2 Abortion and ‘conscientious objection’ in South Africa

The need for regulation

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1 Introduction

South Africa’s Choice on Termination of Pregnancy (CTOP) Act is a ground-breaking law for women’s sexual and reproductive health and rights in South Africa and serves as a benchmark for law reform globally.¹ The Act was part of a package of rights extrapolated from South Africa’s 1996 Constitution that recognizes the right to bodily and psychological integrity including the right to make decisions concerning reproduction and the right to health care, including reproductive health. The Act was partly a result of feminist political action,² and a response to prevent the death of South African women through backstreet terminations.³ The Act is a complete departure from the 1975 Sterilization Act, which had stringent grounds for permitting abortion that were compounded by cumbersome administrative procedures.⁴

The Act provides for abortion on demand up to 12 weeks of pregnancy. Between 13 to 20 weeks, women⁵ can obtain abortion on the following grounds: physical or mental health, foetal anomaly, if the pregnancy is a result of rape or incest and on grounds of socio-economic circumstances. After 20 weeks of gestation, a woman can only terminate her pregnancy if determined by a medical practitioner that it poses a serious danger to the woman’s health or life, or if the foetus will ‘suffer from a severe physical or mental abnormality’.

The CTOP Act recognizes that in the first trimester, in addition to doctors, midwives who have undergone prescribed training could perform an abortion. With a view to enhancing accessibility to abortion services, an amendment to the CTOP Act in 2008 included the training of registered nurses to conduct the procedure during the first trimester. Broadening the role of healthcare workers including nurses to deliver services is viewed as a significant way for the realization of access to termination of pregnancy care.⁶

Despite the very liberal nature of the law, the Act does not directly address conscientious objection.⁷ Conscientious objection has been defined as ‘the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs’. The hope was that the omission of a conscience clause in the Act would circumvent controversy and legal challenges.⁸ Instead, it has the effect of serving as a major barrier to the implementation of the law in practice.⁹

Given the unregulated practice of conscientious objection in South Africa, there is no clear answer as to what extent the CTOP Act allows healthcare providers to conscientiously object to performing abortions. This chapter investigates the lack of regulation regarding the scope of conscientious objection to abortion in South Africa. The chapter aims to clarify the essential conditions needed to ensure that women who seek access to abortion services are treated with respect for their reproductive autonomy and human dignity.

The chapter proceeds in four parts. Part I briefly considers the conceptualization of conscientious objection. Part II of the chapter maps both the international and national framework on conscientious objection. Part III examines the impact of the conscientious objection on the rights of women. Part IV illustrates the ethical and legal challenges. The chapter concludes by reflecting on how the right to freedom of conscience should be balanced with women's right to legal abortion services and care.

2 Conceptualizing conscientious objection

The concept of conscientious objection has been historically associated with the right to refuse to take part in the military or in a war due to religious or moral reasons.¹⁰ This has been co-opted in the healthcare arena. Recent developments have shown that freedom of conscience continues to be accepted as a limitation to reproductive healthcare, including women's right to termination of pregnancy.¹¹ The Global Doctors for Choice in their White Paper examining the prevalence and impact of conscientious objection, conclusively demonstrate an increase in the practice of healthcare providers' refusal to provide abortion services.¹² Health care providers continue to invoke 'conscientious objection' to deny services including emergency contraception and other forms of contraception, sterilization and infertility treatment.¹³ As this chapter focuses on abortion care, conscience claims are mainly made on refusal to provide abortion care.

Conscientious objection is a complex issue of competing rights: women's rights to safe, legal abortion and the healthcare providers' claimed right to refuse.¹⁴ As abortion remains a contentious moral issue, women's legal right to access health services is sometimes in opposition to the provider's right to refuse duty of care. In justifying the right to conscientious objection, John Rawls, for instance, sees the practice of conscientious objection as an exception to the *prima facie* duty to obey the law based on one's personal conscience.¹⁵ Within the context of health care, Bernard Dickens has argued that the right to conscientious objection precedes the legalization of abortion.¹⁶

Various scholars have discussed freedom of conscience in health care following Mark Wicclair's comprehensive analysis of the three emerging approaches: conscience absolutism, the incompatibility thesis and compromise.¹⁷ On the one hand, according to absolutism or the maximum accommodation paradigm, a provider's conscientious conviction is privileged over that of the patients, in which there is no obligation to disclose or refer.¹⁸ The argument in favour of conscientious objection is that it violates healthcare providers' right to freedom

of conscience. On the other hand, the incompatibility thesis means disallowing the exercise of conscientious objection as it is contrary to professional obligations.¹⁹ Thus, healthcare providers should not have a right to refuse.²⁰

In critically analysing the two aforementioned extreme positions, Wicclair argues for the compromise or balance approach, which involves a reasonable accommodation provided by the employer, but which also entails provider duties including referral.²¹ This, however, remains a lofty goal that is difficult to achieve in practice. It has also been illustrated that although it is possible to allow conscientious objection to abortion and still ensure women's access to services, in most cases, it does not sufficiently protect women's reproductive right.²² Wendy Chavkin et al have also noted that the balancing act between the competing rights becomes very difficult when there is a thin line between conscience based on religion and political position.²³ The emergence of two main defences: that the exercise of conscientious objection should be allowed and that recommendations on how refusal can be managed to prevent the harms that it can create are premised on a call for respect of the moral integrity of healthcare providers.²⁴

Laura Harris et al., note that conscientious objection is 'the only way to refuse to provide abortions that are permitted by law'.²⁵ Those who are against the idea of conscientious objection have argued that unlike in the military, conscientious objection does not have a place in reproductive healthcare.²⁶ Joyce Arthur and Christian Fiala label conscientious objection as a 'dishonourable disobedience'²⁷ to laws and ethical code and call for its ban due to its violation of patients' rights.²⁸ Another argument against conscientious objection is that the right to refuse jeopardizes women's health and human rights, as it unfairly privileges a doctor's conscience over that of their patients.²⁹ Conscientious objection, they contend, weakens the full realization of reproductive rights and women's equality.³⁰

Against this background, the recognition of the right to freedom of religion, conscience and thought, and state's obligation to respect that right, is well established. This chapter works on the premise that there is a right to conscientious objection. However, this is not an absolute right as it should not unduly disadvantage or deny women access to health services which they have a legal right to receive. Ultimately, there should be an explicit law that regulates conscientious objection and limits healthcare provider's personal right of conscience. Freedom of conscience is recognized as a fundamental right at the international, regional and domestic levels.

3 International and regional human rights standards

Historically, objections based on the freedom of thought, conscience and religion have been invoked in relation to compulsory military service. The recognition of freedom of conscience is a component in a democratic and pluralist society. This right is guaranteed in international, regional and national

human rights instruments and guarantees a right to conscience. South Africa, as a member of both the United Nations (UN) and the African Union (AU), has signed and ratified these core international human rights treaties.

This section examines international and regional frameworks on the right to freedom of conscience. The purpose of this analysis is to show the standards that South Africa has agreed to abide by under international and regional human rights instruments.

3.1 United Nations level

Freedom of conscience is guaranteed in international human rights instruments. Article 18 of the Universal Declaration of Human Rights (UDHR) states 'Everyone has the right to freedom of thought, conscience and religion: this right include freedom to... manifest his religion or belief in teaching, practice, worship and observance'. This article is replicated in Article 18(1) of the International Covenant on Civil and Political Rights (ICCPR). The Human Rights Committee in General Comment 22 on Article 18 notes that while the right to conscientious objection is not explicitly stated in the Covenant, it believes that such a right could be read into Article 18. However, the recognition of the right to conscientious objection by the Committee was within the context of individual claims on the right to refuse to perform military service. Article 18(3) of ICCPR further goes on to place limitation on the manifestation of one's religion or belief as this may affect other people, as well as the state. Thus, the right to conscientious objection is not absolute. International and regional human rights treaty bodies have found that the freedom to manifest one's religion or belief can be subjected to restrictions.³¹

UN Human rights treaty monitoring bodies have also called on states to ensure that the exercise of conscientious objection does not hinder the access to reproductive health services. The Committee on the Elimination of all Forms of Discrimination against Women (CEDAW Committee) responsible for compliance of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) issued General Recommendation No. 24 on Article 12 on Women and Health noting that refusal to provide certain reproductive health care for women is discriminatory. Additionally, it obligates states to take steps to guarantee access to services when providers are permitted to refuse to provide such services.

In General Comment No 36 on the right to life, the Human Rights Committee notes that state parties have a duty to ensure that women and girls are able to effectively access safe and legal abortion by removing barriers that are a result of the exercise of conscientious objection by healthcare professionals.

The UN Committee on Economic, Social and Cultural Rights (Committee on ESCR), which monitors the implementation of the International Covenant

on Economic, Social and Cultural Rights (CESCR) issued General Comment No. 22 on the Right to Sexual and Reproductive Health, which noted that the obligation to protect the right to health includes state obligations to take measures to prevent private actors from imposing barriers to services including conscience claims to refuse to provide abortion.

The treaty monitoring bodies have likewise raised the issue of conscientious objection in their concluding observations on state party reports. Within the South African context, the Committee on ESCR, in its concluding observation on South Africa's initial report in November 2018, recommended that health professionals 'who invoke conscientious objection provide referrals within their own facility or to a nearby facility so that their objection does not impede women's access to abortion services'.

3.2 African regional level

At the regional level, the African Charter on Human and Peoples' Rights (African Charter) provides for freedom of conscience under Article 8. 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 recognizes abortion as a right. Article 14 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. As of January 2019, more than 75 per cent of African states have ratified the Maputo Protocol.³² This is an indication of the favourable reception that the Protocol enjoys in the continent as the foremost legal instrument on women's rights.³³ However, it is important to note that some African countries have entered reservation to the provision on abortion upon ratification including Cameroon, Kenya, Uganda and Rwanda.³⁴ However, it is argued that reservations cannot be construed as serving to restrict international and regional human rights obligations.

Article 26 of the Protocol enjoins state parties to adopt budgetary measures, to fulfil the rights guaranteed in the Protocol. While ratification is desirable, implementation of the Maputo Protocol is absolutely imperative in order to impact the lives of women. Implementation has been admittedly slow as women continue to face barriers to access abortion services even in countries where abortion has been liberalized. An estimated 6.2 million women have unsafe abortion in the African region.³⁵ Women from sub-Saharan Africa constitute the highest incidence of deaths at 62 per cent (29,000) from unsafe abortion.³⁶

The African Commission on Human and Peoples' Rights (African Commission) has also taken steps to provide interpretive guidance to women in Africa by elaborating on specific rights while assisting states to fulfil their obligations under the Maputo Protocol. Towards this end, the African Commission adopted General Comment No 2 in 2014 on Article 14(1) (a), (b), (c) and (f) and Article 14(2) (a) and (c) of the Protocol on reproductive health rights on

28 November 2014. The General Comment focuses on measures to promote and protect sexual and reproductive rights of women and girls including access to safe abortion.³⁷ Article 14 (2) obligates state parties to take all appropriate measures to ensure medical abortion.

Unprecedentedly, the Commission addressed states' duty to adequately regulate the practice of conscientious objection in the reproductive health sphere. As the General Comment notes, healthcare providers directly involved in providing abortions services may invoke conscientious objection but not in emergency situations. Premised on their obligations under the Maputo Protocol, states are obliged to:

ensure 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.³⁸

In addition, the General Comment further notes that state obligations relating to enabling and political framework also entail ensuring healthcare providers do not deny women access to safe abortion information and services.³⁹ General Comment No 2 is a critical resource for ensuring access to safe and timely legal abortion. In particular, the African Commission sends a clear message to African states that permit conscientious objection, that they must establish and implement effective regulatory framework so as to guarantee that such refusals do not undermine women's access to legal abortion services.

The African Commission, which can receive communications alleging violations on the African Charter and its subsequent protocols, and the African Court on Human and Peoples' Rights (African Court) have not yet had the opportunity to develop their jurisprudence on the scope of the right of conscientious objection within the sexual and reproductive health services sphere.

The other regional human rights systems also recognize an individual's right to freedom of religion, conscience and thought. At the European level, the right to freedom of thought, conscience and religion is provided in Article 9 of the European Convention for the Protection of Human Rights and Fundamental Freedoms. It further requires the exercise of the right to be 'subject to such limitations as are prescribed by law and as are necessary in a democratic society in the interests of public safety, for the protection of public [...] health, or the protection of the rights and freedoms of others'.⁴⁰ Limitation on the exercise of conscientious objection has been reaffirmed by the European Court of Human Rights in several cases in the context of reproductive healthcare. In the inter-American human rights system, the American Convention on Human Rights also guarantees freedom of thought, conscience and religion with limitations (Article 12). Both the International American Commission on Human Rights (IACHR) and the Inter-American Court have not explicitly addressed the subject of conscientious objection in the context of reproductive healthcare.

4 The legal scope of conscientious objection in South Africa

According to the World Health Organization (WHO)'s Global Abortion Policies Database, more than 70 countries allow health care providers to refuse to provide abortion care, invoking conscientious objection.⁴¹ Conscientious objection is widely practised around the world and has been enshrined in law in countries such as the United Kingdom, Australia, France and the United States.⁴²

4.1 *The Constitution of South Africa*

The South African Constitution recognizes reproductive autonomy. Section 12(2) of the Constitution guarantees a 'right to make decisions concerning reproduction'. Section 27(1) of the Constitution also provides for the right of access to healthcare services including reproductive healthcare. Section 27 further implies that the state is not only obligated to refrain from unfairly interfering with the individual's right to pursue reproductive healthcare services, but also to provide care where the individual is incapable of paying. The obligation arising from this section would imply that the state and or other entities or individuals should refrain from obstructing access to healthcare services including abortion without justifications.⁴³ A refusal of care would be deemed to be unjustifiable and thus constitute an infringement of section 27(1)(a) of the Constitution.

Given that the South African Constitution is value-based, the right to reproductive autonomy and access to reproductive healthcare are intimately linked to the rule of law and to the enjoyment of other rights including equality and respect for human dignity. Respect for human dignity is a foundational value that is crucial for addressing conflicting interests.⁴⁴ The UN Working Group on the Issue of Discrimination against Women in Law and in Practice shares this same reasoning when it stated:

The right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy, involving intimate matters of physical and psychological integrity, and is a precondition for the enjoyment of other rights.⁴⁵

The Constitution recognizes the implied right to conscientious objection. According to section 15 (1) of the Constitution, 'everyone has the right to freedom of conscience, religion, thought, belief and opinion'. The Constitutional Court on respecting diversity has acknowledged that 'the essence of equality lies not in treating everyone in the same way, but in treating everyone with equal concern and respect'. Like other constitutional rights, this right is not absolute.

4.1.1 *Limitation clause*

It is important to note that fundamental rights under the Constitution are not absolute and are subject to the limitation clause under section 36(1). The

limitation clause takes as its premise, that fundamental rights cannot be enjoyed in such a way that does not pay attention to the rights of others or the wider societal interests. Thus, conscientious objection cannot be exercised in such a way that permits healthcare works to impose their anti-abortion views on women seeking abortion. While healthcare providers have a freedom to choose to refuse to participate in an abortion procedure, the rights of the pregnant woman and the interests of the society must be taken into account.⁴⁶

Section 36 limits the right to conscientious objection and imposes a duty to a minimum, to provide the pregnant client with information about where she can obtain an abortion. Section 36 of the Constitution supports the limitation of the right to conscientious objection where maternal life or health is in serious danger or there is a medical emergency. A health care 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.

4.2 Choice on termination of Pregnancy Act

The Act, which took effect in 1997 'promotes reproductive rights and extends freedom of choice by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs'.

As alluded to earlier, there is no express provision regulating conscientious objection in the CTOP Act. However, Ngwena noted that an earlier draft of the Bill contained a conscience clause that provided as follows:⁴⁷

- (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.

The Act does not explicitly mention a right to 'conscientious objection' for health care providers, but it is clear on the professional obligations of providers. Refusal to provide abortion only applies to the actual procedure, this means that those that are directly not involved do not have the right to refuse. A similar approach was adopted in the decision of the UK Supreme Court in the *Greater Glasgow Health Board v Doogan*. The Court held that:⁴⁸

It is unlikely that, in enacting the conscience clause, Parliament had in mind the host of ancillary, administrative and managerial tasks that might

be associated with those acts. Parliament will not have had in mind the hospital managers who decide to offer an abortion service, the administrators who decide how best that service can be organised within the hospital, the caterers who provide the patients with food and cleaners...

Accordingly, healthcare providers are under a legal and ethical obligation to provide care to patients suffering from complications of abortion. However, these regulations in the CTOP Act are not fully adhered to or implemented.

However, the South African case of not having a conscientious objection clause is not unique, as in most African countries and elsewhere it is not addressed and hence, remains largely unregulated.⁴⁹ In the African context, one of the exceptions to the rule is the *Zambian Termination of Pregnancy Act of 1972* which allows for a limited scope of the exercise of conscientious objection. This has been supplemented by guidelines.⁵⁰ A sharp contrast to this is the *Zimbabwean Termination of Pregnancy Act of 1972* that is not limited in scope and does not adhere to international and regional human rights standards.⁵¹

The CTOP Act makes it an offence if any person 'prevents the lawful termination of a pregnancy or obstructs access to facility for the termination of pregnancy'. The penalty is a fine or imprisonment for up to ten years. It could be argued that healthcare providers, including nurses and midwives, who refuse or omit to refer a patient to another doctor who is prepared to terminate pregnancies lawfully or a facility where abortion may be done, are preventing lawful termination of pregnancy or obstructing access to a facility for the termination of pregnancy. This section is rationally connected to the following: (i) the right to freedom of conscience is not absolute especially in relation to the medical profession; (ii) the constitutional and legal rights of women are protected as they are not obstructed from exercising such right; and (iii) it is reasonable, as it can be interpreted to mean that it does not compel health care providers in non-emergency cases to participate actively in abortion procedures.

The Act further provides that a woman who requests an abortion from a medical practitioner or registered midwife 'shall be informed of her rights under [the] Act by the person concerned'. The provision creates a duty on healthcare providers which is a reasonable and justifiable limitation on their right to freedom of conscience. Despite a healthcare provider's opposition to abortion on grounds of conscience, he or she is obliged to give a woman information about the law that enables her to exercise her constitutional and legal rights. Effective information when abortion is legal is 'directly relevant for the exercise of personal autonomy.'

Despite the lack of defined scope of obligations incurred by healthcare providers as a result of the absence of an expressed conscientious clause in the Act, this does not mean the complete absence of regulatory laws. Since the Constitution is the supreme law, it follows that section 15 on freedom of conscience and section 36 on general limitation of rights apply to this Act. In South Africa, as opposed to other jurisdictions such as in some Scandinavian

and Eastern European countries, health care providers have a constitutional right to conscientious objection.⁵²

It is noteworthy that courts in South Africa have not yet clarified the issue of conscientious objection. The case of *Charles and Others v Gauteng Department of Health* (Kopanong Hospital) was about a nurse's refusal to prepare patients for follow-up treatment following a termination due to her religious beliefs at the Kopanong Hospital in Vereeniging which led to her reassignment by the director to another department. She eventually quit in May 2004.⁵³ On the basis of the Promotion of Equality and Prevention of Unfair Discrimination Act, she sued the then Minister of Health and the hospital for unfair discrimination on the grounds of religion and conscience. In 2007, the Labour Appeal Court of South Africa in Braamfontein transferred her case of a healthcare professional's refusal to provide care to the Commission for Conciliation, Mediation and Arbitration (CCMA).

The other known case was in 2010 when 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.⁵⁴ The anti-abortion discourses materializing in these two cases show a subtler means of deploying power. For instance, the pro-life movement utilizes labour laws grounded on non-discrimination and the exercise of the constitutional right to freedom of conscience, religion, thought, belief and opinion to slowly chip away at abortion access across the country. Opening the issue as one of a worker's right to non-discrimination and utilizing labour laws would mean setting legal precedent that would claw back on a liberal abortion law.

As the debate between women's rights to safe and legal abortion versus the protection of healthcare provider's moral integrity rages on, this line of strategy provides a discursive opportunity that facilitates the use of 'freedom of conscience' and 'non-discrimination' as legitimate ideation to push the pro-life movement agenda forward. This is akin to Marc Steinberg's assessment of how actors will look for 'gaps, contradictions and silences' in order to 'depict shared understanding of injustice, identity, righteousness for action, and a vision of the preferred future'.⁵⁵

4.3 National guidelines

4.3.1 Draft national guidelines for implementation of termination of pregnancy services in South Africa

Currently, South Africa does not have a formal system for conscientious objection declaration and practice. Recognizing such a gap, the National Department of Health developed draft guidelines for the provision of abortion in 2018.⁵⁶ In these guidelines, the term 'conscientious objection' is being regulated as what it actually is: an obstruction to access or an obstruction to care as noted in the Act. This is because the guidelines are not based on the freedom of conscience provision in the Constitution, but rather, on the provisions of the Act which

does not stipulate conscientious objection. Section 10 of the Act notes that it is a crime for anyone to prevent a legal abortion or obstruct access to an abortion facility. The penalty is a fine or imprisonment for up to ten years.

The guidelines obligate a practitioner who refuses to provide abortion services based on personal beliefs to refer the client to a colleague or facility that is able to offer such services. The client's right to information and access to health care services, including abortion, should always be provided for. The guidelines affirm that such refusal should not be to the detriment of the client seeking an abortion.⁵⁷

The guidelines also address the issue of conscientious commitment, that is, a health care provider adhering to their primary health professional ethics: duties to treat and care for patients.⁵⁸ The individual conscientious objection of a health care worker cannot violate the rights of the other healthcare workers who are willing to provide abortion services.⁵⁹

4.3.2 Professional ethical guidelines

The right to conscientious objection has been recognized in professional codes of conducts from varied sectors.⁶⁰ At the national level, professional ethical guidelines of South Africa's medical, nursing and midwifery societies support and protect their members' exercise of conscience while emphasizing providers' duty to prevent their beliefs from serving as a barrier to their patients access to services and information. The 2013 South Africa Nursing Council's Code of Ethics listed termination of pregnancy and conscientious objection as ethical dilemmas that nurses face but was silent on how they should be addressed. Subsequent revisions provide that a nurse is required to tender in writing their refusal to their employer.⁶¹ The Health Professions Council of South Africa recommends a similar approach in allowing healthcare providers to object to providing termination of pregnancy services on the basis of their religious and cultural beliefs.⁶²

Despite these professional ethical guidelines, conscientious objection relating to abortion has not been enshrined into law. The consequences of such a gap serves as an obstacle to the efficacy of a liberal abortion law in practice.⁶³ As there are no clear laws or guidelines, the environment is conducive to health care providers acting within their 'own' interpretation of the law. Thus, this can lead to the systemic abuse and misinterpretation of what the right entails.⁶⁴ It also results to inadequate personnel to perform abortion procedures.⁶⁵

5 Ethical and legal challenges: the need to regulate

Health providers who are unable to exercise their duty of care due to personal conscience still have ethical responsibilities to their patients.⁶⁶ Due to the unregulated nature of conscientious objection in South Africa, it makes it difficult to translate the legal right to abortion into effective access to services. In order to regulate conscientious objection to abortion, there are certain conditions that need to be addressed.

(a) *Duty to refer*

The International Federation of Obstetricians and Gynecologists' (FIGO) criteria for conscientious objection includes: giving notice of one's objection based on conscience grounds, referring patients to colleagues and providing emergency care when needed.⁶⁷ The *Technical Guidelines of the WHO on Safe Abortion* also state that in order to ensure that the practice of conscientious objection does not delay care within the context of lawful abortion services, healthcare providers must refer women, or where referral is not possible, must provide safe abortion services to which women are legally entitled to.⁶⁸

Indeed, as the United Kingdom's Supreme Court noted in the Doogan case:

it is a feature of conscience clauses generally within the health care profession that the conscientious objector be under an obligation to refer the case to a professional who does not share that objection. This is a necessary corollary of the professional's duty of care towards the patient.

Furthermore, it can be argued that a healthcare provider who refuses to terminate a pregnancy lawfully and omits to refer a patient to another provider is preventing the lawful termination or obstructing access to a facility for the termination of pregnancy under the CTOP Act. This should not be construed as an infringement of the freedom of conscience provision in the Constitution.

However, given that this has not had the effect of preventing the exercise of conscientious objection to the detriment of women's rights to access legal abortion, laws, policies and codes of ethics must clearly provide that healthcare professionals must refer their patients to other appropriate providers for termination of pregnancy services that the practitioners cannot or will not deliver. Healthcare providers cannot just legally abandon their patients.

(b) *Who can object?*

There is need for clear guidance on who can exercise conscientious objection to abortion services. Dickens and Cook note that the right to conscientious objection protects the personal convictions of personnel who actually perform an abortion procedure rather than those assisting or facilitating the procedure.⁶⁹

Given that the South African courts have not yet had an opportunity to deal with the right to conscientious objection within the context of abortion, it can borrow from the approach of courts from other jurisdictions. For example, the Colombian Court in the case of Case T-388/09 reiterated the principle that the right to conscientious objection can only be exercised by health care providers 'directly involved in performing a procedure necessary to terminate the pregnancy'.⁷⁰ In determining whether a judicial officer could invoke the right to conscientious objection to reclude himself from an application for injunction to compel a health facility to provide legal abortion under Colombian law, the Court declared that the right to conscientious objection is only applicable

to personnel directly involved in the procedure for termination of the pregnancy.⁷¹ Thus, the right to conscientious objection is not applicable to a judicial officer hearing a case on abortion, as it undermines the very essence of the legal system of the state. While conceding that judicial officers can hold personal convictions, the Court notes that this does not mean the abdication of their primary duty to apply the Constitution.⁷²

This approach was previously laid down in the T-209/08 case dealing with the right to conscientious objection by healthcare professionals. In this case, as a result of rape, a 13-year-old girl became pregnant. She was refused abortion by her healthcare company based on conscientious objection by its physicians. She was then referred to Erasmo Meoz de Cúcuta University Hospital which also invoked conscientious objection to the abortion procedure on behalf of its entire medical staff.

In delimiting the scope of the conscientious objection, the Court held following: 1) women's fundamental rights including timely access to abortion should be guaranteed and respected; 2) conscientious objection is not a right to which institutions or the State are entitled and that only natural persons can exercise that right; 3) the existence of a professional obligation on the part of the healthcare provider who refuses to perform abortion, to immediately refer to another health professional equipped to provide abortion services; and 4) the justification for invoking conscientious objection by a healthcare provider must be made in writing. The Court further held that the state is obligated to guarantee an adequate number of providers who are equipped to provide abortion services. The European Court of Human Rights echoes this in *R.R v Poland*, when it notes 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 obtaining access to services to which they are entitled under the applicable legislation.⁷³

Thus, despite the possibility for individual healthcare providers to refuse to provide abortion services on the grounds of conscience, this does not absolve the state from its obligation to provide services (including information and materials resources) arising from the fulfilment of an abortion right.

The court decisions mentioned above are important juridical resources for interpretation for South Africa in ensuring the efficacy of the CTOP Act to ensure women's right to prompt and effective access to abortion. This also speaks to South Africa's constitutional goal of substantive equality that addresses inequalities in reproductive health.⁷⁴

(c) *Register of conscientious objectors*

It is particularly crucial that a register of abortion services be kept in each facility noting the clinical details of the client, referral process and the name of

the personnel objecting. This will ensure that the state fulfils its obligation of ensuring that there are enough healthcare providers in hospitals and clinics to protect women's right to autonomy. The draft guidelines note that the following standards must be in place:

- Health professionals who are not willing to provide abortion services must inform their Facility Manager in writing when applying for a position in the facility.
- Facility Managers need to confirm whether a staff member is fit for purpose in terms of providing abortion services when appointing staff.
- Each objecting staff member must be dealt with individually. Abortion provision should never be dealt with in a group, or as a group action.
- Refusal only applies to trained health professionals and not to groups or an institution. Likewise, it does not apply to support personnel or complementary services.
- In non-emergency cases, professional health providers who believe that their religious or moral beliefs may affect the treatment or the advice that they provide may refuse to participate in an abortion, but must:
 1. Explain their refusal to the client in a manner that does not stigmatise or judge the client
 2. Explain to the client their right to request a safe abortion
 3. Make the necessary arrangements to enable the client to be seen by a provider who will conduct the abortion
 4. Update the facility register to note the refusal to treat.

Thus, it is critical that there are clear guidelines as to who can object, how they object and what they can object to.

6 Conclusion

In order to ensure women's right to exercise reproductive autonomy and access to timely legal abortion services in South Africa, domestic laws must effectively regulate and oversee the practices of healthcare professionals in relation to their implied right to conscientious objection. As noted above, numerous studies have shown that the failure to effectively regulate and monitor such refusals have served as a barrier to women's ability to obtain safe and legal abortion in South Africa. Such failure contravenes international human rights obligations of the South African government, which require that where states allow healthcare professionals to refuse to provide abortion care on grounds of conscience or religion, they must establish effective legal and oversight framework to ensure that such refusals do not hinder women's access to legal abortion in practice.

Thus, the South African state should design and implement a comprehensive and effective legal and policy framework, as well as oversight mechanisms

to govern the practice of conscientious objection by healthcare providers to ensure that they do not trample on women's access to safe, legal abortion.

Notes

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