6 Regulating conscientious objection to legal abortion in South Africa

Abortion remains a highly controversial topic in many countries, where the competing rights of women and healthcare providers are often in conflict. The exercise of conscientious objection by healthcare providers in the context of reproductive healthcare can create significant barriers to women's access to safe and legal abortion services. Although South Africa has limited laws and jurisprudence governing the exercise of conscientious objection, recent developments in international norms and jurisprudence have opened new possibilities for legal exploration.

In this chapter, I will build on the insights gained in the previous chapters and delve deeper into the complex issue of regulating conscientious objection to legal abortion in South Africa, taking into consideration its uses and consequences. In the first section, I will discuss existing domestic laws and regulations that could be used to regulate conscientious objection. Drawing on international human rights law and comparative law, the second part of this chapter will propose an approach that the courts should take in developing judicial interpretations of the exercise of conscientious objection and reproductive rights. The legal scope of conscientious objection should be limited to ensure that healthcare providers can refuse to provide care only if it does not harm women's access to safe and legal abortion services. This book aims to contribute to the ongoing discussion of regulating conscientious objection and to offer new perspectives on how to balance the rights of women and healthcare providers in the context of reproductive healthcare.

1 Unpacking human rights obligations

While conscientious objection is widely recognised in the context of military service, it is also a relevant issue in the medical field, particularly in reproductive healthcare services. Reproductive healthcare services continue to be a highly contentious moral issue in the face of a growing emphasis on women's sexual and reproductive health and rights. However, healthcare providers' conscience-based refusal to provide reproductive health services such as emergency contraception, other forms of

contraception, sterilisation, infertility treatment, and abortion care can have serious consequences for women's human rights.[1]

Conscientious objection in healthcare has been a subject of debate among scholars, with various positions emerging.[2] The absolutism paradigm prioritises healthcare providers' conscience convictions over patients', and they are not obliged to disclose or refer. The incompatibility thesis, however, does not allow healthcare providers to exercise conscientious objection since it goes against their professional obligations, and they do not have the right to refuse. The compromise approach advocates for reasonable accommodation and referral obligations. However, implementing this approach in practice is challenging. Some scholars argue that unlike in the military, conscientious objection should not be permissible in reproductive healthcare.[3]

Although the UN has primarily addressed conscientious objection in the military, it is crucial to consider its implications in the medical field, particularly in relation to women's reproductive healthcare. In this regard, UN human rights treaty monitoring bodies have emphasised the need to prevent healthcare providers' conscientious objection from hindering women's access to reproductive health services and endangering their human rights.[4] The Committee on the Elimination of all Forms of Discrimination Against Women (CEDAW Committee), responsible for enforcing CEDAW, has issued General Recommendation 24 on women's health obligations, which underscores states' duty to guarantee women's access to reproductive healthcare services, even if healthcare professionals refuse to provide them based on their conscience.[5] Nevertheless, women must be referred to alternative providers to ensure their reproductive rights

1 See International Women's Health Coalition & Mujer Y Salud En Uruguay (MYSU) 'Unconscionable: When providers deny abortion care' (2018) https://iwhc.org/wp-content/uploads/2018/06/IWHC_CO_Report-Web_single_pg.pdf (accessed 5 November 2018). See also C Fiala & JH Arthur 'Dishonourable disobedience – Why refusal to treat in reproductive health care is not conscientious objection' (2014) 1 *Woman-Psychosomatic Gynaecology & Obstetrics* 12.

2 MR Wicclair *Conscientious objection in health care: An ethical analysis* (2011) 32-36.

3 JH Arthur & C Fiala 'The FSRH guideline on conscientious objection disrespects patient rights and endangers their health' (2018) 44 *BMJ Sexual & Reproductive Health* 145; see B Johnson Jr et al 'Conscientious objection to provision of legal abortion care' (2013) 123 *International Journal of Gynaecology & Obstetrics* S60.

4 See Committee on Economic, Social and Cultural Rights, Concluding observations on the fourth periodic report of Argentina, 1 November 2018, UN Doc E/C.12/ARG/CO/4 (2018) para 55.

5 CEDAW Committee, General Recommendation 24: Article 12 of the Convention (Women and health), A/54/38/Rev.1, chap. I (1999).

are protected,[6] since forcing them to continue their pregnancy against their will could constitute torture, cruel, degrading, and inhumane treatment.[7]

The Committee on Economic, Social and Cultural Rights (CESCR) has provided guidance on states' obligations to ensure the right to sexual and reproductive health in the form of General Comment 22.[8] Accordingly states are responsible for respecting, protecting, and fulfilling the right to health, which includes sexual and reproductive health as provided in General Comment 14 on the right to health.[9] To fulfil the duty to protect, states must ensure that conscientious objection by healthcare providers does not impede access to services.[10] This requires ensuring an adequate number of trained healthcare providers are available in public and private facilities. In addition, the Human Rights Committee has emphasised in General Comment 36 on the right to life that states must remove barriers to safe and legal abortion that arise from conscientious objection by healthcare professionals.[11] Such efforts are essential to ensure that women and girls have access to safe and legal abortion services.

In addition to the General Comments issued by the treaty monitoring bodies, they have also addressed the issue of conscientious objection in their concluding observations on state party reports.[12] For example, the Human Rights Committee drew attention to the impact of the 'conscience clause' in Poland, which has led to a shortage of safe abortion services and an increase in unsafe abortions.[13] Meanwhile, the CEDAW Committee's concluding observations on Hungary highlighted the need for conscientious objection to be 'accompanied by information about

6 As above.

7 CEDAW Committee, General Recommendation 35 on gender-based violence against women, 26 July 2017, UN Doc CEDAW/C/GC/35 (2017) para 18. See also Human Rights Committee *Whelan v Ireland* CCPR/C/119/D/2425/2014 (2017); *Mellet v Ireland* CCPR/C/116/D/2324/2013 (2016).

8 CESCR, General Comment 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 2 May 2016, UN Doc E/C.12/GC/22 (2016).

9 CESCR 'General Comment No 14: the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 11 August 2000, UN Doc E/C 12/ 2000/4 (2000).

10 General Comment 14 (n 9) para 14.

11 Human Rights Committee, General Comment 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life, 3 September 2019, UN Doc CCPR/C/GC/36 (2019) para 8.

12 See CEDAW 'Concluding Observations on the seventh periodic report of Argentina', 25 November 2016, UN Doc CEDAW/ARG/CO/7 (2016).

13 Human Rights Commission, Concluding Observations on the seventh periodic report of Poland, 23 November 2016, UN Doc CCPR/POL/CO/7 (2016).

alternative options, and for it to remain a personal decision rather than an institutionalised practice'.[14]

Similarly, the CESCR raised concerns about conscientious objection in its Concluding Observation on South Africa's initial report in November 2018. The Committee recommended that health professionals who invoke conscientious objection provide referrals within their own facility or to a nearby facility to ensure that their objection does not impede women's access to abortion services.[15] These instances illustrate the importance of addressing conscientious objection in the context of reproductive healthcare to protect women's access to essential services and safeguard their human rights.

The African Commission has made a significant step by acknowledging the importance of effectively regulating conscientious objection in the context of reproductive health. General Comment 2 issued by the Commission outlines that healthcare providers can claim conscientious objection in the provision of abortion services, except in emergency situations where immediate medical attention is required.[16] Premised on their obligations under the Maputo Protocol, states are required to:

> [E]nsure that health services and healthcare providers do not deny women access to contraception/family planning and safe abortion information and services because of, for example, requirements of third persons or reasons of conscientious objection. [17]

In addition, the General Comment 2 further notes that state obligations relating to enabling and political framework also entails ensuring healthcare providers do not deny women access to safe abortion information and services.[18] In particular, the African Commission sends a clear message to African states that permit conscientious objection, requiring them to establish and implement an effective regulatory framework to ensure

14 CEDAW Committee, Concluding observations on the combined seventh and eighth periodic reports of Hungary adopted by the Committee at its fifty fourth session (11 February-1 March 2013), 1 March 2013, UN Doc CEDAW/C/HUN/CO/7-8 (2013) para 31(d).

15 CESCR, Concluding observations on the initial report of South Africa, 29 November 2018, UN Doc E/C.12/ZAF/CO/1 (2018) para 66(b).

16 African Commission on Human and Peoples' Rights, General Comment 2 on article 14(1)(a), (b),(c) and (f) and Article 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2014) para 26.

17 General Comment 2 (n 16) para 48.

18 General Comment 2 (n 16) paras 26 & 48.

that such objections do not undermine women's access to legal abortion services.

While there is currently no established jurisprudence on conscientious objection in the context of sexual and reproductive health services by the African Commission and African Court on Human and Peoples' Rights (African Court),[19] developments in international norms and jurisprudence offer guidance and potential avenues for legal interpretation in South Africa.

International human rights law provides guidance on how states can guarantee the protection, respect, and fulfilment of the rights of abortion seekers. In light of the aforementioned discussion, these guidelines include ensuring that there are enough healthcare providers who do not object to the provision of abortion services and that they are distributed equitably throughout the country. Additionally, clear, and enforceable regulations regarding conscientious objection must be established and adequately enforced, with non-compliance addressed and sanctioned accordingly. States should also define precisely who may object to what aspects of care, prohibit institutional claims of conscience, mandate prompt referral to non-objecting providers, and ensure that conscientious objection is exercised in a non-punitive and respectful manner. These measures can help ensure that the exercise of conscientious objection does not infringe upon the human rights of abortion seekers.

2 Global medical standards

Professional codes of conduct at the international level have also acknowledged the right to conscientious objection, further emphasising the significance of this recognition alongside legal and ethical frameworks.[20] This recognition highlights the importance of balancing the rights of healthcare providers and patients in the context of reproductive healthcare services. For instance, the International Confederation of Midwives (ICM) revised its International Code of Ethics for Midwives in 2014, acknowledging that the midwifery profession seeks to improve the quality of care for women, babies, and families.[21] The ICM states that midwives

19 Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights (1998).

20 B Dickens & RJ Cook 'The scope and limits of conscientious objection' (2000) 71 *International Journal of Gynaecology & Obstetrics* 71.

21 International Confederation of Midwives 'International code of ethics for midwives' (2014) Preamble https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-international-code-of-ethics-for-midwives.pdf (accessed 4 March 2018).

have the right to conscientious objection but must ensure that they do not impede women's access to care. They must also provide information on available alternatives and facilitate the transfer of care to other providers if necessary.[22]

Conversely, the ICM's approach to abortion-related care has undergone a significant shift in recent years. While the 2014 version of the International Code of Ethics for Midwives did not explicitly address abortion, the 2018 Essential Competencies for Midwifery Practice acknowledges the importance of providing care for unintended or mistimed pregnancies, including counselling women on their options and referring them to appropriate providers and post-abortion care.[23] This updated position is consistent with the ICM's recognition of the right to reproductive healthcare, including access to safe and legal abortion, as an essential component of women's health and well-being. As such, midwives are expected to respect women's decisions and provide them with accurate and comprehensive information to help them make informed choices about their reproductive health.

In 2022, the World Health Organisation (WHO) published its abortion care guidelines that incorporate precautionary measures aimed at preventing the practice of conscientious objection from causing any delay in the provision of lawful abortion services.[24] Additionally, WHO has provided guidance that

> health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.[25]

While the WHO emphasises the need to ensure timely access to healthcare services regardless of conscientious objections, the International

22 International Confederation of Midwives (ICM) 'Revised Core Document: International definition of the midwife' (2017). The Core Document was adopted at Brisbane Council meeting in 2005, revised and adopted at Durban Council meeting in 2011 with a further revision and adoption at the Toronto Council meeting, 2017, at 1 https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf (accessed 15 February 2019).

23 International Confederation of Midwives (ICM) 'Essential competencies for midwifery practice' (2018) 16 https://www.internationalmidwives.org/assets/files/general-files/2019/02/icm-competencies_english_final_jan-2019-update_final-web_v1.0.pdf (accessed 15 February 19).

24 WHO 'Abortion care guideline' (2022) 60-61.

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

Federation of Obstetricians and Gynaecologists (FIGO) has also recognised the significance of conscientious objection in reproductive healthcare, provided that it does not impede women's access to essential services.[26] By recognising and establishing guidelines for conscientious objection, professional organisations like the WHO and FIGO aim to balance the right of healthcare providers to object on conscience grounds with the responsibility to ensure that patients receive the healthcare services they require.

3 Delineating the legal scope of conscience objection in South Africa

3.1 The limitation clause

It is important to note that even though the Choice on Termination of Pregnancy Act does not contain an explicit clause on conscientious objection, it is not completely unregulated. As highlighted in Chapter 3, the Constitution of South Africa acknowledges the right to freedom of conscience, religion, thought, belief, and opinion under section 15(1). Nevertheless, this right is not absolute and should be weighed against other conflicting constitutional rights. According to the Constitution, fundamental rights are subject to the limitation clause. Section 36(1) states:

> (1) The rights in the Bill of Rights may be limited only in terms of the law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including –
> (a) the nature of the right;
> (b) the importance of the purpose of the limitation;
> (c) the nature and extent of the limitation;
> (d) the relation between the limitation and its purpose; and
> (e) less restrictive means to achieve the purpose.
> (2) Except as provided in subsection (1) or any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights.

26 FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health 'Ethical guidelines on conscientious objection' (2006) 14 *Reproductive Health Matters* 148.

The limitation clause takes as its premise, that the enjoyment of fundamental rights pays attention to the rights of others or collective interests. Thus, Halton Cheadle has argued that:

> The limitation clause provides a basis by which the majority can have its political will, but only within a framework which demands that the exercise of political power is subject, at the very least, to rational justification.[27]

This section emphasises the argument that the limitation clause in the Bill of Rights can be utilised to weigh and balance constitutional rights that are in conflict. To determine the scope of conscientious objection, it is necessary to assess whether limiting healthcare providers' right to freedom of conscience, thought, and religion is justified and reasonable. Proportionality is applied in exercising the limitation clause to make this determination. In *S v Makwanyane*,[28] Chaskalson P, the former president of the Constitutional Court, stated that:

> The limitation of constitutional rights for a purpose that is reasonable and necessary in a democratic society involves the weighing up of competing values, and ultimately an assessment based on proportionality. This is implicit in the provisions of section 33(1). The fact that different rights have different implications for democracy, and in the case of our Constitution, for 'an open and democratic society based on freedom and equality', means that there is no absolute standard which can be laid down for determining reasonableness and necessity. Principles can be established, but the application of those principles to particular circumstances can only be done on a case by case basis. This is inherent in the requirement of proportionality, which calls for the balancing of different interests. In the balancing process, the relevant considerations will include the nature of the right that is limited, and its importance to an open and democratic society based on freedom and equality; the purpose for which the right is limited and the importance of that purpose to such a society; the extent of the limitation, its efficacy, and particularly where the limitation has to be necessary, whether the desired ends could reasonably be achieved through other means less damaging to the right in question.[29]

As previously discussed, when balancing conflicting constitutional rights, it is essential to consider the significance of the right being limited and the importance of the purpose behind the law that is limiting the right. In the case of healthcare providers who deny abortion services based

27 H Cheadle 'Limitation of rights' in MH Cheadle et al *South African constitutional law: The Bill of Rights* (2002) 694.

28 *S v Makwanyane* 1995 (3) SA 391 (CC).

29 *S v Makwanyane* para 104.

on their conscience, it can be argued that this denial may infringe on a woman's right to life as provided in the Constitution and her rights under the ICCPR.[30]

The Constitutional Court in the *Makwanyan*e case acknowledged that in balancing conflicting rights, different rights carry different implications for a democratic society based on freedom and equality.[31] While the Bill of Rights does not establish a hierarchy of rights, the Interim Constitution[32] under section 33(1) distinguished between rights that required rational justification and those that did not.[33] The *Makwanyane* decision set the groundwork for future developments in the proportionality test, including the content of section 36(1) of the Constitution.

When considering the issue of conscientious objection, a proportionality approach can be useful. Veronica Undurraga proposed a framework with three tests: suitability, necessity, and strict proportionality.[34] The first test examines whether the intervention contributes to a legitimate constitutional aim, while the second test considers alternative measures that have the least impact on fundamental rights. The final test, strict proportionality, weighs the benefits of limiting rights against the disadvantages. This framework can help judges balance a healthcare provider's right to freedom of conscience against a woman's right to reproductive autonomy and access

30 See General Comment 36 (n 11).

31 *S v Makwanyane* para 104.

32 Act 200 of 1993. Section 33 provided as follows:
(1) The rights entrenched in this Chapter can be limited by law of general application, provided that such limitation –
(a) Shall be permissible to the extent that it is –
(aa) reasonable; and
(bb) justifiable in an open and democratic society based on freedom and equality; and
(b) Shall not negate the essential content of the right in question, and provided further that any limitation to –
(aa) a right entrenched in section 10, 11, 12, 1481), 21, 25 or 30 (1) (d) or (e) or (2); or
(bb) a right entrenched in section 15, 16, 17, 18, 23 or 24, in so far as such rights relates to free and fair political activity, shall, in addition to being reasonable as required in paragraph (a) (i), also be necessary.
(2) Save as provided for in subsection (1) or any other provision of this Constitution, no law, whether a rule of common law, customary law or legislation, shall limit any right entrenched in this Chapter.

33 The approach in *Makwanyane* was applied in *National Coalition of Gay and Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) para 34.

34 V Undurraga 'Criminalisation under scrutiny: How constitutional courts are changing their narrative by using public health evidence in abortion cases' (2019) 27 *Sexual and Reproductive Health Matters* 5.

to healthcare.[35] By applying this approach, judges can determine whether the limitation of a healthcare provider's right to conscientious objection is justifiable and reasonable.

To assess whether it is proportionate to limit the exercise of conscientious objection, a three-part framework can be used. The first part examines the importance of the purpose of the limitation and the rights and interests it protects in a democratic society based on human dignity, equality, and freedom. The second part considers whether there are less restrictive ways to achieve the purpose of the limitation, and whether there are better-suited methods of achieving the goals of limiting that particular right in ways that are less invasive than the right that is to be limited. If less invasive measures exist, they should be chosen. The third part evaluates the beneficial effects of imposing such a limitation. To determine whether a provider's refusal to provide abortion care is proportionate, these three parts must be considered. Thus, in assessing the proportionality of a healthcare provider's conscientious objection to providing abortion care, three key considerations must be evaluated:

(1) Is there a legitimate aim for limiting the provider's objection to abortion care?
(2) Are there alternative measures available to achieve this aim that are less restrictive of the provider's right to conscientious objection? and
(3) Can a fair balance be struck between the provider's right to object and the interests of the pregnant woman in accessing healthcare services, particularly regarding her reproductive autonomy?

A proportionality analysis can help to determine whether limiting a healthcare provider's conscientious objection to abortion care is justifiable under South African law.

3.1.1 Legitimate aim

The first step in determining whether limiting a healthcare provider's conscientious objection to abortion care is proportional is to identify a legitimate aim for such a limitation. Allowing healthcare providers to refuse to provide abortion care based on their personal beliefs can hinder pregnant women's access to healthcare services, particularly for those residing in areas with limited healthcare providers. This situation may force women to seek unsafe abortions, which can lead to physical and

35 See V Undurraga 'Proportionality in the constitutional review of abortion law' in RJ Cook et al (eds) *Abortion law in transnational perspective: Cases and controversies* (2014) 77-97.

mental harm, and even loss of life. In this context, limiting conscientious objection aims to ensure that pregnant women have access to the full range of lawful healthcare services, and that their right to healthcare access and the right to life are protected without discrimination or infringement of their privacy. Therefore, it can be argued that limiting conscientious objection is a legitimate aim that serves to promote and protect the rights of pregnant women.

3.1.2 Alternative means

When examining the second determination, there may be alternative measures to address conscientious objection, such as referring the patient to another healthcare provider. However, referral should be subject to certain conditions, such as ensuring that the patient's access to care is not unduly delayed or obstructed, and that the referral does not discriminate against the patient.

3.1.3 Balancing rights

When weighing the competing rights of the healthcare provider and the pregnant woman, the potential benefits of denying the right to conscientious objection must be balanced against the interests of the provider, including their freedom of conscience and human dignity. However, the rights of the pregnant woman and the interests of society must also be taken into account, such as the need to ensure access to timely and safe abortion care. In emergency situations, healthcare professionals cannot rely on conscientious objection as it poses a risk to the life and health of the pregnant woman, which serves as an exception to the invocation of conscientious objection.

3.2 The need to regulate: Ethical implications

3.2.1 Duty to save lives

Healthcare providers who choose to exercise their right to conscientious objection must still uphold their ethical obligations to their patients. In order to achieve this balance, FIGO has established criteria for healthcare providers who object on conscience grounds, which include informing patients of their objection in advance, referring them to other providers who can offer the necessary services, and delivering emergency care when require.[36] The Code of Ethics also affirms that:

36 FIGO (n 26).

> [a] physician's right to preserve his/her own moral or religious values does not result in the imposition of those personal values on women. Under such circumstances, they should be referred to another suitable health care provider. Conscientious objection to procedures does not absolve physicians from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay.[37]

Therefore, healthcare providers must strike a balance between their freedom of conscience and their ethical responsibilities towards their patients.

Within the South African context, the legality of this exception to conscientious objection finds support in the Constitution where maternal life or health is in serious danger or there is a medical emergency.[38] Section 27(2) of the Constitution further guarantees everyone the right not to be refused medical treatment in emergencies. A healthcare worker can therefore not legally or ethically object to the rendering of care in cases of life or health-endangering emergencies associated with abortion procedures. Many of the countries with express provisions on the right to conscientious objection to abortion in their abortion laws, do make the same exceptions. The Abortion Act of 1967 in the United Kingdom (UK) contains a provision, namely section 4(2), which clarifies that the right to conscientious objection to abortion does not negate the obligation of healthcare providers to engage in treatment that is essential to save the life or prevent serious, permanent injury to the physical or mental health of the pregnant woman. In other words, healthcare providers are still required to provide emergency care to pregnant women in critical conditions, even if they have a conscientious objection to abortion.[39] The 2009 Mexico City General Health Law permits healthcare providers to exercise conscientious objection but with restrictions in emergency circumstances. Additionally, hospitals are required to have staff members who do not object to providing abortion care.[40]

37 As above.

38 This is in line with General Comment 36 (n 11).

39 Chap 87, 1967 https://www.legislation.gov.uk/ukpga/1967/87/pdfs/ukpga_19670087_en.pdf (accessed 12 February 2019).

40 G Ortiz-Millan 'Abortion and conscientious objection: Rethinking conflicting rights in the Mexican context' (2017) 29 *Global Bioethics* 2.

The exception to the invocation of conscientious objection in emergency situations is crucial to protect the pregnant woman's rights to life and human dignity.[41] Judge Arthur Chaskalson, the former President of the Constitutional Court, emphasised that respect for human dignity is a fundamental value that requires balancing conflicting interests.[42] This was also affirmed in the *Makwanyane* case where the Court acknowledged the constitutional value of Ubuntu,[43] which emphasises respect for human dignity by recognising every person's status as a human being entitled to unconditional respect, dignity, and value, and that this status comes with a corresponding duty to give the same.[44] Therefore, healthcare providers who object on conscience grounds have ethical responsibilities to their patients, including giving notice of objection, referring patients to colleagues, and providing emergency care when needed.

In this regard, healthcare professionals have a responsibility to uphold general principles of medical ethics, which means ensuring that their actions align with these principles. The professional ethical guidelines of South Africa's medical, nursing, and midwifery societies allow healthcare providers to exercise conscientious objection but emphasise their responsibility to ensure that their beliefs do not hinder patients' access to services and information. For example, the 2013 South Africa Nursing Council's Code of Ethics listed termination of pregnancy and conscientious objection as ethical dilemmas that nurses face but did not specify how they should be addressed, while subsequent revisions require nurses to submit their objections in writing to their employer.[45] The Health Professions Council of South Africa also recommends a similar approach

41 Section 10 of the Constitution provides that everyone has inherent dignity and the right to have their dignity respected and protected.

42 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* 196.

43 Although there are varied definitions of Ubuntu, it was introduced in the Interim 1993 Constitution of South Africa but not subsequently in the 1996 Constitution. 'Ubuntu' is considered a key component of African philosophy as a way of life and entails ethos of mutual respect, human dignity and fairness. See L Mbigi *Ubuntu: The African dream in management* (1997); KE Klare 'Legal culture and transformative constitutionalism' (1998) 14 *South African Journal on Human Rights* 146.

44 *Makwanyane* para 224.

45 See for example, SANC 'Code of ethics' (2013) 7-8 http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_comment2_rights_of_women_in_africa_eng.pdf (accessed 28 January 2018); South African Nursing Council 'Ethical standard' 10 & 13 http://www.sanc.co.za/pdf/Learner%20docs/Standards%20-%20Ethical%20Standards.pdf (accessed 30 January 2018); Health Professions Council of South Africa 'Guidelines for good practice in the healthcare professions: General ethical guidelines for reproductive health' (2016) Booklet 8, sec 8.5 https://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/conduct_ethics/Booklet%208%20.pdf (accessed 30 January 2018).

for healthcare providers based on their religious and cultural beliefs.[46] While the emphasis that healthcare providers beliefs should not hinder patients' access to healthcare services and information, the practicality of ensuring access to healthcare in life-threatening situations, such as the case of the woman who died in Ireland in 2012 after being refused an abortion because of the presence of a heart-beat of the foetus, can be difficult to determine.[47]

3.2.2 Duty to provide information

Section 36 of the South African Constitution imposes a duty on healthcare providers to provide a pregnant client with information on where to obtain an abortion, which is supported by the Choice on Termination of Pregnancy Act. Section 6 of the Act, which requires that a woman seeking abortion is to be informed by a medical practitioner or registered midwife of her rights creates a reasonable and justifiable limitation on the healthcare provider's right to freedom of conscience, requiring them to inform a woman seeking an abortion of her rights under the law. Despite their opposition to abortion on grounds of conscience, healthcare providers must provide effective information to pregnant women as it is directly relevant to the exercise of their personal autonomy.[48]

The refusal by healthcare providers to provide information about abortion, with the intention to frustrate the system, is seen as a breach of their duty to provide care and could be viewed as an act of civil disobedience rather than conscientious objection. While there is some overlap between the two concepts, civil disobedience is usually a public act, while conscientious objection is centred on the individual who invokes it and is not intended to serve as a rallying point for others to join. According to Hannah Arendt, the rules of conscience are based on self-interest, and the fear of being alone and having to face oneself can be an effective deterrent from wrongdoing, but this fear is not persuasive to others.[49]

Therefore, healthcare providers who refuse to provide women with access to information may not have a legitimate claim of conscientious

46 Health Professions Council of South Africa (n 45) Booklet 8, sec 8.5 at 13.

47 M Berer 'Termination of pregnancy as emergency obstetrics care: The interpretation of Catholic health policy and the consequences for pregnant women' (2013) 21 *Reproductive Health Matters* 9.

48 *P and S v Poland* ECHR App 57375/08 (30 October 2012) para 111.

49 H Arendt *Crises of the Republic: Lying in politics, civil disobedience on violence* (1972) 64 & 67.

objection as they make assumptions about what the woman will do with the information. The CESCR'S General Comment 14 and General Comment 22 both highlight the importance of the right to information as a key component of the right to health, particularly in relation to sexual and reproductive health.[50] In addition, the Committee stresses that healthcare services, including sexual and reproductive health services, particularly as it relates to the right to accurate information must be available, accessible, acceptable, and of good quality.[51] In 2012, the African Commission released its first General Comment on article 14(1)(d) and (e) of the Protocol, which clarified provisions related to the protection of women's rights to protection against sexually transmitted infections, including HIV/AIDS, and emphasised the need for states to take concrete measures to ensure the realisation of these rights.[52] The Commission reaffirmed the obligation of states to:

> [P]rovide access to information and education, which should address all taboos and misconceptions relating to sexual and reproductive health issues, deconstruct men and women's roles in society, and challenge conventional notions of masculinity and femininity.[53]

The African Commission also obliges states to ensure that the information provided is non-judgmental and understandable in terms of content and language.

3.2.3 Duty to refer

Section 6 of the Choice on Termination of Pregnancy Act does not explicitly impose an obligation on healthcare providers who refuse to perform abortions or provide care to refer the woman to another practitioner or facility. The Act has been supplemented by the National Termination of Pregnancy Guidelines, which requires healthcare providers who refuse to

50 CESCR General Comment 14 (n 9) paras 3, 11 and 16 and General Comment 2 (n 8) para 5.

51 As above.

52 African Commission on Human and Peoples' Rights, General Comments on article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa http://www.achpr.org/files/instruments/general-comments-rights-women/achpr_instr_general_comments_art_14_rights_women_2012_eng.pdf (accessed 10 January 2019); M Geldenhuys et al 'The African Women's Rights Protocol and HIV: Delineating the African Commission's General Comment on articles 14(1)(d) and (e) of the Protocol' (2014) 14 *African Human Rights Law Journal* 681.

53 ACHPR (n 52) para 26.

offer abortion services on personal grounds to refer clients to a colleague or facility that can provide such services.[54]

Some objectors to abortion argue that referring a woman seeking an abortion to another provider or facility could still be considered complicity. However, the duty of the state under section 7(2) of the Constitution to uphold the rights in the Bill of Rights could be used to establish a legal obligation to refer the woman to another provider or facility. This would help ensure that access to abortion services is not unjustly hindered. While section 6 of the Act does not explicitly impose a duty to refer, relying on section 7(2) could provide a basis for such a duty. This is important because hindering access to services related to abortion can have serious implications for women's health and autonomy.

While section 6 of the Act could be read to imply that healthcare providers who refuse to perform abortions or provide care should refer the woman to another practitioner or facility, it does not explicitly. Additionally, section III of the *International Code of Ethics for Midwives* recognises that:

> (c) midwives may decide not to participate in activities for which they hold deep moral opposition; however, the emphasis on individual conscience should not deprive women of essential health services
> (d) Midwives with conscientious objection to a given service request will refer the woman to another provider where such a service can be provided.[55]

In 2021, the High Court of New Zealand heard a case brought by the New Zealand Health Professionals Alliance Inc against the Attorney General (NZPHA).[56] The case concerned the no-referral position that some health professionals had taken on conscientious objection to abortion. The court found that this position had no basis in the Abortion Legislation Act 2020, which introduced the concept of disclosure of a health professional's objection to abortion to the patient at the earliest opportunity.[57] The presiding judge acknowledged that a woman's access to timely abortion services was directly linked to her fundamental rights, such as her right to health, liberty, and security of person, and freedom from discrimination,

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

55 National Department of Health (n 54) 2-3.

56 *New Zealand Health Professionals Alliance Inc v Attorney General* (NZPHA) [2021] NZHC 2510.

57 As above.

all of which were protected by international human rights instruments that New Zealand had ratified.[58]

WHO has also emphasised that healthcare providers must refer women seeking abortions or, if referral is not possible, must provide services within the scope of their legal obligation.[59] However, it is important to establish clear guidelines defining the extent of healthcare professionals' duties, as well as determining how to balance the competing rights of healthcare professionals and women seeking abortions. In the absence of amendments to the Act to clarify these issues, it would be the responsibility of the courts to provide guidance and interpretation.

4 Developing a jurisprudential approach to conscientious objection

4.1 Comparative analysis of national and international approaches to conscientious objection

In South Africa, there has not been a clear legal stance on conscientious objection in healthcare by the courts. In an attempt to seek legal clarification, Doctors for Life International brought a civil case to the Equality Court, which was later transferred to the Labour Court. The case, *Charles v Gauteng Department of Health (Kopanong Hospital)*,[60] involved a nurse who refused to prepare patients for follow-up treatment after an abortion due to her religious beliefs. This resulted in her being reassigned to another department by the director and eventually resigning in May 2004.[61] The nurse sued the then Minister of Health and the hospital for unfair discrimination based on religion and conscience under the Promotion of Equality and Prevention of Unfair Discrimination Act.[62] However, the case was transferred to the Commission for Conciliation, Mediation and Arbitration (CCMA) by the Labour Appeal Court of South Africa in Braamfontein in 2007.[63]

58 As above.

59 See WHO 'Health worker roles in providing safe abortion care and post abortion contraception' (2015).

60 *Charles v Gauteng Department of Health (Kopanong Hostpital)* (2007) 18 ZALAC JA67/06.

61 'Anti-abortion nurse referred to CCMA' *IOL News* 23 June 2007 https://www.iol.co.za/news/south-africa/anti-abortion-nurse-referred-to-ccma-358940 (accessed 15 February 2019).

62 Act 4 of 2000 (amended by the Judicial Matters Amendment Act 66 of 2008).

63 *Charles case* (n 60) 1. I was unable to find any relevant ruling from the CCMA.

In 2010, through an arbitration, a physician who was dismissed for protesting against termination of pregnancies was reinstated by the Free State Health Department on the basis that the dismissal was unfair.[64] These two cases highlight how anti-abortion activists are subtly utilising power by framing the issue as a matter of worker's rights to non-discrimination and exercising their constitutional right to freedom of conscience, religion, thought, belief, and opinion. However, approaching the issue through this lens risks setting a legal precedent that could undermine South Africa's liberal abortion laws.

A similar approach was used in *FAFCE v Sweden, the Federation of Catholic Families in Europe (FAFCE)*,[65] in which it was argued that Sweden was violating the right to non-discrimination of healthcare workers, because there is no established legal framework that allows them to refuse to provide abortion services by on conscience grounds. The European Committee on Social Rights, however, found that the right to health and non-discrimination, which the European Social Charter[66] guarantees did not give healthcare workers a legal entitlement to refuse to perform abortion services based on conscience claims.[67]

As the debate between women's rights to safe and legal abortion versus the protection of healthcare provider's moral integrity rages on, this approach provides a discursive opportunity for the pro-life movement to push their agenda forward, using the concepts of 'freedom of conscience' and 'non-discrimination' as legitimate arguments. This is akin to how Marc Steinberg suggests that actors will look for 'gaps, contradictions, and silences' to advance their agenda and 'depict shared understanding of injustice, identity, righteousness for action, and a vision of the preferred future'.[68]

In August 2019, a doctor faced a six-member disciplinary inquiry panel of the Health Professions Council of South Africa (HPCSA) after he expressed his personal belief that abortion constitutes the killing of an

64 'Anti-abortion doc reinstated' *News24* 8 March 2010 https://www.news24.com/southafrica/news/anti-abortion-doc-reinstated-20100308 (accessed 15 February 2019).

65 99/2013 Euro Committee of Social Rights (17 March 2015).

66 The European Social Charter (Revised) Eur TS 163 (1996).

67 As above.

68 MW Steinberg 'The talk and back talk of collective action: A dialogic analysis of repertoires of discourse among nineteenth century English cotton spinners' (1999) 105 *Journal of Sociology* 751.

unborn human being to a patient at the 2 Military Hospital in Wynberg.[69] As a result, he was prohibited from practicing medicine and faced potential sanctions such as a warning, a fine, suspension, or termination of his registration with the HPCSA if found guilty. On 29 October 2019, the doctor's appeal to drop the charges was dismissed by the panel. The case was ongoing until a year later when the HPCSA dropped the charges of unprofessional conduct against him. The reason for this sudden decision was not specified, but it was noted that the complainant no longer wished to pursue the matter.[70] This turn of events highlights the complex nature of disciplinary proceedings in the medical field and the importance of complainants in seeing these proceedings through. HPSCA noted that:

> [It] received an affidavit from the complainant indicating that she no longer wishes to proceed with the complaint that was filed against Dr. De Vos. She further advised that she does not wish to testify against De Vos nor participate in the hearing.[71]

This was a long-drawn-out process of over three years. Health workers from Wynberg Military seemed to be intimated at the HPCSA hearings by the huge presence of ACDP supporters. Regardless of the reason, it is important to note that the HPCSA has a duty to protect the public and ensure that healthcare professionals adhere to ethical standards. The disciplinary inquiry panel's decision to initially pursue the case demonstrates this duty, but the sudden decision to drop the charges may raise questions about the effectiveness of the disciplinary process.

In addition, there is a general drive to make this doctor a martyr and politicise the issue. The statement by the African Christian Democratic Party (ACDP) MP Marie Sukers praising the doctor's actions is an example of this.[72] It is important to remember that the inquiry is not about the doctor's beliefs or opinions, but rather his conduct and whether it was in line with professional standards and the law. In her op-ed in

69 A Viljoen 'Vague charges against pro-life doctor hold up case and career for two years, says attorney' *Gateway News* 29 August 2019 http://gatewaynews.co.za/vague-charges-against-pro-life-doctor-hold-up-case-and-career-for-two-years-says-attorney/ (accessed 1 September 2019).

70 S Fokazi 'HPCSA lets anti-abortion doctor off the hook after complainant withdraws' *Herald Live* 7 October 2020 https://www.heraldlive.co.za/news/2020-10-07-hpcsa-lets-anti-abortion-doctor-off-the-hook-after-complainant-withdraws/ (accessed 3 January 2023).

71 As above.

72 'ACDP in solidarity with anti-abortion doctor ahead of HPCSA inquiry' *IOL News* 26 August 2019 https://www.iol.co.za/news/south-africa/acdp-in-solidarity-with-anti-abortion-doctor-ahead-of-hpcsa-inquiry-31348694 (accessed 3 January 2023).

the Guardian, Dr Tlaleng Mofokeng, the former vice chairperson of the Sexual and Reproductive Justice Coalition (SRJC) and now UN Special Rapporteur on the Right to Health wrote:

> Now the issue of medics refusing to give women the procedure they are requesting has increased so much that some of us feel the system itself has become an enabler of violence against women. First, it does not discipline health workers who are dishonourable in my view. Second, it doesn't support providers in the system who are offering abortions.[73]

To address the ongoing debate between freedom of religion and conscience and the rights of women to access abortion services, lawfare can be employed.

4.2 Conscience v care: The battle in courts over conscientious objection

Lawfare refers to the strategic use of rights, law, and litigation to advance contested political and social goals. Court-centred strategies can be utilised to effect change by working within the existing law, changing the interpretation of laws, constitutional provisions, and international treaties, as well as their application and enforcement. Siri Gloppen defines lawfare as the means by which different actors use legal tools to achieve their goals.[74]

In the context of abortion access, courts in South Africa could play a crucial role in interpreting the Constitution and laws in a manner that upholds women's rights to reproductive health, including access to safe and legal abortion services. By hearing cases and setting precedent, courts could establish a legal framework that balances the rights of healthcare providers to conscientious objection with the rights of women to access essential healthcare services. In its landmark decision in the *Minister of Health v Treatment Action Campaign* (*TAC*) case,[75] the Constitutional Court asserted its power for substantive standard-setting noting that:

> South African Courts have a wide range of powers at their disposal to ensure that the Constitution is upheld … How they should exercise those powers

73 H Summers 'Conscientious objection': when doctors' beliefs are a barrier to abortion' *The Guardian* 22 June 2018 https://www.theguardian.com/global-development/2018/jun/22/should-doctors-be-free-to-refuse-patients-an-abortion-on-personal-grounds (accessed 3 January 2023).

74 S Gloppen 'Conceptualizing lawfare' (2021) 17 *Revista Direito GV* 5.

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

> depends on the circumstances of each particular case. Here due regard must be paid to the roles of the legislature and the executive in a democracy. What must be made clear, however, is that when it is appropriate to do so, courts may – and if need be must – use their wide powers to make orders that affect policy as well as legislation.[76]

The Court's decision, which declared that the government had a constitutional obligation to provide anti-retroviral drugs to prevent mother-to-child transmission of HIV, illustrates how courts can be a powerful tool for advancing the rights of marginalised and vulnerable groups. It is important to note that the judgment has been criticised for its marginalisation of reproductive autonomy of black women living with HIV.[77] As argued by Catherine Albertyn, '[a]bsent in the Constitutional Court judgment is any meaningful reference to reproductive autonomy of women in public hospitals, beyond a single mention of the capacity of the hospital'.[78] In the context of abortion, there is an opportunity for the courts in South Africa to play a crucial role in interpreting the Constitution and laws in a manner that upholds women's rights to reproductive health, including access to safe and legal abortion services.

Litigation as a means to obtain guidance on the exercise of conscientious objection is a complex issue that is highly dependent on contextual factors such as the availability of resources and the existence of barriers such as economic, social, political, and legal factors. In other countries, investigations into opportunity structures have been undertaken to determine the feasibility of such an approach.[79] However, a potential challenge in litigation on refusal to offer abortion services based on religious beliefs or conscience is the need to demonstrate the systematic nature of the practice. Despite this challenge, feminist organisations have advocated for the use of the court as a tool to hold the government accountable 'due to the lack of will on the part of the state to ensure that abortion provision occurs without fear, stigma and shame in [the] country'.[80]

76 *TAC* case para 113. On criticism of the restrained nature of the court's decision and how the case could have centred women's reproductive autonomy, see 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.

77 See C Albertyn 'Gendered transformation in South African jurisprudence: Poor women and the Constitutional Court' (2013) 3 *Stellenbosch Law Review* 591.

78 Albertyn (n 76) 112-113.

79 Interview with Colombian law professor via Skype on 27 June 2019. See also P Bergallo & AR Michel 'Constitutional developments in Latin American abortion law' (2016) 135 *International Journal of Gynaecology and Obstetrics* 228.

80 Interview with legal practitioner via Email on 29 March 2019.

In line with this thinking, litigation can be employed as a strategic tool by the pro-abortion movement in South Africa to advocate for a regulatory framework that enables women to access abortion services in cases where healthcare professionals refuse to provide them. One potential approach is to file a court application to declare that the exercise of conscientious objection by healthcare providers violates section 27 of the Constitution. The court would then evaluate the proportionality of limiting the exercise of freedom of thought, conscience, and religion through a section 36 analysis. However, the feasibility of such litigation would depend on contextual factors, including the availability of resources and the systemic nature of the practice.

In order to effectively regulate conscientious objection to abortion, it is crucial to address certain conditions and questions surrounding the scope of the right. These include who is entitled to object and to what activities, when should it be raised, and what are the duties of the objectors. Since the South African courts have not yet had the opportunity to address these issues within the context of abortion, they can look to the approaches of courts from other jurisdictions for guidance. One example of such guidance can be found in key Colombian Constitutional Court cases, which have addressed some of the key issues that need to be addressed in the South African context. By drawing on the approaches taken in these cases, South Africa can develop a regulatory system that effectively balances the right to conscientious objection with the right to access safe and legal abortion services. These cases have been described as having 'considerable significance and instruction nationally, regionally, and internationally'.[81]

The Constitutional Court of Colombia addressed the right to conscientious objection by healthcare professionals in a case involving a 13-year-old girl who became pregnant as a result of rape. The healthcare provider refused to provide her with an abortion on the basis of conscientious objection by its physicians. The girl was then referred to another hospital, which also refused to provide the procedure based on the institution's conscience refusal claims on behalf of its entire medical staff.[82]

81 R Cook et al 'Healthcare responsibilities and conscientious objection' (2009) 104 *International Journal of Gynaecology and Obstetrics* 249; O'Neill Institute for National and Global Health Law & Women's Link Worldwide 'T-388/2009- Conscientious objection: A global perspective on the Colombian experience' (2014).

82 Decision of Colombian Constitutional Court: *T-209/08* (2008). Translation provided by the Lawyers Collective (New Delhi, India) and partners for the Global Health and Human Rights Database Judgment T-209/08 https://www.globalhealthrights.org/wp-content/uploads/2013/10/Translation-T-209-08-Colombia-2008.pdf (accessed 30 December 2018).

In delimiting the scope of the conscientious objection on who can object, the Court held that institutions cannot exercise conscientious objection, as only natural persons are able to exercise such a right.[83] This decision is in line with an earlier ruling from 2006, [84] which affirms that neither legal entities nor the state can claim conscientious objection. Only natural persons have the right to exercise this right, which is based on religious conviction. Therefore, institutions such as clinics, hospitals, and healthcare centres cannot refuse to perform an abortion based on conscientious objection. If a physician claims conscientious objection, they must still refer the woman to another physician who can perform the abortion without violating her fundamental rights. Later, there may be a determination regarding whether the conscientious objection was valid or not, which can be made through mechanisms established by the medical profession.

The Colombian Constitutional Court further established jurisprudential standards in the case of *T-388/09*,[85] where it emphasised that the right to conscientious objection can only be exercised by healthcare providers who are directly involved in the performance of a necessary procedure to terminate a pregnancy. The case examined whether a judicial officer could refuse to hear an application for an injunction that would require a health facility to provide legal abortion under Colombian law based on conscientious objection. The Court ruled that the right to conscientious objection only applies to personnel directly involved in the procedure for termination of pregnancy, and not to a judicial officer.

Having such juridical resource is vital in determining who can legally object to abortion. This is because there is a global disparity in determining who can object, which is partly due to the different values placed on the competing rights of healthcare professionals and women. According to Dickens and Cook, the right to conscientious objection only protects the personal beliefs of healthcare workers who are directly involved in performing the procedure, and not those who are assisting or facilitating it.[86] This position is supported in Zambia, where an objector can only be the 'abortion provider' and not the 'support staff'.[87] These standards provide

83 Decision of Colombian Constitutional Court: *T-209/08* (2008) (n 82) paras 4.3-4.17.

84 See Decision of the Colombian Constitutional Court: Case *T-355/06* (2006), where the Court considered healthcare professionals' right to the conscientious objection.

85 Decision of the Colombian Constitutional Court: *Case T-388/09* (2009).

86 Dickens & Cook (n 20) 74-76.

87 For an analysis the regulatory framework on Zambia, see, E Freeman & E Coast 'Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices' (2019) 221 *Journal of Social Science and Medicine* 106.

guidance on the scope of conscientious objection that South African courts could draw on in determining the limits of healthcare professionals' right to conscientious objection within the context of abortion.

The variation in the scope of conscientious objection globally highlights the need for a clear legal framework to regulate the right. While some countries like France limit the right to healthcare providers only, other countries like Zimbabwe extend the scope to any person employed within a healthcare facility. This lack of consistency creates ambiguity and raises questions about the balance of competing rights. In order to ensure that conscientious objection does not become a tool for discrimination and denial of care, it is important to establish clear guidelines and standards that uphold the rights of both healthcare providers and women seeking abortion services.

In the case of *Greater Glasgow Health Board v Doogan*,[88] the United Kingdom's Supreme Court clarified what constitutes 'participation' in the context of conscientious objection to abortion. The Court held that only those directly involved in the procedure, such as doctors or nurses who perform the abortion, can claim conscientious objection. This means that other healthcare professionals, such as midwives who simply provide administrative or emotional support, cannot claim the right to conscientious objection.[89] This decision aligns with the principles of effective access to abortion services, as it ensures that women can access the services, they need without unnecessary barriers created by individuals who are not directly involved in the procedure. Refusal to provide abortion ought only to apply to the actual procedure, this means that only those who are directly involved have the right to refuse.[90]

4.3 Applying an intersectional framework ensure access to services

The right to sexual and reproductive health includes access to abortion services, and it is the duty of states to ensure that these services are provided.[91] However, when states allow healthcare providers to exercise conscientious objection, they must also ensure that there are enough providers available to prevent a violation of women's fundamental right

88 *Greater Glasgow Health Board v Doogan* [2014] UKSC 68, affirming a previous British case, *Janaway v Salford Health Authority* [1988] 3 All ER 1079 at 1082.

89 *Greater Glasgow Health Board v Doogan* (n 88) para 38.

90 Interview with National Department of Health representative via telephone on 22 February 2019.

91 General Comment 22 (n 8).

to healthcare.[92] The European Committee of Social Rights upheld this standard in the case of *International Planned Parenthood Federation European Network (IPPF- EN) v Italy*,[93] finding that Italy had violated the right to health and non-discrimination provisions of the European Social Charter due to its failure to address the high number of conscientious objectors, which impeded access to abortion services. The Committee emphasised the intersectional and multiple nature of the violations caused by this lack of access.[94]

Utilising an intersectional framework involves taking into account the various intersecting characteristics of women, including race, class, geographic location, and socio-economic status. This approach allows for a more nuanced understanding of African women's experiences, moving beyond simplistic and homogenising representations. The failure of the government to adequately regulate the exercise of conscientious objection and ensure adequate access to abortion services disproportionately affects women based on their class, race, age and geographical location. In its 2017 report, Amnesty International noted that 505 of the 3 880 public facilities operating in South Africa were designated to provide abortion services, only 197 did so.[95] The unregulated exercise of conscientious objection poses significant challenges to the provision of safe and accessible abortions, thereby contributing to the prevalence of backstreet abortions. To address this issue, courts have the power to compel governments to establish appropriate measures, policies, and resources that fulfil their legal and constitutional obligation to provide safe and accessible abortion services. In this regard, the European Court of Human Rights has repeatedly upheld restrictions on conscientious objection,[96] and has explicitly affirmed in the *RR v Poland*[97] that:

> States are obliged to organise the health services system in such a way as to ensure that an effective exercise of freedom of conscience of health professionals in the professional context *does not* prevent patients from

92 *T-209/08* case (n 82) para 4.16.

93 *International Planned Parenthood Federation European Network (IPPF- EN) v Italy* 87/20 ESCR (adopted on 10 September 2013 and delivered on 10 March 2014).

94 *International Planned Parenthood Federation European Network (IPPF- EN) v Italy* (n 93) para 190.

95 Amnesty International 'Barriers to safe and legal abortion in South Africa' (2017) 8 https://www.amnestyusa.org/files/breifing_barriers_to_safe_and_legal_abortion_in_south_africa_final_003.pdf (accessed 10 January 2018).

96 This in line with art 9 of the European Convention on Human Rights on freedom of conscience. See, *Pichon & Sajous v France* ECHR App49853/99 (2001).

97 *RR v Poland* ECHR App 27617/04 (2011).

> obtaining access to services to which they are entitled under the applicable legislation.[98]

Thus, the South African courts should adopt a framework that prioritises women's autonomy in matters of reproductive healthcare and seeks to rectify disparities in reproductive health. By doing so, the courts would be upholding the constitutional mandate to ensure that all citizens have access to healthcare services as enshrined in section 27(1)(a) of the Constitution.

As a signatory and ratified member of core international human rights treaties, both through the UN and AU South Africa is obligated to uphold and implement the provisions contained within core human rights treaties. A human rights-based approach acknowledges the right of healthcare providers to refuse to provide abortion services based on conscience but holds the government accountable for fulfilling its obligation to provide these services. This includes providing information, materials, and resources necessary for safe and legal abortion. Litigation can bring about changes in legislation and jurisprudence, as well as material effects on policy and administrative practices.[99] It serves as a reminder that when the state fails to ensure access to safe and legal abortion by addressing the issue of conscientious objection, it violates the human rights instruments it has ratified.

5 Conclusion

The issue of conscientious objection to the provision of safe and legal abortion services is a complex and multifaceted issue that requires careful consideration and delicate balance between the right to freedom of conscience and women's right to access safe and legal abortion services. While healthcare professionals have a right to freedom of conscience, this right should not be used to deny women access to essential healthcare services. It is imperative that a comprehensive legal framework is developed to ensure that women's rights are protected, and healthcare professionals are held accountable. The failure to regulate and monitor medical professionals in relation to their implied right to conscientious objection serves as a barrier to women's ability to obtain safe and legal abortion. The Constitutional Court must take a leading role in developing a legal framework that balances these competing rights. The discussions and legal decisions made in South Africa could have implications beyond

98 *RR v Poland* (n 97) para 206. Emphasis added.

99 S Gloppen 'Studying courts in context: The role of nonjudicial institutional and socio-political realities' in L Haglund & R Stryker (eds) *Closing the rights gap: From human rights to social transformation* (2015) 291-318.

its borders, especially in other African countries that have also ratified international human rights treaties. It is therefore vital that medical bodies, human rights practitioners, and non-governmental organisations continue to advocate for legal regulation and monitoring to ensure that women are not denied access to the healthcare services they need. Ultimately, a rights-based approach to the issue of conscientious objection will ensure that healthcare professionals uphold their ethical duties while protecting the rights of women.