the Health Portfolio Committee, who argued that such a clause could not be introduced during public hearings on amendments because it is not found in either the principal Act or the amendment.[90] Since the unsuccessful attempts to reintroduce the clause in 2004 and 2007, no other attempts have been made to include it. However, in 2017, a private member Bill was introduced by Cheryll Dudley of the ACPD, which would have required mandatory counselling, ultrasound, and third-party authorisation by a social worker in cases of abortion sought on socio-economic grounds.[91] Although the Bill did not include a conscience clause, it reflects efforts by the anti-choice movement to restrict women's right to reproductive autonomy.[92] MP Dudley argued that the Bill aimed to protect women's right to make an informed choice.[93] Though ultimately rejected by the Parliamentary Portfolio Committee on Health in May 2018,[94] Dudley's comments resonate with the discourses of nurses in the subsequent chapter.

Despite the legalisation of abortion, there is still a lack of mainstream debate in South Africa on how politics, ideology, and political decisions affect the right to abortion. This is largely due to the controversial nature of the topic, resulting in politicians avoiding discussion unless it is tabled

http://pmg-assets.s3-website-eu-west-1.amazonaws.com/docs/2007/071113denosa.htm (accessed 20 May 2019).

90 National Assembly (n 84 above).

91 Choice on Termination of Pregnancy Amendment Bill B34 of 2017 (2018) https://discover-sabinet-co-za.uplib.idm.oclc.org/webx/access/billtracker/bills17/B034-2017.pdf (accessed 4 May 2019).

92 See LB Pizzarossa & E Durojaye (2019) 'International human rights norms and the South African choice on termination of pregnancy act: An argument for vigilance and modernisation' (2019) 35 *South African Journal on Human Rights* 50, where they argue that the Bill submitted by the ACDP did not comply with international human rights norms.

93 Transcript of speech by MP Dudley in Parliament (1 February 2018) https://www.acdp.org.za/why_pro_life_christians_should_support_choice_on_termination_of_pregnancy_amendment_bill (accessed 4 May 2019).

94 See National Assembly 'Report of the Portfolio Committee on Health on the Choice on Termination of Pregnancy Amendment Bill B34 of 2017' (2018) https://pmg.org.za/tabled-committee-report/3318/ (accessed 4 May 2019).

before Parliament.[95] The Sexual and Reproductive Justice Coalition (SRJC) conducted a review of the manifestos of the three major political parties in South Africa – the ANC, DA, and Economic Freedom Fighters (EFF) – in the run-up to the May 2019 elections. Their findings revealed that none of the parties had addressed the issue of abortion in their manifestos.[96] As a result, the SRJC called on these parties to support an increment to the 2020 budget for sexual and reproductive health.[97]

Notwithstanding the importance of regulating conscientious objection, it is essential to recognise that even when conscience-based refusals are legally allowed, they may not always function effectively in reality.[98] Simply having laws in place does not ensure that healthcare providers who object to providing abortion care will not impede women's access to safe and legal abortions.

3.1 Regulatory body

It is widely believed that the National Department of Health and its provincial departments have not conducted a meaningful awareness campaign since the enactment of the Act.[99] This has resulted in healthcare providers lacking awareness and understanding of their obligations, leading to ineffective implementation, and compromising women's access to safe abortion services. The National Department of Health's conceptualisation of conscientious objection is also a contributing factor to the problem. There is no systematic use of conscientious objection, and healthcare providers simply refrain from participating in abortion

95 R Davies 'Abortion in South Africa: a conspiracy of silence' *Daily Maverick* 30 September 2013 https://www.dailymaverick.co.za/article/2013-09-30-abortion-in-south-africa-a-conspiracy-of-silence/ (accessed 10 June 2017).

96 See ANC '2019 Manifesto: Let's grow South Africa together' (2019); DA 'The manifesto for change: One South Africa for all' (2019); EFF '2019 Manifesto: Our land and jobs now' (2019) (on file with author).

97 P Pilane '2019 elections: What do the top three parties say about sexual & reproductive justice' *Daily Maverick* 18 March 2019 https://www.dailymaverick.co.za/article/2019-03-18-2019-elections-what-do-the-top-three-parties-say-on-sexual-and-reproductive-justice/ (accessed 19 March 2019). See also L Carmody & M Stevens 'Reproductive justice: The missing issue in party manifestos for 2019 Election' *Daily Maverick* 5 May 2019 https://www.dailymaverick.co.za/article/2019-05-05-reproductive-justice-the-missing-issue-in-party-manifestos-for-2019-election/ (5 May 2019).

98 Research shows evidence of this in various countries, including Mexico City and Italy. See G Ortiz-Millan 'Abortion and conscientious objection: Rethinking conflicting rights in the Mexican context' (2017) 29 *Global Bioethics* 1; F Minerva 'Conscientious objection in Italy' (2015) 41 *Journal of Medical Ethics* 170.

99 Interview with pro-abortion activist via Skype on 21 February 2019.

services.[100] A study on the attitudes of healthcare providers towards abortion termination revealed that the absence of a comprehensive regulatory framework has contributed to providers' lack of understanding of what constitutes conscientious objection.[101]

3.2 National Guidelines for Implementation of Termination of Pregnancy Services in South Africa

The aim of the National Termination of Pregnancy Guidelines, developed by the National Department of Health and published in 2019, is to provide a comprehensive framework for the implementation of the Act and its subsequent amendment.[102] The guidelines cover various aspects of termination of pregnancy, including the conditions under which it may be terminated, the designation of facilities, counselling, consent, regulations, offences, and penalties. By not singling out termination of pregnancy, but rather incorporating it as part of a broader strategy of comprehensive reproductive health services, the guidelines seek to address stigma and improve the implementation of the Act.[103]

Key considerations of the Act focus on provision of adequate training to healthcare providers, developing criteria for the designation of facilities where termination of pregnancy services can be provided, establishing a national standardised clinical referral algorithm to ensure efficient and effective referrals for patients, addressing conscientious objection in a way that does not compromise women's access to services, and developing appropriate protocols and ensuring healthcare providers are aware of their obligations in emergency settings.

Although the Act does not address conscientious objection, the Guidelines aim to regulate the practice by defining it as an 'obstruction to care or access'. This is because section 10 of the Act criminalises the obstruction of access to abortion services, which carries a penalty of a fine or up to ten years' imprisonment. The guidelines require healthcare providers who refuse to offer abortion services on personal grounds to refer clients to a colleague or facility that can provide such services, in accordance with international standards. This has resonance in other

100 Interview with National Department of Health representative by telephone on 22 February 2019.

101 J Harries et al 'Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study' (2014) 11 *BMC Reproductive Health* 1 at 4-5.

102 National Department of Health 'National guidelines for implementation of termination of pregnancy services in South Africa' (2019).

103 Interview with National Department of Health representative by telephone on 22 February 2019.

countries, as a majority of national laws that allow conscientious objection, do require health providers to refer to a volunteer colleague.[104] The right to information and access to healthcare services, including abortion, should always be upheld, and refusal to provide such services should not harm the client seeking an abortion.

The effectiveness of the National Termination of Pregnancy Guidelines is highly dependent on how they are implemented and monitored by the National Department of Health and its provincial departments.[105] It is crucial that there are mechanisms in place to ensure that healthcare providers comply with the guidelines, and that conscientious objection is not used as a pretext to deny women access to safe abortion services.

4 Concluding reflections

The Choice on Termination of Pregnancy Act gives effect to the constitutional right to bodily and psychological integrity, which includes the right to make decisions about one's reproduction and to security in and control over one's body. It also gives effect to the right to have access to reproductive healthcare services. These rights are intimately linked to the enjoyment of the rights to dignity, privacy, and equality. The right to access safe and legal abortion as provided in the Act is emboldened by certain international human rights law norms and standards.

However, the Act's implementation faces several challenges, including healthcare professionals' refusal to provide care. In this chapter, I explored the reasons behind the absence of a conscientious objection provision in South Africa's Choice on Termination of Pregnancy Act. Through mapping the discursive resources and framings used by key state and non-state actors, it was revealed that political forces and special interest groups played a significant role in determining the strength of this provision.

Despite this absence, the National Department of Health has developed guidelines to regulate the practice of conscientious objection, which oblige practitioners who refuse to provide abortion services to refer clients to a colleague or facility. However, the effectiveness of these guidelines remains to be seen, as concerns around their implementation and monitoring persist. It is clear from the available evidence that healthcare professionals' refusal to provide care is a significant barrier

104 V Fleming et al 'Freedom of conscience in Europe? An analysis of three cases of midwives with conscientious objection to abortion' (2018) 44 *Journal of Medical Ethics* 104.

105 Interview with public health professor and researcher via Skype on 20 February 2019.

to accessing safe and legal abortion services. The prevalence of unsafe abortions is evidenced by the widespread advertising of illegal and quick abortion services.[106] The next chapter focuses on the structural conditions in which abortion-providing nurses perform their abortion services.

106 R Jewkes et al 'Why are women still aborting outside designated facilities in metropolitan South Africa' (2005) 112 *BJOG: An International Journal of Obstetrics and Gynaecology* 1236.