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Abortion in South Africa: The Consequences of Conscientious Objection

Greta Alice Bertolè

London School of Economics and Political Science

Abstract

This article sheds light on the increasing rate of conscientious objection in the healthcare sector. As many international actors suggest, safe abortion guarantees a more comprehensive protection of women's sexual and reproductive rights. In this context, the refusal demonstrated by the health care workers prevents the benefits correlated with the legalization of abortion from being realized, especially in the developing countries. More specifically, this article investigates the role of conscientious objection among the health personnel in South Africa. As supported by the literature, the abortion reform in South Africa has been highly progressive. However, this legislation has now been facing a number of legal challenges.

Keywords: abortion, South Africa, women's rights.

Introduction

Globally the emphasis on women's sexual and reproductive rights has become a major topic of discussion. The rising importance of this matter is correlated with what the World Health Organization (WHO) and many other international actors have highlighted over the past few decades: safe and legal abortion can dramatically halt the rate of maternal and child mortality (De Mesquita and Finer, 2005). As a result, many developed countries enacted more liberal and permissive abortion laws in conformity with human rights principles (Cook et al., 2009).

Later on, some developing countries followed the same path, leading to the decriminalization of abortion; one such country being South Africa. However, this consensus for a wider protection of the abortion rights has been accompanied by a growing rate of conscientious objection across the health sector.

This article is geared to investigate the impact of conscientious objection in South Africa. The structure of this article is as it follows: first, a detailed interpretation of the practice of conscientious objection under international bodies will be provided, as well as the arguments made by various scholars on this subject. Second, the abortion law implemented in South Africa, also known as the Choice on Termination of Pregnancy Act (CTOPA), will be studied. Additionally, the major hurdles faced by regulation will be presented, notably the strong opposition from the Christian Lawyers Association and the unregulated nature of conscientious objection. Lastly, the research, focusing on the attitudes of health workers towards abortion, will demonstrate how conscientious objection is considered one of the bigger obstacles to the implementation of the CTOPA.

The Practice of Conscientious Objection

In the past four decades, the majority of the countries witnessed an increasing protection of sexual and reproductive health rights, leading to the implementation of more liberal abortion policies, especially in the Western countries (Dickens and Cook, 2011). However, consequently, a growing rate of conscientious objection has emerged in the healthcare sector by doctors, nurses, and a range of personnel who are less directly involved in the abortion services, such as administrative staff and pharmacists who are responsible for dispensing contraceptives (De Mesquita and Finer, 2005). Originally, conscientious objection stems from the military services and has existed since the Middle Ages. However, more recently, it has spread amongst the healthcare workers as a result of the liberalization of abortion in the US and in the UK between the 1960s and the 1970s (Harris et al., 2016). In a nutshell, conscientious objection is defined as 'the clinician's refusal to perform abortion services because of religious and moral beliefs' (Harris et al., 2016, p.1).

International laws and treaties have attempted to properly conceptualize this practice, and national legislations have set out, in various terms, the scope and the limits of conscientious objection (De Mesquita and Finer, 2005). As Article 18 Clause 1 of the International Covenant

on Civil and Political Rights (ICCPR) emphasizes, conscientious objection is grounded in the right of freedom of thought, conscience and religion that every individual can exercise. However, this practice is subject to limitations under international law, because Article 18 Clause 3 of the ICCPR clearly states that 'freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others' (Cook et al., 2009, p.249). Moreover, the International Federation of Gynecology and Obstetrics (FIGO) provides the most comprehensive ethical guidelines on the subject matter. These guidelines state that 'conscientious objection to treating a patient is secondary to the primary duty, which is to treat, provide benefit and do not harm' (Zampas, 2013, p.65). Therefore, conscientious objection triggered a debate on how the religious and moral beliefs can have an impact on the women's right to access free and safe abortion (Harris et al., 2016).

In the literature, there are defenders and opponents of conscientious objection. The first consider this practice as morally justifiable, based on the assumption that individual conscience is an essential right (Cowley, 2016). The latter argue that conscientious objection is incompatible with professional obligations and some pro-choice scholars described it as a 'dishonorable disobedience' (Fiala and Arthur, 2017, p.255). The studies show that the conscience-based refusal performed by the clinicians is between 14 and 80 per cent in the healthcare facilities and clinics, depending on the country (Chavkin et al., 2013). As the World Health Organization (WHO) reports, conscientious objection quickly became one of the major barriers to lawful abortion services (Zampas, 2013). The negative consequences of this practice are especially notable in developing countries, where it is more likely that women will face greater barriers to accessing safe abortion due to the lack of economic and social resources. The body of the research on women's health demonstrates how strict the criteria is for having an abortion in the developing world. In fact, one third of these 1.3 billion women live in countries, in which the right to an abortion is completely forbidden or is only allowed under exceptional circumstances, such as saving the woman's life (Singh, 2010). Furthermore, only 15 per cent of these women live in countries, where abortion is exclusively permitted to protect their mental and physical health (Singh, 2010). As a result, women have preferred to seek out for illegal abortions or they have continued their unwanted pregnancy (Coast, 2018). As Ganatra et al. (2017) demonstrate, more than 25 million unsafe abortions occur annually. From these unsafe abortions, the estimates of mortality and morbidity suggest that a quarter result suffered severe complications after the procedure, resulting in 46,000

result and 3 million in complications associated with unsafe abortion, which have not been treated properly (Coast, 2018).

The Evolution of the Abortion Legislation in South Africa

During the colonial times and apartheid, abortion was regulated in South Africa by the Abortion and Sterilization Act of 1975, which permitted abortion in limited circumstances, for instance in the case of rape or incest and if the life of the mother was in real danger. This legislation clearly reflected South Africa's Christian views and strong moral beliefs, which viewed abortion not as a woman's free choice but as a medical necessity (Albertyn, 2015). The legislation also deepened the social and economic disparities in the South African society. If the majority of white women were able to access legal abortion services, black women from rural and poor backgrounds were forced to rely on illegal abortions, also called "backstreet abortions" (Albertyn, 2015). As soon as the transition to democracy began, women's reproductive rights and freedom of choice, supported by feminist arguments, played a key role in the political agenda. In response to this movement, the South African government implemented a new abortion reform, which was the Choice on Termination of Pregnancy Act 92 of 1996 (CTOPA), which took a stand in favor of female reproductive rights (Albertyn, 2015).

The Nature of the Choice on Termination of Pregnancy Act (CTOPA)

The progressive nature of the CTOPA can be seen in the Preamble of the Act, which highlights that 'women and men have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and that women have the right of access to appropriate health care services to ensure safe pregnancy and childbirth' (Choice on Termination of Pregnancy Act, 1996, Pretoria). Under legal terms, the CTOPA states that women have the legal right to request a termination of pregnancy by a doctor or a registered nurse up to the 12th week of gestation (Vincent, 2012). Subsequently, between the 13th and 20th weeks of gestation, the termination of pregnancy can occur if the doctor believes that the woman's life is at risk, the fetus could suffer from mental and physical abnormalities, the pregnancy is the result of a rape or incest or it can severely affect the economic status of the woman. After 20 weeks, abortion is permitted only if the woman's life is in danger or in case of severe malformations of the fetus (Vincent, 2012). From these terms, it is evident that the CTOPA's main goal was to protect women's health and to prevent unnecessary deaths

related to unsafe abortion rates in South Africa (Trueman et al., 2012). Therefore, the South Africa's abortion legislation was considered as one of the most liberal in the world, especially in comparison to the abortion policies of other sub-Saharan African countries (Vincent, 2012).

The Opposition Towards the CTOPA

However, conservative beliefs and traditions associated with Christian values threatened to eradicate the primary purpose of the CTOPA. In fact, as soon as the CTOPA was promulgated, the Christian Lawyers Association and the Doctors for Life sought to overturn the legislation, arguing that there had been a constitutional violation of the rights of the fetus. This first attempt was unsuccessful as the Constitutional Court did not identify a fetus as a juridic person (O' Sullivan, 2008). Subsequently, the Christian Lawyers Association challenged the provision of the CTOPA which allowed minors to request a termination of pregnancy without the parental consent (Christian Lawyers Association v. Ministry of Health, 2005). They implied that minors were not capable of making their own reproductive decisions without parental guidance. The Constitutional Court argued that minors were able to consent, because 'a valid consent can only be given by someone with the intellectual and emotional capacity for the required knowledge, appreciation and consent' (Albertyn, 2015, p.441). This second attempt by the Christian Lawyers Association to undermine the reproductive freedom of women in South Africa was also unsuccessful.

When this law was implemented, the government vigorously intervened to guarantee equity and access to healthcare services through the development of national policies, which could reallocate all the necessary resources, in order to provide efficient reproductive health services (Albertyn, 2015). The positive effects associated with the enactment of the CTOPA started to emerge soon after, which was supported by the strong commitment of the government to improve the quality of the abortion services and to reduce backstreet abortions. The studies conducted by the Department of Health showed a consistent reduction in maternal mortality and morbidity, especially amongst young women, as well as a decrease in the rates of women dying from complications associated with unsafe abortions (Albertyn, 2015). However, many scholars stress that the implementation of the CTOPA was slow and faced enormous obstacles. The two primary hurdles were associated to the structure of the health system and the role of the health providers. Most health providers were not willing to provide abortion services and, consequently, there were not enough health facilities which offered abortion services to women (Vincent, 2012). Studies demonstrate that the majority of

pregnancy terminations, which was nearly 76 per cent, were performed during the first trimester by trained nurses, whereas second and trimester services were not available due to the unwillingness of the trained medical practitioners (Trueman et al., 2012). In the early 2000s, roughly 292 health facilities were designed to perform abortion services, but, as the Department of Health reported, only 32 per cent of these facilities were actually working as termination providers (Department of Health, 2000). According to the studies, 95 per cent of these health facilities were located in the cities, and only 28 per cent were effective online (Van Bogaert, 2002). More specifically, in the Northern Provinces, such as Northern Cape, there were no designated facilities, whereas in the Eastern Cape Province there were only 10 functioning health facilities. Women were therefore forced to travel a long distances in order to acquire a safe and legal abortion (Vincent, 2012). This dramatically deepened the inequalities between women in South Africa, which was an already widespread issue during the times of the Abortion and Sterilization Act of 1975. It is undoubtable that South African women, in general, were granted greater access to abortion services, however this access was very limited for poor women living in the rural provinces. Due to the limited number of functioning facilities in South Africa, not all the women could afford to travel and to reach the health facilities in the other provinces, and so they were forced to choose backstreet options (Albertyn, 2015). Additionally, rural women were even more disadvantaged, because of the lack of the knowledge around the CTOPA legislation. One survey shows that 60 per cent of them were completely unaware of the CTOPA and what it encompasses for women's reproductive rights (Van Bogaert, 2002).

The main issue with the practice of conscientious objection by health care providers in South Africa is that is not regulated under the CTOPA. In fact, the CTOPA is completely silent with respect to including a clause around conscientious objection. Trueman et al. (2012) suggest that this clause has not been included in the regulation, because the policymakers did not want to give the impression that the health workers are legally forced to provide abortion services (Trueman et al., 2012). Section 10 of the CTOPA only refers to the physical obstruction to the law, stating that 'any person who prevents the lawful termination of pregnancy or obstruct access to a facility for termination of pregnancy, shall be guilty of an offence and liable on conviction to a fine or to imprisonment for a period not exceeding 10 years' (Choice on Termination of Pregnancy Act, 1996, Pretoria). Because of this lack of guidance, conscientious objection became a barrier to the successful implementation of the CTOPA. 72 per cent of public health facilities in South Africa exercise their right of conscience-

based refusal, which has contributed to the growing rate of unsafe abortion. (Van Bogaert, 2002).

The Attitudes of Health Care Providers in South Africa

As previously argued, women in South Africa face many obstacles in accessing safe abortion services. The major hurdle is the right to conscientious objection, which is invoked by many doctors and health care providers, on the grounds of moral and religious beliefs (Harries et al. 2020). More specifically, the health providers who identify themselves as Christians are strongly against abortion and they consider it as a "sin" and also as a "murder". Generally speaking, the literature did not entirely address the factors that could help shape the health professionals' attitudes towards abortion in South Africa. However, the study conducted by Harries et al. (2009) provided some answers. This research is conducted in the Western Cape Province, whereby in-depth interviews and focus groups took place in both public sector facilities and non-governmental organizations (NGOs) (Harries et al., 2009). The results highlight a strong degree of confusion regarding the right to exercise conscientious objection as health care providers were not fully aware of the circumstances in which they could invoke the right of conscientious objection (Harries et al., 2009). Additionally, even the non-nursing staff, such as the cleaning team in the hospital, refuse to provide any form of assistance to the women who just had an abortion. Religion, coupled with moral reasons, appears to be the key factor that affects the willingness of the health workers to provide abortions (Harries et al., 2009). Subsequently, we learn from this study that conscientious objection has dramatic consequences in every aspect of the abortion process, starting from the prescription of the medication to the assistance in the emergency room (Harries et al., 2009).

Harries et al. (2014) conducted a second qualitative research study in 2014 with the aim of exploring the refusal of abortion services in the Western Cape Province. From the 48 in-depth interviews conducted, it emerges a deep misinterpretation of the right of conscientious objection, because a high rate of health providers incorrectly invokes this practice. As a result, it 'became an all-encompassing opportunity for non-participation in abortion services' (Harries et al., 2014, p.4). On the other hand, some health managers argue that this type of objection would have been abandoned in some circumstances for a financial remuneration, claiming that 'if you offer them some money, some type of incentive and they will rush there, so I think that sometimes people object for the wrong reason' (Harries et al., 2014, p.4).

The resistance towards abortion services has been identified not only in the Western Cape Province, but also in the remaining provinces in South Africa. For instance, Harrison et al. (2000) reported a poor understanding of conscientious objection, right after the implementation of the CTOPA, by health care providers in KwaZulu-Natal, a province located in the North East of South Africa (Harrison et al., 2000). In fact, in KwaZulu-Natal, which is a conservative area in South Africa, only six of the 40 health care facilities offered abortion services and many nurses were not trained to provide abortions (Harrison et al., 2000). In this province, Harrison et al. (2000) also investigated the attitudes towards abortion and the implementation of the CTOPA, through in-depth interviews of local community and the district hospitals. The results of this research demonstrate a consistent opposition to abortion, which is heightened by the ignorance of the law and the influence of traditional community norms (Harrison et al., 2000). Even though the majority of nurses and community members were aware of what the CTOPA encompasses, only 11 per cent of them show their full support for it and only roughly 18 per cent of the health personnel supported abortion on request. A stronger support for abortion in the case of rape or incest was apparent in the study, as nearly 60 per cent of the community members and the nurses agreed with it. However, in the case of socioeconomic hardship and an abortion request, this percentage is lower reaching approximately 10 per cent (Harrison et al., 2000).

Another issue that arises is the stigma associated not only to the woman who seeks an abortion but also to the health worker who is willing to provide an abortion. A study conducted in termination of pregnancy (TOP) facilities located in Gauteng and North West Provinces, emphasizes that the majority of the health workers refuse to provide abortion services in the designated facilities (Teffo and Rispel, 2017). This creates an unfriendly working environment, in which the TOP providers are stigmatized, and they are labelled as “murderers” and “baby killers”. In this research, a nurse reported that ‘for a long time I was called an undertaker, a killer amongst other things’ (Teffo and Rispel, 2017, p.5). These judgmental attitudes can create conflicts, and they worsen the relationship between the TOP colleagues and can also overwhelm feelings of loneliness. To add greater pressure, there were also some doctors, who were highly trained and qualified, that decided to shift their responsibility onto the registered nurse as they did not want to assist a woman who request an abortion (Teffo and Rispel, 2017).

Conclusion

To conclude, this article has provided a conceptualization of the practice of conscientious objection. This global issue has been addressed by a variety of international treaties and guidelines, yet the divisiveness around the right of conscience of the health workers and women's reproductive rights continues to pervade such treaties and guidelines. More specifically, this article has explored the impact of conscientious objection in South Africa. Despite the remarkably progressive abortion legislation, which was introduced during the democratic transition of the country, the research studies discussed throughout the article highlight the major barrier that the right of conscientious objection became to a successful implementation of the CTOPA. The studies demonstrate a widespread unwillingness of the health care providers to provide abortion services in many provinces in South Africa due to their religious and moral beliefs. They also suggest that pro-choice doctors and registered nurses face a hostile working environment, in which they are labelled as murders and baby killers. The case study of South Africa clearly shows how the legalization of abortion did not sufficiently contribute to reduce the number of unsafe abortions. To address this issue, clear guidelines concerning conscientious objection should be implemented, as well as a broader access to abortion education for the population, especially for those living in the rural areas.

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