This monograph launches the **PULP Emerging Voices Series**, which aims to give voice to young African scholars, including by publishing recent winners or runners up of the PULP Christof Heyns Memorial Thesis Award.

Choice and Conscience offers a fresh and insightful perspective on the highly debated issue of conscientious objection in abortion care. Satang Nabaneh's socio-legal approach, which draws on both traditional legal scholarship and African feminist intellectual traditions, provides a nuanced understanding of how legal norms construct and maintain power relations. By focusing on the experiences of nurses in South Africa, Nabaneh explores the complexities of conscience, discretionary power, and socio-cultural and political factors that influence nurses' decisions about whether or not to conscientiously object. In the wake of the recent rollback of abortion rights in the United States and the trend towards liberalisation within the African region, Nabaneh provides an important African perspective on how the international human rights framework should strike a contextual balance between freedom of conscience and ensuring access to abortion. *Choice and Conscience* will interest lawyers, activists, policymakers, scholars, and students exploring the dynamic intersections of law, healthcare, and gender politics.

Choice and Conscience … stands as a significant and valuable addition to the ongoing global scholarship on this critical issue. It underscores the vital concept that intersectionality should occupy a central place in our examination of how various local contexts give rise to layered forms of privilege and disadvantage.

Dr Tlaleng Mofokeng, UN Special Rapporteur on the right to health

… Nabaneh's study of "law in action" zeros in on South African nurses--gatekeepers who often object to the practice for reasons of "conscience." Her interviews of these nurses and her analysis complicate our understanding of challenges to abortion access, providing lessons applicable not only to South Africa and other African countries, but everywhere where there is a gap between formal law and its application.

Mindy Jane Roseman, JD, PhD, Yale Law School

Written from an African feminist perspective, this book offers fresh insights into our understanding of the intersection between politics, mobilisation of discretionary power and the exercise of conscientious objection to abortion by mid-level providers.

Charles Ngwena, Professor of Law, Centre for Human Rights, University of Pretoria

This book offers powerful insights about how informal and background norms in health systems function constrain or enable reproductive justice. Focusing on conscientious objection to abortion by nurses (including midwives) in South Africa, Nabaneh sketches the importance of a feminist analysis that is situated in Africans' lived realities.

Alicia Ely Yamin, Harvard University

ISBN 978-1-7764484-5-6

Pretoria University Law Press
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CHOICE AND CONSCIENCE

Satang Nabaneh

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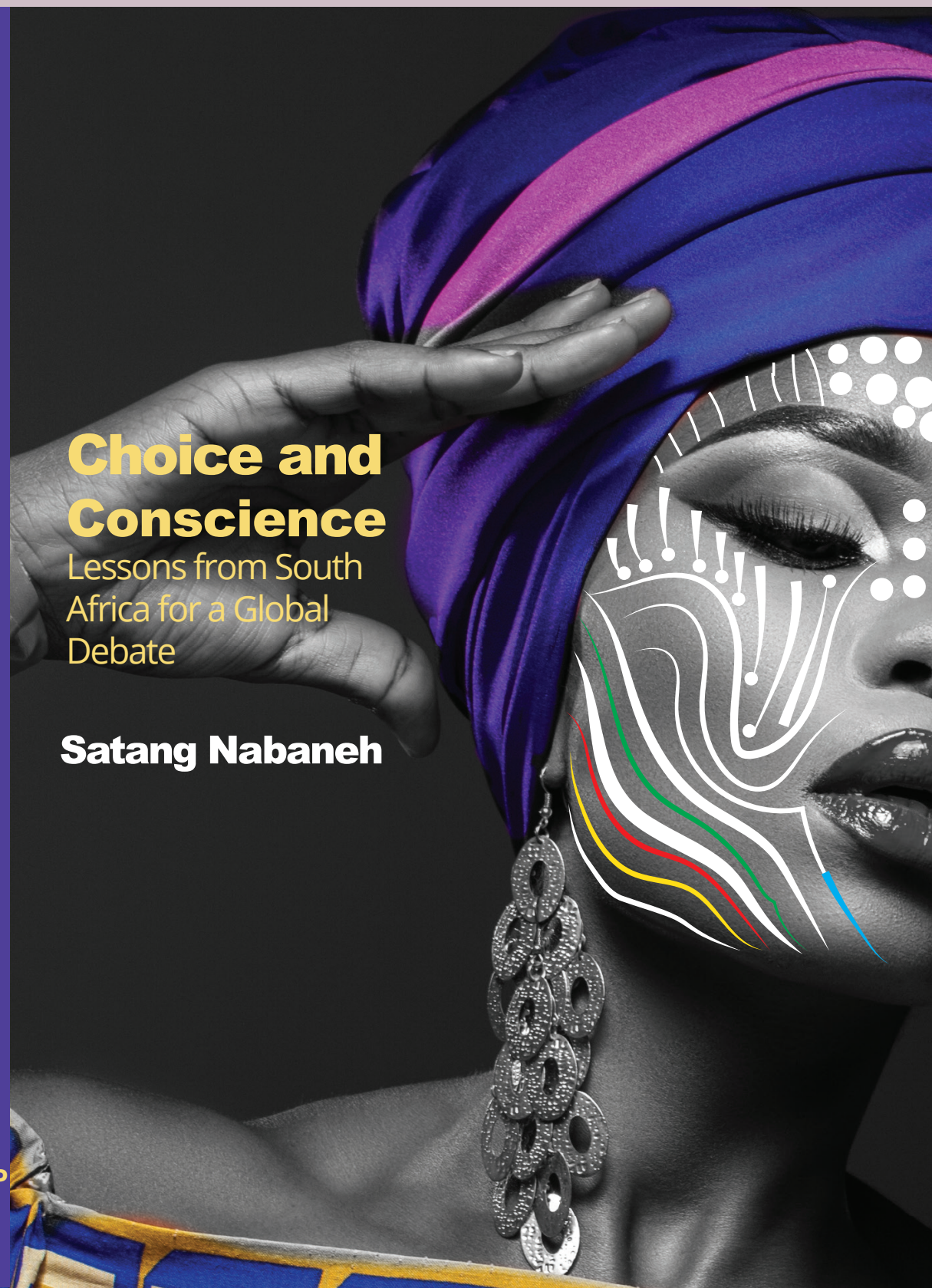

Choice and Conscience

Lessons from South Africa for a Global Debate

Satang Nabaneh

Choice and Conscience:
Lessons from South Africa for a Global Debate

Satang Nabaneh

Pretoria University Law Press
PULP
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www.pulp.up.ac.za

2023

Choice and conscience: Lessons from South Africa for a global debate

Published by:
Pretoria University Law Press (PULP)
The Pretoria University Law Press (PULP) is a publisher at the Faculty of Law, University of Pretoria, South Africa. PULP endeavours to publish and make available innovative, high-quality scholarly texts on law in Africa. PULP also publishes a series of collections of legal documents related to public law in Africa, as well as text books from African countries other than South Africa. This book was peer reviewed prior to publication.

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Printed and bound by:
Pinetown Printers, South Africa

To order, contact:
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Faculty of Law
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Cover design:
DN Ikpo

ISBN: 978-1-7764484-5-6

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Choice and conscience: Lessons from South Africa for a gobal debate *is a necessary and timely read. Abortion laws, such as South Africa's, provide formal guarantees to decide and act to terminate a pregnancy; but they fail to engage with the background rules, social and cultural contexts, and gendered power asymmetries, which in turn impede implementation.*

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Alicia Ely Yamin, Harvard University

Foreword

Women's rights to equality, the highest attainable standards of physical and mental health, and the benefit from scientific progress, including access to quality services related to reproductive and sexual health, are firmly entrenched in international and regional human rights instruments. These rights and entitlements have been reaffirmed in consensus agreements and are recognised by international, regional, and national mechanisms, as well as in jurisprudence.

In 1994, the International Conference on Population and Development (ICPD) took a significant step by acknowledging the inextricable link between women's rights to reproductive and sexual health and their overall well-being. This recognition was not merely a symbolic gesture but a defining moment that solidified the understanding that any form of discrimination against women in matters of health and safety constitutes a grave affront to their human dignity. The notion of human dignity, coupled with the principle of equality, finds its articulation in the Universal Declaration of Human Rights (UDHR), a foundational document that underpins freedom, justice, and peace in our world.

I am pleased to write the foreword for this significant book, which delves into the intricate interplay between choice, conscience, and the right to sexual and reproductive health, an integral part of the right to health. As the UN Special Rapporteur on the Right to Health, I have seen first-hand the challenges that women, adolescents, girls, and all persons capable of becoming pregnant encounter when seeking quality healthcare, particularly when their health needs are placed unfairly at odds with the beliefs of healthcare providers.

Sexual and reproductive health rights (SRHR) are essential facets of the right to life, the right to health, the right to education, and the right to equality and freedom from discrimination. Ensuring access to SRHR services is a critical factor in empowering women and girls to attain the highest standards of health and well-being. This includes access to information and to safe abortion, an indispensable component of comprehensive healthcare services.

Over the past three decades, United Nations (UN) treaty-monitoring bodies and special procedures branch have recognised and affirmed abortion as a human right. This consensus is evident in concluding observations, general comments, general recommendations, independent expert reports and interventions as third parties in court proceedings, and decisions on communications brought under UN treaties' optional protocols. In Africa, the right of women to access safe abortion has been enshrined as a fundamental human right through the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).

Despite the positive trend toward the decriminalisation of abortion, many countries have not yet translated domestic legal reforms into access in real terms and without discrimination to safe abortion services. Even in countries where abortion is legally permitted, women often encounter barriers to accessing safe services. One significant hurdle that lies at the level of clinical care is the exercise of conscientious objection by healthcare providers, which they evoke to allow them to refuse to perform a task that goes against their conscience, and it is important to point out that this behaviour is almost always associated with services and tasks related abortion care and no other areas of medicine.

The Choice on Termination of Pregnancy Act came into effect in South Africa in February 1997, with hopes it would promote female reproductive autonomy by providing free access to abortion. While the Act is celebrated as a historic moment for women, today's reality could not be more different. Access to health services continues to be affected by spatial injustice, which reflects a combination of racial segregation, colonial and apartheid repression, and the Government's failure to address stark inequalities in the infrastructure and resources of the public health system. The legal framework is important and necessary, but it is not sufficient to ensure that women have access to abortion. As a doctor, I have seen what lack of access to safe abortions means: too many women in South Africa experience complications and preventable deaths.

In accordance with decisions made by human rights treaty bodies, even in cases where conscientious objection is permitted, governments bear the responsibility of ensuring unimpeded access to reproductive health services for women and safeguarding the principle that conscientious objection remains a matter of individual belief rather than an institutional practice. The exercise of the right to freedom of religion or belief should never be deployed as a rationale for gender-based discrimination and should not serve as a justification for obstructing the realisation the right to the highest attainable standard of physical and mental health.

In this context, Choice and Conscience: Lessons from South Africa for a Global Debate stands as a significant and valuable addition to the ongoing global scholarship on this critical issue. It underscores the vital concept that intersectionality should occupy a central place in our examination of how various local contexts give rise to layered forms of privilege and disadvantage. In this regard, it highlights the specific and compounding impact of power on individuals.

This book serves as a valuable resource, one that can inform and shape our collective perspective on the fundamental right to sexual and reproductive health. It reminds us that the struggles faced by women, adolescents, girls, and all individuals capable of becoming pregnant are not confined to a single region; they are universal. By sharing the experiences and lessons learned in South Africa, this book contributes to a broader international dialogue, fostering a collective understanding of the issues at hand. I highly recommend this book to a wide audience, including scholars, researchers, practitioners, human rights activists and advocates, lawyers, and policymakers, not only within Africa but also globally.

In an increasingly interconnected world, where local dynamics often have far-reaching implications, understanding the complex relationship between gendered power dynamics, and decision-making processes to providing abortion services by mid-level providers is paramount. Choice and Conscience provides valuable insights and lessons that will guide us in forging a more equitable and rights-based approach to these critical issues.

Dr Tlaleng Mofokeng
UN Special Rapporteur on the Right to the
Highest Attainable Standard of Physical and
Mental Health

Preface

This book is the culmination of a journey that began with my research on conscientious objection to abortion in South Africa for my doctoral thesis. As a feminist scholar, I have always been fascinated by the intersection of law, policy, and social justice issues, particularly in the context of reproductive rights. However, I noticed a significant gap in the discussion surrounding conscientious objection to abortion within the African context, and the unique challenges that healthcare providers face when attempting to provide abortion care.

Through my engagement with healthcare providers, policymakers, and advocates working in the field of reproductive health and rights in South Africa and beyond, I have sought to explore the complexities of conscientious objection to abortion. This book examines the legal, social, and ethical implications of this practice for healthcare providers and the broader community through an African feminist lens.

This book has been a true labour of love, and I hope that it will serve as a resource for scholars, policymakers, and activists working towards the realisation of reproductive rights and justice for all.

During my research, I was deeply moved by the remarkable courage, unwavering resilience, and unwavering commitment of the nurses who dedicate themselves to providing abortion services. These nurses are true heroes, often working in difficult circumstances and facing significant social, political, and professional barriers. Yet, they persevere, driven by a deep sense of compassion and a desire to provide the best possible care to their patients. As bell hooks once said, "The function of art is to do more than tell it like it is – it's to imagine what is possible." In the context of abortion services, these nurses not only confront the realities of their work but also envision a future where access to safe and compassionate care is a fundamental right for all individuals.

Their stories challenged my preconceptions and broadened my perspective, highlighting the need to acknowledge the complexity and diversity of experiences within the nursing profession. I hope that by presenting the intersectional experiences of nurses providing or not

providing abortion services, I can contribute to a greater understanding of these experiences. By sharing their stories, I hope to bring attention to the critical role of nurses in the delivery of quality healthcare and to encourage a more empathetic and supportive approach to healthcare provision, one that was envisioned when the Universal Declaration of Human Rights was drafted nearly seventy-five years ago.

Satang Nabaneh
Pretoria, 2023

Acknowledgments

I am sincerely grateful to the numerous individuals who have played a crucial role in helping me complete this book. Their unwavering support, encouragement and inspiration have been invaluable.

First and foremost, I would like to thank my supervisors, Prof Charles Ngwena and Prof Siri Gloppen, for their guidance and support throughout my doctoral studies and post-doctoral fellowship. Their dedicated supervision, mentorship, and motivation over the past few years have been invaluable.

I am also grateful to the CMI-UiB Centre on Law & Social Transformation for funding my doctoral studies as part of the 'Political determinants of sexual and reproductive health: Criminalisation, health impacts and game changer' project, supported by the Research Council of Norway (grant number 248159). I am privileged to have been part of the Bergen Exchanges on Law & Social Transformation community, and I will always consider myself a proud #Lawtransformer.

My sincere appreciation goes to the African Population and Health Research Center (APHRC) for awarding me the African Doctoral Dissertation Research Fellowship (ADDRF) 2018-2020. This fellowship not only provided financial support but also enabled me to participate in valuable training to enhance my research.

I am deeply grateful to the Ipas South Africa office, especially Dr Makgoale Magwentshu and Matokgo Makutoane, for their willingness to share information and facilitate access to healthcare facilities. Being part of the Ipas Innovation Lab, working on conscientious objection in Mexico, Bolivia, and South Africa, was a pivotal experience.

Special thanks are due to Marion Stevens, former Chairperson of the Sexual and Reproductive Justice Coalition (SRJC), for her invaluable contacts and networks, as well as to Prof Cathi Albertyn for granting me access to her remarkable archive.

I am thankful to the healthcare providers, policymakers, and researchers whose invaluable time and information made my research possible.

I owe a debt of gratitude to my extraordinary friends and colleagues at the Centre for Human Rights, whose unwavering support and friendship have been a constant source of strength throughout this journey.

I am also ever grateful to the Pretoria University Law Press (PULP) editorial team: Prof Charles Fombad, Lizette Hermann, Liesl Hager, and Kate Painting. Many thanks to David Ikpo for the breath-taking book cover. I benefited immeasurably from the peer reviewers' constructive and comments, leading to substantial improvements to the manuscript.

I am thankful to Susan Weaver who generously read parts of the manuscript and provided invaluable insight. Any errors are attributable only to me.

Special thank you to Dr Tlaleng Mofokeng, UN Special Rapporteur on the right to the highest attainable standard of physical and mental health, who generously wrote the foreword to this book.

I am tremendously thankful to Njundu Drammeh and Musu Bakoto Sawo for being significant pillars of support.

Finally, I owe a profound debt of gratitude to my family: my father and mother, Sheriffo Nabaneh and Mamanding Ceesay, and my siblings: Fatou, Lamin, and Baboucarr, for their unconditional support and prayers. I am incredibly blessed to have enjoyed the steadfast support of my second family, including the late Mamo Cham (May Allah's Blessings be Upon Her) and Papa Cham.

My beloved #MMCs: my husband, Mam Mbye Cham, my son, Mahy, and our newest addition to the family, Zaina, who came into our lives during the time of writing this book, were a constant source of support. I am endlessly grateful for their love and inspiration.

About the author

Satang Nabaneh is an African feminist socio-legal scholar and human rights practitioner, dedicated to advancing human rights and equality. She holds a doctorate and master's degree in law from the University of Pretoria, a bachelor's degree from the University of The Gambia, and a newly minted Ph.D. in law from the University of Washington. She is also a Post-Doctoral Fellow with the Centre for Human Rights, Faculty of Law at the University of Pretoria, and a Research Fellow with the Centre on Law and Social Transformation, Chr Michelsen Institute, at the University of Bergen, Norway. She is a member of the Initiative for Strategic Litigation in Africa (ISLA) Panel of Experts.

Dr Nabaneh is interested in the application of black feminist legal theory, decolonial feminist pedagogy, and legal philosophy through an interdisciplinary and empirical socio-legal approach to law, rights, and justice. Her research has focused on the global human rights architecture, gender equality, women's rights, democratisation and autocratisation, constitution-making, and transitional justice. She has published several book chapters and articles on these topics.

Dr Nabaneh is currently the Director of Programs at the Human Rights Center and Research Professor, School of Law at the University of Dayton. She is also an affiliate faculty member in the university's Human Rights Studies, Women's and Gender Studies and Race and Ethnic Studies: Africana Studies programs. Nabaneh is a sought-after speaker and conducts workshops and trainings. She has co-edited two books: *The Gambia in transition: Towards a new constitutional order* (Pretoria University Law Press, 2022) and *Sexual harassment, law and human rights in Africa* (Palgrave Macmillan, August 2023).

Nabaneh's scholarly contributions have been recognised through the prestigious Florence Mahoney Award for Women in Academia, which she has received twice from She Awards Gambia. She is the Women in Law Initiative's 2023 Justitia Academia (International) Laureate and now serves on its Academic Advisory Board.

The Christof Heyns Memorial Thesis Award

The Memorial Thesis Award was introduced to honour the memory of the late Professor Christof Heyns, who passed away in March 2021. Professor Heyns was a founder of the Pretoria University Law Press and took the initiative towards the introduction of this prize. This prize underlines his exceptional passion for promoting scholarship and a life devoted to initiating innovative ideas to make the world a better place for all. There can be no better way to begin to recognise the enormous contribution that Professor Heyns has made to advancing scholarship, research and publication in Africa, by Africans and on Africa.

Students who have completed, or will complete, their doctoral studies in law at an African University in a certain year, are encouraged to submit their doctoral theses for consideration for the Christof Heyns Memorial Thesis Award, which is awarded on an annual basis.

Dr Nabaneh's doctoral dissertation, '*Power dynamics in the provision of legal abortion: A feminist perspective on nurses and conscientious objection in South Africa*,' completed in 2020, is a runner-up of the first Christof Heyns Memorial Thesis Award of 2021.

List of abbreviations

African Charter	African Charter on Human and Peoples' Rights
African Commission	African Commission on Human and Peoples' Rights
AIDS	Acquired immunodeficiency syndrome
APBET	Policy for Alternative Provision of Basic Education and Training Kenya
ART	Antiretroviral therapy
ARV	Antiretroviral
ASALs	Arid and semi-arid lands Kenya
ATRAHDOM	Asociación de Trabajadoras del Hogar, a Domicilio y Maquila Guatemala
AU	African Union
AUC	African Union Commission
CAL	Coalition of African Lesbians
CDC	Centre for Disease Control
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CEDAW Committee	Committee on the Elimination of Discrimination against Women
CEHURD	Centre for Health, Human Rights and Development
CESCR	Committee on Economic Social and Cultural Rights
COIDA	Compensation for Occupational Injuries and Diseases Act South Africa
COMESA	Common Market for Eastern and Southern Africa
COVID-19	Coronavirus disease 2019
CRC	Convention on the Rights of the Child
CRPD Committee	Committee on the Rights of Persons with Disabilities
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil society organisations
DWYPD	Department of Women, Youth and People with Disabilities South Africa
FCT	Federal Capital Territory
FGM	Female genital mutilation
FPE	Free Primary Education Kenya
GBV	Gender-based violence
GCC	Gulf Cooperation Council
GDP	Gross domestic product
GVAW	Gender-based violence against women
HIV	Human immunodeficiency virus
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICT	Information and Communication Technologies
ILO	International Labour Organisation
IMF	International Monetary Fund
IOM	International Organisation of Migration
IPV	Intimate partner violence

KTN	Kenya Television Network
LBQT	Lesbian, bisexual, queer and transgender
LGTIQA+	Lesbian, gay, transgender, intersex, queer, asexual and others
Maputo Protocol	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
MBC	Mauritius Broadcasting Corporation
MDGs	Millennium Development Goals
MHM	Menstrual hygiene management
MTP	Medium-term plan
NACONEK	Policy Framework for Nomadic Education in Kenya
NESP	Nigeria Economic Sustainability Plan
NFE	Non-formal education Kenya
NGF	Nigerian Governors Forum
NGOs	Non-governmental organisations
NSR	National Social Register Nigeria
OHCHR	Office of the High Commissioner for Human Rights
Older Persons' Protocol	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Older Persons in Africa
OVCs	Orphans and vulnerable children
PMTCT	Prevention of parent to child transmission
PPE	Personal protective equipment
SAPS	South African Police Service
SDGEA	Solemn Declaration on Gender Equality in Africa
SDGS	Sustainable Development Goals
SGBV	Sexual and gender-based violence
SRHR	Sexual rights and health rights
STDs	Sexually transmitted diseases
STIs	Sexually transmitted infections
UAE	United Arab Emirates
UDHR	Universal Declaration of Human Rights
UIF	Unemployment Insurance Fund
UN	United Nations
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees
UNODC	United National Office on Drugs and Crime
WHO	World Health Organisation
WIEGO	Women in Informal Employment: Globalizing and Organizing
WMDW	Women migrant domestic worker

To my parents,

Sheriffo Nabaneh and Mamanding Ceesay,

For believing in me, letting me be loud and visible.

THIS ONE IS FOR YOU.

PROLOGUE

FREE TO CHOOSE

The Choice on Termination of Pregnancy Act
Was strongly opposed, but now it is a fact
That in villages and cities country wide
Women at last are free to decide

Free to decide, our values collide
Bearers of light, yet helpers in plight
If I were you and you were me
Would we defend our right to be?

No said the patriarchs. No said the Pope
We can't let you down this slippery slope
But I'm here already, with my neck in a rope
On my hands and knees – please throw me some hope

They came in their numbers; they came in their hurt
But we turned our backs on the 'sin and the dirt'
We scold and cajole: – 'I'd hate you to sin,'
Pushing them nearer the back-street bin

Our staff were resistant, and also were sad
Some of us thought these women were bad
Not all unwilling, [though] – many turned away
Until they heard what the women had to say

Their reasons were many, their reasons were varied
Most came resolute, and almost all came wearied
Some were divorced, and some were well wed
Some came with hunger, and mouths to be fed

Some whose boyfriends once hearing had fled
Some had been raped in their own private bed
Some were too young, and some were too old
But they were brave, and their stories were told

Free to decide, our values collide
Bearers of light, yet helpers in plight
If I were you, and you were free
Would we defend our right to be?

Dr Jim te Water Naude[1]

1 Reproductive Rights Alliance 'Five-year review of the implementation of the Choice on Termination of Pregnancy Act, 92 of 1996: 1997-2002' *The Barometer* (2002) 1.

PART I:

Conscience claims: Laws and policy

Introducing *Choice and conscience: Lessons from South Africa for a global debate*

> Interviewer: Has anybody mentioned, [including] previous management, how that process happens? If a nurse does not want to provide, what does she do? What happens? Who does she speak to? Is there a form? Is there a procedure?
>
> Nurse: I'm not sure because, you know, this is complicated. When I arrived here … there was no leadership and governance, there was no management at all … So, I was not given any report, so I came here as I am, but we've been hearing it's via the grapevine.
>
> Interviewer: Okay, so to your knowledge, there are no policies or procedures for conscientious objection?
>
> Nurse: No … But we are guided by ethics.
>
> Interviewer: Do you have an Ethics Committee?
>
> Nurse: Not really. I'm trying to establish Committees.

In the bustling city of Johannesburg, the promise of safe and lawful abortion services is often a facade that obscures a much darker reality. Despite the progressive abortion laws in the country, women still encounter significant barriers when seeking reproductive healthcare.[1] This harsh reality was brought to light in a shocking *Daily Sun* newspaper article entitled: 'House of abortion horror', which exposed the reality of illegal abortion providers in the country.[2] The article recounted the harrowing story of a 19-year-old woman who was caught by the police attempting to take pills to terminate

1 Committee on Economic, Social and Cultural Rights, Concluding Observations on the initial report of South Africa, 29 November 2018, UN Doc E/C.12/ZAF/CO/1 (2018) para 65.

2 'House of abortion horror!' *Daily Sun* 10 June 2013 http://www.politicsweb.co.za/news-and-analysis/house-of-abortion-horror--daily-sun (accessed 30 August 2017).

her five-month-old foetus.[3] The incident led to the arrest of Kute, an illegal abortion provider from Uganda, and revealed the squalid conditions in which these procedures were carried out. The article was accompanied by a disturbing photo of a poorly kept room being used for surgery.[4] It was a grim reminder of the dangers and risks associated with illegal abortions. In 2017, five fake doctors were found guilty of illegally terminating pregnancies, violating sections 7 and 10 of the Choice on Termination of Pregnancy Act 92 of 1996. They were sentenced to six months in prison, a small measure of justice for the women who were left vulnerable and at risk in their quest for reproductive autonomy.[5] These stories are just a few examples of the challenges that women face in accessing safe and legal abortion services, even in countries with seemingly progressive laws.

Despite the incredible gains made in protecting women's reproductive rights over the past few decades, conscientious objection has emerged as a critical disabling factor in this fight. Healthcare providers are increasingly refusing to provide abortion services on the basis of their religious, moral, philosophical, or ethical beliefs, leaving women vulnerable and at risk. The debate around conscientious objection and its impact on women's reproductive rights has become one of the most striking trends in the abortion debates. Across the world, the practice of healthcare providers refusing to provide abortion services is on the rise.[6] Conscientious objections have shifted from the traditional basis of one refraining from military service to one where objectors seek exemptions from a broad range of sexual and reproductive health services, including contraception, to refusing to issue licenses for same-sex couples. This has created a complex issue of competing rights between women's rights to safe, legal abortion and healthcare providers' claimed right to refuse.[7]

With the increasing use of conscientious objection by healthcare providers to refuse to provide abortion services as countries around the globe continue to reform their abortion laws, it is imperative to examine the various factors that contribute to this contentious issue. Additionally, exploring potential solutions that can balance the competing rights of

3 'Bogus abortion doctors sentenced to six months in jail' *African News Agency* 7 June 2017 https://www.iol.co.za/news/south-africa/gauteng/bogus-abortion-doctors-sentenced-to-six-months-in-jail-9604146 (accessed 30 August 2017).

4 As above.

5 As above.

6 See W Chavkin et al 'Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses' (2013) 123 *International Federation of Gynecology and Obstetrics* S41 at S44.

7 J Harries et al 'Health care providers' attitudes towards the termination of pregnancy: A qualitative study in South Africa' (2009) 9 *BMC Public* Health 1.

healthcare providers and women seeking reproductive healthcare services is crucial. This raises critical questions about the legitimacy and scope of such claims, the lawful limits of conscientious objection, who has the right to object, and how the process of making such claims should be regulated.

Conscientious objection is a practice widely recognised and enshrined in law in many countries worldwide, including the United Kingdom, Australia, France, and the United States.[8] Despite being widely celebrated as a model law on abortion, the Choice on Termination of Pregnancy Act does not explicitly tackle the issue of conscientious objection.[9] This is a common occurrence in most African countries and other regions, where the issue remains largely unregulated.[10] However, there are exceptions to the rule, such as the Zambian Termination of Pregnancy Act of 1972, which allows for a limited scope of conscientious objection to be exercised.[11]

Given the lack of explicit regulation on conscientious objection in many countries, the issue of limited access to safe and legal abortion services is further compounded. In South Africa, this problem is particularly acute, with estimates indicating that only a small proportion of health facilities offer abortion services, leaving women with few options for accessing this essential healthcare service.[12]

Choice and conscience offers a fresh perspective on a highly debated topic that has significant implications for reproductive healthcare services worldwide. I am interested in delving into the complex and multifaceted issue of conscientious objection in abortion care, focusing specifically on the experiences of nurses in South Africa. Given the similar legal scope of practice between nurses and midwives within the context of South Africa's abortion law,[13] I have chosen to use the term 'nurses' to include 'midwives' with requisite training while taking into account specific nuances of each profession.

8 A Heino et al 'Conscientious objection and induced abortion in Europe' (2013) 18 *European Journal of Contraception and Reproductive Health Care* 231.

9 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) 17.

10 OR Gustavo 'Abortion and conscientious objection: Rethinking conflicting rights in the Mexican context' (2017) 29 *Global Bioethics* 5.

11 See Zambia Termination of Pregnancy Act, 1972.

12 Committee on Economic, Social and Cultural Rights (n 1) para 65.

13 The South African Nursing Council regulates both nurses and midwives.

Through a critical examination of the law on the ground, I seek to contribute to an understanding of the nature and scope of conscience, discretionary power, and the broader socio-cultural and political factors that influence nurses' exercise of conscientious objection. By exploring these questions, I aim to provide insights into the challenges faced by healthcare providers and the impact of conscientious objection on women's access to safe and legal abortion care.

In this book, I approach these questions from the perspective of the traditional legal scholarship paradigm and feminist intellectual traditions in a number of ways by examining the legal norms (formal, informal, or background rules) with lived experiences and a first-hand account of nurses. Thus, this book, which builds on broader socio-legal work, bridges a variety of analytical perspectives, combining knowledge of the law and how it shapes power relations on the ground, which is notably lacking within the African context. In particular, this book sheds light on the issue of conscientious objection as a limitation to reproductive healthcare, specifically in the context of women's access to abortion services. The ongoing debates about abortion are not limited to countries where it is legal. They are also present in countries where abortion is restricted. This is a particularly relevant issue in the current global discourse on reproductive healthcare, as conscientious objection is increasingly being used as an anti-abortion strategy to limit access to services, even where it is legally permitted.

This book also stands out by offering a unique socio-legal perspective on conscientious objection in abortion care, which is rarely studied in the context of Africa. By incorporating both the traditional legal scholarship paradigm and feminist intellectual traditions, the book provides a nuanced perspective on the ways in which power relations are shaped and maintained through legal norms. Here I develop a critical African feminist perspective framework, which incorporates aspects of African feminism[14] and general feminist theorising to address the gaps in the literature. Much of this book bridges analytical perspectives to provide an understanding of how legal norms, both formal and informal, shape power relations on the ground. An attempt to widen the global discourse on conscientious objection and its impact on women's reproductive rights.

14 While recognising plurality (African feminisms) within the context of various localised realities in Africa, I will use the singular – *African feminism* – to acknowledge common features.

1 Studying law in action: Reflections

The production of knowledge is influenced by the researcher's epistemology and experiences. As such, it is vital to acknowledge how we come to know what we think we know and how our experiences shape our understanding of the world.[15] Examining the 'law in action', is premised on the recognition of the importance of understanding how laws, norms and rights are realised through lived experiences. This means exploring the discrepancies between what the law says and what actually happens in practice.

I apply an intersectional analysis to offer critical insights into the complex subjectivities and experiences of nurses from a simultaneous viewpoint of privilege and oppression. This re-echoes Katherine Barlett's claim that 'victims do not have exclusive access to the truth about oppression'.[16] I hope therefore to convey the ways in which lived identities, structural systems, and forms of power intersect and change.

As a feminist researcher, scholar, and activist, I draw on feminist theories of knowledge to explore the experiences of nurses providing or not providing abortion services through narratives. Throughout this book, I present the differences in nurses' experiences, knowledge, and situatedness through feminist inquiry. While the narratives are important, how I read them, understand them, and disseminate the information from a feminist perspective is equally crucial. I acknowledge my personal values, biases, and assumptions in the knowledge production process.

My background and experiences, including my upbringing in a Muslim society with strict abortion laws, my feminist activism, and my membership in various women's rights organisations, inform the research presented in this book. As I conducted this research, I was aware of certain limitations that could impact the validity and scope of my findings. One significant limitation was that I am not a healthcare professional, which meant that I came to this study as an outsider to the world of healthcare. While this may have allowed me to bring a fresh perspective to the research, it also meant that my personal understanding of the challenges faced by nurses in the field was limited. Another limitation I had to contend with was that I was not born and raised in South Africa, where this study was conducted. As

15 MJ Alexander *Pedagogies of crossing: Meditations on feminism, sexual politics, memory, and the sacred* (2005) 2. See D Lewis 'African gender research and postcoloniality: Legacies and challenges' in O Oyěwùmí (ed) *African gender studies: A reader* (2005) 381-382.

16 KT Barlett 'Feminist legal methods' (1990) 103 *Harvard Law Review* 875.

an outsider, I was conscious that I could not provide a universal truth that would be representative of all women living in South Africa, particularly nurses. I was acutely aware of the past institutionalised racism that existed in the country, something I have not experienced personally.

Despite these limitations, I remained committed to the research and the stories shared by the nurses who participated. Throughout each stage of the process, from conducting fieldwork to writing and revising the manuscript, I was determined to avoid presenting a singular narrative of 'the South African nurse'. Instead, I was grateful for the privilege of witnessing and re-narrating these stories, knowing that they could contribute to a greater understanding of the complex relationship between gendered power dynamics, subjective fields, and nurses' decision-making processes.

2 The structure of this book

The rest of this book is divided into three main sections. Part I, ***Conscience claims: Laws and policy***, I suggest a (re)framing of the debate through an African feminist approach as a crucial foundation for understanding conscientious objection and its impact on abortion care. In Chapter 1, I argue that while western feminist theories are valuable, they are not adequate enough to capture the abortion issue in Africa in general and more specifically in South Africa. In Chapter 2, I explore the current debate on conscientious objection and its relevance to the African region, emphasising the lack of visibility of Africa in the current discourse. This chapter highlights the need for an Africa-focused discussion to address the changing landscape of abortion in the region. In Chapter 3, I examine the normative framework of abortion in South Africa, arguing that the current legal framework does not fully regulate the practice of conscientious objection and fails to comply with international human rights obligations. This analysis is essential in understanding the challenges faced by healthcare professionals in providing abortion care in South Africa and beyond.

In Part II, ***Nurses as shapeshifters: Stories, agency, and testimonies***, the two substantial chapters provide a powerful and nuanced look into the complex world of nurses and their work with abortion care. Chapter 4 unpacks the power dynamics at play in conscience claims and the discursive construction of nurses' work in this field. This chapter illuminates the challenges nurses face while providing abortion services in public health facilities. In the second part of Chapter 4, with the two stories of nurses who own their stand-alone abortion clinics, I reflect on the unique gendered professional practices within the private sector. In

Chapter 5, I use numerous narratives to explore the factors that shape nurse' motivations regarding conscientious objection and the various framing discourses that influence their practical decisions to provide or not provide abortion services. At the same time, power relations are manifested and reinforced within this space, I explore factors that shape and influence these power dynamics. These chapters present a compelling and much-needed exploration of the realities of nurses' experiences in this critical area of healthcare.

In Part III, ***Charting a legal path forward: Strategies for change***, I return to one of the fundamental themes of the book: What is the legal and ethical scope of conscientious objection, especially as it relates to the essential conditions required to safeguard respect for women's reproductive autonomy and human dignity when they seek abortion services? Through a comparative analysis of international human rights law and existing abortion legislation, Chapter 6 delves into the regulation of conscientious. I argue in this chapter that courts need to adopt a proactive approach in interpreting conscientious objection, ultimately ensuring its alignment with constitutional provisions and international human rights standards.

Finally, in the conclusion (Chapter 7), I reflect on the broader implications of the research presented and outline avenues for future scholarship. By providing a comprehensive analysis of conscientious objection in relation to abortion care, the book sheds light on the various challenges faced by nurses and offers proposals for regulation that better align with international human rights standards while acknowledging that there is no bullet-proof checklist.

1

An African feminist exploration of conscientious objection to abortion

> We define and name ourselves publicly as feminists because we celebrate our feminist identities and politics. We recognise that the work of fighting for women's rights is deeply political, and the process of naming is political too. Choosing to name ourselves feminists places us in a clear ideological position. By naming ourselves as feminists we politicise the struggle for women's rights, we question the legitimacy of the structures that keep women subjugated, and we develop tools for transformatory analysis and action. We have multiple and varied identities as African feminists. We are African women – we live here in Africa and even when we live elsewhere, our focus is on the lives of African women on the continent. Our feminist identity is not qualified with 'ifs', 'buts' or 'howevers'. We are feminists. Full stop.
>
> – Charter of feminist principles for African feminists, 2006

Since the 1990s, the international health and development agenda has recognised the importance of sexual and reproductive health and rights. This was highlighted by the International Conference on Population and Development (ICPD) in 1994, which drew attention to the issue of women's sexual and reproductive health.[1] The Fourth World Conference on Women in 1995, where African feminists played a significant role, also emphasised the importance of reproductive autonomy and was instrumental in the adoption of the Beijing Platform for Action.[2] In Africa, the momentum around women's reproductive health has continued to grow.[3] The adoption of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) by the African Union (AU) in 2003 was a significant milestone.[4] This was followed by the adoption of General Comment 2 on reproductive

1 United Nations (UN) 'Report of the International Conference on Population and Development' A/Conf.171/13/Rev.1 (1995).

2 United Nations (UN) 'Report of the Fourth World Conference on Women' A/CONF.177/20/Rev.1 (1996).

3 See CG Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 783.

4 African Union, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted 11 July 2003, entered into force 25 November 2005.

health rights in 2014, further strengthening the rights of women in Africa.[5] Overall, the recognition of sexual and reproductive health and rights as a key part of the international health and development agenda has brought attention to the importance of these issues in ensuring the health and well-being of individuals, particularly women.

While the Maputo Protocol is deemed innovative, there are conflicting messages about women's roles as exemplified in the health and reproductive rights provided under article 14, as there continues to exist an uneasy tension between a focus on equal choice that resonates with liberal feminism while aligning it with women's distinct roles within religious and traditional norms.[6] Generally, there has been a trend toward liberalisation of abortion on the continent. However, despite this changing abortion landscape, women in sub-Saharan Africa continue to face the most significant risk globally for unintended pregnancy resulting in unsafe abortion, given that most African countries have restrictive abortion laws. As of 2019, the region has the highest abortion-related case-fatality rate of any world region. Even where women meet the legal requirements, for the majority of African women, abortion services are frequently unavailable or inaccessible. While it can be argued that feminists are busy with 'bread, butter and culture' issues, particularly in Africa, and focused on campaigning for abortion reform, it is precisely because of the changing abortion landscape that it becomes necessary to address the issue of conscience claims.

1 Negotiating with African feminism[7]

Given this context, there is utility in engaging with the practice of conscientious objection from an African feminist lens. The theoretical lines I follow, extend, and sometimes diverge from are largely located in African feminism. Thereby contributing to the scholarship on African feminist discourses on abortion and the interpretation of African women's resistance. African feminist scholars reject the idea of a uniform position and emphasise the importance of visualising African women's realities. They see the need to optimise the African gaze and utilise relevant 'transcultural knowledge' while avoiding the enforcement of hegemonic

5 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 (2014).

6 F Banda 'Blazing a trail: The African Protocol on Women's Rights comes into force' (2006) 50 *Journal of African Law* 76.

7 While recognising plurality (African feminisms) within the context of various localised realities in Africa, I will use the singular – *African feminism* – to acknowledge common features.

and universalising knowledge emerging from a 'Eurocentric canon'.[8] From the standpoint of women's everyday lives, in this case, the lives of nurses, feminist theories afford a space for conceptualising power, knowledge and discourse. Such an approach is suitable for theorising relations of power and subject formation, which are all reflected within the day-to-day operation of nurses who give abortion care. However, there is a tacit caution about universalising women, which pays little attention to the range of experiences. In this sense, Audre Lorde, an African American writer, and feminist, expresses, 'there is a pretence to homogeneity of experiences covered by the word sisterhood that does not in fact exist'.[9]

African feminist scholars have portrayed the problematic nature of the Western-centric lens of the 'universalised woman', which is not responsive to the range of women's experiences.[10] Chandra Mohanty situates this problem as one wherein western women place themselves as the 'primary referent', serving as a benchmark to measure deviation from.[11] She argues that a discursive practice is formed within the context of Western feminist representations of other women, which reinforces systems of domination that they seek to dismantle.[12] Contemporary expressions of African feminism are focused on the recognition and affirmation of the diverse experiences of African women. Rather than being preoccupied with visualisation alone, African feminism seeks to reframe dominant narratives about African women by highlighting their agency and challenging patriarchal structures that oppress them.

In response to Western-based feminism, the pioneering works of African feminist theorists such as Filomina Steady, Oyeronke Oyewumi, Ifi Amadiume, and Akina Maman have led to the articulation of the African feminist theory.[13] This theory is grounded in the recognition of the unique historical, social, and cultural contexts of African women's experiences and seeks to challenge the universalising tendencies of Western feminism. Obioma Nnaemeka succinctly notes that African

8 C Ngwena *What is Africanness? Contesting nativism in race, culture and sexualities* (2018) 217.

9 A Lorde *Sister outside: Essays and speeches* (1984) 116.

10 See I Amadiume *Reinventing Africa: Matriarchy, religion and culture* (1997); P Gqola 'Ufanele uqavile: Blackwomen, feminisms and postcoloniality in Africa' (2001) 16 *Agenda* 17.

11 CT Mohanty 'Under Western eyes: Feminist scholarship and colonial discourses' (1988) 30 *Feminist Review* 61 at 61-62.

12 As above.

13 See A Mama *Beyond the masks: Race, gender, and subjectivity* (1995).

feminism *'is* because it *resists*'.[14] While acknowledging its connections with international feminism, African feminism places a specific emphasis on addressing the unique needs and struggles of women in Africa.[15] Filomena Steady characterises African feminism as humanistic because it takes into account the totality of human experience, beyond just oppression based on race or class.[16]

The starting point for African feminism is the recognition that there is no single, uniform position that represents African women's experiences. African feminists aim to theorise the complexities of the relationships that exist within the context of colonialism, post-colonialism, imperialism, and social-economic exclusion.[17] Patricia McFadden highlights how African and white men colluded to exclude African women from emerging urban spaces in colonial towns and cities, which illustrates the gendered exclusion and 'othering' of African women.[18] This exclusion and marginalisation of African women has been a persistent challenge, and African feminist theory seeks to address it by emphasising the importance of including African women's voices and experiences in the struggle for gender equality.

The theoretical and analytical paradigm of the book is rooted in the observation of African women's lived experiences, and builds on existing feminist theories, specifically African feminism. The primary goal is to provide a feminist analysis of the practice of conscientious objection that centres on women's experiences. This analysis critically examines the gendered implications of existing laws, or the lack thereof, and their assumed link with health service provision, with a particular focus on South Africa. Through this examination, the book aims to develop insights into the power dynamics that underlie the provision of legal abortion within the broader African context.

In this research, a feminist lens is utilised that focuses on nurses, who are predominantly women, instead of doctors. The triangular relationship between healthcare providers, nurses, and patients illustrates the implicit power and hierarchical dynamics that are prevalent in patriarchal societies.

14 O Nnemeka 'Introduction: Reading the rainbow' in O Nnemeka (ed) *Sisterhood, feminisms & power: From Africa to the Diaspora* (1998) 6.

15 CB Davies 'Introduction: Feminist consciousness and African literary criticism' in CB Davies & A Graves (eds) *Ngambika: Studies of women in African literature* (1986) 8-10.

16 FC Steady 'African feminism: A worldwide perspective' in R Terborg-Penn & A Benton (eds) *Women in Africa and the African Diaspora: A reader (*1996) 4.

17 S Ardnt 'Perspectives on African feminism: Defining and classifying African-Feminist literatures' (2002) 54 *Agenda: Empowering women for gender equity* 32.

18 P McFadden 'Cultural practice as gendered exclusion: Experiences from Southern Africa' in A Sisask (ed) *Discussing women's empowerment: Theory and practice* (2001) 64.

Women's access to reproductive healthcare, including termination of pregnancy, is closely linked to power. Power structures exercised in patriarchal societies exert influence over women's power of agency over their own bodies, which in turn negatively affects the institutions and systems in society against women.[19]

It is acknowledged that power relations play a critical role in deciding the position of women and the subjective experience arising out of that location.[20] These power dynamics can manifest in 'paternalistic control', which, as Sally Sheldon explains, involves influencing the woman not to end a pregnancy or, in the case of an objector, refusing to provide an alternative to the woman seeking an abortion.[21] As bell hooks stresses, while all women suffer in some way, they are not all oppressed or equally oppressed.[22]

Shifting the focus from universal theorising, a crucial aspect to consider is intersectionality, which illuminates the interconnectedness of various identities, including race, class, gender, sexuality, disability, and others, with 'interlocking systems of oppression'.[23] However, some critics of the concept of intersectionality argue that it lacks a defined methodology, as social categories are simply listed without recognition of their manifestation of power in specific contexts.[24] Kimberlé Crenshaw suggests that it is insufficient to merely assert a range of identities in intersectionality; rather, one must understand their differences in historical and social contexts.[25] As African women are not homogenous, Ebenezer Durojaye and Olubayo Oluduro argue that variables such as age, socio-economic status, and rural or urban dichotomy must be considered when applying intersectionality in various African contexts.[26] This holistic approach is in line with Sylvia Tamale's observation that 'the dialectical relationship between gender, class, ethnicity, religion, imperialism, and

19 T Braam & L Hessini 'The power dynamics perpetuating unsafe abortion in Africa: A feminist perspective' (2004) 8 *African Journal of Reproductive Health* 43 at 45-47.

20 See J Butler *Gender trouble: Feminism and the subversion of identity* (1999).

21 S Sheldon *Beyond control: Medical power and abortion law* (1997) 66.

22 Sheldon (n 21) 57.

23 PH Collins *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (1990) 18.

24 See JC Nash 'Re-thinking intersectionality' (2008) 89 *Feminist Review* 1; V Patil 'From patriarchy to intersectionality: A transnational feminist assessment of how far' (2013) 38 *Signs: Journal of Women in Culture and Society* 847.

25 K Crenshaw 'Mapping the margins: Intersectionality, identity politics, and violence against women of color' (1991) 43 *Stanford Law Review* 1241.

26 E Durojaye & O Oludoro 'The African Commission on Human and Peoples' Rights and the woman question' (2016) 24 *Feminist Legal Study* 321.

neo-colonialism is especially pertinent for an analysis of gender relations in the African context'.[27]

In order to gain insights into cultural shifts and their implications, Uma Narayan proposes the use of a methodology that traces the history of changes over time.[28] In South Africa, gendered division of nursing was historically shaped by inequalities related to race and class.[29] By examining this history, we can gain insight into how the identity and work of professional nurses have evolved over time. This historical understanding provides a crucial basis for critically examining the current role of nurses in providing abortion services. Focusing solely on race, or the 'Afrocentric standpoint' as Patricia Hill Collins points out, can overlook how gender power dynamics are influenced by multiple factors.[30] Therefore, by using a broader intersectionality approach, we can better understand the impact of various social categories on nurses' experiences providing legal abortion services. Although intersectionality has its limitations, we can still use it to contextualise South Africa's situation and gain insights from a critical African feminist perspective. This approach helps us examine how power dynamics shift as we discuss abortion legalisation and how these dynamics vary in different times, locations, and material contexts. Moreover, this framework is useful for understanding nurses' experiences with conscientious objection when it comes to providing abortion services in South Africa.

This book adopts Joan Williams' approach of using lawyers as persuaders to shape social discourse, with the aim of reframing existing rhetoric to promote feminist objectives.[31] Using this framework, I explore crucial issues related to power, knowledge, gender, and the laws surrounding abortion and conscientious objection. By applying this lens, I seek to challenge essentialist thinking and acknowledge the complexities of multiple identities.

27 S Tamale *When hens begin to crow: Gender and parliamentary* (1999); O Oyěwùmí *The invention of women: Making African sense of gender discourse* (1997) 3.

28 U Narayan 'Essence of culture and a sense of history: a feminist critique of cultural essentialism' (1998) 13 *Journal of Feminist Philosophy* 86.

29 C Burns 'A man is a clumsy thing who does not know how to handle a sick person: Aspects of the history of masculinity and race in the shaping of male nursing in South Africa, 1900-1950' (1998) 24 *Journal of Southern African Studies* 695.

30 PH Collins *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (1990) 234.

31 J Williams 'Gender wars: Selfless women in the republic of choice' (1991) 66 *New York University Law Review* 1559 at 1562.

2 Methodology

Drawing on my background as a lawyer and feminist, I sought to address the questions animating this book on *law in action* through a combination of normative and empirical methods, providing insights into the intersection of law and social practice. While the Choice on Termination of Pregnancy Act does not directly address conscientious objection, this book provides an empirical focus on a case study of South Africa.[32] Despite the fact that abortion can be obtained on demand in South Africa, various challenges hinder access to abortion services.[33] This is consistent with Rachel Rebouché's observation that liberal laws do not necessarily lead to increased access to abortion services.[34] The lack of a legal framework to regulate conscientious objection, accessibility difficulties for poor or marginalised women, stigma, and lack of information on how to access safe abortion services are among the most common barriers to accessing abortion services in South Africa.

The book's particular focus on conscientious objection is driven by the lack of clarification of rights and obligations, which creates a discretionary space for healthcare providers, influenced by power relations. By addressing these issues from a socio-legal perspective, this book contributes to the literature on the challenges of accessing safe abortion services in Africa and highlights the importance of addressing the intersection of legal and social factors that impact reproductive health care access.

Throughout the book, I utilise a wide range of sources to provide a comprehensive examination of conscientious objection to abortion provision in South Africa. These sources include interviews, doctrinal analysis, and archival research, such as the Constitution, laws, cases, and parliamentary Hansards, as well as other relevant archival records. To fully comprehend South Africa's obligations regarding conscientious objection, international and regional human rights instruments were

32 J Gerring *Case-study research: Principles and practices* (2007) 20. See also HE Brady & D Collier *Rethinking social inquiry: Diverse tools, shared standards* (2010).

33 See for example, KA Trueman & M Magwentshu 'Abortion in a progressive legal environment: the need for vigilance in protecting and promoting access to safe abortion services in South Africa' (2013) 103 *American Journal of Public Health* 397; M Favier et al 'Safe abortion in South Africa: 'We have wonderful laws but we don't have people to implement those laws' (2018) 143 *International Journal of Gynaecology and Obstetrics* 38; A Harrison et al 'Barriers to implementing South Africa's Termination of Pregnancy Act in rural KwaZulu/Natal' (2000*)* 15 *Health Policy and Planning* 424.

34 R Rebouché 'A functionalist approach to comparative abortion law' in RJ Cook et al *Abortion law in transnational perspective* (2014) 101.

also gathered and studied, primarily from the United Nations (UN), African Union (AU), European Union (EU), and foreign case law. This situates the discussion of conscientious objection within a broader framework of not just constitutionalism but also international human rights, which has transnational significance. Additionally, a broad range of secondary materials, such as government reports, survey and census data documents, demographic and health reports, reports from non-state actors, newspapers, and other media materials, were used extensively. This approach ensures a thorough analysis of the complex socio-legal issues surrounding conscientious objection and abortion provision in South Africa.

More importantly, the book's focus on the politics of nurses' locations and their impact on restricting and punishing pregnant women they deem underserving requires an understanding of the theoretical frames and embodied methodologies nurses navigate. To achieve this, I draw on interview and focus group data with public sector nurses that was collected as part of a larger three-country study on conscientious objection led by Ipas in South Africa, Mexico, and Bolivia.[35] I also conducted in-depth interviews with nurses in private facilities in Gauteng, which is urban and Limpopo, which has a large rural population. The rationale behind the inclusion of these two provinces was to ensure diversity in the data sites, both in terms of their locations and the type of facilities they represent, particularly regarding reproductive health indicators. The objective was to gain a comprehensive understanding of both the commonalities and differences in approaches across the sites. One contributing factor to the contrasting characteristics between urban and rural landscapes could be the availability of different types of private health facilities. For instance, in Gauteng, typical with urban areas, there is access to specific private clinics like Marie Stopes, which are not present in Limpopo. However, it was observed that nurses who owned their own private clinics were present in both provinces. Furthermore, certain cultural norms and beliefs were found to be more prevalent in rural areas. These cultural factors likely influenced the healthcare practices and approaches utilised in those regions.

Relevant stakeholders, including policy makers, Non-Governmental Organisations (NGOs), women's and human rights activists, and institutions, were also interviewed using qualitative semi-structured

35 The author was a consultant, serving as a member of the innovation team to provide technical guidance related to developing and testing interventions to address the use of conscientious objection among public sector health care workers to deny women's access to safe, legal abortion services in Bolivia, Mexico and South Africa. The views expressed by the author in the analysis do not necessarily reflect those of Ipas.

interviews.[36] Observational data was also collected by attending Ipas VCAT (values clarification for action and transformation) workshops as a participant observer.

The empirical focus on nurses drew data from a sample of 33 nurses[37] involved in different aspects of abortion service provision in public and private facilities that offer abortion services in urban areas of Gauteng and rural areas of Limpopo. The majority of these nurses were female and black, as they form the majority of nurses with termination of pregnancy certification and practice. The South African Nursing Council (SNC) register shows that 79 nurses (75 female nurses and 4 male nurses) have registered the certificate in termination of pregnancy as an additional qualification,[38] with a slight gradual reduction in this number over the past five years.[39]

Although there are male nurses, the majority of nurses are female, which accounts for the gendered profession of nursing, which portrays not only how power works among themselves but also the male-female dimension of power in the healthcare system.[40] Nursing as a profession is gendered in nature, which is primarily female-dominated, and its implications on power dynamics within the profession and the larger healthcare system. The book primarily focuses on the subjectivity of female nurses, examining how their beliefs, practices, and attitudes towards various issues, such as abortion work, are shaped by the prevailing social norms and values. Through interviews with informants, the book provides an understanding of the factors that shape female nurses' day-to-day practice, including legal, professional, moral, ethical, and religious considerations. Overall, the book provides valuable insights into the intersection of gender, profession, and social norms and their influence on the experiences and attitudes of female nurses.

36 Attempts were made to conduct interviews with pro-life organisations, but this was not constructive. They shared documentations regarding their institution's positions on conscientious objection, which have also been used in this thesis.

37 This includes the six focus group discussions conducted in public facilities in Gauteng and Limpopo by the Centre for Aids Development, Research and Evaluation (CADRE) on behalf of Ipas South Africa (transcripts on file with researcher).

38 South African Nursing Council (SANC) 'Registrations and listed qualifications: Calendar year 2022' (2023) https://www.sanc.co.za/wp-content/uploads/2023/01/Stats-2022-2-Registrations-and-Listed-Quals.pdf (accessed 2 January 2023).

39 South African Nursing Council (SANC) 'Annual statistics' https://www.sanc.co.za/sanc-statistics/ (accessed 2 January 2023).

40 See WHO 'The world health report' (2006) http://www.who.int/whr/2006/en/ (accessed 12 March 2018).

3 Conclusion

The chapter starts by highlighting the significance of African feminist theory in understanding power dynamics in various forms and provides an analytical framework for examining the experiences of nurses within the abortion context. I argue that African feminists can play a vital role in investigating conscientious objection to abortion from an African feminist perspective. African feminist scholars reject the notion of a singular viewpoint and stress the importance of recognising the unique historical, social, and cultural contexts of African women's experiences. In this way, African feminism aims to reframe dominant narratives about African women by and to highlight their agency while confronting patriarchal structures that oppress them. Therefore, an exploration of conscientious objection to abortion must avoid universal knowledge derived from western centric and instead strive to incorporate diverse and transcultural perspectives.

Building on this, the next chapter explores the current debate surrounding conscientious objection and its relevance to the African region. I draw attention to the lack of visibility of Africa in the current discourse and stress the importance of an Africa-focused discussion. By doing so, we can gain a deeper understanding of the changing landscape of abortion in the region and how conscience clauses are being implemented in practice. The aim is to shed light on the implications of these developments for women's access to safe and legal abortion services in Africa.

2 Conscientious objection in the African context

The issue of conscientious objection is a complex one, as it involves conflicting rights: the right of women to access safe and legal abortions and the right of healthcare providers to refuse to provide abortion services based on their religious or moral beliefs. This disagreement around abortion raises important questions about how the law should handle the issue of freedom of conscience. Conscientious objection is a practice that is widely exercised around the world, and many countries have laws and regulations that explicitly protect it, according to the World Health Organisation (WHO).[1] However, there are also countries such as Finland and Sweden that do not allow medical professionals to refuse to provide abortion care on the grounds of conscientious objection.[2] The Global Doctors for Choice, in their White Paper on the prevalence and impact of conscientious objection, have found that healthcare providers' refusal to provide abortion services is increasing.[3] This book works on the premise that there is an implied right to conscientious objection, which must be understood within the broader context of freedom of conscience.

In this chapter, I delve into the implied right to conscientious objection, as informed by UN and regional human rights norms. The African context is specifically examined, with attention given to the changing abortion landscape and notable legal and policy reforms. The chapter also scrutinises conscience clauses in African countries, exploring the extent of their scope and limitations.

1 See generally, World Health Organisation (WHO) 'Global abortion policies database' https://abortion-policies.srhr.org/ (accessed 2 January 2023).

2 A Heino et al 'Conscientious objection and induced abortion in Europe' (2013) 18 *European Journal of Contraceptive Reproductive Health Care* 231. See, W Chavkin et al 'Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses' (2013) 123 *International Federation of Gynaecology and Obstetrics* S41.

3 See Chavkin et al (n 2) S44.

1 The implied right to conscientious objection

The implied right to conscientious objection allows healthcare providers to refuse to participate in medical procedures, such as abortion, based on their personal beliefs or conscience. This right is not explicitly stated in most legal frameworks but is often interpreted as an extension of the right to freedom of thought, conscience, and religion. At the heart of conscientious objection lies the individual's moral compass, their sense of right and wrong, and the freedom to act in accordance with these beliefs. This freedom is considered a cornerstone of democratic and pluralistic societies, where the diverse range of religious and moral convictions is respected.[4] International and regional human rights instruments enshrine the fundamental right to freedom of conscience. Article 18 of the Universal Declaration of Human Rights (UDHR) asserts that '[e]veryone has the right to freedom of thought, conscience and religion: this right includes freedom to … manifest his religion or belief in teaching, practice, worship and observance'. This principle is reflected in article 18(1) of the International Covenant on Civil and Political Rights (ICCPR), underscoring the importance of this right as a fundamental aspect of human dignity and autonomy.

The right to exercise conscientious objection has existed before the decriminalisation of abortion laws.[5] It was historically associated with compulsory military service, where individuals could refuse to participate in war based on their freedom of thought, conscience, and religion.[6] In 1993, the Human Rights Committee adopted General Comment 22 on article 18 of the ICCPR to help state parties implement their international obligations related to freedom of conscience, thought, and religion.[7] General Comment 22 acknowledges that although the right to conscientious objection is not explicitly stated in the Covenant, it can be inferred in article 18 as the use of lethal force can seriously conflict with an individual's freedom of conscience and their right to manifest their religion or belief.[8] The Human Rights Committee has affirmed that

4 Council of Europe 'Women's access to lawful medical care: The problem of unregulated use of conscientious objection' Doc 12347 (2010) para 11.

5 BM Dickens 'The rights to conscience' in R Cook et al (eds) *Abortion law in transnational perspective: Cases and controversies* (2014) 210.

6 See Human Rights Council 'Conscientious objection to military service: Analytical report of the Office of the United Nations High Commissioner for Human Rights' A/HRC/35/4 (2017) https://undocs.org/A/HRC/35/4 (accessed 15 February 2019).

7 Human Rights Committee, General Comment 22: Art 18 on freedom of thought, conscience or religion, 30 July 1993, UN Doc CCPR/C/Rev.1/Add.4 (1993).

8 General Comment 22, para 11.

the right to conscientious objection is an essential aspect of the freedom of thought, conscience, and religion. This was demonstrated in the case of *Jeong et al v Republic of Korea*,[9] where the Committee found that the country's non-recognition of conscientious objection and absence of an alternative to compulsory military service violated article 18 of the ICCPR.[10] The Committee emphasised that conscientious objection to military service is inherent to the freedom of thought, conscience, and religion.[11] The recognition of the right to conscientious objection by the Committee was limited to individual claims regarding the right to refuse to perform military service. This implies that individuals should be allowed to demonstrate their beliefs and also have the right not to be compelled to act against their conscience.

In *Yeo-Bum Yoon and Myung-Jin Choi v Republic of Korea*,[12] the Committee further notes that the right to freely practice one's religion or belief does not necessarily include the right to reject all legal obligations. However, it does offer a degree of protection in line with article 18, paragraph 3, which safeguards against being compelled to act against a sincerely held religious belief. Article 18(3) of the ICCPR states that individuals have the freedom to express and demonstrate their religion or beliefs, but this freedom may be limited only by laws that are necessary to protect public safety, order, health, or morals, or the rights and freedoms of others. This places limitation on the manifestation of one's religion or belief as this may affect other people, as well as the state. This echoes article 29(2) of the Universal Declaration of Human Rights (UDHR), which emphasises that while individuals have the right to exercise their rights and freedoms, those rights may be subject to limitations that are established by law. These limitations should only be implemented for the purpose of promoting respect for the rights and freedoms of others and upholding moral values, public order, and the general welfare in a democratic society. In light of article 18(3) of the ICCPR and article 29(2) of the UDHR, it can be inferred that the exercise of conscientious objection is not an absolute right. The freedom to express one's religion or belief can be subject to limitations prescribed by law for the protection of public safety, order, health, morals, or the rights and freedoms of others.

9 UN Human Rights Committee, Views: Communications No 1642-1741/2007, 27 April 2011, UN Doc CCPR/C/101/D/1642-1741/2007 (2011).

10 HRC (n 9) para 7.2.

11 HRC (n 9) para 7.3. See *Atasoy and Sarkut v Turkey* (19 June 2012) UN Human Rights Committee, CCPR/C/104/D/1853-1854/2008 (2012) para 16.

12 UN Human Rights Committee (23 January 2007) CCPR/C/88/D/1321-1322/2004 (2007) para 8.3.

The African human rights system recognises freedom of conscience through article 8 of the African Charter on Human and Peoples' Rights (African Charter).[13] The interpretation of article 8 by the African Commission on Human and Peoples' Rights (African Commission) has predominantly centred on the importance of the right to freedom of worship as evident in various cases.[14] The recent decision by the African Court of Human and Peoples' Rights (African Court) in the case of *African Commission v Kenya*[15] pertains to the right to freedom of religion. The Court found that the Kenyan government had violated the Ogiek's right to freedom of worship by forcibly evicting them from their ancestral lands. The Court found that the government's actions had prevented the Ogiek from practicing their religion freely, as they could no longer access their sacred sites or traditional places of worship.[16]

Other regional human rights systems also acknowledge an individual's right to freedom of religion, conscience, and thought. For instance, the European Convention for the Protection of Human Rights and Fundamental Freedoms, in article 9, guarantees the right to freedom of thought, conscience, and religion, subject to limitations prescribed by law and necessary in a democratic society for the protection of public safety, health, or the rights and freedoms of others.[17] Despite the recognition of conscientious objection as a fundamental right, the exercise of this right is not absolute, as confirmed by the European Court of Human Rights in several cases relating to reproductive healthcare.[18]

The Inter-American human rights system, in its American Convention on Human Rights, also provides for freedom of thought, conscience, and religion, subject to limitations under article 12.[19] While neither the

13 OAU, African Charter on Human and Peoples' Rights, 27 June 1981, OAU Doc CAB/LEG/67/3/Rev 5, ILM 58 (1982), entered into force 21 October 1986.

14 See for example, *Amnesty International v Sudan* Communications 48/90, 50/91, 89/93; and *Centre for Minority Rights Development (Kenya) and Minority Rights Group International on behalf of Endorois Welfare Council v Kenya*, 276/2003 (ACHPR 2010).

15 *African Commission on Human and Peoples' Rights v Republic of Kenya* ACtHPR, Application No 006/2012 (2017).

16 *African Commission on Human and Peoples' Rights v Republic of Kenya* (n 15) paras 166-167.

17 European Convention for the Protection of Human Rights and Fundamental Freedoms, opened for signature 4 November 1950, 213 UNTS 221, Eur TS 5 (entered into force 3 September 1953).

18 See *Pichon & Sajous v France* ECHR (2 October 2001), App No 49853/99; *RR v Poland* ECHR App No 27617/04 (2011).

19 American Convention on Human Rights (adopted 22 November 1969) OASTS No 36, OAS Off Rec OEA/Ser.L/V/II.23, doc 21, rev 6 (entered into force 18 July 1978).

International American Commission on Human Rights (IACHR)[20] nor the Inter-American Court has explicitly addressed conscientious objection in the context of reproductive healthcare, the fact that the exercise of this right is not absolute underscores the need for a careful balancing of competing rights, particularly in situations where conscientious objection may potentially impede the realisation of other fundamental human rights.[21]

2 The evolving abortion landscape in Africa

2.1 Protecting women's reproductive rights in Africa

There has been an increasingly prevalent shift towards the liberalisation of abortion laws globally, with the African region being no exception to this trend. This trend has been largely driven by efforts to broaden the eligibility criteria for abortion services. In recent years, there has been an increasing recognition of abortion as a human right by various United Nations (UN) treaty-monitoring bodies. This recognition is reflected in their concluding observations, general comments, recommendations, and decisions on communications brought under UN treaties' optional protocols.

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is unique as it expressly recognises abortion as a right.[22] Article 14(2) of the Protocol obligates states to permit abortion where pregnancy poses a risk to the life or health of the woman or to the life of the foetus, or where pregnancy is a result of sexual assault, rape, or incest. Furthermore, article 26 of the Protocol direct states to adopt budgetary measures in order to fulfil the rights provided in the Protocol.

20 The IACHR had made several pronouncements regarding the limitation of the right to conscientious objection within the military service. See for example *Cristian Daniel Sahli Vera v Chile* Case 12219, Inter-Am Comm'n HR, Report No 43/05, OEA/Ser.L/V/II.124 doc 5 (2005).

21 A 2012 ruling might be applicable though it did not address healthcare professionals' right to exercise conscientious objection. see *Artavia Murillo v Costa Rica* Judgment, Inter-American Court (ser C) No 257 (2012).

22 C Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 783.

As of August 2023, 43 out of the 55 African states have ratified the Maputo Protocol.[23] This is an indication of the favourable reception that the Protocol enjoys in the continent as the foremost legal instrument on women's rights.[24] However, it is important to note that some African countries such as Cameroon,[25] The Gambia,[26] Kenya,[27] Rwanda[28]

23 The latest country to ratify is South Sudan in June 2023, see https://au.int/en/pressreleases/20230607/south-sudan-becomes-44th-country-ratify-protocol-womens-rights#:~:text=The%20Republic%20of%20South%20Sudan,AU)%20to%20ratify%20the%20Treaty (accessed 8 June 2023). There are 13 countries (Botswana, Burundi, Central African Republic, Chad, Egypt, Eritrea, Madagascar, Morocco, Niger, Sahrawi Arab Democratic Republic, Somalia, South Sudan, and Sudan) which have not ratified. See, African Union 'Ratification table: Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' https://au.int/sites/default/files/treaties/37077-sl-PROTOCOL%20TO%20THE%20AFRICAN%20CHARTER%20ON%20HUMAN%20AND%20PEOPLE%27S%20RIGHTS%20ON%20THE%20RIGHTS%20OF%20WOMEN%20IN%20AFRICA.pdf (accessed 27 November 2019).

24 F Viljoen *International human rights law in Africa* 2nd ed (2012) 50-59.

25 Reasoning for the reservation: 'The acceptance of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in African should in no way be construed as endorsement, encouragement or promotion of homosexuality, abortion (except therapeutic abortion), genital mutilation, prostitution or any other practice which is not consistent with universal or African ethical and moral values, and which could be wrongly understood as arising from the rights of women to respect as a person or to free development of her personality. Any interpretation of the present Protocol justifying such practices cannot be applied against the Government of Cameroon.'

26 The Gambia made blanket reservations that were lifted in 2006. See S Nabaneh 'The impact of the African Charter and the Maputo Protocol in The Gambia' in V Ayeni (ed) *The impact of the African Charter and Maputo Protocol in selected African States* (2016) 77.

27 Kenya also entered the following reservations: 'The Government of the Republic of Kenya does not consider as binding upon itself the provisions of Article 10(3) and Article 14(2)(c) which is inconsistent with the provisions of the Laws on health and reproductive rights.'

28 Rwanda lifted its reservations in 2012 to allow women to access abortion services when the pregnancy is as a result of rape, incest, or forced marriage and where continued pregnancy endangers health. See Center for Reproductive Rights (CRR) 'Rwandan Government takes critical step in recognizing women's fundamental human rights' (14 August 2014) https://reproductiverights.org/press-room/rwandan-government-takes-critical-step-in-recognizing-women%E2%80%99s-fundamental-human-rights (accessed 20 August 2019); Government of Rwanda '11th, 12th and 13th periodic reports of the Republic of Rwanda on the implementation status of the African Charter on Human and Peoples Rights and initial report on the implementation status of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' (2017) para 78 https://www.achpr.org/states/statereport?id=111 (accessed 20 August 2019).

and Uganda,[29] entered reservations to the provision on abortion upon ratification of the Protocol.[30] While both the African Charter and the Protocol are silent on reservations, article 19 of the Vienna Convention on the Laws of Treaties (Vienna Convention)[31] allows states to enter into a reservation to a treaty.[32] Article 2(1)(d) of the Vienna Convention defines a reservation as:

> [A] unilateral statement, however phrased or named, made by a state when signing, ratifying, accepting, approving, or acceding to a treaty, whereby it purports *to exclude or modify the legal effect of certain provisions* of the treaty in their application to that state.[33]

The effects of state reservations made to the Maputo Protocol can be discussed in two ways. First, where domestic law offers women more rights than the Protocol or, for that matter, rights equal to those found in the Protocol, it means that such reservation does not substantively limit those rights. Article 31 of the Protocol provides that:

> [N]one of the provisions of the present Protocol shall affect more favourable provisions for the realisation of the rights of women contained in the national legislation of States Parties or in any other regional, continental or international conventions, treaties or agreements applicable in these States Parties.

South Africa made an interpretative declaration on article 31 of the Charter.[34] The declaration reads:

> It is understood that the provisions contained in article 31 may result in an interpretation that the level of protection afforded by the South African Bill of

29 Uganda's reservation on article 14(2)(c) of the Protocol reads: 'Article 14(2)(c) of the Protocol is interpreted in a way of conferring an individual right to abortion or mandating a state party to provide access thereto. The state is not bound by this clause unless permitted by domestic legislation expressly providing for abortion.'

30 African Commission on Human and Peoples' Rights 'Status of implementation of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa by Justice Lucy Asuagbor Commissioner, Special Rapporteur on the Rights of Women in Africa' (2016) 3 http://www.peaceau.org/uploads/special-rapporteur-on-rights-of-women-in-africa-presentation-for-csw-implementation.pdf (accessed 10 January 2019).

31 Article 19 of the Vienna Convention on the Law of Treaties (1969) 1155 UNTS 331.

32 J Dugard *International law: A South African perspective* 4th ed (2011) 417-422.

33 Article 2(1)(d) of the Vienna Convention (emphasis added).

34 While the Vienna Convention does not expressly provide for, or define, interpretative declarations, John Dugard has argued that in some instances, an interpretative declaration may constitute reservation. See Dugard (n 29) 418.

> Rights is less favourable than the level of protection offered by the Protocol, as the Protocol contains no express limitations to the rights contained therein, while the South African Bill of Rights does inherently provide for the potential limitations of rights under certain circumstances. The South African Bill of Rights should not be interpreted to offer less favourable protection of human rights than the Protocol, which does not expressly provide for such limitations.

South Africa's declaration was made on the premise that since the Bill of Rights contained a limitation clause while the Protocol does not, an assumption might be made that the Protocol has more favourable provisions. In making this interpretative declaration, South Africa boldly proclaimed that its Bill of Rights offered more favourable human rights protection for women in South Africa than the Protocol offered, especially in the case of abortion.[35] South Africa also made a reservation on article 6(h) of the Protocol to protect children's citizenship rights, using a similar line of reasoning.[36]

Secondly, it is important to note that even though a state may make reservations to a treaty, it is still obligated to adhere to the provisions to which it has not made reservations. This should not be seen as a limitation to draw upon the protections afforded by other international and regional human rights treaties to which the state is a party. It is crucial to prioritise the implementation of the Maputo Protocol as this will have a significant impact on the lives of women, despite reservations made by some states during the ratification process.

Consequently, the African Commission has taken steps to provide interpretive guidance by elaborating on specific rights while assisting states to fulfil their obligations under the Maputo Protocol. Article 45(1)(b) of the African Charter empowers the African Commission to establish principles and rules to address human rights issues. To this end, the African Commission first adopted a General Comment in 2012 on article 14(1)(d) and (e) of the Protocol, clarifying provisions related to the protection of women's rights against sexually transmitted infections,

35 See also S Nabaneh 'A purposive interpretation of article 14(2)(c) of the African Women's Protocol to include abortion on request and for socio-economic reasons' LLM thesis, University of Pretoria, 2012 (on file with the author).

36 The statement of reservation on article 6(h) of the Protocol reads: 'South Africa enters a reservation on this Article, which subjugated the equal rights of men and women with respect to the nationality of their children to national legislation and national security interests, on the basis that it may remove inherent rights of citizenship and nationality from children.'

including HIV/AIDS.[37] It stresses the importance of states providing access to comprehensive education and information that dispels myths and misunderstandings surrounding sexual and reproductive health. This should include addressing gender roles and stereotypes, and challenging traditional concepts of masculinity and femininity.[38]

On 28 November 2014, the Commission adopted General Comment 2 on reproductive health rights under Article 14(1)(a), (b), (c) and (f) and Article 14(2)(a) and (c) of the Protocol.[39] By specifically addressing the issue of abortion, General Comment 2 serves as a significant soft law instrument consolidating international best practices on the obligation of states to respect, promote, protect and fulfil the rights related to the sexual and reproductive health of women and girls in the African region. As a valuable benchmark, it provides guidance on measures to be taken to ensure access to safe abortion, making it a crucial tool for promoting and protecting sexual and reproductive rights.

The incidence rate of unsafe abortions in the African region is alarmingly high, with estimates indicating 26 per 1 000 for married women and 36 per 1 000 for unmarried women during 2010 to 2014.[40] Furthermore, women from sub-Saharan Africa had the highest incidence of deaths from unsafe abortions, accounting for 62 per cent of the total deaths (29 000 out of 47 000) in 2008.[41] To address this pressing issue, the African Union (AU) adopted the Revised Maputo Plan of Action 2016-2030, which reaffirms the importance of sexual and reproductive health and rights.[42] This Plan of Action recognises the unfinished business in this area as articulated in Agenda 2063 and the Sustainable Development Goals (SDGs).[43]

37 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' (2012).

38 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.

39 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' (2014).

40 G Sedgh et al 'Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends' (2016) 388 *Lancet* 258.

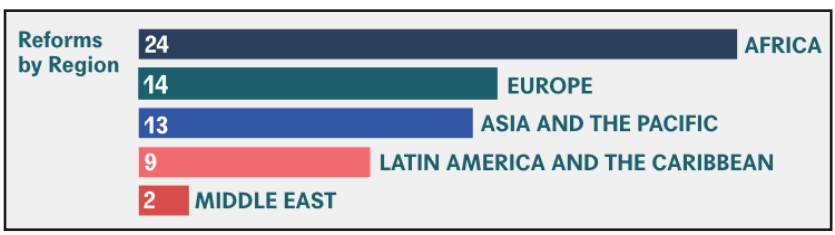
41 World Health Organization (WHO) 'Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008' (2011) 28.

42 African Union Commission *Maputo Plan of Action 2016-2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights* (2016) 2.

43 General Assembly Resolution 'Transforming our world: the 2030 Agenda for Sustainable Development' A/RES/70/1 (2015).

2.2 Towards liberalising African abortion laws: An overview

The history of abortion laws in Africa can be traced back to European laws from the 18th century that were imposed on colonial states.[44] These laws, which criminalised abortion were later adopted in the penal codes of colonised states as colonial legacies. As a result, restrictive abortion laws have been the norm in Africa for several decades, with few exceptions. However, there has been a growing trend towards the liberalisation of abortion laws in Africa, with many countries expanding abortion grounds beyond just saving the life of the pregnant woman. This trend is reflected in the map below.



Source: Center for Reproductive Rights

Several African countries have adopted liberal abortion laws, such as South Africa, Cape Verde,[45] Zambia,[46] Tunisia and Mozambique. The South African Choice on Termination of Pregnancy Act is a notable example of a liberal abortion law in Africa. The Act, which came into effect in 1997, grants women the right to choose whether to have a safe and legal abortion, based on their individual beliefs. The Preamble acknowledges the state's responsibility to provide reproductive health services to all and ensures that women can exercise their right to choose without fear of harm.[47] The Act was designed to correct the past injustices of the restrictive abortion grounds of the 1975 Abortion and Sterilization Act, which only permitted abortion in cases of a serious threat to the life or health of the pregnant woman, foetal malformation, or pregnancy resulting from unlawful carnal intercourse.[48] This had a disproportionate impact on poor black women, who were unable to access safe and legal abortion services, leading to

44 CG Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 783.

45 Law of 31 December 1986 of Cape Verde.

46 Zambian Termination of Pregnancy Act of 1972.

47 Preamble, para 5.

48 Act 2 of 1975. See SM Klausen *Abortion under apartheid: Nationalism, sexuality, and women's reproductive rights in South Africa* (2015).

illegal abortion.[49] Section 2 of the Act, permits abortion on demand up to 12 weeks of pregnancy and on various grounds between 13 to 20 weeks of gestation, including physical or mental health, foetal anomaly, rape, incest, and socio-economic circumstances. After 20 weeks, a woman may only terminate her pregnancy if it poses a serious risk to her life or health, or if the foetus will be severely malformed. The Act does not require consent from a woman's spouse or parental consent for minors.

Tunisia is unique as a Muslim majority country that allows for abortion on demand since 1973.[50] Mozambique has taken a step forward in protecting the reproductive rights of women by revising its Penal Code in 2014.[51] This revision has broadened the circumstances under which abortion is not considered a crime, providing women with more autonomy over their own bodies. Specifically, the revised code allows for abortion on demand up to 12 weeks of gestation, and up to 16 weeks in cases where the pregnancy results from rape or incest. Abortion is also permitted up to 24 weeks in cases of foetal malformation and without a gestational age limit if the pregnant woman's life is in danger, she suffers from a chronic-degenerative disease, or if the foetus is inviable. This progressive legislation recognises and prioritises the physical, psychological, and mental well-being of pregnant women.[52]

In 2004, Ethiopia implemented a series of reforms to its Penal Code in order to align it with the country's Constitution, which was enacted a decade earlier.[53] While abortion remained restricted as outlined in article 551 of the Penal Code, the reforms introduced several important exemptions that significantly expanded access to abortion services. These exemptions were in line with the Maputo Protocol, and allowed for termination of pregnancy in cases where the continued pregnancy endangered the life or physical health of the pregnant woman, in cases of rape or incest, if the woman is a minor or mentally unfit to bring up a child, or if the foetus has an 'incurable and serious deformity'.[54] Importantly, the

49 R Hodes 'The culture of illegal abortion in South Africa' (2016) 42 *Journal of Southern African Studies* 80.

50 I Maffi & L Tonnessen 'Editorial: The limits of the law: Abortion in the Middle East and North Africa' (2019) 21 *Health and Human Rights* 1.

51 M Frederico et al 'Factors influencing abortion decision-making processes among young women (2018) 15 *International Journal of Environmental Research and Public Health* 329.

52 Further amendments in 2019 were considered to have a negative impact on perceptions about the legality of abortion.

53 D Bridgman-Packer & S Kidanemariam 'The implementation of safe abortion services in Ethiopia' (2018) 143 *International Journal of Gynaecology & Obstetrics* 19.

54 Article 551 of the 2005 Revised Penal Code of Ethiopia.

revised Penal Code also stated that 'the mere statement by the woman is adequate to prove that her pregnancy is the result of rape or incest', which helps to protect women who may be too afraid or ashamed to seek medical attention following a sexual assault.[55] Following the revision of the Penal Code, the Ethiopian Ministry of Health issued technical and procedural guidelines for safe abortion services in June 2006, in accordance with article 552(1) of the Revised Criminal Code. Taking cues from South Africa's example, these guidelines allowed midwives and public health nurses to perform abortions in addition to those already authorised to do so. This helped to expand access to safe and legal abortion services across the country, particularly in rural and underserved areas where trained medical professionals may be scarce.

The Constitution of Kenya, 2010 represents a significant shift in the country's approach to reproductive rights. Article 43 guarantees the right to the highest attainable standard of health, which includes reproductive health, while article 26(4) expands the grounds under which a safe abortion can be performed. Now, medical providers can perform an abortion where there is danger to the life or health of the mother, in cases where emergency treatment is needed, or as allowed by any other written law. This progressive stance is in stark contrast to the previous restrictions under section 240 of the Penal Code. This has been affirmed by the High Court in the case of in *Federation of Women Lawyers (FIDA – Kenya) v Attorney General*,[56] although generally, the ambiguity of the constitutional provisions regarding abortion mean that the legality of abortion remains unclear. In March 2022, the Kenyan High Court made a landmark decision in *PAK v Attorney General*,[57] holding that medically necessary abortion is a fundamental constitutional right. The court's decision took into account various legal frameworks, including Kenya's constitutional provisions, national criminal laws, and international commitments, to demonstrate how ambiguous abortion policy can lead to harmful criminalisation of patients and providers. Essentially, the ruling shows how unclear laws around abortion can have serious consequences for those seeking or providing necessary medical care.

Moreover, the promulgation of the Health Act, 2017 further expanded the grounds on who can perform abortions. Clinical officers, nurses, and midwives are now authorised to perform this vital service, thus increasing access to safe and legal abortions.[58] These legal and policy changes are

55 Article 552(2) of the 2005 Revised Penal Code of Ethiopia.

56 [2019] eKLR Petition 266 of 2015.

57 [2022] KEHC 262 (KLR) Petition E009 of 2020.

58 Section 6(2) of the Kenyan Health Act, 2017.

crucial in ensuring that women in Kenya can exercise their reproductive rights and access safe abortion services without fear of prosecution.

In recent years, there have been significant developments in Francophone Africa regarding access to safe and legal abortion. The Democratic Republic of the Congo (DRC) made history in 2018 when it became the first Francophone African country to introduce radical reforms to broaden access to abortion.[59] This was achieved through the publication of the Maputo Protocol in the official gazette, which paved the way for the endorsement of standards and guidelines for implementing the Protocol's directives by the Ministry of Public Health in 2020.[60]

In a similar vein, the Parliament of Benin made a ground-breaking decision in October 2021 to decriminalise abortion under most circumstances. Women are now able to access abortion services when a pregnancy is likely to cause them 'material, educational, professional, or moral distress'.[61] This significant step marks a departure from the restrictive laws and attitudes towards abortion that have traditionally been prevalent in many African countries.

These developments reflect a growing recognition of the importance of reproductive rights and access to safe abortion in ensuring women's health and autonomy. These developments reflect a growing recognition of the importance of reproductive rights and access to safe abortion in ensuring women's health and autonomy despite implementation challenges. However, this incremental and progressive shift is in sharp contrast to the recent United States (US) Supreme Court decision in *Dobbs v Jackson Women's Health Organization*.[62] In this decision, the Court upheld a Mississippi State law that bans abortion after 15 weeks of pregnancy. The Court also ruled that the US Constitution does not 'prohibit the citizens of each State from regulating or prohibiting abortion'.[63] This decision effectively overturns *Roe v Wade*,[64] the landmark 1973 decision that established a constitutional right to abortion.

59 Safe Engage & APHRC 'Policy change for women's rights: A case study of the domestication of the Maputo Protocol in the Democratic Republic of Congo' (2021).

60 Safe Engage & APHRC (n 56) 8.

61 S Johnson 'Benin passed one of Africa's most liberal abortion laws. Why are women still dying?' *The Guardian* 28 February 2023 https://www.theguardian.com/global-development/2023/feb/28/benin-africa-liberal-abortion-laws-women-still-dying (accessed 1 March 2023).

62 142 S Ct 2228, 2242 (2022)

63 *Dobbs* (n 62) 79.

64 410 US 113 (1973). See also *Planned Parenthood v Casey* 505 US 833 (1992).

In contrast, significantly, close to 50 per cent of African states now recognise health as a ground for abortion. Only a minority of states have retained colonial-era laws, which historically, have been highly restrictive of abortion. This group includes, Angola, Central African Republic, Congo (Brazzaville), Democratic Republic of Congo, Egypt, Gabon, Guinea-Bissau, Madagascar, Malawi, Mali, Mauritania, Mauritius, The Gambia, Senegal, Somalia, Sudan, South Sudan, Tanzania, and Uganda. Some have amended their old criminal rules, but the majority protect the status quo.

According to the Guttmacher Institute's 2020 estimates, the majority of women of reproductive age in Africa live in countries with highly restrictive abortion laws.[65] Unfortunately, this means that most of the abortion laws of the state parties to the Maputo Protocol are not in line with its provisions. The slow progress in achieving access to safe abortion services in the African region can be attributed to a range of factors that disable access to abortion services beyond just broadening the grounds of abortion, including conscientious objection.

3 Conscience clauses in African countries

Conscientious objection is a contentious issue in the provision of abortion services globally, and the African region is no exception. Conscience clauses, relating to specific rules and regulations around vary by country and jurisdiction. In the context of African abortion laws, most domestic laws do not directly address this issue, resulting in a lack of regulation, leaving healthcare providers to interpret and apply their own beliefs in their practice. This trend is not unique to Africa and is common in many other regions worldwide.[66] In South Africa which will be discussed in depth in the next chapter, the Choice on Termination of Pregnancy Act does not directly address conscientious objection.

While most African countries do not directly address conscientious objection in their laws, there are a few exceptions to this rule. One such exception is the Zambian Termination of Pregnancy Act of 1972, which permits a limited scope of the exercise of conscientious objection.[67] However, the Act notes that the exercise of conscientious objection

65 Guttmacher Institute 'Factsheet: Abortion in Africa' (2020) https://www.guttmacher.org/sites/default/files/factsheet/abortion-subsaharan-africa.pdf (accessed 10 June 2022).

66 OR Gustavo 'Abortion and conscientious objection: Rethinking conflicting rights in the Mexican Context' (2017) 29 *Global Bioethics* 5.

67 See the Zambia Termination of Pregnancy Act, 1972.

should not extend to practitioners' obligation to participate in any necessary treatment to save the life or prevent grave permanent injury to the physical or mental health of a pregnant woman. The Ministry of Health's Standards and Guidelines on abortion have further clarified this issue.[68] Nevertheless, it has been argued that the practice of conscientious objection remains largely unregulated as there is no requirement to record one's refusal.[69]

The Zimbabwean Termination of Pregnancy Act of 1972 stands in sharp contrast to the Zambian Termination of Pregnancy Act of the same year, particularly with regards to the exercise of conscientious objection. Section 10 of the Zimbabwean Act explicitly states that no healthcare worker, including any person employed in any capacity at a designated institution, shall be obliged to participate or assist in the termination of a pregnancy, regardless of any contrary laws or agreements. This approach disregards international and regional human rights standards, which recognise conscientious objection as a right that should not impede access to essential healthcare services, including abortion.

In 2014, the Kenyan Ministry of Health issued guidelines on the management of post-abortion care, which outlined the responsibilities of healthcare providers in providing post-abortion care to patients, regardless of the circumstances under which the abortion was carried out.[70] The guidelines require that healthcare providers provide post-abortion care services to all patients, regardless of their personal beliefs, and that conscientious objection should not impede access to these services.

4 Conclusion

Africa has seen significant developments in its abortion laws, with a trend towards more liberal frameworks that recognise women's reproductive rights. However, the implementation of these laws has been slow, with women facing numerous barriers to accessing safe abortion services. One of the key obstacles is the exercise of conscientious objection, which is not adequately addressed in most African countries. Despite constitutional protections for conscientious objection, it can conflict

68 C Ngwena 'Conscientious objection to abortion and accommodating women's reproductive health rights: Reflections on a decision of the Constitutional Court of Colombia from an African regional human rights perspective' (2014) 58 *Journal of African Law* 193.

69 E Freeman & E Coast 'Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices' (2019) 221 *Journal of Social Science and Medicine* 106.

70 Ministry of Public Health and Sanitation & Ministry of Medical Services 'National Guidelines for Quality Obstetrics and Perinatal Care' (2012).

with other fundamental rights such as equality, dignity, and freedom of expression, leading to clashes between individual rights. In South Africa, despite having progressive laws and policies on abortion, the exercise of conscientious objection by healthcare providers presents a significant challenge to the effective implementation of the law. The next chapter will delve into the legal and policy landscape of abortion in South Africa.

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.

PART II:

Nurses as shapeshifters: Stories, agency, and testimonies

4

Nurses' agency and power in abortion care: Personal stories and perspectives

Nurses are a crucial group of health service providers in South Africa,[1] with over 271 000 registered nurses according to data published by the South African Nursing Council in 2023.[2] The majority of these nurses are women, currently 242 280 are registered, and many work in the public health sector.[3] Despite the central role they play in the promotion and provision of essential health services, including safe abortion care, the nursing profession in South Africa faces shortages and conflicts between the needs of nurses and the communities they serve.[4]

As earlier noted, an amendment to the Choice on Termination of Pregnancy Act in 2008 expanded the pool of people who can perform abortion to empower nurses who receive appropriate training to perform first trimester services. Consequently, the implementation of the liberalised abortion law heavily depends on nurses as they are often in control of the provision of the services.

Although nurses play essential roles in abortion provision, research on the changing nature of their work within the broader health system context is scarce. This chapter seeks to address this gap by examining the power relations and medical discourses that shape the experiences of nurses who provide abortion services. Using primary research with nurse providers

1 P Barron & A Padarath 'Twenty years of the South African Health Review' in P Barron & A Padarath (eds) *The 20th edition of the South African Health Review* (2017) 4. See also, LC & A Padarath (eds) *The South African Health Review* (2018) http://www.hst.org.za/publications/Pages/SAHR2018 (accessed 20 June 2019).

2 South African Nursing Council 'Persons on the Register: Stat 2/2022(b)' (2022) NRSCSTAT71 1-3 https://www.sanc.co.za/wp-content/uploads/2023/01/Stats-2022-2-Registrations-and-Listed-Quals.pdf (accessed 15 January 2023). The number on the register includes all categories of nurses on the register. It also includes those professionals who are retired, overseas, working part-time, working in other sectors or not working at all.

3 Health Systems Trust *South African Health Review* (2017) 306.

4 See L Rispeli & J Bruceii 'A profession in peril? Revitalising nursing in South Africa' in Health Systems Trust *South African Health Review 2014/15* (2015) 117-227. See also Health Systems Trust (n 3) 306.

and observational data, I explore range of nurse providers' experiences in both public[5] and private healthcare settings.

This chapter is divided into two main sections. The first section explores the challenges that nurses face when providing abortion services in public health facilities. The second section provides an analysis of the obstacles that nurses encounter when running their independent abortion clinics. These clinics are not associated with government facilities or private clinics like Marie Stopes South Africa. By examining these two areas, we can gain a deeper understanding of the unique experiences of nurses in both settings and the barriers they face in providing abortion care.

1 Nurses' abortion work: An overview

Nurses in South Africa are able to conduct the whole abortion procedure in the first trimester when they are eligible abortion providers. Only doctors can perform abortions after 12 weeks. As one nurse described:

> As trained nurses, the Act allows us to do termination up to 12 weeks and above that (13 weeks up to 20 weeks), it is done by the doctor. So, in most of our facilities we don't have second trimester termination of pregnancy. We only have first trimester that is being offered by us nurses.

While nurses are not allowed to perform abortion procedures beyond the first trimester, they still play a crucial role in the provision of abortion services. They are responsible for administering medication and managing care during the procedure. This includes preparing patients for the procedure by taking medical histories, drawing blood, providing counselling, and administering drugs to examine the cervix. Additionally, nurses are responsible for post-abortion care.[6] A majority of the nurses

5 The data of the public sector was collected as part of a larger three-country study on conscientious objection led by Ipas in South Africa, Mexico, and Bolivia. This includes the six focus group discussions conducted in public facilities in Gauteng and Limpopo by the Centre for Aids Development, Research and Evaluation (CADRE) on behalf of Ipas South Africa (transcripts on file with author). The author was a consultant and served as a member of the innovation team to provide technical guidance related to developing and testing interventions to address the use of conscientious objection among public sector healthcare workers to deny women's access to safe, legal abortion services in Bolivia, Mexico and South Africa. The views expressed by the author in the analysis do not necessarily reflect those of Ipas.

6 Currently, Misoprostol alone is the standard of care for medical termination of pregnancy in public health sector: See D Constant et al 'Assessment of completion of early medical abortion using a text questionnaire on mobile phones compared to

interviewed were trained and knowledgeable about the manual vacuum aspiration but were not necessarily trained on medical abortion procedure (including Misoprostol and Mifepristone used as abortifacients).

Generally, the training provided to nurses is often incomplete or outdated. Some nurses only receive theoretical training, while practical training is limited due to a shortage of instructors. This has resulted in some nurses being unable to practice and having to work in other areas of healthcare. For example, an older nurse recounted how she attended the theoretical training in 2000 but was never given the opportunity to complete the practical due to shortage of instructors. So even though she was willing, she was unable to practice and thus went to theatre instead.[7]

In some cases, the training provided to abortion providers in public health facilities also includes a values clarification and attitude transformation (VCAT) component. Organisations like Ipas South Africa[8] conduct VCAT trainings in Gauteng and Limpopo, which engage participants in open dialogue to explore their values and attitudes about abortion and reproductive health issues.[9] These workshops aim to move providers through a progressive scale of support for abortion and reproductive rights. One nurse who previously provided abortion services until she was transferred to a different department noted the usefulness of these value clarifications:

> You cannot come to be a service provider when you have negative attitudes towards the service. I'm going to misinform the patient or whatever, so I have to not impose my beliefs and views on the patient. If the patient comes and says 'I want an abortion' I must give

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.

7 Participant observation during Ipas whole site orientation in Limpopo, May 2019.

8 Ipas South Africa is part of the international non-profit organisation that works globally to improve access to safe abortion and contraception. Ipas South Africa partners with health departments in two provinces, Gauteng and Limpopo, to increase women's access to safe, high-quality abortion services.

9 Ipas 'Abortion attitude transformation: A values clarification toolkit for humanitarian audiences' (2018) 3. On the impact of the VCAT trainings, see, EMH Mitchel et al 'Accelerating the pace of progress in South Africa: An evaluation of the impact of values clarification workshops on termination of pregnancy access in Limpopo' (2005).

> the service that they require, irrespective of how I feel about it and not being judgemental.

According to one nurse interviewed, the 2008 amendment that extended eligibility to nurses to provide first-trimester abortion services elicited mixed reactions among their colleagues. While some supported the amendment and saw it as a way of expanding access to safe abortion care, others were resistant to the idea. A nurse shared her own initial reaction:

> Before abortion was legalised, we were questioned, and we had discussions of our views towards what we think about the legalisation of abortion. For me I was pro-abortion since then because of what I had seen people going through. I used to work at … where every day we would be having patients going to theatre for evacuations and some of them with complications and we were saying if there was a safe abortion services that are provided for these women, we wouldn't be having these complications or having people or young girls and women dying of that. So that's why I was pro-abortion.

One reported issue is that some nurses who have been trained to provide abortion care end up not doing so, which is seen as problematic. A Facility Manager noted this and stated that some individuals 'reverse' their decision to provide the service. Nurses may have different reasons for this, as reported by one nurse:

> Yes, there is one, but she's a Christian. She did practice, but not for long, and then she went to work in maternity. Apparently, the husband became, you know, superior, and she had to stop practicing.

The failure of trained nurses to provide abortion care poses a significant challenge to the availability of safe and effective abortion services. Inadequate uptake of training opportunities contributes to the shortage of qualified abortion providers, leaving designated facilities unable to provide essential services. As a result, women may resort to private or illicit abortions, risking their health and wellbeing.

In the private healthcare sector, medical abortion is the preferred method for terminating pregnancies, with appointments made online or via telephone. However, in public health facilities, surgical abortion is the primary method, resulting in disparities in access to services. The complex and disjointed nature of abortion provision, which often takes place in hidden spaces, is not integrated into the everyday life of medical clinics, further complicating the client's pathway to accessing abortion services as shown in Figure 1.

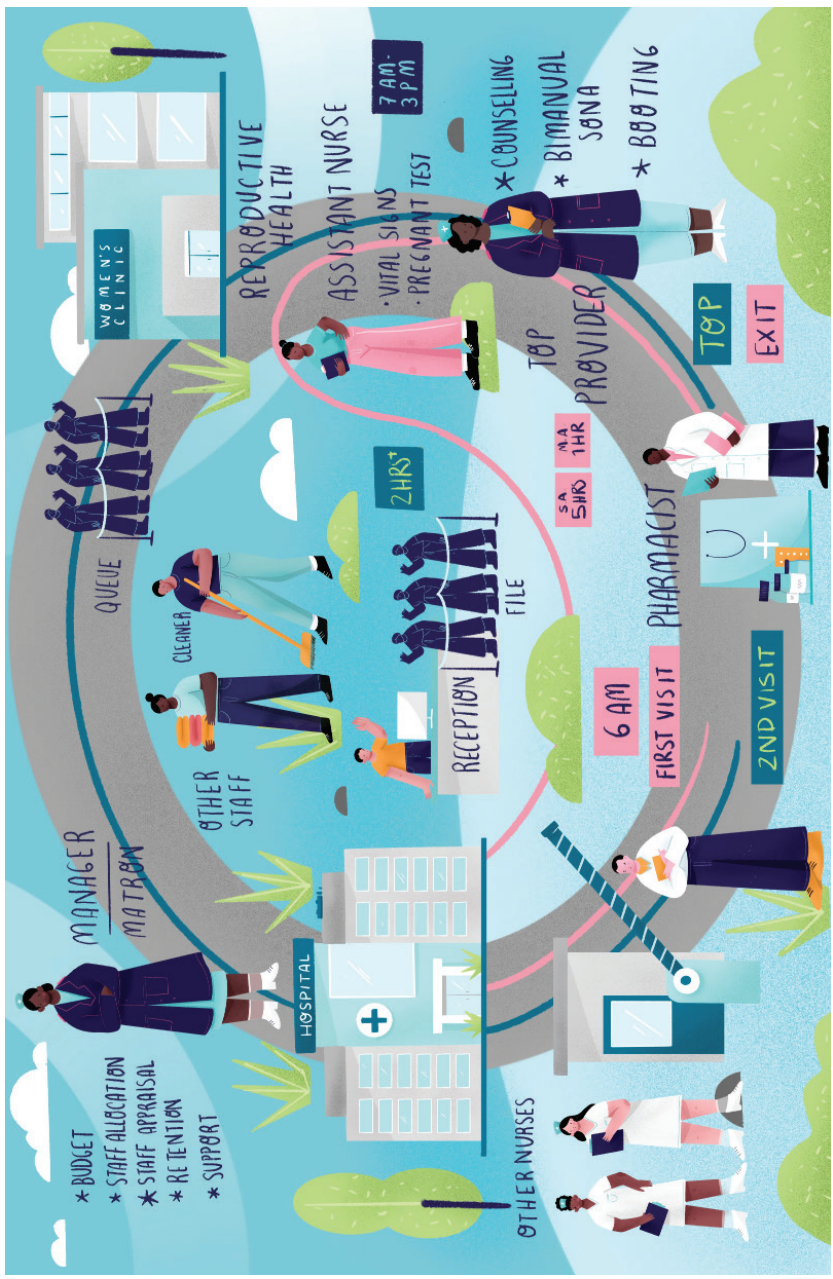


Figure 1: Client pathway for abortion access in a public health facility

This fragmentation of services, compounded by variations in providers' preparedness to offer comprehensive care, remains a prevalent challenge in South Africa's healthcare system. Thus, ensuring the availability of qualified and willing healthcare providers is crucial to guaranteeing effective and accessible abortion services.

The role of nurses in providing abortion care can vary widely, and this has important implications when it comes to conscientious objection. The first level of involvement consists of nurses who have undergone training as termination of pregnancy providers and are directly involved in performing the procedure for first trimester abortions. These nurses perform manual examinations or use ultrasound[10] to determine gestational age and they may administer medications like Cytotec or perform procedures like manual vacuum aspiration to terminate the pregnancy within the first nine weeks. They also assist in the operating room during surgical procedures.

The second level of involvement includes registered nurses who are not specifically trained to provide abortions but who still provide abortion-related services. These nurses may refer patients to authorised facilities for abortion, provide pre- and post-abortion counselling, and perform tasks such as taking vital signs, conducting pregnancy tests, and scheduling appointments.[11]

The third level of involvement includes nurses who do not participate in any aspect of abortion care and only perform general nursing duties. Some of these nurses may provide post-abortion care and contraceptive counselling, while others choose to abstain from these activities. Overall, the varying levels of involvement of nurses in abortion care demonstrate the complex dynamics of power and responsibility within the healthcare system.

The rest of the chapter is divided into two parts that provide an in-depth look at the challenges that nurses face in providing abortion services. Part 1, titled '"Dirty work": Experiences of nurses who provide abortion services in the public sector', sheds light on the experiences of nurses who work in public facilities and the difficulties they encounter while providing abortion services. Part 2, titled 'Shifting construction of nurses' abortion

10 Given that not all facilities have a sonar (ultrasound machines), clients would need to be referred to another facility that provides ultrasound services.

11 Services are provided within specific time frames during the day and not necessarily on a daily basis in some facilities. Patients are usually required to book an appointment based on the availability of the provider and the capacity of the facility.

work', delves into the multiple barriers that nurses face when running their own independent abortion clinics.

2 'Dirty work': Experiences of nurses who provide abortion services in the public sector

Through interviews with nurse providers on their experiences with providing abortion services, a recurring theme that emerged was the absence of an environment that fosters support and enables effective service delivery. This overarching theme was further expounded by three inter-related sub-themes: unsupportive management and inadequacies in the health system; lack of specialisation in abortion services; and negative attitudes of colleagues and pervasive stigma.

2.1 Unsupportive facility management and health system deficiencies

Generally, there were nurse providers who felt that they sometimes receive support from management and other staff:

> From my perspective where I am working, there is a lot of support. There is a few that I may not even know that are objecting but most of the people are supportive, even the manager is so supportive. So, I know in the beginning when we started around 2013 there was a lot of objection but now, I think people are beginning to accept it … but it depends on facilities, it depends on people, but at my facility to tell the honest fact, there is too much support.

Another nurse stated:

> There is a support, but they support you from a distance – they don't want to involve themselves in it.

One of the main challenges faced by nurses providing abortion services in public facilities is the lack of support from facility management. Many nurses who were interviewed highlighted this as a significant barrier to effective service provision. In fact, a nurse who previously worked in the public sector and later became an independent provider recalled her experience on her first day, where she felt unsupported:

> The matron in the hospital called me in her office and asked what was wrong with me? She advised that I should read the Bible as I was

> committing a sin. However, few months later, the same matron came to me for help regarding her pregnant daughter.

Others noted:

> You know, if they care, they will give us more support. They will check, even not on a daily basis, weekly, once a week to check, are you okay? How are you coping? There is anything wrong? So, they didn't bother about that. You only see them when there is a complaint that the people didn't get help at the facility. So, the thing that they are pushing is that the department is running. That is how they don't care.

> It's because they don't care. They are less concerned about these people of TOP … They don't know how important this is. I think if they will get that information, how important it is for a person to do a TOP, then that will make them feel that if you don't have equipment to work, you don't have someone to help, and you need someone to relieve you, because I have to work from Monday to Friday, you see. When I am going for leave, there is no one who is relieving me. When you come back, a lot of people are waiting for you, some of them not qualifying.

Although a prescribed training is required in line with the Choice on Termination of Pregnancy Act for a nurse to be able to perform abortion procedures and which is vital for broadening access,[12] nurses generally felt that there was a lack of proactive effort on the part of the facility managers to facilitate the training for willing nurses.[13]

> I know of a colleague who was willing, it's a guy actually. He was willing to be trained for the service, and he would always come and see [the facility manager] maybe for information and find out if there is any training that is being provided. He never got the training.

The lack of support from facility management is compounded by significant shortcomings in the public health system, such as the failure to retain nurses as abortion providers, inadequate space within the facilities,

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

13 This is contrary to the position of the Democratic Nursing Organization of South Africa (DENOSA). See 'Submission by the Democratic Nursing Organization of South Africa (DENOSA) regarding the Choice on Termination of Pregnancy Amendment Bill 21 of 2007' (2007) http://pmg-assets.s3-website-eu-west-1.amazonaws.com/docs/2007/071113denosa.htm (accessed 20 May 2019).

and a general lack of prioritisation of the services by facility managers, particularly as it relates to staff shortage. A nurse who was interested in getting trained shared her experience.

> [The facility manager] told me that I can't go for training. They can't send me because they are short-staffed. If they take me this side from antenatal, who will be working in this place?

There has also been reports that this might be age-related as well:

> Again, I have heard an incident whereby they go according to your age. Where does that affect the service? You are a [professional nurse] at the end of the day, and then you find management telling you that you are too young to be providing such a service, or you do not have a child yet, and so you do not go and provide the service. I was willing to do it, I was told I am too young, that I will be traumatised and stuff. But personally, I don't mind.

According to the nurses' accounts, there seemed to be a prevalent sentiment of dissatisfaction and difficulty in retaining trained nurses, which they attributed to a lack of support and appreciation from facility management:

> The other one [previous provider], they said she got sick, because she was so traumatised about the place where she was working. Even now, she is on sick leave, for almost a year.

The inadequate prioritisation of abortion services is reflected in the small, uninviting and 'dingy' workspaces, which negatively impact women's experiences of seeking such services. Nurses expressed their frustration:

> The way the building is, it's like there is a lack of privacy, a lot of judgement, because you will find more of them gossiping that she is here to do abortion, just look how young she is. How can she sleep with a boyfriend? Even those pregnant women who are there for our service, they look at them, like seeing that maybe they are talking, they know that if you follow this Sister, they even know the Sister. If you follow this Sister and you come this side for the sonar, you are here for abortion. They know that. I think maybe if they can provide it somewhere else, so that they can have their own privacy. Because yes, they have their own privacy that side where they do.

> [T]he equipment, last time I asked them to order some instruments. From January [2019] till now, I never received it. I never received even a report that we are still waiting for your instruments or whatever

> … But if you go to the office and said: 'I don't have this, I don't have this', they said: 'You must compromise. You must use whatever you have.'

As highlighted above, public facilities are inundated with the unavailability of medication and equipment and human resources challenges, which exacerbates nurses' workload as shared by this nurse:

> Respondent: At my facility, for now I am a professional nurse, working with TOP. At TOP, I am working with an auxiliary nurse who is assisting me with the instruments. But for me, I think it's very hectic, according to the number of patients that I am seeing per day.
>
> Interviewer: How many do you see on an average day?
>
> Respondent: They come as large numbers, so I can't provide more than seven people per day. So sometimes you find that there are more than 50 or 100.
>
> Interviewer: Really?
>
> Respondent: Yes. So, I will only do sonars by myself. After sonar, I book them. I used to do the sonars on Mondays. On Mondays maybe I will take 30, as an example. So, when I took 30, I will book them according to days. Maybe on Tuesday I will book five, like that. So, it's so hectic, because I have to provide, as me alone and myself. No one is helping me, assisting me in the department. Then the other thing, the family planning is also done by me. I do family planning, I do counselling, pre and post, the observations, to observe the patient, that they are okay after the procedure.

A non-provider had this to say:

> I feel that okay, I am actually looking at it from the perspective of abortion provider. I feel like for her to be the only person that works there, it's a disadvantage. It's a disadvantage in the sense that she has to do all the procedures by herself. She has to prepare and clean the instruments and prepare the room as well, by herself. She has to do all the sonars for every patient that comes in here. Looking at the fact that also with the paperwork that is involved in the service that is provided.

Facility managers emphasised their efforts to reinstate termination of pregnancy services and provide necessary equipment despite financial

limitations, as they were aware of the negative impact of the lack of services on women seeking abortions. Facility managers shared:

> The [TOP] services were not running when I arrived, but in the past, as I understand, they were running. I don't know what happened, but people resigned, people are no longer here. So, we thought we needed the services, based on the statistics, people who do backstreet abortions, unwanted pregnancies, no family planning. Then we spoke to the DEM, which is District Executive Manager. Then he decided, let's go to X [name removed] and do research. The Sister who was providing services there was seconded here. Then we opened the clinic there to run even at night ... but here we only do services from seven to four during the week, and seven to one on Fridays. So, there is only one trained professional nurse, who is working with an enrolled nursing auxiliary, who is not trained, but is willing.

> [T]hose people need support, and they are dealing with something that's not so simple.

> I was surprised, because with us, Treasury, we are hiring not only CTOP Sisters, even any other personnel; we are waiting for April due to budgetary constraints. But once we are given the go-ahead, I think it wouldn't be a problem.

However, nurses had a contrary view about the support received from facility managers, noting that:

> Like for instance, [facility managers] are denying people who want to do it. They don't want to take [nurses] to training. They said they are short-staffed, whereas they are prioritising other departments like other than TOP … they make sure that there is only one person who is doing termination of pregnancy. She doesn't have any support from any staff members. So, this person, she can come back tomorrow and say I'm tired, I need early pension, then the TOP department will be closed.

This research found that the shortage of abortion providers, coupled with the absence of a clear plan to train and replace retiring providers, results in a heavy workload for existing abortion providers and a high likelihood of burnout. The findings from the interviews and focus group discussions suggest that nurse providers often work in environments that lack essential equipment, are understaffed, and do not provide adequate support. This finding is consistent with previous research, which has highlighted that the challenging working conditions of providers make the provision of

abortion services difficult.[14] The shortage of human resources ultimately leads to burnout and high levels of stress.[15]

2.2 Non-specialty of abortion service

One of the major themes that arose from the research was the absence of incentives and recognition for abortion work. Based on the accounts of the interviewed nurses, some of them pursued abortion training with the assumption that it was considered a specialty and would offer career advancement opportunities. This perception was based on their understanding that the Department of Health had intended it to be so.

> Some of them they went for training thinking it is a specialty and they would earn from it. Since there aren't any incentives given, they say no, they can't do it. They would rather go to other specialties where they can be paid because we're working in an environment that really needs money, without money you can't do anything. So, they opt to go for specialties that pay rather than continuing to do a thing that does not pay. They don't want to do a thing that does not give them food because at the end of the day we have to eat, we have to take children to school, so and so, yes.

Another lamented:

> Yes. So, people are going for courses that are paying but termination of pregnancy is not paying so people are reluctant to do it and also, it's hard work but there's no incentive, nothing. Like with the department, they promised earlier on, but they made a U-turn immediately. They promised incentives, incentives, incentives, incentives.

When the Department of Health made the decision not to consider termination of pregnancy services as a specialty and declined to provide higher remuneration for nurses who provided abortion care, some nurses opted to stop providing this service. This lack of recognition and compensation was seen as a major disincentive to continuing to provide termination of pregnancy services.

14 LRC Mamabolo & J Tjallinks 'Experiences of registered nurses at one community health centre near Pretoria providing termination of pregnancy services' (2010) 12 *African Journal of Nursing and Midwifery* 73.

15 See similar findings in A Norris et al 'Abortion stigma: a reconceptualization of constituents, causes, and consequences' (2011) 21 *Women's Health* S49.

> And even those that were providing, they have stopped providing because it is hard work, you are working alone heavily so but nobody recognises that. I mean financially. We are working alone, you can check on our statistics, one person doing such a work per day, with so many patients alone. You admit, you give treatment, you counsel, when you go home you feel like if you can have a driver to drive you home.
>
> [T]he worst part is that as a TOP provider, you don't benefit anything. If you work Monday to Friday and over the weekend you don't work, you are only getting tired and saying not going to claim any overtime, no Sundays. Then you are only getting tired and others saying, 'oh you are complaining about backache, no one is forcing you to terminate'. Meanwhile people in the ward are getting money for working on Sundays.

Nurses reported that providers get transferred to other departments thereby leading to shortage:

> We even have providers who deserted the services because they were tired, they were not taken care of, because there's no incentive, monetary incentive and if they can bring an incentive into the service like any other specialty, people come back. We will see too many people going for training, we will see termination of pregnancy as [big as] any other service like TB or HIV.

2.3 Attitudes of colleagues, stigma and burn-out[16]

According to the nurses who provide abortions, their colleagues held negative and judgmental attitudes towards them, and they were often stigmatised and harshly judged. They were given derogatory labels such as 'baby killers', 'lucifer', 'mortuary', and 'murderers'. As one nurse provider put it:

> I am called 'professional murderer', friends no longer want to talk to me because I work in an abortion clinic.

Further, a nurse shared her experience of how she was insulted:

16 While this section focuses on public sector nurse providers, it is important to note that the insults and naming calling is also experienced by some nurses the private clinic as noted in the quote below: We are constantly harassed by hecklers calling us 'murderers' and 'baby killers'. But there is not much we can do except ignore them. It is frustrating.

> The last time [I was called names], it was from one of the security guards. In fact, he said to me: 'Sister, after doing what you are doing, because it's like you are murdering kids, you are killing babies. Do you go for cleansing, and who is cleansing you?' You know our rituals, you know, the black rituals, we always go after mourning, the funeral and everything, we need to be cleansed. I mean, it doesn't sit well with me. Some will say: 'Are you working there? Are you also killing babies?' Stuff like that, you know.

These comments were confirmed by a nurse objector who stated:

> Well, I think sometimes I'm unfair, because I blame them. I go like: 'Why you agree to do this? You are a murderess'.

In some instances, public sector nurses narrated that several of their co-workers were not supportive:

> Some of the staff members are negative especially in my facility. I'm working alone. I needed an assistant from at least a junior level or next to come and help on busy days. They all refused and said that they can't cope with seeing me killing babies; they don't even know, the doctor is not even interested to see what I'm doing and they're thinking it is as if I'm taking out babies and killing babies. They are so negative and then that leads to me working alone now.

Another explained how support staff including the cleaning staff refuse to clean the room where abortion procedures are performed:

> What I have observed is that some of the cleaners do not even want to see that room. If the person who is cleaning on that day has taken a day off, I will end up reporting to my manager that no one is coming to clean. They will say 'the bloody room, sister of blood room, no I do not want to see myself there' but now lately that I have tried to orientate them that what I need is only to clean and leave the room clean.[17]

The stigma and discrimination that nurse providers experience take a significant emotional toll on them, often resulting in burnout and a shift to other departments or the private sector. Negative comments and attitudes from colleagues leave nurse providers feeling isolated, victimised, and

17 See also Ipas 'Factsheet: Findings from in-depth interviews with abortion providers and health system managers' (2018) 2 https://ipas.azureedge.net/files/SAFAPE18-HowtoImproveSACSouthAfricaPublicHealthFacilities.pdf (accessed 19 April 2019).

stigmatised. Several studies have highlighted that even in places where abortion is legal, providers continue to struggle with stigma and a lack of support, making it challenging to provide high-quality abortion services.[18] Both women who seek abortions and those who provide such services are subject to stigmatisation.[19]

Stigma is defined as 'an attribute that links a person to an undesirable stereotype. leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one'.[20] Abortion stigma, as defined by Anuradha Kumar, Leila Hessini, and Ellen Mitchell, refers to the 'negative attributes ascribed to women who seek to terminate a pregnancy', marking them as inferior to ideals of womanhood.[21] Stigma operates within individual, organisational, and societal structures. In the context of nurse providers, abortion stigma is related to the negative attributes ascribed to those nurses who provide termination of pregnancy services. Colleagues stigmatise nurses who provide abortion services and often do not see them as lifesaving but as involved in unethical services.

For these nurse providers, stigma is driven from the context in which they operate. The experience of stigma by a nurse who provides abortion services is acutely different from that of a woman seeking abortion, or who has had an abortion. Nurses who provide abortion services are stigmatised based on their work in abortion services, which is viewed as 'dirty work' and not in line conceptions of what it means *to be a nurse* and *a member of the nursing profession*. This is because abortion work becomes closely tied to the professional identity of these nurses resulting in continuous exposure to stigma.[22] Abortion provision becomes *an isolating and stigmatising profession.*

Despite this, the nurse providers have coping mechanisms to deal with the stigma and negative attitudes from colleagues. They view their work as helping women and providing respectable nursing care, and their sense of professional responsibility outweighs the judgmental attitudes of

18 LA Martin et al 'Abortion providers, stigma and professional quality of life' (2014) 90 *Contraception* 581; LA Martin et al 'Measuring stigma among abortion providers: Assessing the abortion provide stigma survey instrument' (2014) 57 *Women Health* 641.

19 See A Kumar et al 'Conceptualising abortion stigma' (2009) 11 *Culture, health and sexuality* 625.

20 E Goffman *Stigma: The management of spoiled identity* (1963) 11.

21 Emphasis added. Kumar et al (n 19) 628.

22 On professional responses addressing stigma, see, RJ Cook & BM Dickens 'Reducing stigma in reproductive health' (2014) 125 *International Journal of Gynaecology and Obstetrics* 89.

their colleagues. They express this through their conscience-based claims. Nurse providers describe their conscience-based claims as follows:

> I've never been so comfortable in my life as a nurse working in the reproductive services doing termination of pregnancies. It's not an awful feeling, you know helping women to go on with their lives with no conscience being free and you know something that you don't know, if a woman has an unwanted pregnancy that woman is bad news. That woman can kill herself if she doesn't reach the services of termination of pregnancy. If a woman doesn't want a pregnancy, she wants that pregnancy out like in a week. She wants to close her eyes and when her eyes are opened, the pregnancy is no longer there. So, helping women to get back to themselves, it's so fulfilling and very comfortable.

> To maintain woman's dignity because you know previously women, we were much oppressed, physically, emotionally and otherwise. You find that you have a boyfriend then he sleeps with you and after you tell him that you are pregnant, he tells you: 'With whom have you decided to make that baby? That is none of my business, that baby is not mine, it's yours.' Then that woman gets frustrated and whatever then when she comes, I remove the thing because it's not wanted rather than leaving that particular woman under that particular stress and unhappiness. That offspring will be born being stressed. I think she will just be a naughty person, fighting with everybody at school, crèches and wherever. She won't be a controlled person because she has developed from a human being that would always be angry and she won't even get love from the beginning, or conception, from the first trimester, formation until the end. So, what do we expect the offspring will be like?

In order to counter the stigma and negative attitudes that nurse providers of abortion services face, support systems are crucial. These systems include group get-togethers with fellow providers to discuss their feelings and experiences, as well as support from family, partners, and friends. It is worth noting that the youngest nurse interviewed, who only worked in the private sector, reported that she had not personally experienced any stigma related to her work. This was in contrast to the experiences of older nurses, particularly those working in public health facilities. The young nurse attributed her lack of stigma to her work environment in the private sector and the pro-choice attitudes of her family and friends.

For nurses working in public facilities supported by Ipas South Africa, debriefing and social engagement sessions are also available as coping

mechanisms. As one provider described, these sessions have been helpful in dealing with the stress and challenges of their work:

> Debriefing by Ipas. That makes us free and understand, and gives you that energy again, that I can go back and do 1, 2, 3.

The lack of support for public hospital nurses in coping with their work conditions is concerning, as highlighted by the Democratic Nursing Organisation of South Africa (DENOSA). While Ipas South Africa organises debriefing sessions for nurses in Gauteng and Limpopo, this is not widely available in public hospitals despite the challenging work environment.[23]

The difficulties faced by the health system in providing termination of pregnancy services are not new, as raised during the early years after the Choice on Termination of Pregnancy Act was passed. Rachel Rebouché notes that the Act's ineffective implementation is indicative of broader issues in the healthcare system.[24] In 2002, the Reproductive Rights Alliance, a coalition of NGOs working in the abortion field, expressed concerns about the reluctance of facility staff and district management to offer or support termination of pregnancy services despite the legal mandate.[25] Similarly, Ames Dhai commented on this issue during the National Parliamentary Health Portfolio Committee's 2002 hearing on abortion services: [26]

> Social justice is called into question when access to safe termination of pregnancy is limited by negative attitudes of staff and the failure of training programmes to prepare personnel for performing termination of pregnancy.

The South African case study reveals that negative societal attitudes towards abortion persist even when it is decriminalised, resulting in ostracisation and discrimination of those who provide and seek abortion services.[27] The implementation of termination of pregnancy services is hampered by the

23 M Lekgetho 'Nurses need debriefing & counselling – Denosa' *Health-E News* 20 April 2017 https://health-e.org.za/2017/04/20/nurses-need-debriefing-counselling-denosa/(accessed 28 August 2019).

24 R Rebouché 'The limits of reproductive rights in improving women's health' (2011) 63 *Alabama Law Review* 4.

25 J Merckel 'Comment from Judith Merckel of the Reproductive Rights Alliance' (2002) *Women Health Project* 7. See, CE Hord & M Xaba 'Abortion law reform in South Africa: Report of a study tour 13-19 May 2001' (2001).

26 As cited above.

27 Guttmacher 'Making abortion services accessible in the wake of legal reforms: A framework and six case studies' (2012) 11.

exercise of conscientious objection by health professionals, unsupportive hospital management, lack of information on services, and inadequate investment in public health services. Access to healthcare is thus dependent on one's social status and financial capacity.

Despite the negative attitudes that nurse providers face from their colleagues, they often come to them for support when they or someone they know has an unwanted pregnancy. This indicates a dualistic morality in which opposition to abortion dwindles when it affects them directly. A similar study in Brazil reported a drastic change in the attitudes of health professionals towards abortion when it affected them personally.[28]

3 Shifting construction of nurses' abortion work

3.1 Why it is so hard to run an abortion clinic

Here, I highlight two nurses who run their own private abortion clinics and draw on personal experiences to illustrate the changing nature of nurses' abortion work. These nurses, sister M (a pseudonym) in Gauteng and sister K (also an alias) in Limpopo, shed light on emerging issues such as difficulties with certification, lack of support, and victimisation. Although independent abortion clinics play a crucial role in providing access to abortion, they still face challenges in maintaining their operations.

28 A Faúndes et al 'The closer you are, the better you understand: The reaction of Brazilian obstetrician-gynaecologists to unwanted pregnancy' (2004) 12 *Reproductive Health Matters* 47.

3.1.1 Sister M

As long as I can remember, I have always wanted to be a nurse. I started working in a general hospital in a farming area in Mpumalanga more than 45 years ago. I later became a nurse for reproductive health from 1988. I used to serve in the mobile clinics which would come to the countryside every three months, where black women could get an injection, sometimes without knowing what the injections were for.[29] Generally during those times, women working in the factories were not allowed to come to the mobile clinic for check-up. Employers did not give them adequate time. During apartheid, I remembered how abortion was done considering that it was highly restricted, especially for black women. 80 per cent of cases we saw were at night, which were mainly for evacuation or post-abortion care.

Before the legalisation of abortion, we as nurses had conversations. We were encouraged to attend workshops and come back and teach others. I was recommended by my fellow sisters when they chorused that 'Sister M should go. She is pro-choice. She does not have a problem with abortion'. Despite my family's resistance as my in-laws were priests in the church but leaning on the strength of Desmond Tutu who came out to support abortion rights, I attended the workshop and then got trained as a provider. My fellow sisters refused on the ground of being 'born again', though most of them just refused because they feared the stigma associated with such work.

[I was motivated to become an abortion provider] when a woman came into the hospital at 28 weeks pregnant. She was given an injection to stop the cervix from opening. However, the woman then took the drips off and hid in the bathroom. We had to search everywhere for her. When we finally found her, the baby was out, and the woman had boiled the baby with the hot shower. This led to my training as a provider in 1999.

29 On the population control programme during apartheid as a way of addressing the epidemic of backstreet abortions, see SM Klausen *Abortion under apartheid: Nationalism, sexuality, and women's reproductive rights in South Africa* (2015) 198-200.

In this story, we learn about the history of abortion in Gauteng during apartheid and after it became legal in 1996. Sister M's interview shows how hard it can be for providers to get permission to run private facilities. Sister M is the eldest nurse I spoke to, being 65 years old. She began working as a nurse in 1974 and became a midwife in 1982. Years later, she left the public sector and worked for a private abortion clinic noting that:

> Lady politicians and celebrities who were publicly against the liberalisation of abortion would come to these private clinics.

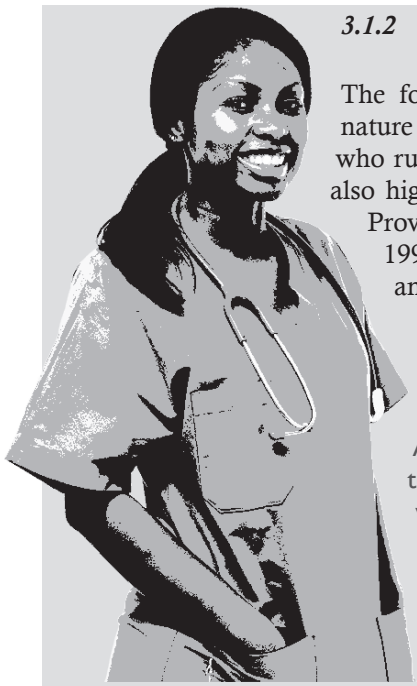
Despite knowing that she was doing great work at the private clinic, she felt that the prices were very expensive and unaffordable. She wanted to help women and girls and not necessarily make money. She noted:

> If a girl comes with ZAR 700 and the clinic says ZAR 900, they will be turned away. Let me catch these girls. I therefore see mostly black women and girls. But also, poor white women also come to me. But if they are rich, they go to the high -end abortion clinics.

On running her independent abortion nursing clinic:

> The Choice on Termination of Pregnancy Act empowered us. During apartheid, nurses could not even do drips. We were regarded as cheap labour. Hence, I decided to set up my own clinic. There is a lot of red tape with designation and the application process takes too long. Most nurses who run their own clinics are not cared for by the Department of Health. My clinic got designated in 2001 and due to restructuring of the office space for residential purposes, we had to move in 2015. Although, I am still in the system, but the clinic is yet to be re-designated since. The accreditors would not come, but they will threaten you with closure and still require statistics from you.

Sister M's description of the designation process and frustration over the designation process resonates with the other nurses running their own private clinics. There is a lot of red tape with the designation of facilities to offer termination of pregnancy services. It was noted that there are usually two Provincial Department of Health staff responsible for the whole province. They are overwhelmed and do not prioritise the process. One of the other problems is that when one moves from the designated site, they need to re-do the whole designation process again.



3.1.2 Sister K

The following narrative reflects the complex nature of abortion work for independent nurses who run their own clinic as the other narrative also highlighted. Sister K is based in Limpopo Province and started as an enrolled nurse in 1992, became a professional nurse in 1999 and midwife in 2002 respectively.

> I did mobile services for a while going to communities and offering services. But this was not challenging enough. As I am a practical person, I went back to maternity in 2005. One day when I was in casualty, a 16-year-old girl came in with a profuse vaginal bleeding with ruptured uterus and the cervix was out. She was apparently taken to a traditional healer. We could not do anything to help her, so we transferred her to the closest referral hospital. However, she stayed with me. I felt she was my daughter and needed to follow up. This motivated me to apply for TOP training in 2005. I wanted to save lives.

She recalled her experience working as an abortion provider in the hospital. She got called names, was over-worked and burnt-out. She finally left public service for private abortion clinic because she felt that she was unable to help women and girls because of the booking system and inadequate number of providers. Out of 60 nurses, there were only two trained abortion providers:

> It was devastating to me how due to the booking system; I was unable to provide timely services to a woman seeking abortion services. Few weeks later, I get called to casualty for the same woman suffering from the consequences of backstreet abortion.

Working as an abortion provider in a public hospital was a very difficult situation characterised by no performance bonus despite being the best performing nurse in the hospital, which was further worsened by an

incident with her unsupportive manager who was only interested in the statistics:[30]

> When I have personal problems at home, the manager will tell me that 'nothing will go right for you'. When my daughter had a miscarriage, she said, 'your daughter will never have a child because you are a baby killer'.

She eventually left the public sector to set up her own private abortion clinic. This also came with an array of problems:

> In May 2018, I was reported to the Department of Health as a result of false information given to them. I was accused of stealing hospital materials for my clinic and illegally operating an abortion clinic. Thirty police officers came to arrest me. There was no search warrant. I have applied for designation a year earlier and yet to hear anything back. I was targeted simply because of perception of being a threat. However, this is confusing, as government is supposed to support health professionals in providing services to women and girls.

These two narratives provide insights into how the identity of nurses in South Africa has evolved in relation to providing abortion services. The healthcare system in South Africa is largely composed of female nurses, which has its roots in the historical shortage of medical professionals during World War II.[31] The history of nursing in South Africa is marked by the emergence of black nurses as a majority in the field, starting with the registration of Cecilia Makiwane in 1908.[32] Makiwane, a product of a nurse training school for black nurses, became the first black professional nurse in the country. This was due to the need for Xhosa-speaking nurses in King William's Town, which led to the establishment of the experimental training school.[33] Over time, more black nurses were trained

30 Facilities are obligated to document and send monthly detailed accounts of procedures performed with disaggregated data for the clients in terms of age, group and gestational age. This is in line with sec 3(4) of the Choice on Termination of Pregnancy Act which obligates the member of the Executive Council to once a year submit statistics of any approved facilities for that year to the Minister.

31 See CE Burns '"A man is a clumsy thing who does not know how to handle a sick person": Aspects of the history of masculinity and race in the shaping of male nursing in South Africa, 1900–1950' (1998) 24 *Journal of Southern African Studies* 695.

32 South Africa Nursing Council 'Born to be a nurse – Cecilia Makiwane' (2019) 3 *#SANCNews* 4.

33 As above.

nationwide, reflecting the changing political landscape and the increasing role of women in the country. Today, black nurses make up the majority of registered nurses with the South African Nursing Council. This change of trend overtime also reflects the changing political landscape and the position of women in the country.

The nursing profession is characterised by a combination of specialised theoretical knowledge and practical experience.[34] As a result, nurses hold and exercise a considerable amount of power. However, it is important to note that knowledge is not neutral, as it carries particular viewpoints and therefore serves as a means for the exercise of power. Nurses further reinforce their power through the wearing of uniforms, which symbolise their status and authority.

The nursing profession is characterised by theoretical specialised knowledge and practical experience, which result in power being held and exercised by nurses. Knowledge is not impartial and signifies specific viewpoints and consequently serves as the vehicle for the exercise of power. In addition, nurses wear uniforms, which reinforces the status quo of having power. The nursing profession's invariable coupling of power and knowledge, as Foucault points out, is complimentary.[35] The dispensation of power through complex social networks includes not only 'agents but also instruments of power'.[36] These instruments of power may include documentation, infrastructures, equipment, and established ways of doing things, all of which are utilised to wield power.

Power is not a fixed entity but rather comprises power relations that are constantly recreated and reinforced over time. For nurses who provide abortions, empowerment came in the form of the Act which allowed them to perform first-trimester abortions, changing the way their professional identities were constructed and creating new opportunities for them.[37] By asserting their agency and moving between the margins and centres of their profession, nurses are creating their own social spaces and locations, as described by bell hooks.[38] This has led to the establishment of specialised abortion clinics owned and operated by nurses, independent of public hospitals, particularly in Gauteng and Limpopo, resulting in an increase

34 RR Sepasi et al 'Nurses' perceptions of the concept of power in nursing: A qualitative research' (2016) 10 *Journal of Clinical and Diagnostic Research: JCDR* LC10–LC15.

35 M Foucault *Discipline and punish* (1977) 27-28.

36 J Rouse 'Power/knowledge' (2005) 34 *Division I Faculty Publications* 11.

37 M Berer 'Provision of abortion by mid-level providers: International policy, practice and perspectives' (2009) 87 *Bulletin of the World Health Organization* 58.

38 bell hooks *Feminist theory: From margin to center* (2000) xvi.

in service provision. Private clinics have become a refuge for those who cannot access public services due to time constraints and booking systems. Some private clinics even offer abortion services outside of regular hours, making them more accessible to those who need them.

Yet, private nurse practitioners, who run their own abortion clinics, face significant challenges when it comes to complying with the designation process. This is because section 3 of the Choice on Termination of Pregnancy Amendment Act outlines a lengthy list of requirements that health facilities must meet in order to be designated to provide abortions. Termination of pregnancy may only take place at a facility which:

(a) gives access to medical and nursing staff;
(b) gives access to an operating theatre;
(c) has appropriate surgical equipment;
(d) supplies drugs for intravenous and intramuscular injection;
(e) has emergency resuscitation equipment and access to an emergency referral centre or facility;
(f) gives access to appropriate transport should the need arise for emergency transfer;
(g) has facilities and equipment for clinical observation and access to in-patient facilities;
(h) has appropriate infection control measures;
(i) gives access to safe waste disposal infrastructure;
(j) has telephonic means of communication; and
(k) has been approved by the Member of the Executive Council by notice in the Gazette.

Through the 2004 amendment of the Choice on Termination of Pregnancy Amendment Act, a member of the executive council (MEC) could designate facilities that could provide abortion services.[39] Additionally, the assigned member could exempt facilities from obtaining approval for abortion services if they provide 24 hours maternity services. While the amendment to the Act was aimed at making abortion more accessible through the removal of long designation procedures, as illustrated above, this has not translated into practice. The wide-ranging requirements that facilities have to comply with in order to be authorised to provide abortion is burdensome for the private sector, especially nurses with limited capital and social networks.

Private nurse practitioners who operate their own abortion clinics face significant challenges when it comes to complying with the designation

39 See, sec 3 of the Choice on Termination of Pregnancy Amendment Act 38 of 2004.

process. On the one hand, complying with the requirements outlined in section 3 of the Act is burdensome and time-consuming, making it difficult for these practitioners to provide abortion services. On the other hand, failure to comply with these requirements can lead to legal consequences and the loss of the ability to provide abortion services altogether.

Despite these challenges, the private sector has played a key role in complementing abortion services provided by the public sector. However, the high cost of private sector service provision means that it is not accessible to all. Moreover, the extensive bureaucratic process of accrediting facilities has resulted in a slow decentralisation of services, with many authorised public health facilities still not providing abortion services.

Nurses who operate their own abortion clinics have also faced continued abuse and disempowerment at the hands of public health officers responsible for designating facilities, particularly when compared to doctors who run their own abortion clinics. This highlights the ongoing power imbalances within the healthcare system, and the need for greater support and recognition for nurse providers in the field of abortion care.

3.2 Negotiating roles and power in the doctor-nurse relationship

Despite the potential of nurses to practice as private practitioners with their own abortion clinics and meeting the challenges of providing quality abortion care, they are faced with the power structures in the health system, which makes it difficult for them to do abortion work. As one nurse lamented:

> The problem is that termination of pregnancy has become commercialised and hijacked by doctors and the selling of pills in informal shops in the townships. For example, due to the influx of foreigners seeking the services, the prices have gone unreasonably up. There are doctors who charge ZAR 5 000, but they are not disturbed like us. They give their patients pills and tell them to go to the hospital when they bleed. We suffer unequal treatment as nurses running our own clinics.

Another one recalls:

> I used to have at least 500 clients per month. However, because we have a doctor in the same building, it has gone down to 100-200 clients per month.

In conversations with nurses, it becomes apparent that there is a tension and professional boundary between nurses and doctors that is often defined by labels such as: 'I am a doctor and you are a nurse.' This boundary is reinforced by gendered and professional hierarchies based on qualifications and licenses.[40] Professional codes and training further distinguish doctors and nurses as separate professions.

The global landscape of senior positions of power within various industries remains dominated by men, while front-line health professionals such as nurses are predominantly women.[41] Despite an increase in the number of women entering the medical profession, men still make up the majority. This has resulted in a patriarchal structure, with predominantly male doctors serving as the head of the team, which is primarily composed of female nurses. This hierarchical observation allows for power imbalances to persist.

The nursing profession, in particular, has been stereotyped as being feminine, perpetuating gendered divisions of labour within the health system that mirror those of society.[42] Nurses are conditioned by the health profession to play a deferential role, contributing to power relations being maintained through social and bureaucratic hierarchies in hospital settings.[43] These structures are designed to ensure that nurses remain in their place, conforming to traditional settings and dictates that preserve the status quo.[44]

Nonetheless, while speaking to the independent nurses, there was a clear sense of questioning of traditional occupational roles and hierarchy between nurses and doctors. They no longer viewed doctors, who are mostly men, as the ultimate authority on women's bodies, as exemplified

40 See S Porter 'Women in a women's job: The gendered experiences of nurses' (1992) 14 *Sociology of Health and Illness* 510; G Andrews 'Nursing as emancipatory practice' in JD Jansen (ed) *Knowledge and power in South Africa* (1991) 165.

41 See WHO 'The world health report' (2006) http://www.who.int/whr/2006/en/ (accessed 12 March 2018).

42 M Takase et al 'Does the public image of nurses matter?' (2002) 18 *Journal of Professional Nursing* 196.

43 CM Chapman 'Image of the nurse' (1977) 24 *International Nursing Review* 166; PM Manojlovich 'Power and empowerment in nursing: Looking backward to inform the future' (2007) 12 *OJIN: The Online Journal of Issues in Nursing* 2.

44 Foucault coined the term 'biopower' to not only focus on the body as a site of subjugation, but also highlights how individuals are implicated in their own oppression through self-surveillance. See M Foucault *The history of sexuality, Vol 2* trans R Hurley (1980) 139.

by the character in Nawal El Saadawi's *Memoirs of a woman doctor*.[45] These nurses have gained their own expertise and experience through working outside of the hierarchical structures of public hospitals. An incident in May 2018, where a professional nurse's clinic was raided by the provincial Department of Health, serves as a clear example of the continued harassment and victimisation faced by private nurse practitioners running their own abortion clinics.[46] It highlights the discriminatory treatment towards nurses compared to doctors, who do not face such crackdowns.

Focus on fake Drs

Maseo Nethanani

THE MEC for Health, Dr Phophi Ramathuba, led a raid on an illegal women's health clinic in Ladanna on Thursday.

Department officials were accompanied by police officers to investigate and close the clinic that was operating without a licence. During the raid, a foetal scope, belonging to the Department of Health, was confiscated as well as other equipment belonging to the state.

Ramathuba said the clinic was run by a professional nurse who was trained by the department but refused to serve the community in government healthcare facilities, rather opting to open her own practice for financial gain, not complying to the laws and bylaws.

"This clinic is illegal as it is not accredited by the Department of Health. Aside from the numerous complaints against the clinic made with the department, it was also worrisome to find equipment belonging to the state. This equipment was purchased by the department to help the people in communities but they were stolen by one of our own professionals, indirectly stealing from Limpopo's people, denying them their basic right to healthcare services," Ramathuba said.

She added the confiscated equipment was taken from Rethabile Clinic and has led to the clinic being unable to help patients due to the stolen equipment.

"We want to investigate what happens to the morals of the medical professionals we train as a department to care for our people. People who come to this illegal clinic have the money to pay for medical care which is essentially stolen from the poor when medical professionals steal state equipment to open their own practices for personal financial gain. We will continue to work with police to investigate the matter and bring the guilty parties to book, an example must be made."

Ramathuba added this was not the only success the department had on Thursday as they also arrested two young males masquerading as doctors at Mankweng Hospital.

"We lose too many women to illegal street abortions from fake doctors. Contraceptives are free at state medical facilities, make use of this service and look after your health. We will continue to root out these illegal medical practices and fake doctors. We will leave no stone unturned to ensure the safety of our people, it is our responsibility to protect them," Ramathuba said.

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Figure 2: News story (Raid on a women's health clinic)

The above discussion portrays the power dynamics at play in the healthcare system, particularly in the provision of abortion services. Nurses challenge the traditional power structures and assumptions about the quality of care provided by doctors. They argue that they offer high-quality services at a lower cost compared to doctors. This challenges the assumption that doctors are the only ones capable of providing safe and effective abortion services. The criticisms levelled against doctors also highlight the issue of accountability in the provision of abortion services. The power dynamics between nurses and doctors reflect larger societal power structures that need to be addressed in order to ensure access to safe and affordable reproductive healthcare for all.

45 The fictional book tells the story of a young woman's encounter during her studies as the only woman in the class in mid-century Egypt. She no longer sees men as 'gods' as described by her mother; due to the misogynistic experiences faced by the women patients she encounters. See, N El Saadawi *Memoirs of a woman doctor* trans C Cobham (1982) (originally published in 1957).

46 M Nethanani 'Illegal woman's health clinic raided in Ladanna' *Review* (Polokwane) 31 May 2018 https://reviewonline.co.za/263822/focus-on-fake-drs/ (accessed 5 June 2019).

4 Concluding reflections

The chapter reveals the intricate and challenging experiences of nurses who provide abortion services. It sheds light on the difficulties faced by nurses who support the right to abortion and carry out the termination of pregnancies. Despite the challenges, many abortion providers demonstrate unwavering dedication to their work.

Through these narratives, we see the dedication of these nurses to their patients, despite the hurdles that compromise the quality of their services. They confront power structures and societal norms that undermine the provision of abortion services. Michel Foucault's notion of resistance and opposition comes to mind, as the provision of abortion services has become 'a point of resistance and a starting point for an opposing strategy'.[47]

The nurses who provide abortion services must navigate complex and sometimes hostile environments. They face criticism and stigmatisation from some members of society and even their colleagues. Nevertheless, these dedicated healthcare providers continue to provide quality services to their patients, even in the face of adversity.

This chapter also brings a new perspective to the existing research on nurses who provide abortion services. Unlike previous studies that only focused on public health nurses, this research also sheds light on the experiences of private sector nurses. By doing so, it challenges the notion that all nurses are the same and instead acknowledges the diversity of their experiences. Through the insights, we can gain a better understanding of abortion service provision in the private sector, including stand-alone abortion clinics owned by nurses.

While previous research has focused on public health nurses, this study is novel with its additional focus on private sector nurses. This speaks to an anti-essentialist position, which does not assume that all nurses are the same. The experiences of nurses in this chapter cannot be encompassed in a single standpoint. The study gives unique insights into abortion service provision in the private sector including stand-alone abortion clinics owned nurses. I traced the career trajectories of two private nurse practitioners who own their abortion clinics to illuminate the complex barriers that they face which overlaps but also varies from that of nurses who provide abortion in public health facilities. Findings showing

47 M Foucault *The history of sexuality, Vol 2* trans R Hurley (1978) 102.

differential treatments between doctors and nurses is a good illustration of the role that power plays in constructing the discourse of competence and regulatory effects in limiting the skills and knowledge of nurses to challenge and uncover truths.[48] This contributes to the maintenance of hierarchies and solidifies the historically disadvantaged position of nursing viewed mostly as a female discipline as opposed to medicine as a male discipline.[49]

In the context of abortion service provision, there is a clear power dynamic between doctors and nurses that is based on their respective knowledge and expertise. This power dynamic reinforces historical hierarchies in the healthcare system, where nursing has traditionally been viewed as a female discipline and medicine as a male discipline. I argue that this power dynamic is further complicated by issues of race, class, gender, and other factors related to reproductive health. As the nursing profession continues to evolve and diversify, so too does the power and knowledge dynamic between nurses and doctors, highlighting the need for ongoing analysis and exploration of these complex issues. As we listen to the stories of nurses, it becomes apparent that their responses to their experiences vary. While each nurse's experience is individual, certain common themes, such as acts of resistance, emerge.

In contrast to this chapter, the upcoming chapter has a specific focus on conscientious objection and its impact on nurses' attitudes and motivations regarding termination of pregnancy services. This narrower scope allows for a more in-depth exploration of the factors that shape nurses' conscientious objection and how it affects their perceptions and understandings of abortion.

48 NJ Ford et al 'Conscientious objection: a call to nursing leadership' (2010) 23 *Nursing Leadership* 46.

49 A Lipp 'Challenges in abortion care for practice nurses' (2008) 19 *Practice Nursing* 326; G Andrews 'Nursing as emancipatory practice' in JD Jansen (ed) *Knowledge and power in South Africa: A critical perspectives across the disciplines* (1991) 163.

5

Navigating a liberal abortion law: The tug of war for nurses

Fragments: Unpacking the context of abortion care provision by (some) South African nurses

Sister Tendani

There was a day when I was sitting at the information desk in the hospital when a young girl approached me, wanting to have an abortion. As a nurse, I had my own objections to the termination of pregnancy, but I didn't want to convince her not to do it. Instead, I gave her some advice and asked her about her reasons for seeking an abortion. She told me that she wanted to terminate her pregnancy because her friend had done it before. I questioned her further about why she had sex before marriage and why she didn't want to keep the baby. She didn't seem to have any valid reasons, so I proceeded to tell her about the potential complications that could arise from having an abortion. I explained that while the procedure itself might be safe, there could be long-term consequences that would affect her ability to have children in the future. I urged her to consider the implications of her decision, especially if she wanted to have a family later in life. The girl was surprised to learn about the possible complications associated with abortion, as she had been told that it was completely safe. I emphasised that while she wouldn't be physically hurt like those who undergo unsafe abortions, there were still risks involved. In the end, the girl decided not to go through with the abortion and instead started attending the antenatal clinic. She eventually gave birth to a healthy baby, and I felt grateful to have been able to offer her some guidance and support during such a difficult time.

Nurse James

In my personal experience, my baby girl was born healthy in December 2018. However, the mother of the child initially wanted to have an abortion despite my objections. She even asked me to accompany her to the facility where the termination would take place. Despite my opposition, I decided to support her and secretly hoped that something would go wrong, and the termination would not be possible. To my surprise, the facility kept postponing the procedure until the baby reached the point of viability, which was at 26 weeks, rendering the termination impossible. In addition to my objections, I secretly informed her family members about her pregnancy since she had not told them. They made sure to keep her from going anywhere and she was constantly supervised. Despite the challenging situation, I am grateful that my baby girl was born healthy and happy.

This chapter endeavours to illuminate the multifaceted ways in which nurses in South Africa exert their right to conscientious objection, interpret ethical guidelines, and construe their professional responsibilities as compassionate healthcare providers. Using a critical African feminist perspective, I explore the attitudes, opinions, and practices of nurses regarding abortion. The chapter draws on empirical data obtained through semi-structured interviews and focus group discussions with nurses. The study assesses how nurses interpret and implement abortion laws and their perceptions of women seeking abortion. Additionally, it examines the factors that shape nurses' motivations for conscientious objection related to termination of pregnancy services.

Nurses were asked about their views on abortion and women's reproductive rights, their perceptions of women seeking abortion services, their professional backgrounds, including their training, and their understanding of conscientious objection. The goal was to examine the legal, professional, moral, ethical, and religious factors that shape their work in abortion services. The following excerpt provides a representative summary of the narrative patterns that emerged from the research, while maintaining anonymity. The selection of data is based on how effectively the quotes expand our understanding of conscientious objection practices. It is important to note that while this account offers insight into nurses' beliefs and actions, it does not reflect the experiences of women seeking abortion services, which has been studied elsewhere.[1]

1 Practices of conscientious objection

In South Africa, healthcare providers can exercise conscientious objection to providing abortion services based on their religious or moral beliefs, even though it is not provided for in the Choice on Termination of Pregnancy Act. This is allowed under the constitutional provision on freedom of thought, belief, and opinion. However, providers still have a duty to inform women seeking abortion of their right to access these services and refer them to another provider or facility. It's important to note that healthcare providers cannot refuse to provide abortion services in case of a medical emergency, as stated in section 27(2) of the Constitution.[2] Therefore, nurses are obligated to provide assistance in such situations.

1 See for example, 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.

2 See also 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 (2018).

There is a lack of available data regarding the prevalence of conscientious objection to abortion. However, it has been estimated that in 2013, less than half of the approximately 260 designated facilities in South Africa provided abortion services.[3] In 2018, this number was estimated to be only 264 out of the 505 designated health facilities.[4] As a result of this shortage of health workers providing abortion services, some women may resort to informal or unsafe abortions.[5]

It is important to clarify that the research did not aim to determine the prevalence of conscientious objection to abortion. However, the data gathered sheds light on how conscientious objection is practiced. Out of the 33 nurses interviewed, seven stated that they do not support the provision of abortion as outlined in the law, while seven were uncertain, as their decision-making was ongoing and non-linear.[6] In private facilities, there were no objections, possibly due to their nature as abortion clinics. Particularly, I found that there was a general lack of understanding of the concept and practice of conscientious objection. A similar study conducted by Jane Harries and colleagues in Western Cape reported similar findings, highlighting that health professionals also did not have a clear understanding of conscientious objection.[7]

3 'Provincial Data: Tri-provincial workshops 2010 data National Department of Health South Africa' as cited in KA Trueman & M Magwentshu 'Abortion in a progressive legal environment: the need for vigilance in protecting and promoting access to safe abortion services in South Africa' (2013) 103 *American Journal of Public Health* 397.

4 Amnesty International 'Briefing: Barriers to safe and legal abortion in South Africa' (2016) 8 https://www.amnestyusa.org/files/breifing_barriers_to_safe_and_legal_abortion_in_south_africa_final_003.pdf (accessed 10 January 2018). See also Committee on Economic, Social and Cultural Rights, Concluding observations on the initial report of South Africa, 29 November 2018, UN Doc E/C.12/ZAF/CO/1 (2018) para 65.

5 R Hodes 'The culture of illegal abortion in South Africa' (2016) 42 *Journal of South African Studies* 79. See also KE Dickson et al 'Abortion service provision in South Africa three years After liberalization of the law' (2004) 74 *Studies in Family Planning* 374.

6 The data of public sector was collected as part of a larger three-country study on conscientious objection led by Ipas in South Africa, Mexico, and Bolivia. This includes the six focus group discussions conducted in public facilities in Gauteng and Limpopo by the Centre for Aids Development, Research and Evaluation (CADRE) on behalf of Ipas South Africa (transcripts on file with researcher). Author was a consultant and served as a member of the innovation team to provide technical guidance related to developing and testing interventions to address the use of conscientious objection among public sector health care workers to deny women's access to safe, legal abortion services in Bolivia, Mexico and South Africa. The views expressed by the author in the analysis do not necessarily reflect those of Ipas.

7 Harries et al (n 1) 3.

The nurses generally showed a lack of familiarity with the concept and practice of conscientious objection. When they chose to absent themselves from performing the procedure, they did not use the term 'conscientious objection'. A nurse shared:

> Well initially I didn't know anything about people objecting to performing any services to patients or the community, but recently, I am back at school, so we have learnt about management and everything that has to do with medicine. So, it was brought to light that as a professional nurse, we all have rights, as like any other patient [sic]. So, we have the right to conscientious objection, with the meaning that we have the right to refuse to carry out duties or tasks that we feel we are not competent enough to perform, or we feel that they are not in line with our values or our beliefs. But then we have to make it in writing, where we notify our supervisors or a manager in writing, also stating the reasons why you don't want to perform a specific duty that is assigned to you, or that is part of your scope of practice.

Other nurse colleagues responded to the comment above:

> No [we have not heard about conscientious objection]. The reason being, [nurse above] has recently enrolled in her [Bachelor of Nursing Science] degree study, so we, in the hospital, we don't have a standing policy that has stated what she has just said. So, we're not aware of that in the hospital. Only, because she is from school, in her books and stuff, but here in the hospital, we don't have that. We don't have a standard policy that specifically states the reasons that she said to us now.

> So, that is why we have so many staff members refusing to perform the service, because of our own culture, we have different cultural beliefs and backgrounds and values. So, it's not to say, and we are not oppressed by the management, but the majority of the staff are refusing to perform the service, due to their own reasons.

There were no formal procedures or policies reported on the withdrawal or non-support of termination of pregnancy by staff. For example, some facility managers mentioned that nurses would refuse to engage in abortion services, but there was no official system for recording objections. Nurses who object to performing abortions were not required to register as conscientious objectors. There was also confusion between what constitutes obstruction of abortion services and conscientious objection.

> People have undergone training; the government spent a lot of money for training and when they come back, they do not want to provide the service ... No, not in this facility, but where I come from. I worked somewhere before. Two were trained but they do not want to implement the services.

When asked about how those who object to termination of pregnancy express their objections, respondents gave vague and unsubstantiated answers. It seems that if someone, including an abortion provider, wants to be excluded from providing or supporting TOP services, they inform their department head, facility manager, union representative, or the District Department of Health in an informal manner. There appears to be a lack of formal policies or procedures for conscientious objection, as indicated by an exchange with a facility manager:

> Interviewer: Do you have an Ethics Committee?
>
> Respondent: Not really. I'm trying to establish committees. I have started with the Quality Assurance Committee. So, we still have a long way to go.

There was a common understanding among the participants that individuals who are trained to provide abortion services but later refuse to do so, usually do it on religious grounds. One facility manager mentioned that some nurses who were sent for advanced training that included termination of pregnancy, later declined to offer abortion services due to their religious beliefs. The manager recalled that these nurses said they had found 'God' and could no longer support abortion services. This suggests that religious beliefs play a significant role in the decision-making of healthcare providers when it comes to the delivery of abortion services.

> Others have started to do this procedure on the line ... in the middle of the year, they just said they cannot continue with this anymore because they have taken God.

The data presented above suggests that the understanding and implementation of conscientious objection is uncertain. In some cases, it appears that conscientious objection is being used to resist abortion laws and the provision of legal abortion. Additionally, there is no formal process for recording objections or reasons given for objections, and there are no standardised policies or procedures for managing the practice. As a result, it is difficult to estimate the number of objectors or the grounds for objecting, but it is clear that poor knowledge of laws and regulations

plays a key role in nurses' perceptions of abortion, even in cases where the law is liberal.

2 Discourses on practical decision-making regarding the provision of abortion services

2.1 Professional duty and responsibility in relation to abortion services

Nurses who provided or supported abortion services considered it their professional duty, often based on personal experiences. They believed that legal termination of pregnancy was necessary to prevent unsafe abortions and save women's lives. According to a nurse in the public sector, her involvement in providing abortion services was crucial to prevent women from resorting to unsafe abortions:

> For a client to say, 'Sister I don't want this baby', you must listen to her. She will even tell you that 'if you don't terminate this pregnancy, I will see the outsiders who will give me medicine that will kill me'.

Nurses also stated that their motivation to provide abortion care was largely driven by the devastating consequences of unsafe abortion, which can result in morbidity and mortality. This sentiment was echoed by several respondents, as seen in the following quotes:

> My township experience and seeing black young women die from backstreet abortions motivated me to get trained and become a provider.

> I was going to say what makes [us] happy, as providers, we are the first, the number one prevention of maternal deaths in South Africa.

A number of nurses also reported that their personal beliefs and experiences played a role in their decision to provide abortion care. Many felt strongly about the right of women to make decisions about their own bodies and reproductive health. One private abortion clinic owner, for example, spoke about how her personal experience with an unwanted pregnancy led her to open her own clinic and provide safe abortion services:

> My 32-year-old friend had backstreet abortion and passed away. I set up a clinic dedicated to her life and safeguarding others to not experience the same.

These nurses are committed to saving lives and providing safe abortion services, as they are aware of the devastating consequences of unsafe abortion methods used and abortion pills sold by street vendors. They have witnessed the use of dangerous methods such as insertion of sharp objects into the vagina, physical manipulations of the womb, and drinking of herbal concoctions to induce abortion. These practices have been used in South Africa for over 150 years and are still prevalent today.[8] Health providers view their work as critical in addressing the consequences of unsafe abortion and are motivated by the desire to give women the right to make decisions about their bodies and reproduction. A nurse narrated:

> A 23-year-old lady from Zimbabwe was brought to casualty 3 weeks ago. She had a history of vaginal bleeding and abdominal pain. She tested positive for pregnancy. However, when we did an ultrasound, the uterus was empty, and the abdomen was flat. As we were not sure what happened, she was admitted for observation. She couldn't explain what happened because she could not speak any local language or English. The person who dropped her off mentioned that she was from Zimbabwe and later left her here. Few hours later due to abdominal and respiratory distress, a sonar was done again thereby leading to the discovery of accumulation of blood. She was then stabilised and transferred to the main hospital in Polokwane. During the operation, they found out that the uterus was perforated with a sharp object and she had bowel injury. She later passed away.

Another nurse also shared:

> A young girl came, it was two or three years back. So, she went through the queue and stuff, and she had big clothes on. You can't see anything is wrong with her, no pink nose or cheeks or anything. She stood up, the patients just move, thinking okay, the queue will move now. She went to the toilet. She went unnoticeably to the male toilet instead of the female. I guess when she sat down everything came out: big head and placenta. After that, she didn't even get into the consulting room, but luckily, she registered at the security gate. On night duty, no taxis, she walked, she fainted along the road somewhere. A patient came and asked whether we had torches. So, I think the patient went in and peed on top of the baby. There is no light, you know, because our poor maintenance also. We found her the next day. We had to call the mortuary.

8 H Bradford 'Herbs, knives and plastic: 150 Years of abortion in South Africa' in T Meade & M Walker (eds) *Science, medicine and cultural imperialism* (1991) 120-147.

In addition, abortion providers recognised the influence of the political and legal landscape on their perception of reproductive rights, as guaranteed by the South African Constitution. They understood the medical norms that required them to serve their clients, and they viewed women seeking abortion services as having agency and the right to make reproductive healthcare decisions.

2.2 Religious and cultural beliefs about abortion

From conversations with nurses, I find that the religious convictions and belief systems of nurses were found to have an impact on their decision to not engage in abortion procedures. Providers who objected to providing abortion services cited their Christian beliefs that abortion is against the ethics of killing:

> I'm against it because you will go and abort, you find that also because of my Christian belief, that's the main thing, my Christian belief … The belief is you are killing, and the Bible says you don't kill, because that person is a human being. According to the Bible, there is nothing such as a mistake. Everybody was a child, who has been conceived, God has got a purpose with that child, and you go, irrespective of the manner, you have conceived that child. God has got a purpose for that child.

> Well, I won't give advice to terminate the pregnancy. I will just speak to the parent, that they must decide what would be best for them, for the child, remember. Ja, but for advising a parent to terminate a pregnancy for a child, I can't also. I still feel religious and not comfortable.

A facility manager's description sets as forth:

> There are and others who have started to do this procedure on the line ... in the middle of the year, they just said they cannot continue with this anymore because they have taken God.

Another explained:

> What she is trying to say is some people [providers] don't want to be referred to as murderers, that's why they don't want to do it ... Yes, they believe it's killing.

Some respondents believed that pregnancy is a gift from God even in cases of rape:

> If it's an issue of rape, incest and things like that, I will advise that person to deliver the baby, give it up for adoption, rather than to kill.

The extracts suggest that the Christian discourse that considers abortion as a sin, aligns with the pro-life perspective that abortion is murder and violates the sanctity of life.[9] The religious arguments were not limited to Christianity but also included traditional African religions and mythologies, particularly in Limpopo province. One nurse provider acknowledged this difference and stated:

> We have been accused of being the reason why there is no rain, because we are doing abortion.

The Limpopo-based nurses highlighted a noticeable contrast in perspectives between individuals living in urban areas and those residing in rural areas, as they shared their experiences.

> They also don't believe like termination in their traditions … Abortion, they feel like it's not allowed in their traditions. We have got different kinds of traditions [sic].

> I think in also their cultures, because I think this thing of cultures and religion is one and the same thing, because they don't want to do the procedure. [They say]: 'My culture doesn't allow me to abort, or whatever.'

The quotes presented demonstrate how the objecting nurses used moral arguments to oppose abortion, drawing comparisons between it and religious and cultural taboos. The influence of cultural and traditional beliefs on attitudes towards abortion is evident. This aligns with the conclusions of a 2017 study, where the author noted a similar connection.[10]

> The African traditional epistemology views abortion as a taboo and its transgression is known to be punished by the earth spirit through shortage of agricultural products, famine, infertility, draught and illness. This punishment

9 See J Daire et al 'Political priority for abortion law reform in Malawi: Transnational and national influences' (2018) 20 *Health and Human Rights Journal* 225.

10 L Molobela 'Exploring black rural Bushbuckridge women's constructions and perceptions of the practice of abortion' MA thesis, University of South Africa, 2017, at 91 (on file with the author).

> may befall particular clan members, the whole family or everyone living in the village.

Although objecting nurses were of the belief that abortion was an unacceptable practice and often cited religion, abortion providers approached the issue from a different religious perspective. They argued that the Christian faith emphasises values such as compassion, humanity, and community, which align with providing access to abortion services. One of the nurse providers, who was also a pastor in her church, elaborated on this stance:

> Since I have mentioned that I am a preacher in my church, some of my colleagues at work they will say: 'But you are a preacher standing on the pulpit every Sunday. How do you feel?' I say: 'My conscience is very clear that I am not killing anyone. I am trying to serve the community, trying to reduce maternal death' and when they say to me: 'But it means you cannot see heaven' and I said: 'Have you ever been in heaven?' We cannot judge people. If somebody comes in and says she needs the service, if I can, I have to do that since I was trained, I have to do that.

Another reported:

> [B]efore I came for training I spoke to my reverend and he said to me because this thing is legalised and as a church we are sorry about what is happening outside, and each day the newspapers report that children are found wrapped in the plastic which it's trauma due to the public; then he said to me as long as you say you support this we are going to support you because this is a good work people are no more going to be traumatised by what we see on TV or what is reported on daily basis.

These two narratives demonstrate how discourse can be repurposed, as it is socially constructed and can be used to further different agendas. Here, the nurse providers used moral arguments to address the issue of unsafe abortions, which is typically associated with the pro-life movement.

Understanding different ideologies, whether political or religious, can help to illustrate how they are used to maintain power structures. Patriarchal societies are an example of such power structures which include institutions, belief systems, ideologies and behaviours that uphold

men's control over women's power of agency over their own bodies.[11] In patriarchal societies, women are often subordinated to men through the family structure, with men as the head of the household. This patriarchal discourse is often tied to traditional and religious beliefs and practices, which reinforces women's subordination.[12] This dichotomy between non-western and western states is illustrative of the differing views on gender roles and power dynamics.

The perspective of Marxist-feminism posits that patriarchal structures underpin the functioning of capitalism as an economic system.[13] Bell hooks employs the term 'imperialist white supremacist capitalist patriarchy' to refer to the interlocking political systems that serve as the foundation of politics and political structures.[14] In *The will to change,* she goes on to contend that the patriarchal system is sustained through various means, including the socialisation of men into dominant gender roles, the objectification and sexualisation of women's bodies, and the undervaluation of caregiving and other activities associated with femininity.[15]

The anti-essentialist perspective on patriarchy challenges the notion that the concept can be universally applied across cultures, which contests the oversimplified understandings of western feminism. This view recognises the interconnected and constantly evolving components of patriarchy as a system, rather than attributing it solely to individuals. Religious beliefs and practices play a significant role in reinforcing male dominance, particularly in relation to reproductive decisions, often through the authority of male religious and cultural leaders. For instance, the Catholic Church relies on priests, while some Protestant churches still regard fathers and husbands as spiritual heads.[16] In Islam, while all humans are viewed as equal before Allah,[17] gender roles are defined, with

11 T Braam & L Hessini 'The power of dynamics perpetuating unsafe abortion in Africa: A feminist perspective' (2004) 8 *African Journal of Reproductive Health* 45.

12 This resonates with the arguments of African theorists that African feminism did not come about as a reaction to patriarchal domination, which was central to western feminism. See G Mikell (ed) *African feminism: The politics of survival in sub-Saharan Africa* (1997) 5.

13 On how the patriarchal nature of the state allows for gender hierarchies to be reproduced, see C MacKinnon *Toward a feminist theory of the state* (1989) 161-162.

14 b hooks *The will to change: Men, masculinity, and love* (2004) 17-18.

15 As above.

16 KA D'Souza 'Abortion and the three bodies: An interpretive understanding of barriers to abortion access in South Africa' (2013) 1 *Journal of Undergraduate Anthropology* 8.

17 Quran verse 39:6 states: 'He created you from one being, then from that (being) He made its mate'.

men typically serving as heads of households and women responsible for child-rearing.[18]

Viewed through a feminist lens, religious and cultural arguments against abortion stem from traditional expectations about women's roles in reproduction and motherhood. Gender norms are rules that governs what is acceptable or unacceptable behaviours based on one's gender.[19] These gender norms constrain what behaviours are deemed acceptable based on one's gender, leading to social sanctions for those who do not conform. Motherhood is considered a key status symbol for women, making it the highest achievement in many societies. Consequently, when a woman decides to have an abortion, she is often perceived as rejecting this societal ideal.[20] This sanctioning of motherhood is part of patriarchal discourse and reinforces the belief that a woman's primary responsibility is childbearing and childrearing.

Abortion is often framed as a transgression against the traditional idea of motherhood.[21] This notion stems from the idea that women are primarily viewed as mothers rather than individuals with reproductive choices. As Martha Fineman and others argue, motherhood has been defined and shaped by male norms and legal definitions.[22] In many African societies, the regulation and control of women's sexuality and reproductive capacity has been used to ensure that women conform to prescribed roles of childbearing and homemaking. However, some African scholars caution against solely viewing motherhood through a western lens and acknowledge that women's autonomy can be celebrated in both public and private spaces.[23] Women's role of wife or mother does

18 Quran verse 4:34. See SS Ali 'Women's human rights in Islam: Towards a theoretical framework' (1997) 4 *Yearbook of Islamic & Middle Eastern Law* 117.

19 GL Darmstadt 'Why now for a series on gender equality, norms, and health?' (2019) 393 *The Lancet* 2375.

20 See P*lanned Parenthood v Casey* 112 S Ct 2791, 505 US 833, 120 L Ed 2d 674, 1992 US LEXIS 4751, 60 USLW 4795, 92 Daily Journal DAR 8982, 6 Fla L Weekly Fed S 663 (US 1992) 168-169. See also KT Bartlett, DL Rhode & JL Grossman *Gender and law: Theory, doctrine & commentary* 5th ed (2009) 692.

21 K Cockrill & A Nack '"I'm not that type of person": Managing the stigma of having an abortion' (2013) 34 *Deviant Behavior* 975.

22 MA Fineman et al (eds) *The neutered mother, the sexual family and other twentieth century tragedies* (1995) 38.

23 S Tamale 'Gender trauma in Africa: Enhancing women's links to resources' (2004) 48 *Journal of African Law* 50.

not necessarily limit women's agency.[24] It is in this line that Ifi Amadiume in *Male daughters, female husbands* argues that motherhood is a sacred and highly regarded aspect in African societies, where women's maternal power is associated with the fertility of the earth, making them crucial producers and providers, thus resulting in their revered status.[25]

While acknowledging the usefulness of presenting African women's maternity as reproductive autonomy, caution should be exercised against romanticising precolonial times as such depictions fail to recognise the constraints that traditional gender roles could impose on women, leading to a double bind on women seeking abortions and contributing to conservative sexual morality that punishes women for non-procreational sexual activity. According to Fitnat Naa-Adjeley Adjetey, cultural norms in Africa subordinate women and limit their reproductive choices, as their responsibility for reproductive labour is seen as essential to keeping the family bloodline alive.[26] Examining motherhood as reproductive autonomy should involve acknowledging it as a means of oppressing women, which portrays abortion as a violation of gender norms. The South African Constitutional Court acknowledges that motherhood can be a source of inequality for women, as it imposes a significant burden.[27]

Nurses utilise the motherhood mandate as a benchmark to make moral judgments of women who decide to have an abortion. There is an overwhelming sense that all women supposedly want to be mothers. The narratives show that when women make a decision to abort, as an indication of their agency, nurses sought to prevent this, in effect reinforcing patriarchal norms of motherhood as an essential aspect of women's lives.

2.3 On women – and the reasons (justifiable or not) for seeking an abortion

While personal, moral, and religious beliefs are often cited by those objecting to abortion, the majority of nurses who object base their involvement in abortion provision on the reasons for women seeking an abortion, acknowledging the complexity of the decision-making process.

24 The recognition of women's special role as mother is reflected in the article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) adopted 11 July 2003, entered into force 25 November 2005.

25 I Amadiume *Male daughters, female husbands: Gender and sex in African society* (1987) 191.

26 FNA Adjetey 'Reclaiming the African Woman's individuality: The struggle between Women's reproductive autonomy and African society and culture' (1995) 44 *American University law Review* 1351 at 1352.

27 *President of the Republic of South Africa v Hugo* 1997 (4) SA 1 (CC) para 38.

Objecting nurses often noted that circumstances such as rape, incest, and risk to the woman's health justify abortion, while still holding their personal views on the matter. For example, quite a number of objecting nurses stated that there were indeed circumstances – such as rape and incest, as well as risk to the woman's health – that justify an abortion. As one noted: 'I only think when it comes to rape, and also when it's, to me, that's kind of acceptable.' Others added:

> Yes, I think with me personally, I was like if you were raped, that's when you can go for abortion. Then something comes to me and says no man, 'God can't give you a trouble which you can't carry'. Then I'm like how are you going to carry that pregnancy for nine months, and then like you were raped? You get my point?

> If you are raped, you have to go to ask for help. There [are] emergency contraceptives. That's where we are going. Yes, if you are raped, you have to go and get emergency contraceptives, and if the emergency contraceptives fail, there is this thing called termination of pregnancy.

Nurses were also more sympathetic and supportive if it was an unplanned pregnancy of a minor due to rape:

> I think when a young girl, of any age, if she is raped, or if she has been molested by a relative or something, I will recommend it, but I'm not 100 per cent recommending it. It will be due to the rape, only the rape.

The few providers who suggested that there should be an exemption when it is 'affecting the health of the mother' observed:

> If it concerns your health, your health is at risk, then go through with it. That's the only reason for me, that I feel it's okay.

> It's medically indicated. I can support that one, because you are terminating the pregnancy because you are trying to save life. It's not that maybe you just want termination of pregnancy, it's not medically indicated, you just don't want the baby.

A critical feminist analysis of *situational objecting nurses*, nurses who object to abortion but make exceptions for certain circumstances, such as rape or risk to physical health, reveals underlying gender stereotypes about women and their perceived roles, with the implication that women without exceptional reasons for seeking an abortion are being put in their place. It is also important to note that these nurses' consideration for justifiable

reasons only extends to physical health and not mental health. In this case, if women do not have exceptional reasons for having an abortion, they would be put in their place.[28]

What is found from the types of arguments advanced by nurses as to *who deserves an abortion*, points to discursive constructions of women who seek abortion. Discourses produce interpretative lenses which shape nurses' beliefs, opinions and understandings.[29] The underlying premise of these discursive positions is also premised on the construction of women as mothers, as highlighted earlier. The reality is that nurses are human beings who live and reproduce norms of the societies in which they live and work.[30] They are not just norm-abiding rule followers or self-interested actors, but rather, their behaviour depends on the *individual,* on the *context* and on the *rules*.[31]

The nursing profession involves specialised knowledge and clinical practice that gives rise to actions of power, which aligns with Foucault's notion that power and knowledge are interdependent.[32] Nurses' knowledge and perspectives shape their attitudes towards women seeking abortions, and gender stereotypes influence their evaluation of which circumstances justify access to abortion services. For example, women who have experienced rape or have medical conditions are often portrayed as *deserving* and as victims, revealing the influence of societal norms on nurses' decision-making.

As deduced from the quotations, narratives of victimhood were common as a justifiable reason for women to access abortion services. The study shows that even if nurses object to abortion generally, they are willing to support abortion provision if a woman seeks an abortion that does not seem to be about demanding reproductive autonomy. Objecting or non-supporting nurses view reasons for abortion not valid unless they pertain to rape or sexual abuse. This has resonance with both the discourse used to support the enactment of the Choice on Termination

28 M Sullivan 'Stereotyping and male identification: "Keeping women in their place"' in C Murray (ed) *Gender and the new South African legal order* (1994) 187.

29 M Foucault *The archaeology of knowledge* trans AMS Smith (2012) 209.

30 SW Salmond & M Echevarria 'Healthcare transformation and changing roles for nursing' (2017) 36 *Orthopaedic Nursing* 21.

31 Emphasis added.

32 M Foucault *Discipline and punish* (1977) 27-28. See also RR Sepasi et al 'Nurses' perceptions of the concept of power in nursing: A qualitative research' (2016) 10 *Journal of Clinical and Diagnostic Research* LC10.

of Pregnancy Act,[33] as well as the pro-choice movement's approach for abortion reform in restrictive settings.[34] From this perspective, women seen as victims of sexual crimes should be allowed to have an abortion since they are blameless and their request is *not a choice against motherhood*.[35] According to this position, these women must be granted limited access to abortion services because it is a painful choice for them to make in light of devastating events that occurred. Abortion within this trauma discourse becomes morally acceptable, which discredits abortion as a normal procedure in women's lives.

While it is understandable that the victimhood argument could potentially elicit empathy from nurses who do not support abortion, it ultimately perpetuates harmful stigmatisation of women who seek abortion for other reasons. It is important to note that the majority of women seeking abortion do not do so because of sexual assault or rape. In fact, research has shown that reasons for seeking abortion vary widely, including financial instability, inconvenient timing, relationship problems, lack of education, and contraceptive failure.

Furthermore, it is crucial to recognise that women who do become pregnant as a result of rape or sexual assault should not be reduced to mere victims, as they are exercising their agency and autonomy in making decisions about their reproductive health. The tendency of nurses to make exceptions based on medical indications may not necessarily support women's autonomous right to access safe abortion, but rather reinforces the societal expectation that women's worth is tied to their role as mothers.

The discourse of victimhood creates a framework that excludes women who have not experienced sexual violence or have medical reasons as not having a justifiable reason for seeking an abortion. This framework fails

33 As one Member of Parliament (MP) in expressing support painted this scenario for parliamentarians to keep in mind: 'Raped women, girls who are sexually abused by their fathers, divorced women who are still expressed and abused by their ex-husbands without realising that this is rape and the divorced independent woman, a woman with five children.' See Republic of South Africa 'Choice on Termination of Pregnancy Bill – Second reading debate' (1996) 16 *Debates of the National Assembly (Hansard) – Third session – First Parliament* (29 October to 1 November 1996) 4796.

34 T Feltham-King & C Macleod 'How content analysis may complement and extend the insights of discourse analysis: An example of research on construction of abortion in South African newspapers 1978-2005' (2016) 15 *International Journal of Qualitative Methods* 1. See also M Berer 'Abortion law and policy around the world: In search of decriminalization' (2017) 19 *Health and Human Rights Journal* 13.

35 Emphasis added.

to recognise that women have the right to make decisions about their own bodies and reproductive health, regardless of the reasons behind them.

2.4 On contraception and 'repeat abortions'[36]

The narratives gathered from nurses who object to providing abortion services consistently highlighted the connection between contraception and abortion. Nurses seemed reluctant to make concessions on their moral beliefs, largely due to how they perceived women who sought abortions.

> So, if you do unprotected sex today and you want termination of pregnancy, to me yes, it is like killing.

Nurses reported difficulty dealing with the lack of responsibility displayed by the patients.

> 'Do it because I made a mistake. I didn't use a condom, I don't want to be pregnant', I don't support that one, I don't think I can support it.

Another stated:

> I think people who should not be allowed to do terminations, for someone who is above 22 years, and that person knows about contraception. So why terminate the pregnancy? And for somebody who says ok I was in love with this person, and I discovered that this person is a gangster, what does that have to do with terminating a pregnancy? Yes, he is a gangster, but does that mean termination has to do with being a gangster and your baby will also be a gangster? This thing of saying the blood runs through the veins, no I do not believe in that. If you believe that your boyfriend is a gangster, why did you have unprotected sex with him instead of saying no my boyfriend is a gangster and I do not want to have a child with a man who is a gangster? No, that's not [right] and for a person who is having two kids and she is on the third pregnancy and decides to terminate, why? Because you went through all those two pregnancies and now you want to terminate, it's not fair. Just leave the people who were raped, those cases, allow them to have termination of pregnancy, not just that I wake up today and decide that I no longer want to keep

36 This study uses the phrase 'repeat abortion' where necessary, when nurses use it to describe women who are considered 'deviant' because they are having more than one abortion. This study uses it with no intention of harm. While this study acknowledges that using the plural 'abortions' is a valuable way to destigmatise the idea of having more than one abortion experience, at the same time phrases such as 'multiple abortion' might be useful to explain the needs of people with different experiences.

> this child, no that is not fair. But for the person who was raped, yes, I would also encourage that one.

The prevailing perception among nurses was that women who sought abortion were using it as a form of contraception, especially in cases of suspected 'repeat abortions':

> I am also of the same view because now since it's been legalised, and also the age, wherein you can start terminating pregnancy, young girls are using it as a means of contraception [sic].
>
> ...
>
> I think we have heard instances where we have had patients coming for antenatal booking and they had like five abortions before. Then you are asking, termination of pregnancy times five, what was happening? It's not like they are teenagers, or they did that when they were teenagers. They were well aware of what they were doing. In most instances, they will tell you, 'no, family planning doesn't go well with me'. So when you try to educate at that point that you know there are other types of family planning that you don't know that you are supposed to know about that could have helped you, then that's the only time they will understand. But even the attitude of the community towards family planning, that's why we are getting those termination of pregnancies that will be following each other every year.

Nurses often cited the example of young women who seek abortion services repeatedly and refuse education on contraception. These women were deemed to be sexually promiscuous, using abortion as a means of contraception.

> [T]hese young females, they love sex and they do not protect themselves and they are busy terminating pregnancies.

The belief that women seeking abortion are using it as a form of contraception was evident in the response of a nurse who objected to providing abortion services when asked if she would refuse to provide post-termination of pregnancy care:

> I think I will counsel that patient, because it will help not for her to go and fall pregnant again, come back again and terminate. I will talk to that person to make sure that will be the first and the last. Then I will counsel, give options of contraceptive methods that are there,

> so she can make a choice if she wants to continue having sex before marriage. I will counsel the patient.

Based on the narratives, it was a widely held belief that an increase in 'repeat abortions' was due to women's refusal to use contraception properly. This was seen as unacceptable by the nurses:

> Some patients come several times to do TOP. At first you can say it's a mistake, but the second time, the third time? You are just saying you are not protecting yourself. We are encouraging unprotected sex, which comes with HIV, which comes with STIs, you know.

> ---

> [I]t is just that I think you put it in different baskets, if I can say that, that there is that group of people that are terminating because they are using termination as a form of family planning. Those people are the ones that I would say I do not know if we are educating them. I am sure [nurse provider] is educating them after each and every time that they come here, but then four or five months later, those same people are here again. So, those people, I do not know what needs to be done or how they can hear us if we say there is family planning. Even if [they are given] family planning, they will use it for the time being, and then forget about it, to fall pregnant again.

Despite the prevailing belief among some nurses that women seek repeat abortions due to their failure to use contraception, there were opposing views. Some nurses acknowledged the need to take into account the specific circumstances of women who seek multiple abortions. These nurses cautioned that factors such as frequent relocation, lack of access to reliable family planning methods, poorly trained healthcare providers, and negative attitudes from health professionals could contribute to women seeking multiple abortions. Such nurses advocated for a more comprehensive approach to reproductive healthcare that takes into account the complex realities faced by women seeking abortion services.

> Besides the fact that the community has attitude towards family planning, I partially blame our health services. Most people are denied access to family planning in some of the clinics. You will find a woman saying she went maybe, I am sorry to point out, but most clinics in Soweto. They deny most people access to family planning.

While another added that:

> You come at two o'clock, they tell you that it's late, come back tomorrow in the morning. In the morning you come there, it's a one-stop service. They will tell you that they are busy with immunisations, they are busy with a clinic, come back later. When they come back later again, it's the same story, that it's in the afternoon, or they are on long tea breaks and whatever. These are the actual formal complaints that we hear from the people in the community. So, that's why I'm saying I partially blame the health services as well. Or they will be saying they don't have stock of Depo or Noristerat or whatsoever, then they end up being resistant to go for family planning, or the attitude of our nurses in the family planning departments. So, I think that needs to be looked at as well.

One provider reported instances in which women seeking termination were not actually pregnant, possibly due to lower-ranked nurses not following proper procedures during pregnancy tests. An independent provider had to turn away a client who had come for the fourth time, despite being counselled on contraceptive use and referred to a social worker.

Furthermore, some providers expressed the belief that abortion was promoting promiscuity among young women, who were not taking responsibility for the potential consequences of unprotected sex, such as pregnancy and HIV. An objecting nurse cited this as her reason for objection:

> Yes, I'm objecting because it promotes the young kids to have sex at an early age, which will lead to early pregnancies, high rates of HIV. So, some of the young girls are using this as family planning. They just have sex, knowing that they will go to the government institution, it's free to do it … So, they have sex at an early age, knowing that there's nothing that can block them. So, they are no longer afraid of HIV, STIs and other health hazards. They just do it.

Others also noted:

> [B]ecause some, the reason is because it's not my husband's child. My husband works away, I was just cheating with another man, and I don't want him to find out.

> Some of them [trained TOP providers] when you ask them, it's their beliefs, they will tell you about their Christianity does not allow them to do that. They can only do that if maybe it's the emergency cases only, if they are forced to save a life but voluntary if the person just comes, just goes and sleeps with a man, and gets pregnant and comes and terminates, they won't attend to that. Even doctors, some of them don't want to do it.

Nurses expressed concerns regarding the impact of abortion on women's fertility and their ability to conceive in the future. They believed that abortion posed a threat to women's reproductive health and could potentially cause infertility.

> [Abortion] can be safe, but then later on it is possible that you might not fall pregnant, you will be married, and your husband will be looking to start a family, what are you going to do?
>
> ---
>
> Me, I won't think it's a good thing to kill a baby. Why, because you can find it's a firstborn, and then you kill that baby, then in the future you find somebody, then you want to marry him, then you can't make another baby.

A nurse shared her experience of stepping in to address future concerns related to abortion. She recounted a situation where a young woman came to the clinic:

> Nurse: I said how old are you, and then she told me. I said do you want to do it, or maybe you want to ask for anyone else. She said no, I want to do it. I was like okay, I didn't want to go further, but I became so emotional. I said: 'You are so young. Have you thought about this thing?'
>
> Interviewer: What did she say?
>
> Nurse: She said: 'Now Sister, you are scaring me off now. What should I expect?' I said: 'I don't know what's going on there. I have never done it before, but I'm asking you, have you thought about it, because when you are doing abortion, it's like the child is there, the foetus is there. You want to get rid of the foetus?' Then she said, 'I don't have a choice, because I'm at school, and then my boyfriend, I don't know where he is, so I need to do it'. She wanted to cry by that time, and then I said okay, let me not go further, and then I directed her. I said:

> 'But when you get there, please think about it. There are so many options; you can talk to your parents about it. Maybe they will say okay, we will accept the child, or maybe they will say to you, let's take the child to the social workers, and if you have got any other problems, you can even come to us, to me, I will refer you to the social workers and then you will make a good decision'. Then she said to me: 'But time is not on my side because there is a cut off period'. I said: 'Oh, I know about that, but please think about it', and then I directed her, and then she went.

The narratives primarily reflect arguments that focus on the consequences of contraceptive misuse and the potential implications of undergoing an abortion. Women who seek abortions for reasons other than contraceptive failure or who seek abortions multiple times are viewed as irresponsible and deviant. Such attitudes perpetuate negative stereotypes about women, who are often discouraged from engaging in non-procreative sexual practices of pleasure and desire. Consequently, nurses are less likely to sympathise with women who seek abortions for reasons related to contraceptive failure or who do not use family planning methods consistently and correctly.

The negative attitudes towards women seeking abortion services are especially pronounced for young, unmarried black women, who are deemed irresponsible and immoral for engaging in non-procreative sexual activities. These negative stereotypes reflect a belief that the availability of abortion services encourages promiscuity and irresponsible behaviour, which are deemed unacceptable, particularly for adolescents.[37] Those nurses who object to providing abortion services believe that teenagers should abstain from sexual activity until marriage as it is morally wrong. They also hold the view that young women should not have access to abortion services, as it could encourage early sexual activity and increase the risk of contracting HIV.

In addition, nurses perceived women who have had one or multiple abortions differently. The term 'repeat abortions'[38] creates a binary categorisation, leading to negative stereotypes and othering of women who have had multiple abortions. Nurses who hold this belief view these

37 A Müller et al '"You have to make a judgment call" – Morals, judgments and the provision of quality sexual and reproductive health services for adolescents in South Africa' (2016) 148 *Social Science & Medicine* 71; K Wood et al 'Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa' (2006) 14 *Reproductive Health Matters* 109.

38 Discussion on this, see L Hoggart, V Newton & L Bury '"Repeat abortion", a phrase to be avoided? Qualitative insights into labelling and stigma' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 26.

women as irresponsible and deviant, often due to the assumption that they are using abortion as a form of contraception. A nurse is quoted as saying that there is no justification for abortion given the availability of family planning and emergency contraception.

There were different views regarding emergency contraception among the nurses. Some nurses couldn't understand why women wouldn't use emergency contraception as a preventive measure against unwanted pregnancies, while others were afraid that promoting emergency contraception would discourage women from using long-term contraceptive methods. This complicated debate over contraception goes beyond the portrayal of women seeking abortions as irresponsible and is likely influenced by the economic and structural challenges faced by these women. Additionally, the lack of widespread promotion and misinformation about emergency contraception may contribute to its perceived abortifacient properties.

3 Implications of negative stereotyping and contradictory discourse

In this chapter, I begin with the premise that although legal changes may permit women to access abortion, healthcare professionals' attitudes, including nurses, can still create barriers. I aim to provide insights into the lives of nurses and the subjective experiences they navigate in the provision of legal abortion care. To achieve this, I integrate multiple dimensions of their realities, including their actions, feelings, and perceptions, as well as their relations of power.

The Democratic Nursing Organisation of South Africa (DENOSA) during its submission to the Parliamentary hearings on the Choice on Termination of Pregnancy (CTOP) Amendment Bill,[39] noted the role of nurses in abortion provision:

> As the major representative body of nurses in South Africa, who are mostly women faced with the same challenges that the Act is trying to address, it is right and proper that while we advocate as a union, we should not [lose] sight of the fact that these providers of health care, who form the majority of the health service providers, are women who also have the right to choice about their own reproductive health.[40]

39 Act 21 of 2007.

40 Submission by the Democratic Nursing Organisation of South Africa (DENOSA) regarding the Choice on Termination of Pregnancy Amendment Bill 21 of 2007 (2007) http://pmg-assets.s3-website-eu-west-1.amazonaws.com/docs/2007/071113denosa.htm (accessed 20 May 2019).

The work involved in providing abortion care creates interactions that reinforce various power relations. Hospitals function as a space where different forms of power dynamics, including vertical and horizontal, are reinforced, thereby perpetuating social and bureaucratic hierarchies within the hospital setting. Nurses hold significant power, not just in disciplining patients but also in subjecting them to surveillance and normalisation. This behaviour can be seen as a manifestation of 'oppressed group behaviour', as described by Margareta Dahl.[41]

Judith Butler's theory on performativity is useful in offering a lens through which to explore power while putting gender at the centre of such analysis.[42] Nurses through the act of performance of their duties, enact the convention of reality. Butler explains this by stating:

> The act that one does, the act that one performs, is, in a sense, an act that has been going on before one arrived on the scene. Hence, gender is an act which has been rehearsed, much as a script survives the particular actors who make use of it, but which requires individual actors in order to be actualized and reproduced as reality once again.[43]

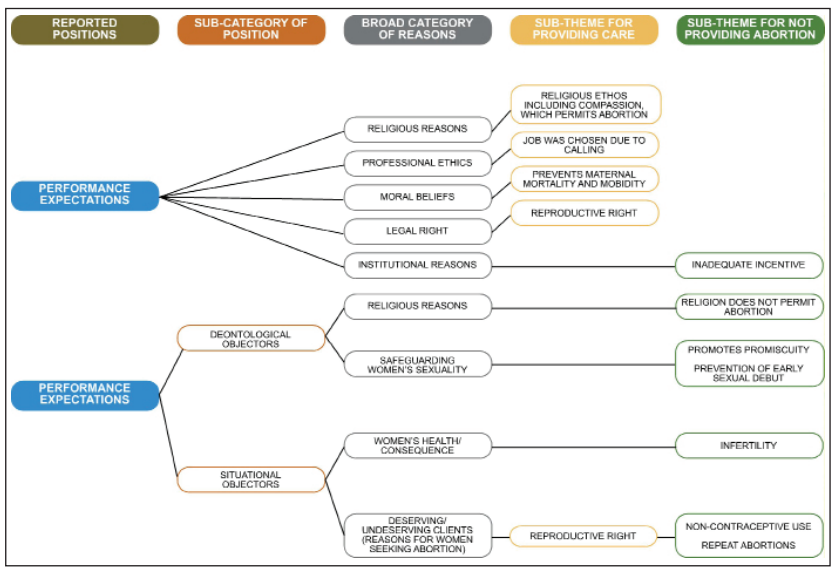
Insights from the aforementioned findings highlight how nurses mirror and perpetuate societal norms within their working and living environments, as evidenced by the differing discourses utilised by both providing and objecting nurses (and even within those groups). It is evident that power dynamics underlie nurses' articulation of these discourses. This chapter has elucidated the often-contradictory motivations and justifications behind non-providing nurses' decisions. Religious beliefs and perceptions of the 'good' or 'bad' nature of abortions based on women's reasons for seeking the service both influence nurses' willingness to provide abortion care. The themes and sub-themes identified in this study are summarised in Table 1 below.

41 M Dahl 'Nurses: An image change still needed' (1992) 39 *International Nursing Review* 12.

42 See J Butler *Gender trouble: Feminism and the subversion of identity* (1999).

43 J Butler 'Performative acts and gender constitution: An essay in phenomenology and feminist theory' in SE Case (ed) *Performing feminisms: Feminist critical theory and theatre* (1990) 272.

Table 1: Overview of deployed discourses



This research, despite having a limited sample size, sheds light on the intricacies of abortion practice. It reveals that the behaviours exhibited by nurses in relation to abortion provision cannot be solely attributed to conscientious objection. Instead, nurses who do not provide abortion services should be identified as 'non-providers' rather than 'conscientious objectors', as they hold distinct perspectives on abortion services. Since morality is not a fixed concept, the narratives of non-providing or objecting nurses can be characterised from two primary perspectives.

The first viewpoint among nurses who object to providing abortion services is that of a small group who hold a firm opposition to termination of pregnancy based on an absolutist doctrine rooted in religious beliefs. They believe that abortion is immoral, and their conviction is based on the notion that God forbids the taking of human life. Therefore, according to this perspective, abortion is a violation of the moral law, which states: 'Thou shalt not kill'. This perspective aligns with the stance of many of the world's major religions, which consider abortion as murder. These nurses view their moral obligation to respect this moral law as being rooted in deontological ethics that place value on human rationality.[44] In line with Kantian theory, nurses who hold an absolutist view against abortion

44 See HJ Gensler 'A Kantian argument against abortion' (1986) 49 *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 83.

are only concerned with the nature of right and the moral content of actions.[45] These nurses believe that it is never morally acceptable to perform or assist in an abortion, regardless of the consequences. They ignore the outcomes of their decision not to provide abortion care. For them, abortion is always wrong, and the principle of universality applies, meaning that ethical judgments apply to every situation involving pregnancy, regardless of the circumstances. Thus, even in cases of rape, where a woman becomes pregnant, they believe that abortion is not justifiable, as the baby can be given up for adoption instead. They argue that there is no need to resort to abortion under any circumstances because it is intrinsically bad.

The majority of non-providing abortion nurses in this research take a different approach compared to the absolutist doctrine. Instead, they can be categorised as 'situational objectors' based on their narratives that exemptions should be made. Their decision-making is affected by contextual factors rather than their individual religious beliefs or cultures. These nurses apply situated moral judgments to determine when abortion is appropriate or not. For instance, nurses contextualise morality when deciding who deserves an abortion. They base their decision on a backward-looking stance or a consequentialist position. Women who have been raped or have a medical condition that is risky to their life or health are deemed deserving of support, while women with weak reasons such as contraceptive failure are not. This approach aligns with the relational ethics of care. A member of parliament (MP) expressed a similar sentiment during parliamentary debates on the Act, stating:

> The Bill challenges the legal rights of parents, guardians and husbands, it promotes promiscuity and irresponsibility amongst our teenagers. It destabilises trust between married couples, and I foresee a great degeneration in family life as we know it today.[46]

Interestingly, in this study, socio-economic reasons did not emerge as a significant factor in determining the willingness of nurses to provide or assist with abortions, although another study has shown that it can be a relevant factor.[47]

45 LC McDonald 'Three forms of political ethics' (1978) 31 *The Western Political Quarterly* 7.

46 Republic of South Africa 'Choice on Termination of Pregnancy Bill- Second reading debate' (1996) 16 *Debates of the National Assembly (Hansard) – Third session – First Parliament* (29 October to 1 November 1996) 4796.

47 See J Harries et al 'Health care providers' attitudes towards the termination of pregnancy: A qualitative study in South Africa' (2009) 9 *BMC Public* Health 1.

On the other hand, the consequentialist perspective on abortion suggests that it should be avoided due to its potential negative consequences. As seen earlier, some nurses expressed concerns about the alleged risks of abortion, such as infertility, which could contribute to a culture of fear around reproductive health. This undue focus on risks associated with abortion has an unwarranted impact on women's decisions about whether or not to terminate a pregnancy. It is also not consistent with the responsibility of healthcare providers to offer evidence-based and non-judgmental information and care regarding sexual and reproductive health.[48]

These nurses' display of paternalism reflects a return to the idea of medical professionals having all the knowledge and power.[49] Women seeking abortions are not seen as capable of making decisions for themselves, based on a gendered belief that they are not fully informed about the potential implications and consequences of their choice. The concern of these nurses is that unrestricted access to abortion can lead to undesirable consequences. As previously mentioned, one of their main worries is that women may use abortion as a form of contraception despite the availability of other family planning methods. This perspective is similar to that expressed by a member of parliament (MP) from the National Party (NP) during the deliberations of the Choice on Termination of Pregnancy Act:

> I, for one, and my party agree that the only way to improve living standards in South Africa us to improve our economy and introduce an effective system of family planning. However, we in the NP are totally opposed to the use of abortion as a method of birth control.[50]

Non-providing nurses believed that women who did not effectively use contraception were irresponsible and therefore turned to abortion as a solution. Most of these nurses considered abortion acceptable, but having multiple abortions was viewed as deviant behaviour that needed to be corrected.[51] However, it was unclear whether women were having multiple abortions due to reluctance, inadequate knowledge, or limited

48 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 (2012) para 26.

49 S Sheldon 'The decriminalization of abortion: An argument for modernisation' (2016) 36 *Oxford Journal of Legal Studies* 334.

50 Republic of South Africa 'Choice on Termination of Pregnancy Bill – Second reading debate' (1996) 16 *Debates of the National Assembly (Hansard) – Third session – First Parliament* (29 October to 1 November 1996) 4794.

51 M Nussbaum *Sex and social justice* (1999) 63.

access to contraceptives.[52] Some nurses admitted that younger providers lacked the necessary competency in family planning provision, delivery, and counselling. Others noted the limited role of the state in ensuring the provision of effective and comprehensive family planning services. Stock-outs of family planning products such were also a common issue in public facilities.[53] As a result, it is necessary to examine the quality and effectiveness of family planning and post-abortion counselling services.

The research shows that nurses' moral or religious beliefs have an impact on women's health, specifically their ability to access safe and legal abortion services. This is because their beliefs reinforce the stereotype that 'womanhood equals motherhood'. The value judgments made by these nurses reflect their exercise of paternalistic control, which can include influencing women not to have an abortion or using their own discretion to decide when to 'allow' women to terminate their pregnancies.

The evidence presented here supports the claim that social and institutional factors, in addition to legal ones, contribute to and shape nurses' perceptions of womanhood and its connections to abortion. This chapter's findings acknowledge the possibility for nurses (in this case, women) to act as agents of patriarchal power against other women.[54] Since power is dispersed and relational, any group or individual can wield it. The nursing profession, with its specialised knowledge and clinical practice, thus becomes a vehicle for the exercise of power. The patient-nurse relationship is already fraught with gendered assumptions based on the patient's presumed role as a mother, creating a situated power relationship. Nurses, through their performance of certain acts, reinforce the conventions of reality, such as the normativity of motherhood and the condemnation of pre-marital or transactional sex, making these seem natural and necessary.[55]

In a Foucauldian sense, nurses engage in discourses that do not solely belong to them. They deploy normalising techniques that create an ideal standard to which they and women seeking abortion services must conform. Through this process, as witnessed from the narratives, women who do not adhere to gender norms are penalised and sanctioned. Such

52 See F Lang et al 'Is pregnancy termination being used as a family planning method in the Free State?' (2005) 47 *South African Family Practice Journal* 52.

53 See Medical Brief 'Birth control stock-outs remain a problem in SA' (6 March 2019) https://www.medicalbrief.co.za/archives/birth-control-stockouts-remain-problem-sa/ (accessed 5 May 2022).

54 b hooks *Feminist theory from margin to center* (1984) 85-87.

55 J Butler *Gender trouble: Feminism and the subversion of identity* (1990) 28.

tactics of organised mentalities aim to domesticate women even when they choose not to exercise their perceived reproductive role of procreation within a framework facilitated by the law. Nurses construct women who seek abortion services as sexually irresponsible, adopting a punitive stance to punish them for their perceived promiscuity. These actions are at odds with the notion that women's access to abortion is grounded in free choice.

In summary, the way in which nurses perceived women and their motivations for seeking abortion services was based on an oversimplified view of the 'universal woman' that failed to consider the complex range of factors that contribute to a woman's decision. It is crucial to recognise the intersectionality of race, gender, and class, as well as other factors such as age, socio-economic status, sexual orientation, and disability. The influence of African mythologies and cultural norms on black women nurses, demonstrates the importance of contextualising intersectional effects.

4 Concluding reflections

In this chapter, I have delved into the practice of conscientious objection among nurses in Gauteng and Limpopo, South Africa, showcasing the discourses and practices that nurses rely on when making decisions about women's access to safe and legal abortion services. The discussion illustrates that the practice of not providing abortion services is indeed prevalent, but due to the lack of standard registers, it is challenging to determine the full extent of this phenomenon.

Unfortunately, the portrayal of women seeking abortions as victims and irresponsible individuals oversimplifies the complex realities of women's lives in South Africa. Moreover, nurses' objections are not solely based on conscience, but also on political beliefs, cultural norms, stigma and discrimination, and inaccurate medical knowledge and evidence. What is most concerning is that despite the liberalisation of abortion over two decades ago, nurses continue to act as gatekeepers, deciding who can and cannot access abortion services based on their own subjective views of whether the reasons for seeking an abortion are 'good' or 'bad'. This perpetuates patriarchal norms of motherhood and reinforces the paternalistic control over women's bodies.

While this chapter has focused primarily on nurses' attitudes towards abortion and conscientious objection, the next chapter will delve into the legal and ethical scope of conscientious objection. Drawing from international human rights law and comparative law, I will prescribe the approach that the courts should take in developing judicial interpretations

on the exercise of conscientious objection and reproductive rights. It is crucial to safeguard respect for women's reproductive autonomy and human dignity when they seek abortion services, and I believe that a clear and nuanced understanding of conscientious objection is essential to achieving this goal.

PART III:

Charting a legal path forward: Strategies for change

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.

7

Conclusion: Rethinking conscientious objection in abortion care

> Looking in from the outside at a country that has liberal law and provides state-supported abortion services one might assume that all is well for women's access to safe abortion services.[1]

Over the past 23 years, South Africa has had a legal framework that recognises reproductive rights through its Constitution and the Choice on Termination of Pregnancy Act. However, access to safe abortion services remains a challenge due to the exercise of conscientious objection by health professionals, including nurses. Conscientious objection allows healthcare providers to refuse to provide abortion services based on their personal or religious beliefs, potentially restricting access to safe and legal abortion for women. This book set out to answer the question of how legal, political, social, and institutional contexts shape nurses' understanding and exercise of conscientious objection on the provision of legal abortion.

My starting point was to develop a critical feminist perspective to develop strategies to improve the transformative potential of sexual and reproductive health and rights for women and girls. By employing feminist socio-legal methodologies to explore discourses and power dynamics, I argued for a principled approach to conscientious objection that balances healthcare providers' rights with women's fundamental rights.

As I conclude this book, I must acknowledge that my personal identity and social locations have played a significant role in shaping my selection of this topic, the research questions, and the approaches taken to answer those questions. As a feminist researcher, I attempted to be reflexive throughout the research process and acknowledged the limitations of my standpoint. The data presented in this book is an abstract view of the research conducted, and it does not fully capture the human interactions, emotions, and motivations of the interviewees. Although the data

1 KA Trueman & M Magwentshu 'Abortion in a progressive legal environment: the need for vigilance in protecting and promoting access to safe abortion services in South Africa' (2013) 103 *American Journal of Public Health* 397.

presented in this book is what I believe to be worthy of presentation, it is not a complete reflection of the views of the interviewees.

Throughout this research, I have taken measures to avoid selectively highlighting evidence that supports my arguments and interpretations. In doing so, I have made a concerted effort to provide an explanation of the methodology used to arrive at my ideas. As demonstrated in previous chapters, I have also drawn upon the works of other researchers to support my conclusions, thus ensuring a well-rounded and rigorous analysis.

1 Main findings

Throughout this book, I have argued that the current ambiguity surrounding conscientious objection in South Africa's liberal abortion law has resulted in unpredictable access to safe and legal abortion services. The competing rights claims of reproductive autonomy and freedom of conscience remain unresolved, creating significant challenges for healthcare providers and patients alike. Specifically, I have asked what practices of discretionary power affect nurses' exercise of conscientious objection, and how and why nurses choose to invoke this implied right. I have also examined the broader socio-cultural, political, and legal factors that shape nurses' actions or inaction when it comes to providing legal abortion services. By considering these questions, I have aimed to provide a comprehensive understanding of the challenges and complexities associated with conscientious objection in the context of legal abortion in South Africa.

The main argument of this book is that the absence of a conscience clause in South Africa's Choice on Termination of Pregnancy Act has resulted in the exercise of conscientious objection by healthcare professionals, particularly nurses, which has negatively impacted women's access to safe and legal abortion services. The book highlights the need for regulation and legal oversight to ensure that the right to conscientious objection does not impede women's access to legal abortion services, while protecting the providers' implied right to refuse. While international and regional human rights instruments guarantee the freedom of conscience, the right is not absolute and can be subject to limitations. The South African Constitution provides a constitutional basis for placing limitations on the right to freedom of conscience. Litigation and judicial interpretation based on a human rights approach could advance the law in relation to conscientious objection and abortion rights, leading to transformative jurisprudence that applies the proportionality framework to protect providers' right to refuse while guaranteeing women's right to access abortion services. I have also shown that courts in various settings have

shown that they can play a crucial role in providing clarity and ensuring greater accountability regarding conscientious objection and abortion care. Despite the potential limitations of engaging with the courts, I argue that various political, economic, and socio-cultural factors create an opportunity structure for litigation processes to regulate conscientious objection in South Africa. These processes can lead to significant legal effects, such as changes in legislation or jurisprudence, as well as material effects on policy and administrative practices, which can address the obstacles posed by the current lack of regulations.[2]

Furthermore, regulating conscientious objection through the law would send a signal that the state has an obligation to effectively implement the right to safe and legal abortion by ensuring that this right is not impeded by the refusal to offer services. In this context, it is essential that the law regulates the practice of conscientious objection by healthcare professionals, including nurses, to safeguard women's right to access abortion services and ensure their reproductive autonomy.

The role of nurses in conscientious objection and abortion care is complex and multifaceted. This book sheds light on the decision-making process that nurses go through and highlights that their decisions are not solely based on their religious beliefs or moral convictions. Rather, their willingness to be involved in abortion care is also influenced by their perceptions of the woman seeking care and the reasons behind her decision. However, this decision-making process can lead to a form of paternalistic control that homogenises all women seeking abortion care and ignores the intersectional factors that influence their decision-making process. Therefore, it is crucial to examine the social and relational context in which nurses make decisions about providing or not providing abortion care, in addition to the legal and medical discourse. By doing so, we can better understand the implications of conscientious objection in practice and develop strategies to ensure that women's reproductive autonomy is respected and protected.

The final aspect of this book concerns the power dynamics that support or constrain nurses in their role as abortion service providers. The findings indicate that inadequate medical supplies, lack of infrastructure, and insufficient support from management are major obstacles that impact the availability and quality of care provided by nurses in public health facilities. These conditions not only make it difficult for nurses to provide

2 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.

safe and ethical care, but also perpetuate stigma and discrimination against nurses who provide abortion services. Another significant challenge is the lack of recognition and remuneration for nurses specialising in abortion care. This not only limits the motivation of nurses to specialise in this area, but also contributes to a shortage of abortion service providers. Moreover, power dynamics play a role in the designation process, with nurses who own standalone private abortion clinics facing unique challenges and treated differently from doctors. This perpetuates hierarchies within the health system and further marginalises nurses who provide abortion care.

Despite these challenges, nurses continue to offer care because of their core ethical values and commitment to the reproductive autonomy of women. However, addressing the challenges faced by nurses providing abortion services is crucial for ensuring access to safe and ethical abortion services. This requires addressing power dynamics within the health system, providing adequate medical supplies, infrastructure, and support from management, and recognising and remunerating nurses as specialists in abortion care. The WHO emphasises the importance of well-equipped facilities and trained healthcare providers in ensuring the availability of safe abortion services.[3] Only by addressing these challenges can we ensure that women have access to the care they need and deserve.

Overall, the findings in this book provide a vital contribution to the under-theorised issue of conscientious objection in the African context and its impact on the provision of abortion services. By exploring the complex relationship between gendered power dynamics, subjective fields, and nurses' decision-making processes, it offers an understanding of the disparities between the legal framework of abortion and its actual implementation in practice. Through an African feminist lens, the book broadens the scholarship on abortion discourses and women's resistance, providing a nuanced perspective on the complex relationship between gendered norms, practices, and ideals. It illuminates the challenges nurses face when providing legal abortion care and offers concrete strategies to address the growing use of conscientious objection to deny safe care, information, and referral. By providing insights into the lived experiences of nurses, this book sheds light on the complexities of abortion and the ways in which power dynamics intersect with other processes, thereby offering valuable insights for researchers, policymakers, and healthcare providers alike.

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

2 Avenues for future research

While beyond the scope of this book, the findings suggest several avenues for future research related to the polarising issue of abortion among nurses. Some are willing to provide abortion services, while others refuse to provide care. In between are nurses who determine who is deserving or undeserving of abortion services. To encourage potential providers to assist in abortion services, there needs to be increased awareness of the law, better remuneration, and improved conditions of service. Future research could focus on strategies to move non-providing nurses towards providing or assisting in abortion services, including the removal of barriers to training and addressing the lack of interest in the specialisation, which could be incentivised with renumeration.

On the other hand, it is important to understand what causes nurses to become less supportive of abortion, particularly in light of conservative activism. Research on resistance at the level of managers could help identify strategies to address resistance to abortion rights, including training on reproductive health rights and values clarification sessions. Additionally, it is crucial to explore the unique situation of nurses running their own abortion clinics and how they navigate the legal and political challenges they face.

Clearer legal and policy guidelines on conscientious objection, stricter rules for objectors, and effective enforcement of laws relating to obstructing access are necessary to ensure women's right to access legal abortion services in South Africa. Bringing attention to the issue by addressing the Parliamentary Portfolio Committee on Health could highlight the problems faced by women and potentially lead to policy changes aimed at protecting their reproductive rights. Ultimately, these future research avenues can help to ensure that women's rights to access timely and safe abortion services are protected.[4]

3 Implications for access to abortion in Africa

While the focus of this book is mainly on South Africa, the findings have strong implications for mediating competing rights and supporting a legal framework that enables access to abortion in Africa.

Over the past few years, Africa has experienced a remarkable shift in its abortion legislation, moving towards more progressive frameworks

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

that acknowledge women's fundamental reproductive rights. As emphasised in Chapter 2, these changes reflect a growing recognition of the critical role that access to safe and legal abortion plays in advancing women's health, well-being, and autonomy. It becomes crucial to discuss conscientious objection and the South African case because this has significant implications for the implementation of these more progressive abortion laws in Africa. The South African case highlights the challenges in balancing healthcare providers' right to conscientious objection with women's right to access abortion services. For example, countries such as Benin, Democratic Republic of the Congo (DRC), Ethiopia, and Mozambique have made significant strides in reforming their abortion laws to ensure women's reproductive rights. Ethiopia has made progress by expanding the legal grounds for abortion to include rape, incest, foetal abnormality, and physical or mental health risks. However, there are concerns that healthcare providers' conscientious objection may limit access to abortion services in practice. Similarly, in Mozambique, the new Penal Code of 2014 decriminalised abortion in cases of rape, incest, foetal abnormality, or risk to the woman's health. Despite this progress, there are reports of healthcare providers denying women access to abortion services based on conscientious objection.

It is important to note that the majority of African countries still have restrictive abortion laws in place, underscoring the need for continued efforts to advance reproductive justice across the continent. One crucial aspect of ensuring access to safe and legal abortion services is equipping healthcare providers with the necessary knowledge and resources to provide such care. Additionally, it's important to ensure that women have access to comprehensive reproductive health information and counselling, regardless of the legal framework surrounding abortion. Overall, while Africa has made significant progress in reforming its abortion laws, there is still a long way to go in ensuring that women have access to safe and legal abortion services. Addressing conscientious objection and finding a balance between healthcare providers' rights and women's rights is crucial for achieving this goal.

4 Concluding reflections

Choice and conscience is the culmination of a personal journey and an unwavering commitment to advancing women's rights, particularly reproductive rights in Africa. Throughout my research, I have been struck by the question of why so many women still struggle to access safe and legal abortion, even in countries with supposedly liberal laws. I have delved into the intricate web of legal, social, and cultural factors that contribute to this persistent injustice. I strongly advocate for a rights-

based approach to regulating conscientious objection, which would utilise international human rights law and comparative law and adopt an intersectional framework. I believe that such an approach is necessary to protect the rights of women seeking abortion care and ensure that healthcare providers can offer these services without discrimination.

As I reflect on the significance of this work, I am struck by the profound implications of conscientious objection for women's rights and gender equality. During my research, I was moved by the remarkable bravery, perseverance, and dedication of the nurses who offer abortion services despite facing numerous challenges. By exploring the experiences and perspectives of nurses, I hope to contribute to a more nuanced and inclusive understanding of this complex issue. Ultimately, my aim is that this book will contribute to creating a more just and equitable society where women can exercise their reproductive rights without fear or stigma, and healthcare providers, including who want to provide these essential services can work in a more supportive environment.

I am committed to making modest but meaningful contributions in terms of theory, methodology, and empirical evidence to the ongoing global discourse on reproductive rights through my work as an African feminist legal scholar-activist.

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