POWER DYNAMICS IN THE PROVISION OF LEGAL ABORTION: A FEMINIST PERSPECTIVE ON NURSES AND CONSCIENTIOUS OBJECTION IN SOUTH AFRICA

NAME: SATANG NABANEH

STUDENT NUMBER: 12376648

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

Co-Supervisor: Siri Gloppen, Professor of Comparative Politics, University of Bergen

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DECLARATION

I declare that this thesis, 'Power dynamics in the provision of legal abortion: A feminist perspective on nurses and conscientious objection in South Africa,' which I hereby submit for the degree Doctor of Laws (LLD) at the Faculty of Law, University of Pretoria, is my work and has not been previously submitted by me for a degree at this or any other tertiary institution.

Name: Satang Nabaneh

Student No: u12376648

Date: 30 November 2019

DEDICATION

"A word after a word
after a word is power."

- Margaret Atwood, "Spelling"

To my parents, *Sheriffo Nabaneh and Mamanding Ceesay*; who let me discover my power at a very early age. Thank you for believing in me and letting me be loud and visible. I found my voice and my power: to fight for the rights of *all* women. This is for you.

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Satang Nabaneh
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ABSTRACT

Though hailed as one of the most exemplary laws on abortion, the 1996 *Choice on Termination of Pregnancy Act* of South Africa does not directly address conscientious objection. The consequences of such a gap serve as an obstacle to the efficacy of a liberal abortion law in practice. Where there are no clear laws or guidelines, the environment is conducive for healthcare providers acting within their 'own' interpretation of the law.

This thesis centres around nurses as the largest single group of health care providers in South Africa. Within this context, it explores the factors that shape how and why nurses exercise conscientious objection to the provision of abortion services. Understanding providers' practices of power in the exercise of conscientious objection requires attention at the intersection between gender hierarchies and power arrangements. The thesis further examines the conditions and challenges of nurses' contemporary role in abortion service provision. It focuses on the structural conditions in which abortion - providing nurses perform their abortion services.

The research conducted in this thesis provides an original contribution by employing feminist socio-legal methodologies to identify the complex and interwoven legal, political, and socio-cultural contexts. I utilised doctrinal and empirical research methods to draw conclusions of how we think about conscientious objection. Through in-depth interviews with nurses and information gathered from government officials, academics and members of civil society such as women's rights organizations and litigators, this thesis determines a number on strategies to improve the transformative potential of sexual and reproductive health and rights of women and girls.

Keywords: abortion, conscientious objection, South Africa, nurses, African feminism

LIST OF ACRONYMS

ACPD	African Christian Democratic Front (ACDF)
African Charter	African Charter on Human and Peoples' Rights
African Court	African Court on Human and Peoples' Rights
ANC	African National Congress
AU	African Union
BoR	Bill of Rights
BPA	Beijing Platform of Action
CEDAW	Convention on the Elimination of All forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CC	Constitutional Court
CLA	Christian Lawyers Association
DA	Democratic Alliance
D & E	Dilation and Evacuation
DFL	Doctors for Life
EFF	Economic Freedom Fighters
FF	Freedom Front
GC	General Comment
HRC	Human Rights Council
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICCPR	International Covenant on Civil and Political Rights
ICPD	International Conference on Population and Development

Maputo Protocol	Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa
MVA	Manual Vacuum Aspiration
NDoH	National Department of Health
NGOs	Non-Governmental Organisations
RRA	Reproductive Rights Alliance
SANC	South African nursing Council
SRJC	Sexual and Reproductive Justice Coalition
UDHR	Universal Declaration on Human Rights
UN	United Nations
Universal Declaration	Universal Declaration of Human Rights
TOP	Termination of Pregnancy
VCAT	Values Clarification and Attitude Transformation
Vienna Convention	Vienna Convention on the Law of Treaties
WB	World Bank
WHO	World Health Organization
ZAR	South African Rand

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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.

CHAPTER ONE

INTRODUCTION

1.1 Background

Abortion was liberalised in South Africa in 1996 with the passing of the Choice on Termination of Pregnancy Act,[1] but due to a widespread practice of conscientious objection among health providers only a minority of designated health facilities offer abortion services. Estimates suggest as low as 7 per cent of South Africa's 3 880 health facilities offer abortion services.[2]

The Choice on Termination of Pregnancy Act was part of a package of rights extrapolated from South Africa's 1996 Constitution that recognises the right to bodily and psychological integrity, including the right to make decision concerning reproduction and the right to healthcare, including reproductive health.[3] The Act was partly a result of feminist political action,[4] and a response to prevent the death of South African women through backstreet terminations.[5] 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.[6] As the then Minister of Health Dr Zuma noted:

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1 Act 92 of 1996. I use the term abortion throughout the study, although, in instances where it is used by respondents or when quoting the Act, which provides for the term 'termination of pregnancy' (TOP), the term is used in the study. The Choice on Termination of Pregnancy Act is henceforth referred to as the TOP Act or just the Act.

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

3 No 108 of 1996. *See* preamble of the Act and sec 27 (1)(a).

4 M Mbali & S Mthembu 'The politics of women's health in South Africa' (2012) 26(2) *Agenda: Empowering women for gender equity* 9.

5 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(1) *Journal of Southern African Studies* 79.

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

> [T]hough termination of pregnancy was legalised in South Africa by the previous government in 1975, the vast majority of poor and mainly black women resort to backstreet terminations because the present law [was] only accessible to the affluent.[7]

The Act provides for abortion on demand up to 12 weeks of pregnancy. Between 13 to 20 weeks, women[8] 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 be severely malformed.[9] Consent from a woman's spouse or in the case of minors, parental consent is not required.

With the aim of increasing women's access to abortion services, an amendment to the Choice on Termination of Pregnancy Act in 2008, for example, empowered registered nurses,[10] with the required accreditation to conduct the procedure during the first trimester.[11] Broadening the role of nurses to deliver services is viewed as a significant advancement towards the realisation of access to termination of pregnancy care.[12] It should be noted that midwives were authorised to provide termination of pregnancy services already in 1996.[13] Given the similar

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7 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) 4759.

8 For the purpose of this study, 'women' means persons of female gender, including girls.

9 Sec 2 of the Act.

10 The Nursing Act 33 of 2005 defines a 'nurse' as a person registered in a category under section 31(1) in order to practice nursing or midwifery. The reference to 'nurse' in this article will be used as a general term with reference to professional nurse and midwife categories described in the Nursing Act.

11 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 and others* 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.

12 WHO 'Safe abortion: technical and policy guidance for health systems' (2012, 2nd edition).

13 Sec 2(2) of the Act.

legal scope of practice between nurses and midwives within the context of South Africa's abortion law,[14] for purposes of this study, the term 'nurses' includes 'midwives' with requisite training.[15]

Currently in South Africa, one can terminate a pregnancy using medications, surgery, or a combination of both. Abortions during early pregnancy, before 9 weeks, can be done with medications.[16] For the second and third trimester, abortions are done surgically or by using medicines in combination with surgery.[17] Women who are less than 12 weeks pregnant can have abortions performed by nurses in addition to doctors who are trained as abortion providers.[18] For second trimester abortions, doctors have to perform the termination, which they mainly do with nursing support.

South Africa's public health sector (which is run by government) is mainly responsible for the provision of abortion services in 'designated'[19] facilities accredited by the National Department of Health. Private health facilities can also provide abortion services upon certification. In this study, the private sector includes all private nurse practitioners and private abortion health facilities (e.g.

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

15 Notwithstanding, the study will pay attention to the specific nuances relating to the midwifery and nursing regimens respectively where necessary.

16 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 (44 Suppl 1) *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.

17 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 (224) *BMC Health Services Research* 1; B Winikoff & WR Sheldon 'Use of medicines changing the face of abortion' (2012) 38(3) *International Perspectives on Sexual & Reproductive Health* 164

18 In this study, an abortion provider is referred to as a registered midwife or registered nurse as such under the Nursing Act (No 50 of 1998) as amended by the Nursing Act No 33 of 2005 and who has undergone prescribed training in terms of the Act.

19 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.

clinics run by non-profit organisation facilities or those owned and run by nurse providers).

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.[20] For example, 43.6 per cent of people living in the rural areas are served by only 12 per cent of the country's doctors and 19 per cent of nurses.[21] A 2007 study on inequalities in healthcare spending and capacity among South Africa's provinces found that Northern Cape received more government funding, US$168 per capita compared with Limpopo's US$101, which is a mostly poor and black province.[22] This translated into Northern Cape having roughly twice as many doctors per capita and four times as many hospitals per capital as Limpopo.[23] The study further found that the richest province, Western Cape had 60 private hospitals, 55 public hospitals, and 1246 doctors for a population of 4.8 million, compared to the poorest province, Limpopo, which had only 6 private hospitals, 44 public hospitals, and 882 doctors for a population of 5.7 million.[24] These inequalities have major consequences for availability of services in the country generally and abortion specifically.

Abortion services in public sector facilities are available free of charge, while private abortion clinics charge fees that range from 800 ZAR to 1,500 ZAR ($55 to $100 approximately) depending on the gestational age and type of abortion procedure.[25] Women who can afford private healthcare are able to access safe

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20 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) 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) 5 & 18.

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

22 D Stuckler et al 'Health Care Capacity and Allocations among South Africa's Provinces: Infrastructure/Inequality Traps after the End of Apartheid' (2011) 101 (1) *American Journal of Public Health* 169.

23 As above, 170.

24 As above, 168.

25 These prices were culled from observations when I visited private abortion clinics.

abortions from doctors or nurses in the private sector, whether these are legally designated facilities or not.

Due to advancements in abortion provision around the world, there is a gradual recognition and move from the dichotomy of legal and illegal abortions and regrouped into 'safe, less safe and least safe.'[26] The criteria for safe abortion laid down by the World Health Organization (WHO) is that abortion would be provided by a trained provider and the usage of an endorsed method.[27] A 'less safe' procedure would mean for instance if a healthcare professional uses a method that is not recommended. The least safe abortion does not meet neither criterion. In this category, abortion is provided by untrained persons who use dangerous methods. It is estimated that worldwide, '55 per cent of abortions can be categorised as safe, 31 per cent as less safe and 14 per cent as least safe.'[28]

In the case of South Africa, these different categories are evident. For example, informal abortions have been considered safe due to the availability of black-market misoprostol and instructions from informal abortion providers for clients to seek help in health facilities in case of complications. There is a semblance of information on obtaining medical care in case of a medical emergency. Of particular interest to this study is the presence of unlicensed or undesignated private abortion clinics that provide safe abortion. This characterisation is based on the abortion procedure performed by an appropriately trained healthcare professional and is usually done using an appropriate method according to the WHO standards.

Despite having a broadly liberal abortion law, South Africa does not have data readily available. The National Department of Health no longer reports on abortion-related death but rather categorises them as miscarriage.[29] For instance, the 2016

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26 B Gantra et al 'Global, regional and subregional classification of abortions by safety, 2010–14: estimates from a Bayesian hierarchical model' (2017) 390(10110) *Lancet* 2372–2381

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

28 Gantra et al (n 26) 2372.

29 See National Department of Health 'Saving mothers 2008-2010: Fifth report on the confidential enquires into maternal deaths in South Africa' (2012).

Saving Mothers Report revealed that 24.8 per cent of maternal deaths were ascribed to miscarriages in public health sector facilities.[30] Abortion and HIV-related deaths are also combined, making it difficult to estimate the number of abortions-only related deaths. South Africa's maternal mortality rate (MMR) is estimated at 138 deaths per 100 000 live births, compared to the estimated MMR of 61 deaths per 100 000 live births in 1997 when the Act was enacted.[31] This can be interpreted to mean that women in South Africa still remain susceptible to the complications of unsafe abortion. For example, in 2016, a 19-year-old Johannesburg student died due to complications arising from an unsafe abortion. She was denied basic information about how to access abortion services at public health facilities and was afraid of the stigma and discrimination she might face.[32] As a result of lack of complete official statistics, there is no data available regarding abortions conducted in private unlicensed abortions clinics or situations of self-medication by women outside the formal health systems.

Unlike the majority of countries globally, South Africa allows certified midwives and registered nurses to perform abortions.[33] Training and certification is considered critical for broadening access and ensuring quality.[34] The Choice on Termination of Pregnancy Act provides that only a person 'who has undergone prescribed training in terms of this Act' may perform a termination of pregnancy. In line with this provision, the South African Nursing Council requires nurses to undergo 160 hours of training that constitutes 80 hours of theoretical training and 80 hours of practical training under the supervision of an experienced provider in a designated hospital

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30 National Department of Health 'Saving Mothers 2011-2013: Sixth report on confidential enquiries into maternal deaths in South Africa' (2016) vi. See also National Department of Health 'Saving Mothers 2017: Annual report on confidential inquiries into maternal death in South Africa' (2018).

31 World Bank Group 'Maternal Mortality Ratio: South Africa' *World Bank Data 2019* https://data.worldbank.org/indicator/SH.STA.MMRT?locations=ZA (accessed 15 May 2019).

32 See Speech by the Special Advisor to the Minister of Social Development of Social Africa at the UN April 2016 as cited in Amnesty International 'Briefing: Barriers to safe and legal abortion in South Africa' (2016) 5.

33 M Berer 'Provision of abortion by mid-level providers: international policy, practice and perspectives' (2009) 87 *Bulletin of the World Health Organization* 58-63.

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

for the certification in abortion provision.[35] Without such clinical training, a nurse is not authorised to perform termination of pregnancies. With regards to midwives, a Midwifery Abortion Care training programme was established as part of the National Abortion Care Programme in 1998 by the Department of Health, in collaboration with 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.[36]

Nurse providers in the private sector are usually trained in the private sector and work in private abortion clinics.[37] There are also nurses who have been trained in public sector and have worked for a long time in those hospitals but move to private clinics or set up their own abortion clinics. It is important to note that while nurses must undergo training and be able to perform abortion services, there is no similar requirement for doctors.

The South African health system is predominantly nurse driven.[38] The SANC register shows that between 2009 and 2018, the number of registered nurses grew from 221 817 to 285 704 showing a net increase of 29 per cent.[39] Thus, nurses are the frontline providers in the implementation of the Choice on Termination of Pregnancy Act as majority of abortion provision in the public sector is done by

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35 South African Nursing Council. See also Ipas 'Learner Manual: Management of termination of pregnancy, incomplete abortion and related reproductive health matters.'

36 K Dickson-Tetteh & DL. Billings 'Abortion care services provided by registered midwives in South Africa' (2002) 28(3) *International Family Planning Perspectives* 145.

37 Recognised private nurse providers are defined in this study as trained abortion nurses in a fixed clinic location

38 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.

39 The number of registered nurses grew by 32 per cent (35, 492). The figures were not disaggregated by sex. See SANC 'Growth in the registers and rolls, 2009 to 2018' (2019) https://sanc.co.za/stats/stat2018/Growth%202009-2018.pdf (accessed 10 June 2019) 2.

trained nurses.[40] The same is true of private abortion clinics like Marie Stopes.[41] The role of nurses is vital as the first contact when women seek abortion services.[42] In giving abortion care before, during and after the procedure, duties of nurses might include: counselling; physical and psychological care; post-abortion care; and sometimes performing the abortion procedure itself as this can be within their legal scope of practice.

Though abortion can be obtained in South Africa on demand, there are different challenges hindering access. Rachel Rebouché notes that liberal laws do not necessarily lead to increased access to abortion services[43] This is true for South Africa. The most common barriers to accessing abortion services include the lack of 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. [44]

The Choice on Termination of Pregnancy Act does not directly address conscientious objection.[45] 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.'[46] The hope was that the omission of a conscience clause in the Act would circumvent controversy and legal

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40 See 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*(3) *American journal of public health* 397–399.

41 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(S4) *International Journal of Gynaecology and Obstetrics* 38-44.

42 AJ Lipp & A Fothergill 'Nurses in abortion care: Identifying and managing stress' (2009) 31(2) *Contemporary Nurse* 111.

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

44 Trueman & Magwentshu (n 40) 398.

45 C Ngwena 'The history and transformation of abortion law in South Africa' *(1998) 30(3) Acta Academica* 32.

46 International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI) (1966).

challenges.[47] Instead, it has the effect of serving as a major barrier to the implementation of the law in practice.[48] Currently, there are no national level abortion guidelines in effect to provide guidance on standards of procedures or care. The lack of clarification of rights and obligations results in the creation of a discretionary space for health care providers, which is influenced by power relations. Understanding providers' practices of conscientious objection requires attention at the intersection between gender hierarchies and power arrangements.

It is important to note that the absence of an express conscientious objection clause in the Choice on Termination of Pregnancy Act does not mean the complete absence of regulation. Since the Constitution is the supreme law, it follows that section 15 (1) on freedom of conscience, which states that "everyone has the right to freedom of conscience, religion, thought, belief and opinion" and section 36 on general limitation of rights apply to this Act. In South Africa as opposed to other jurisdiction such as some Scandinavian and Eastern European countries, health care providers have an implied constitutional right to conscientious objection.[49] Recent developments have shown that freedom of conscience continues to be accepted as a limitation to reproductive healthcare, including women's right to access abortion services.[50]

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.[51] However, the South African case of not having a conscientious objection clause is not unique. Similar situations pertain in most African countries

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47 See C Ngwena 'An appraisal of abortion laws in South Africa from a reproductive health rights perspective' (2004) *International and Comparative Health Law and Ethics: A 25 Year Retrospective* 708.

48 C Ngwena 'Conscientious objection and legal abortion in South Africa: Delineating the parameters' (2003) 28(1) *Journal for Juridical Science* 193-194; MC Engelbrecht *et al* 'The operation of the Choice on Termination of Pregnancy Act: Some empirical findings' (2000) 23 (2) *Curatonis* 6.

49 C Fiala *et al* 'Yes we can! Successful examples of disallowing conscientious objection in health care' (2016) 21(3) *European Journal of Contraception and Reproductive Health Care* 201.

50 MR Wicclair 'Conscientious objection in medicine' (2000) 14(3) *Bioethics* 206.

51 A Heino *et al* 'Conscientious objection and induced abortion in Europe' (2013) 18(4) *European Journal of Contraception and Reproductive Health Care* 231-233.

and elsewhere, where the issue of conscientious objection is not addressed and hence, remains largely unregulated.[52] 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.[53] This has been supplemented by guidelines.[54]

1.2 Problem statement

After more than 20 years of a liberal abortion legislation, many women in South Africa still lack access to safe abortion care.[55] A few years ago, 'House of Abortion Horror' was the front-page story in the Daily Sun (a South African newspaper).[56] The article described how the police stopped a 19-year old woman from taking the pills to abort her five-months foetus. This raid led to the arrest of Kute, the illegal abortion provider from Uganda.[57] The story was accompanied by the picture of a dishevelled room which served as a surgery room.[58] In 2017, the Johannesburg Magistrate's Court found five bogus doctors guilty of illegally terminating pregnancies in contraventions of sections 7 and 10 of the Choice on Termination of Pregnancy Act and sentenced them to six months imprisonment.[59]

Despite a legal abortion environment, this remains the norm with dramatic increase in lamppost advertisements for 'pain free, same day' abortions which has in many cases led to serious consequences.[60] Poor women are tremendously

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52 OR Gustavo 'Abortion and conscientious objection: Rethinking conflicting rights in the Mexican Context' (2017) 29(1) *Global Bioethics* 5.

53 See *Zambia Termination of Pregnancy Act* 1972.

54 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.

55 C Albertyn 'Claiming and defending abortion rights in South Africa' (2015) 11 (2) *Revisya Direito GV* 430.

56 '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).

57 As above.

58 As above.

59 '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).

60 Trueman & Magwentshu (n 40) 398. See also S Ferguson 'Abortion is legal in South Africa—But illegal clinics are thriving. Why? *The Development Set* 3 April 2017.

affected by the deteriorating health systems, lack of political will and non-vibrant civil society, stigma and opposition.[61] For those women who are rich (and white), they can afford private health services, while poor women (mostly blacks) rely on the state or illegal providers increasingly seen on lamppost advertisements.[62]

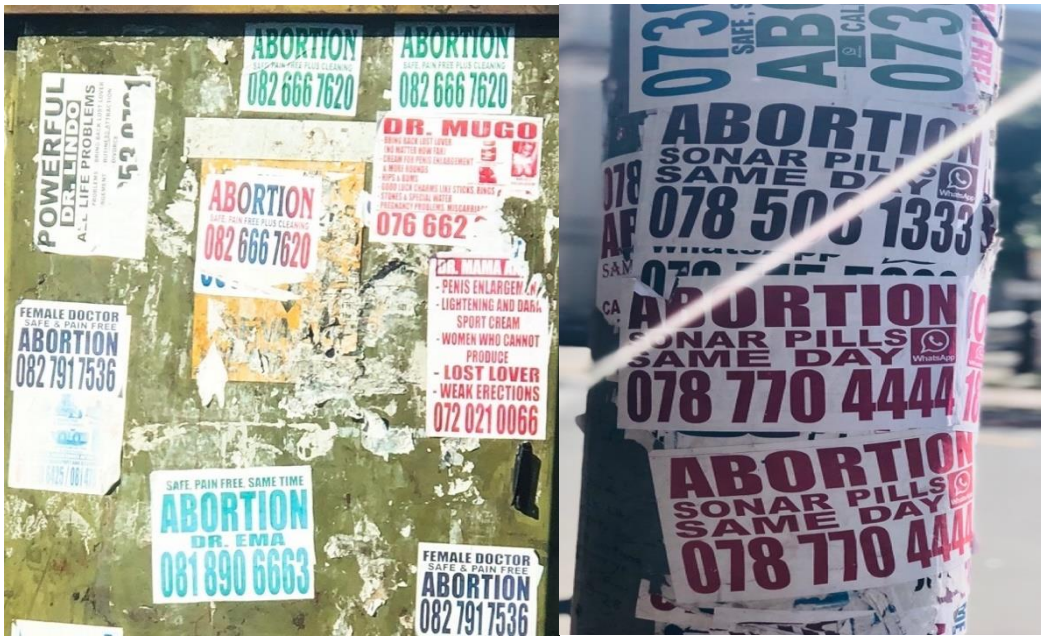

Figure 1: Advertisements for 'safe' 'quick' and 'pain free' abortions plastered around in Gauteng and Limpopo, South Africa. (Photos by Satang Nabaneh)

Lack of accessibility is further compounded by the shortage of health facilities that provide abortion services. In 2015, it was estimated that less than 40 per cent of designated facilities actually provided abortion services.[63] According to Amnesty International, as of November 2016, the National Department of Health has confirmed that there are 505 facilities of 3880 government health facilities (13 per cent), which have been designated to provide abortions services, but only 264 health facilities (7 per cent) were providing first and second trimester services.[64]

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61 Albertyn (n 55) 430.

62 R Jewkes et al 'The Impact of age on the epidemiology of incomplete abortions in South Africa after legislative change' (2005) 112 *British Journal of Obstetrics & Gynaecology* 355.

63 Albertyn (n 55) 429-454.

64 Amnesty International 'Briefing: Barriers to safe and legal abortion in South Africa' (2016) https://www.amnestyusa.org/files/breifing_barriers_to_safe_and_legal_abortion_in_south_africa_final_003.pdf (accessed 10 January 2018) 8.

However, what makes this situation worse is the inadequacy of health system information as there are no available data to tell where to find these 264 public health facilities. The health system deficiencies including the limited number of abortion facilities can be ascribed to the shortage of health professionals willing to provide the service, worsened by the unregulated practice of conscientious objection. Although the percentage of conscientious objectors in these facilities cannot be ascertained, the practice has been said to be very rampant and an major impediment to the procurement of legal abortions. As earlier noted, one of the main reasons for the continued existence of the clandestine abortion industry despite a progressive legal framework is the ability of healthcare professionals including nurses to opt out of providing abortion services. Nurses who often provide the majority of care for women undergoing abortions continue to refuse to take part in abortion care on the grounds of conscience or religious beliefs.

Against this background, this study hypothesises that the absence of a legal framework regulating the practice of conscientious objection serves as a main obstacle for the delivery of safe abortion services. As alluded to earlier, there is no express provision regulating conscientious objection in the Choice on Termination of Pregnancy Act. Although, section 15 of the Constitution is implicitly used to allow for health professionals to opt out of providing abortion services, there still are no government protocols or guidelines addressing conscientious objection to abortion. Because of the absence of clear guidance, providers do not have adequate understanding of when and how conscientious objection can be exercised.[65]

What emerges from this is a picture that indicates that the exercise of conscientious objection by healthcare professionals including nurses, is largely unregulated, creates harm to women and remains a major barrier to access services.[66] Therefore, this study pays particular attention to the numerous complex factors that impact on the right to conscientious objection to abortion and its exercise within the South

65 J Harries *et al* 'Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study' (2004) 11 *Reproductive Health* 3.

66 As above, 16

African context. Several studies note that healthcare providers' refusal to provide abortion care is mainly on the grounds of religious and moral beliefs.[67] Rather than focusing only on a religious variable, this study centres on power relations – including legal, political and social structures to provide alternative explanations of how nurses understand and exercise conscientious objection in the provision of care to women seeking or undergoing abortion.

Within this context, it explores the factors that shape how nurses understand and exercise their legal scope of practice related to abortion, including the exercise of conscientious objection. Given the politicised nature of abortion, an analysis of the complex and interwoven legal, political, and socio-cultural contexts from a feminist perspective is employed. As Catriona Macleod and Tracy Feltham-King note, abortion 'speaks to and draws on, localized understandings of women's role, the role of the state, the sanctity of life and society's obligation to women and the right to privacy.'[68]

Noting that there is inadequate empirical research, this study adds to the body of knowledge around the shifting gendered power relations within which nurses work and how it supports or constrains provision of abortion services. This follows the belief that insights into the lives of nurses and to the many subjective fields they navigate relating to provision of legal abortion care, allow an understanding of the complex ways that power dynamics interacts with other processes. Because of their multiple positions in any given context regardless of being a male or female, '[a nurse] may be an oppressor, a member of an oppressed group, or simultaneously oppressor and oppressed.'[69]

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67 See A Harrison *et al* 'Barriers to implementing South Africa's Termination of Pregnancy Act in rural KwaZulu/Natal' (2000*)* 15 (4) *Health Policy and Planning* 424.

68 CI Macleod & T Feltham-King 'Representations of the subject 'woman' and the politics of abortion: An analysis of South African newspaper articles from 1978 to 2005' (2002) 14(7) *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care* 749.

69 PH Collins *Black feminist thought: Knowledge, consciousness, and the politics of empowerment* (1990) 225.

As a result, this study targets the unique and individual ways of thinking, feeling and behaviour of nurses, on their decision to terminate or not terminate a pregnancy, not only at the material time but over time as their lives continue and beliefs evolve and change. Such a framework is an avenue for learning and revealing the complexities of abortion and the experiences, beliefs, thoughts and memories involved.

1.3 Research aims and objectives

The main aim of this research is to examine how legal, political, socio-cultural and institutional factors shape nurses' understandings and practice of conscientious objection to abortion-related care.

This thesis aims to:

1. examine the scope and limitations of the right of nurses to exercise conscientious objection to abortion;

2. provide a better understanding of the discursive resources and framings drawn on by key state and non-state actors in South Africa that contributed to the absence of a conscientious objection provision in the Choice on Termination of Pregnancy Act;

3. offer insights into how nurses understand and exercise conscientious objection to abortion; and

4. capture how shifting power dynamics, operate to support or constrain nurses' provision of termination of pregnancy services.

1.4 Research questions

The overall research question is:

In what ways do the legal, political, social and institutional contexts shape how nurses understand and exercise conscientious objection on provision of legal abortion?

In this study, I therefore, investigate the following research questions:

1. What is the scope and limitations of the right of nurses to exercise conscientious objection to abortion?

2. What discursive resources and framings were drawn on by key state and non-state actors in South Africa that contributed to the absence of a conscientious objection provision in the Choice on Termination of Pregnancy Act?

3. What practices of discretionary power influences nurses' exercise conscientious objection relating to provision of legal abortion? In particular, how and why do nurses exercise conscientious objection?

4. How do shifting dynamics including professional norms, socio-cultural values and wider political and legal factors underpin nurses' action or failure to act in the provision of legal abortion?

1.5 Significance of the study

The study of how nurses practice conscientious objection to provision of abortion services provide an opportunity to examine the applicable legal theory and law in practice. In addressing how changes in the law may not in themselves lead to changes on the ground, this study attempts to contribute to scholarship on the discrepancy between abortion law and practice.

Understanding what shapes nurses' norms, behaviours and how they navigate spaces in abortion provision can inform strategies to reduce abortion stigma that has direct implications for improving access to services and uptake. The study further contributes towards critical understandings and interrogation of the role of nurses in fulfilling the right to access safe legal abortion services through uncovering both internal and external social and professional conditions that intersect and either support or constrain nurses. The study in combining both the doctrinal and empirical approach adds to the methodological debate on the exercise of conscientious objection in different fields.

The study is of direct practical relevance for the sexual and reproductive health and rights of women in South Africa. Due to the limited scope of this study, the experiences of women seeking abortion services is not explored as it has been amply studied.[70] The assessment of conscientious objection in practice has implications for what regulations and guidelines are needed to ensure access to safe and legal abortion services. The result of the study can assist actors in the health system reform, including government, professional associations, civil society, donors and development agencies, to address this complex issue.

1.6 Literature review

The concepts and theories that underpin this study arise out of earlier sections in this chapter. Since the theoretical background will be discussed in detail in chapter two, this section provides a brief review of relevant research in the area of conscientious objection to abortion.

Conscientious objection is a complex issue of competing rights: women's rights to safe, legal abortion and the healthcare providers' claimed right to refuse.[71] The Global Doctors for Choice, in its White Paper examining the prevalence and impact of conscientious objection, conclusively demonstrates an increase in the practice of healthcare providers' refusal to provide abortion services.[72] Within the South Africa context, even though scholars have addressed the issue of conscientious objection, there is limited research that combines a normative and empirical approach to the study of conscientious objection within the nursing profession.

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70 See for example Hodes (n 5 above); Harries *et al* (n 65 above); RK Jewkes *et al* 'Dramatic decline in abortion mortality due to the Choice on Termination of Pregnancy Act' (2005) 95 *South African Medical Journal* 250.

71 J Harries *et al* 'Health care providers' attitudes towards the termination of pregnancy: A qualitative study in South Africa' (2009) 9 (296) *BMC Public* Health 1.

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

Various scholars have discussed freedom of conscience in healthcare following Mark Wicclair's comprehensive analysis of the three emerging approaches: conscience absolutism, the incompatibility thesis and compromise.[73] According to absolutism or 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.[74] The incompatibility thesis means disallowing the exercise of conscientious objection as it is contrary to professional obligations.[75] Thus, healthcare providers do not have a right to refuse.

In critically analysing the two abovementioned extreme positions, Wicclair argues for the compromised or balanced approach, which involves a reasonable accommodation provided by the employer, but which also entails provider duties including referral.[76] The balanced approach, however, remains 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.[77] Wendy Chavkin *et al* have 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.[78] The emergence of two main defences (that the exercise of conscientious objection should be allowed and recommendations on how refusal can be managed to prevent the harms that it can create) is premised on a call for respect of the moral integrity of healthcare providers.[79]

Harris and others note that where abortion is legally permitted by law, conscientious objection is the only means through which health providers can

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73 MR Wicclair *Conscientious objection in health care: An ethical analysis* (2011) 32.
74 As above, 34-36.
75 As above, 81-82.
76 As above, 86.
77 W Chavkin *et al* 'Regulation of conscientious objection: An international comparative multiple-case study' (2017) 19(1) *Health and Human Rights Journal* 55-68.
78 As above, 66.
79 As above, 87.

demonstrate their position regarding abortion.[80] A key problem with this approach is that it is simply a boycott: an attempt to claw back a constitutionally provided right and the legality of abortion, as in the case of South Africa. Some have argued that unlike in the military, conscientious objection does not have a place in reproductive healthcare.[81] Christian Fiala and Joyce Arthur label conscientious objection as a 'dishonourable disobedience'[82] to laws and ethical codes and call for its ban due to its violation of patients' rights.[83] Additionally, others have argued that the exercise of conscientious objection jeopardises women's health and human rights as it unfairly privileges a doctor's conscience over that of their patients.[84] Conscientious objection, they contend, weakens the full realisation of reproductive rights and women's equality.[85]

Global studies have also shed light on conscientious objection as a barrier to accessing safe abortion services that drives women to unsafe abortion.[86] The exercise of conscientious objection in reproductive healthcare, in particular for abortion services has the potential to undermine the dignity and autonomy of women and stigmatises their healthcare needs.[87] Stigma is defined as 'an attribute that links a person to an undesirable stereotype leading individual to reduce the bearer from a whole and usual person to a tainted discounted one.'[88] Building on

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80 LF Harries *et al* 'Conscientious objection to abortion provision: why context matters' (2016) *Global Public Health* 1. *See* B Johnson Jr *et al* 'Conscientious objection to provision of legal abortion care' (2013) 123 *International Journal of Gynecology & Obstetrics* S60.

81 JH Arthur & C Fiala 'The FSRH guideline on conscientious objection disrespects patient rights and endangers their health' (2018) 44(2) *BMJ Sexual & Reproductive Health* 145.

82 C Fiala & JH Arthur 'Dishonourable disobedience – Why refusal to treat in reproductive health care is not conscientious objection' (2014) 1 *Woman- Psychosomatic Gynecology & Obstetrics* 12.

83 As above.

84 C Zampas 'Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings' (2013) *International Journal of Gynaecology & Obstetrics* S64. see also R Baker 'Conscience and unconscionable' (2009) 23 *Bioethics* ii-iv.

85 C Fiala & JH Arthur 'There is no defence for 'conscientious objection' in reproductive health care' (2017) 216 *European Journal of Obstetrics & Gynecology and Reproductive Biology* 255.

86 See Chavkin (n 77).

87 C MacLeod 'Harm or mere inconvenience? Denying women emergency contraception' (2010) 25(1) *Hypatia* 11.

88 E Goffman *Stigma: the management of spoiled identity* (1963) 11.

Goffman's conceptualisation of stigma, stigma relating to abortion is defined by Anuradha Kumar *et al.* 'as a negative attribute ascribed to women who seek to terminate a pregnancy that marks them internally or externally, as inferior to ideals of womanhood.'[89] Research further demonstrates that stigma related to abortion provision influences ways and the extent to which women can access care.[90] As this study focuses on nurses, I utilised the growing body of research that seeks to explore nurses' experiences of abortion stigma, which is closely aligned to their professional identity as providers.[91]

A recent study on how norms influence the provision of abortion services in South Africa shows that nurses make moral judgments about their clients classifying them into 'worthy' and 'unworthy' of support.[92] Further research has shown that in addition to religious and age variables, life experiences of nurses have a substantial effect on their attitude about the provision of legal abortion.[93] Walker has additionally suggested that nurses who already have children of their own tend to have negative views on termination of pregnancy.[94]

There has, however, been relatively little feminist research focused on how nurses understand and exercise conscientious objection, related to abortion care. Drawing on diverse feminist perspectives including African feminist theories, this study contextualises a response through the construction and utilisation of the critical

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89 A Kumar et al. 'Conceptualising abortion stigma' (2009) 11(6) *Culture, health and sexuality* 628.

90 See KA Hessini & L Mitchell 'Conceptualising abortion stigma' (2009) 11 *Culture, Health & Sexuality* 625.

91 RJ Cook & BM Dickens 'Reducing stigma in reproductive health' (2014) 125 *International Journal of Gynecology and Obstetrics* 89–92. See also LA Martin et al 'Abortion providers, stigma and professional quality of life' (2014) 90(6) *Contraception* 581-587; LA Martin et al. 'Measuring stigma among abortion providers: Assessing the abortion provide stigma survey instrument' (2014) 57(7) *Women Health* 641-661.

92 S Rohrs 'The influence of norms and values on the provision of termination of pregnancy services in South Africa' ((2017) 6 *International Journal of Africa Nursing Sciences* 39.

93 NE Mokgethi *et al* 'Professional nurses' attitudes towards providing termination of pregnancy services in a tertiary hospital in the North West province of South Africa' (2006) 29(1) *Curationis* 32.

94 L Walker 'My work is to help the woman who wants to have a child not the woman who wants to have an abortion: Discourse of patriarchy and power among African nurses in South Africa (1996) 55(2) *African Studies* 43.

African feminist perspective.[95] The analytical framework takes into account the intersectional characteristics of women such as race, class, geographic location and socioeconomic status.[96] The usage of this lens creates an opportunity to transcend the representation of African women as homogenous. This suggestive theoretical and analytical paradigm is grounded in empirical observation that is useful for detailed analysis of the lived experiences of African women.[97] As such, this study that seeks to provide a feminist analysis of the exercise of conscientious objection centralises the experiences of women. In other words, the study critically analyses the gender implications of enacted laws or lack of, and its assumed causal link with health service provision.

While focusing on South Africa, I develop insights into the power dynamics underlying provision of legal abortion. Considering the foregoing, this study utilises a feminist lens that focuses on nurses (who are predominantly women) rather than doctors. The triangular relationship between healthcare providers, nurses and patients illustrate the implicit power and hierarchical dynamics. Women's access to reproductive health care including termination of pregnancy is closely linked with power.[98] Such power dynamics include power structures exercised in patriarchal societies that exert influence over women's power of agency over their own bodies, which in turn influence the institutions and systems in society negatively against women.[99] Tamara Braam and Leila Hessini succinctly put it:

> Women's bodies, as the personification of society reproducing itself, represent a critical arena for power struggles. Society has found ways to exert control over women's bodies through law, customs and traditions, and value systems.[100]

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95 This analytical framework is in line with bell hook's definition of feminisms, see B Hooks *Feminist Theory* (1984) 15.

96 See A Gouws 'Feminist intersectionality and the matrix of domination in South Africa' (2017) 31(1) *AGENDA* 19-27.

97 A first-hand account or story of an experience with a phenomenon of interest.

98 Bambra *et al* 'Towards a politics of health' (2005) 20(1) Health *Promotion International* 187.

99 T Braam & L Hessini 'The power dynamics perpetuating unsafe abortion in Africa: A feminist perspective' (2004) 8(1) *African Journal of Reproductive Health* 45-47.

100 As above, 44.

Knowledge is closely aligned with the production of 'regimes of truth' which are constituted through power relations.[101] For example, medical knowledge is a privileged site found within discourses that create and sustain gender inequalities.[102] While Foucault's work has been instructive to feminist approaches, its main shortcoming is the lack of engagement with gender, consequently, making the female subject invisible.[103] This study acknowledges that power relations play a critical role in deciding the position of women and the subjective experience arising out of that location.[104] These power dynamics can be manifested in 'paternalistic control', which as Sally Sheldon explains, may involve influencing the woman not to end a pregnancy, or in the case of an objector, refuse to provide an alternative to the woman seeking abortion.[105]

From a standpoint of women's everyday lives, in this case, nurses, feminist theories afford a space for conceptualising power, knowledge and discourse.[106] 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 against using universalistic tendencies found in Western feminism based on differences between African and European gender systems.[107] This is because of the problematic concept of the 'universalised woman' arising out of a Western-centric-essentialist lens that pays little attention to the range of women's experiences.[108] Essentialism denotes:

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101 M Foucault *Power/ knowledge: Selected interviews and other writings 1972-1977* (1980) 93.

102 Foucault describes medical doctors as 'priest of the body.' See M Foucault *The birth of the clinic: An archaeology of medical perception* (2003)32; M Thomson 'Rewriting the doctor: Medical law, literature and feminist strategy' in S Sheldon & M Thomson *Feminist perspectives on health care law* (1998) 174.

103 EA Buker 'Hidden desires and missing persons: A feminist deconstruction of Foucault' (1990) 43(4) *The Western Political Quarterly* 811.

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

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

106 See RJ Cook 'Women's international human rights Law: The way forward' in RJ Cook (ed) *Human rights of women: National and international perspectives* (1995) 5; SN Hasse-Biber (ed) *Handbook of Feminist research: Theory and praxis* (2007).

107 I Amadiume *Reinventing Africa: Matriarchy, religion and culture* (1997).

108 For example, D Lewis 'Feminism and the radical Imagination' (2007) 21 (72) *Agenda: Empowering Women for Gender Equity* 18; P Gqola 'Ufanele uqavile: Blackwomen, feminisms and postcoloniality in Africa' (2001) 16(50) *Agenda* 17.

> the idea that there is some common, underlying attribute or experience shared by all women, independent of race, class, sexual orientation, or other aspects of their particular situation.[109]

Katharine Barlett describes the privileging of a group of women, mostly, white, middle-class, heterosexual women, as having the same effect of discounting women's experience as found in male norms.[110] While moving away from universal theorising, attention should be paid to the intersectionality, which illustrates how different identities including, race, class, gender, sexuality, disability and others intersect,[111] with 'interlocking systems of oppression.'[112]

Despite its wide appeal, criticism of the concept of intersectionality focuses on its lack of a set methodology as identities are simply listed without recognising that social categories are manifestations of power within particular contexts.[113] Kimberlé Crenshaw cautions that when thinking about intersectionality, it is not enough to just assert an array of identities, but rather, there is need to understand the differences in various historical and social contexts.[114]

Given its possible application and meanings in various African contexts, Ebenezer Durojaye and Olubayo Oluduro argue that as African women are not homogenous, there is need to consider variables such as age, socio-economic status and rural/urban dichotomy.[115] In fully keeping with this holistic approach, Sylvia Tamale notes that 'the dialectical relationship between gender, class, ethnicity,

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109 M Chamallas *Introduction to Feminist Legal Theory* (2003) 78.

110 KT Bartlett 'Gender law' (1994) 1 *Duke Journal of Gender, Law and Policy* 1-20. See also E Spelman *Inessential woman: Problems of exclusion in feminist thought* (1988).

111 K Crenshaw 'Mapping the margins: Intersectionality, identity politics, and violence against women of color' (1991) 43 (6) *Stanford Law Review* 1241.

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

113 See JC Nash 'Re-thinking intersectionality' (2008) 89 *Feminist Review* 1-15; V Patil 'From patriarchy to intersectionality: A transnational feminist assessment of how far' (2013) 38 (4) *Signs: Journal of Women in Culture and Society* 847-867.

114 Crenshaw (n 111) 1298.

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

religion, imperialism, and neo-colonialism is especially pertinent for an analysis of gender relations in the African context.'[116]

Uma Narayan further argues that in order to analyse and understand cultural changes, a history of change methodology is needed.[117] Given South Africa's specific circumstances, historically, race and class inequalities marked the gendered division of nursing in South Africa.[118] Such historical documentation helps us understand the shifting constructions of professional nursing identity and nursing work across time. This serves as essential foundation from which to critically examine the conditions of nurses' contemporary role in abortion service provision.

However, an exclusive focus on race or what Patricia Hill Collins call an 'Afrocentric standpoint,' can mask the ways in which gender power relations is often dependent on multifaceted factors.[119] Thus, theorising within a broader intersectionality framework can explain the role and impact for power dynamics of different social categories that informs nurses' lived experiences within their legal scope of abortion work.[120] Despite the problematic features of intersectionality, an attempt is made to contextualise the concept within the South African setting through the critical African feminist perspective. This analytical approach, which applies intersectionality is helpful in accounting for shifting power relations in the framework of general discussion over the liberalisation of abortion and how that varies across time, place and material contexts. In addition, is also useful in understanding the lived experiences of nurses in exercising conscientious objection to the provision of abortion services in South Africa.

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116 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.

117 U Narayan 'Essence of culture and a sense of history: a feminist critique of cultural essentialism' (1998) 13(2*) Journal of Feminist Philosophy* 86.

118 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(4) *Journal of Southern African Studies* 695-717.

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

120 See F Anthias 'Intersectionality what? Social divisions, intersectionality and levels of analysis' (2013) 13(1) *Ethnicities* 3-19.

1.7 Methodology

This thesis was informed by a feminist socio-legal methodological approach in attempting to examine the exercise of conscientious objection to abortion provision in South Africa.[121] A feminist methodology is used alongside Foucauldian theory on power and knowledge as discussed in chapter two. The study approached the issue of conscientious objection from the perspective of the traditional legal scholarship paradigm and applied feminist methodology in a number of ways. The study combined the examination of legal norms (formal, informal or background rules)[122] with lived experiences, a first-hand account of nurses. A feminist analysis as a methodological frame was employed to explore how knowledge is constituted in nursing practice in relation to conscientious objection, the multiple subjectivities of nurses and the impact of the complex environment on the mechanisms and reasons why nurses practice conscientious objection related to abortion care. [123]

The study combined doctrinal legal methods (such as reading laws and cases) with empirical work such as interviews. Primary sources including the Constitution, laws, cases, parliamentary Hansards were critically analysed. In order to understand South Africa's existing obligations, global and regional human rights instruments were gathered and studied. These data sources were primarily from the United Nations (UN), African Union (AU), European Union (EU) and foreign case law. The study also used both primary data from interview and focus group data. Primary data was generated through qualitative semi-structured interviews conducted with nurses and key informant interviews with policy makers, international Non-Governmental Organisations (NGOs), women's and human rights

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121 Methodology is defined as 'theory or analysis of how the research does or should proceed,' S Harding *Feminism and methodology* (1987) *2.*

122 Background rules pay attention to the environment and local context of the practice. These also include looking at laws, regulations and policies that govern health services or individuals but does not specifically regulate abortion. For instance, the WHO notes that abortion service delivery depends on employment policies that aims to recruit diverse health professionals including midwives, nurses and health assistant.

123 On discourse analysis, see LA Wood & RO Kroger *Doing discourse analysis: Methods for studying action in talk and text* (2000).

activists and institutions. Ethical approval for the study was obtained from the Research Ethics Committees of both the Faculty of Law, and the Faculty of Health Sciences, University of Pretoria respectively.

A broad range of secondary materials was also used extensively. These included government reports, survey and census data documents, demographic and health reports, among others, which are used throughout the study. Documents from non-state organisations were also widely used. Other secondary sources of data include scholarly works: academic books and journal articles as well as newspaper and other media materials. More details about aspects of the methods are provided in chapter three.

1.8 Thesis structure

This thesis is organised into seven chapters.

Chapter one is an introductory chapter. It gives an overview of the study, the research problem, objectives, research questions and literature review.

The second chapter of this thesis presents the theoretical and methodological considerations that have guided this study. In this chapter, I outline different feminist approaches with a focus on African feminism. I then move on to discuss the central concept of power and feminist perspectives on power and knowledge production. In the final part, I also introduce the 'Critical African Feminist Perspective' as a theoretical-methodological framework.

Chapter three, *research methods*, provides details of the method used, including data collection and analysis. Upon establishing how the study was conducted, I present the results, analysis, interpretation and discussion of the data collected in the study in the following three parts. In the final part of the chapter, I reflect on my position and discuss the implications for situated knowledge production. I also reflect on the challenges encountered during the data collection and analysis processes.

Chapter four, *scope and limitations of conscientious objection in South Africa,* describes and analyses the normative framework. It is concerned with what the law stipulates. Through a rights-based analysis, I argue that the national legal framework plays a limited role in regulating the practice of conscientious objection and does not comply with South Africa's international human rights obligations. Drawing from international human rights law and comparative law, this section further explores the approach the courts should take in developing judicial interpretations of the exercise of conscientious objection to ensure better implementation of constitutional provisions and the abortion legislation.

Chapter five, *abortion discourses and conscientious objection: an analysis of parliamentary debates on South African abortion law*, is a legislative mapping of discourses employed during debates around the Choice on Termination of Pregnancy Act leading to an absence of an explicit provision on conscientious objection. The chapter addresses the dominant political discourses during the different debates and shows how the influence of religion and moral framings underpinned the lack of textual standard on conscientious objection in the Act.

Chapter six*, nurses' performative contradiction in abortion care: The limits of abortion reform,* explores nurses' understandings and perceptions around abortion. It also examines the factors that shape nurses' motivations on conscientious objection relating to termination of pregnancy services. I identify and name three different framing discourses that pertains to how nurses make practical decisions to provide or not provide abortion services or care. After presenting these findings, I apply the conceptual and analytical framework to understand the rhetoric of theses framings and how they work as gendered discourses to reproduce gender norms.

Chapter seven, *nurses' abortion work: stories, agency and testimonies,* broadly focuses on the health system context and how nurses are located within their work environments. This chapter has two parts. In the first half of the analysis I examine

the challenges that nurses face in providing abortion services in public health facilities. In the second half of the analysis, I present two personal narratives of nurses who own their stand-alone abortion clinics in Gauteng and Limpopo provinces respectively to highlight the key emerging issues they face. Through a focus on nurses who own abortion clinics, I examine the discursive construction of nurses' abortion work. Applying the conceptual framework, I provide insights into the gendered professional practices within the private sector.

Chapter eight summarises the study. I discuss the implications of my findings and the limitation of the study. I conclude the thesis by suggesting further research agendas to extend the thematic focus and methodological insights.

CHAPTER TWO

THEORETICAL CONSIDERATIONS

The theoretical framework guiding this study is grounded in an African feminist methodology to examine how nurses understand and conceptualise conscientious objection and the lived experiences of nurses who do abortion work. Given that the issue of abortion has always been politicised,[1] this approach pays attention to gendered power relations and explores feminist perspectives on Foucault's work on power. Thus, this chapter provides an overview of the nuanced theoretical tools utilised to examine the phenomenon of conscientious objection within the South African context.

Based on the above, this chapter is organised in three sections. It begins with an overview of African feminism[2] and then explores diverse feminism theories as a crucial starting point to understanding provider's practices of power in relation to the provision of abortion services. I contend 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. The chapter then proceeds to discuss Foucauldian theory of power and feminist perspectives on power and knowledge regimes. The final section of this chapter attempts to construct the critical African feminist perspective as an analytical framework to examine the implementation of South Africa's liberal abortion law. It illustrates how African feminist methods and approaches can be useful tools in conducting abortion research in Africa.[3]

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1 F Bloomer *et al* (eds) *Reimaging global abortion politics: A social justice perspective* (2019) 1.

2 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.

3 Although where necessary, the chapter makes linkages with human rights implications of the exercise of conscientious objection, it does not deal with this in depth, as this is addressed in chapter 4: Scope and limits of conscientious objection in South Africa.

2.1 Understanding African feminism

> *Naming ourselves as feminist*[4]
>
> 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.[5]

The above passage demonstrates the naming and claiming of the space to be *feminist* and *African*.[6] While it is beyond the scope of this thesis to illustrate the theoretical debate of 'who an African is,' which is discussed elsewhere,[7] African feminists are not a homogenous identity. Due to the multiplicities and pluralities of identities, there is no one African feminism.[8] It is important to note there is no uniformity or consensus amongst African feminists with respect to the approaches that can be adopted to address gender inequality in the region. Thus, this had led to different approaches and the creation of a variety of African feminist theories.[9] However, there are shared issues across the continent given the patriarchal cultures and colonial history.

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4 Assumption should not be made that everyone cited in this section identify as feminist.

5 African Feminist Forum (AFF) 'Charter of feminist principles for African feminists' (2006) http://awdflibrary.org/bitstream/handle/123456789/119/AFF%20Feminist%20Charter%20Digital%20%E2%80%93%20English.pdf?sequence=2&isAllowed=y (accessed 5 May 2019) 3.

6 Emphasis added. As above, 5.

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

8 See S Tamale 'Exploring the contours of African sexualities: Religion, law and power' (2014) 14 *African Human Rights Law Journal* 150-177

9 See R Goredema African feminism: The African woman's struggle for identity' in J Kangira and Ph-J Salazar(eds) (2010) 1(1) *African Yearbook of Rhetoric - Gender rhetoric: North-South* 33-41.

African scholars such as Sylvia Tamale have located feminism in Africa within the broader context of realities and multiple oppression structures arising out of colonialism, slavery, racism, neo-colonialism and globalisation.[10] Due to Africa's colonial history, African feminism has tended to be post-colonial.[11] In other words, its historical base, as Gwendolyn Mikell asserts, is rooted in 'female integration within largely corporate and agrarian-based societies with strong cultural heritages that have experienced traumatic colonization by the West.'[12] African feminism did not come about primarily as a reaction to patriarchal dominance.

African feminism is defined by its problems with the ideas and notions of Western ideologies of feminism. Feminism carries different meanings for different people. It is not a homogeneous theory, practice or school of thought as evident in its pluralities, including liberal feminism, radical feminism, socialist feminism and post-structuralist feminism.[13] Liberal feminism shares similar views with traditional liberal philosophies, taking as a starting point, that freedoms are essential for both men and women.[14] Theorists such like Mary Wollstonecraft[15] and Harriet Taylor Mill[16] asserted that due to exclusion of women from decision-making in society, women's true potential was not fully realised.[17] Given that liberal feminism is premised on viewing people as autonomous being, the consequences of such, as Mary Becker explains, is that:

> Human well-being therefore should increase as individuals have more choices. Sexism operates by pressuring and requiring, sometimes by law, individuals to fulfil male and female roles regardless of their individual preferences. The solution to inequality between women and men is to offer individuals the same choices

10 S Tamale *African Sexualities: A Reader* (2011) 1.

11 Tamale (n 8 above) 10.

12 G Mikell *African Feminism: The Politics of Survival in Sub-Saharan Africa* (1997) 5.

13 These are not the only feminist school of thoughts, nor is it an indication that there is consensus amongst feminist theorists within these praxes. Rather, they serve the purpose for this study. See M Chamallas *Introduction to feminist legal theory* (2003) 18.

14 S Andermahr *et al A concise glossary of feminist theory* (1997).

15 M Wollstonecraft *A vindication of the rights of woman: With strictures on political and moral subjects* (1792).

16 HT Mill 'Enfranchisement of women' (1851*) Westminster & Foreign Quarterly Review* 295-296.

17 G Gerson 'Liberal feminism: Individuality and oppositions in Wollstonecraft and Mill' (2002) *50*(4) *Political Studies* 794–810.

> regardless of sex. The legal standard of formal equality is an expression of this solution.[18]

Liberal feminism aims to make society understand women as full human beings with the same potential as men.[19] Women's right to vote and to be voted into political office is a product of liberal feminism.[20] Liberal feminists view gender as socialised behaviour based on sex that is traced to biology.[21] This also feeds into the overall shortcomings of liberal feminism, as its sameness conceptualisation does not recognise differences, but demands for same opportunities and legal rights as men for women.

In relation to abortion, liberal feminism's push for greater access to safe abortion as a basic right is premised on claims of privacy, autonomy and individual choice as illustrated in *Roe v Wade*.[22] The argument is premised on the consideration of abortion as belonging to the private sphere and therefore becomes exclusionary from government intervention. However, the rights secured in *Roe v Wade* fell short of 'abortion on demand' as the Supreme Court held that the right to privacy prohibits state from interfering with abortion performed only in the first trimester.[23] Claiming abortion as an issue relating to women's individual autonomy does not adequately interrogate the medicalisation of the process by placing the decision in the hands of health professionals.[24] Zillah Eisenstein argues that '[women's] right to control their bodies has not been accepted as a tenet of the state.'[25] Thus, liberal feminist theory does not do much in problematising

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18 M Becker 'Patriarchy and inequality: Towards a substantive feminism' (1999) 21 *The University of Chicago Legal Forum* 32–33.

19 As above.

20 M Chamallas *Introduction to Feminist Legal Theory* (2003) 36.

21 As above, 45.

22 410 US 113 (1973). See R Nossiff 'Gendered citizenship: Women, equality, and abortion policy' (2007) 29(1) *New Political Science* 61-76.

23 R Nossiff 'Gendered citizenship: Women, equality, and abortion policy' (2007) 29(1) *New Political Science* 61-76. See also CA MacKinnon *Feminism unmodified: Discourses on life and law* (1987) 93-102.

24 R Siegel 'Reasoning from the body: A historical perspective on abortion regulation and questions of equal protection' (1992) 44 *Stanford Law Review* 261-381.

25 ZR Eisenstein *The radical future of liberal feminism* (1981) 241.

paternalistic control of women by the state, thereby masking hierarchy and perpetuating dominant patriarchal discourses and norms.[26]

Radical feminism, on the other hand, conceives the state as patriarchal, which requires that the improvement of women's lives can only be achieved with the dismantling of the structure of male domination.[27] Radical feminists claim that the patriarchal nature of the state allows for gender hierarchies to be reproduced through a variety of legal and other means that allows for male control of women in both private and public spheres.[28] Catharine MacKinnon aptly describes it:

> The state is male in the feminist sense: the law sees and treats women the way men see and treat women. The liberal state coercively and authoritatively constitutes the social order in the interest of men as a gender – through its legitimating norms, forms, relations to society, and substantive policies.[29]

Radical French feminist, Simone de Beauvoir in illustrating the stereotyping of the other argued that the othering of women by men is more poignant than stereotyping based on race and class.[30] Patriarchal societies embody power structures including institutions, belief systems, ideologies and behaviours that maintains men's control over women's power of agency over their own bodies.[31] This is also in line with African feminist viewpoint of sexuality as the central piece in the African women's oppression.[32] Since the state itself is patriarchal, radical feminists believe that the improvement of women's lives can only be achieved with the dismantling of the structure of male domination.[33] Within this theorisation, gender became decoupled from the body and it became to be viewed as a social

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26 See CA MacKinnon 'Feminism, Marxism, method and the state: Toward feminist jurisprudence' (1983) 8 *Signs* 635; MacKinnon (n 23) 36-37.

27 ZA Maharaj 'Social theory of gender' (1995) 49 *Feminist Review* 50-65;

28 CA MacKinnon *Toward a feminist theory of the state* (1989).

29 As above, 161-162. See also CA MacKinnon 'Feminism, Marxism, method and the state: An agenda for theory' (1982) *Signs* 515.

30 See S de Beauvoir *The second sex* (1949).

31 T Braam & L Hessini 'The power dynamics perpetuating unsafe abortion in Africa: A feminist perspective' (2004) 8(1) *African Journal of Reproductive Health* 45-47.

32 S Tamale 'Eroticism, sensuality and "women's secrets" among the Baganda: A critical analysis' (2005) 5 *Feminist Africa* 9-36.

33 ZA Maharaj 'Social theory of gender' (1995) 49 *Feminist Review* 50-65.

construct to subordinate women.[34] It is in this sense that radical feminism advocate for legalised abortion. Given women's subjugation is due in part to their child bearing and child rearing roles, they argue that seizing control over means of production is the means to guaranteeing liberation from the state.[35] While radical feminism provides useful insights, its approach of essentialising the state as monolithic is problematic as there is no single terrain of power.[36]

Building on Marxist theories with a focus on the economic system and arising from ideas about the systematic oppression of women, socialist feminism claims that the state functions both as an instrument of patriarchy and that of the ruling class.[37] In this sense, they recognise the oppressive structure of the capitalist society as a catalyst for women's oppression in patriarchal society. Socialist feminists working on abortion rights argue that the demand for reproductive freedom cannot be claimed in isolation but within a broader struggle for social and economic change. In this thinking, Rosalind Petchesky claims that 'women make their own reproductive choices [...] under conditions and constraints they, as mere individuals, are powerless to change'.[38] Thus, socialist feminists claim that the demand for reproductive freedom must go hand in hand with social and economic changes within capitalist societies. While apt, the limitation of socialist feminism is that it is not broad enough to encompass the many aspects of female oppression that cannot be explained within the convergence of patriarchal female oppression and the capitalist mode of production.[39]

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34 As above.

35 For example, DK Weisberg *Applications of feminist legal theory to women's lives: Sex, violence, work and reproduction* (1996).

36 LJ Rupp 'Revisiting patriarchy' (2008) 20(2) *Journal of Women's History* 136-140.

37 ZR Eisenstein 'Constructing a theory of capitalist patriarchy and socialist feminism' (1999) 25 (2-3) *Critical Sociology* 196-217.

38 R Petchesky *Abortion and woman's choice: The state, sexuality and reproductive freedom* (1990) 11.

39 B Bozzoli 'Marxism, feminism and South African studies' (1983) 9(2) *Journal of Southern African Studies* 139-171.

For post-structuralist feminism, the state is not taken as a monolithic entity but rather, as composed of gendered structures.[40] For socialist feminists, gender became viewed through the lens of determining the process through which it is constituted based on the ideologies of capitalism and patriarchy. Post-structural feminists drawing inspiration from Foucault's work on power, engaged in analysing gender as part of a discourse, based on social orders.[41] For example, post-structural feminist Judith Butler interrogated the belief that gender behaviour and sexuality are natural, arguing that patriarchal societies are heteronormative by requiring men and women to perform gender.[42] From her observation, Butler posits that gender is not what we are but what we do through performativity. It is a spectrum, which exposes the fictitious character of hegemonic concepts of gender and sexuality entrenched in law or culture.[43]

As illustrated above, the taxonomies of feminist theories while different do have overlaps, which need to be acknowledged. However, these categories do not have universal usage. A major criticism of these strands of feminisms is their premise of the 'universalised women,' rooted in its focus on white women, which is detrimental to other classes of women.[44] Black feminist scholars argued that feminist theory was exclusionary as it marginalised women of colour and centred the experiences of white women.[45] This has had significant consequences including the development of black feminism or 'third wave feminism.'[46] In this sense, African-American writer and feminist Audre Lorde expresses:

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40 G Waylen 'Gender, feminism and the state: An overview' in V Randall & G Waylen (eds) *Gender politics and the state* 1-17.

41 See R Petchesky 'Reproductive freedom: Beyond "a woman's' right to choose"' (1980) 5(4) *Signs* 661–685; L Gordon *Woman's body, woman's right: A social history of birth control in America* (1976).

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

43 As above.

44 Chamallas (n 20) 19; See also KT Bartlett 'Gender law' (1994) 1 *Duke Journal of Gender, Law and Policy* 1-20.

45 B Hooks *Ain't I a woman: Black women and feminism* (1981); A Lorde *Sister outside: Essays and speeches* (1984).

46 Third-wave feminist theories includes womanism, coloured women consciousness, post-colonial theory, critical theory, transnationalism, ecofeminism and queer theory.

> [B]y and large, within the women's movement today, white women focus upon their oppression as women and ignore differences of race, sexual preference, class and age. There is a pretence to homogeneity of experiences covered by the word sisterhood that does not in fact exist. [47]

Like Lorde, another African-American feminist, Bell Hooks stresses that even that all women suffer in some way, they are not all oppress or equally oppressed.[48] The discontent with these strands of feminism is reflective of African perspectives, which claims Eurocentric bias that treats all women as a homogenous group.[49] For instance, Ifi Amadiume, among others, cautions against using universalistic tendencies grounded in Western feminism, based on differences between African and European gender systems.[50] Pumila Gqola makes a similar argument by pointing out the problematic concept of the Western-centric lens of the 'universalised woman,' which is not responsive to the range of women's experiences.[51] This criticism stems from Western feminists' focus on the white-western-middle-class subject reinforcing the same biases inherent in 'masculinist philosophy.'[52] Chandra Mohanty situates this problem as one wherein western women place themselves as the 'primary referent,' serving as a benchmark to measure deviation from.[53] 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.[54]

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47 Lorde (n 45) 116.

48 As above, 57.

49 See B Guy-Sheftall 'African Feminist discourse: A review essay' (2003) 58 *Agenda: Empowering Women for Gender Equity* 31-36.

50 I Amadiume *Reinventing Africa: Matriarchy, religion and culture* (1997).

51 P Gqola 'Ufanele uqavile: Blackwomen, feminisms and postcoloniality in Africa' (2001) 16 (50) *Agenda* 17.; See also b hooks *Feminist theory* (1984) 15.

52 See R Hunter 'Deconstructing the subjects of feminism: The essentialist debate in feminist theory and practice' (1996) 6 *Australian Feminist Law Journal* 135- 162. See also D Lewis 'Feminism and the radical Imagination' (2007) 21 (72) *Agenda: Empowering Women for Gender Equity* 18.

53 CT Mohanty 'Under Western eyes: Feminist scholarship and colonial discourses' (1986) 30 *Feminist Review* 61-62.

54 As above.

Thus, current expressions of African feminism have been said to be pre-occupied with visualising the realities of African women. Therefore, in response to Western-based feminism, the pioneering works of theorists such as Filomina Steady,[55] Oyeronke Oyewumi,[56] Ifi Amadiume[57] and Akina Mama[58] led to the articulation of African feminist theory.[59] This theory is conceptualised as an approach that is characterised by resistance to Western conceptualistaion of feminism. As Obioma Nnaemeka succinctly writes, '[African feminism] *is* because it *resists*.'[60] In this regard, Susan Ardnt argues that the context of African societies necessitates 'African feminism,' which critically examines African gender relations and problems that African women face.[61] Ama Ata Aidoo echoes this when she notes the following:

> Africans should take charge of African land, African wealth, African lives, and the burden of African development. It is not possible to advocate for independence for the African continent without also believing that African women must have the best that the environment can offer. For some of us that is the crucial element of our feminism.[62]

Indeed, it is precisely on this account that African feminism, while acknowledging its linkages with international feminism, pays particular attention to needs that affected women in Africa.[63] Filomena Steady sees African feminism as a humanistic one because of its emphasis on the totality of human experience and not just oppression based on race or class.[64] This attempt at differentiation from both

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55 See FC Steady 'African Feminism: A Worldwide Perspective' in R Terborg-Penn & A Benton (eds) *Women in Africa and the African Diaspora: A Reader (*1996).

56 O Oyewumi *African women and feminism: Reflecting on the Politics of Sisterhood* (2003).

57 See I Amadiume *Male Daughter, Female Husbands: Gender and sex in African Society* (1987).

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

59 O Mangena 'Feminism (Singular), African feminisms (Plural) and the African diaspora' (2003) 58 *Agenda: Empowering Women for Gender Equity* 100.

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

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

62 AA Aidoo 'African Women Today' in O Nnemeka (ed) *Sisterhood, feminisms & power: From Africa to the Diaspora* (1998) 47.

63 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.

64 Steady (n 55) 4.

Western and African-American feminisms have led to one of the well-known variation of African alternatives: *African womanism* different from Alice Walker's *womanism*.[65] In her conceptualisation of the term, Chikwenye Okonjo Ogunyemi[66] argues that this is necessary because both Western and African-American feminisms 'overlook African peculiarities.'[67]

The tension between African feminism and western feminism is also encompassed in the issue of cultural relativism, which is evident in the Female Genital Mutilation (FGM) debate, wherein western feminists argue that FGM is a violation of women's human rights. While African feminists agree on this, they criticise framings that depict the practice as barbaric and backward.[68]

Moreover, while western-based feminism distanced itself from domesticity on the basis of women's relegation to the private sphere, African women feminists celebrate their ability to be part of both the public and private domain.[69] This might also point to the other major critique of western feminism; its major preoccupation of gender as the defining factor of women's roles and functions.[70] The argument is that western-based feminism is grounded on a categorical binary between male and female that is not truly reflective of the African perspective.[71] In *Male Daughter, Female Husbands: Gender and Sex in African Society*, Amadiume's examination of the flexible gender system of the Nnobi Igbo in Nigeria illustrates that the concept of 'gender' does not necessarily inform social categories.[72] But, the claims of difference in positioning that Western feminism is entirely gender-centred is not

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65 Emphasis added. See CO Ogunyemi 'Womanism: The dynamics of the contemporary black female novel in English' (1985) 11(1) *Signs: Journal of Women in Culture & Society* 63-80.

66 A Walker *In search of our mother's gardens: Womanist* (1983).

67 CO Ogunyemi *Africa wo/man palava. The Nigerian novel by women* (1996) 114.

68 L Ouzgane & R Morrell (eds) *African masculinities: Men in Africa from the late Nineteenth century to the present* (2005).

69 S Tamale 'Gender trauma in Africa: Enhancing women's links to resources' (2004) 48 *Journal of African Law* 50-61.

70 Oyewumi (n 56) 2.

71 For example, P Gqola 'Ufanele uqavile: Blackwomen, feminisms and postcoloniality in Africa' (2001) 16(50) *Agenda* 11-22;

72 Amadiume (n 57).

totally merited. For instance, Marxist feminism's claim that the patriarchal nature of the state allows for gender hierarchies to be reproduced through a variety of legal and other means, makes assumptions about other categories such as class.[73] Moreover, African-American alternative conceptualisations of feminism also pays attention to the race-class-gender approach.[74]

The point of departure for African feminism is that while there is no uniform position, it lends itself to theorising of relationships in more complex ways, characterised within the context of colonialism, post-colonialism, imperialism and social-economic exclusion.[75] Indeed, as Patricia McFadden points out, 'the manner through which African and white men colluded to keep African women outside the emerging urban spaces of the colonial town and city' illustrates gendered exclusion and 'othering' of African women.[76]

Furthermore, to ensure that the specificity of African feminism does not result in a separatist movement and theorisation that is not useful to advance better conditions for women, there have been conversations around the utility of broadening of the horizon to include individuals (male or female, whether born in Africa, of African descent living in the diaspora), or groups and organisations based in Africa.[77]

2.3.1 Contributions and gaps

Whilst African feminist theory is an apt theoretical paradigm for this study, a general concern is its lack of engagement with abortion. During the past few decades, a rights-based approach to sexual and reproductive health has evolved,

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73 MacKinnon (n 26) 639.

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

75 Ardnt (n 61) 32.

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

77 See for example, M Chiweshe 'African men and feminism: Reflections on using African feminism in research' (2018) 32(2) *Agenda* 76-82.

which recognises reproductive freedom as a key element of women's human rights.[78] The rights-based approach guarantees that individuals have the right to the highest attainable standard of health, including the right to life, survival, the right to control sexual and reproductive life, and the right to take reproductive decisions.[79] Since the 1990s, sexual and reproductive health and rights has been recognised as key part of the international health and development agenda. In 1994, the International Conference on Population and Development (ICPD) brought attention to women's sexual and reproductive health.[80] In addition, during the Fourth World Conference on Women in 1995, notable African feminists were involved in leading efforts to reaffirm reproductive autonomy.[81] The Beijing Platform for Action further provided a 'holistic view of health and the social, political and economic factors affecting health.'[82] These two agreements have contributed immensely to the entrenchment of women's reproductive rights are human rights.[83] African momentum around women's reproductive health also continues to expand.[84]

At the African Union (AU), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)[85] was adopted

78 M Eriksson, *Reproductive Freedom: In the context of international human rights and humanitarian law* (2000) 10 as cited 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, at 1 (on file with the author).

79 R Thomas et al 'Assessing the impact of a human rights-based approach across a spectrum of change for women's, children's and adolescents' health' (2015) 17(2) *Health and Human Rights Journal* 13.

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

81 United Nations (UN) 'Report of the Fourth World Conference on Women, A/CONF.177/20 (1995).

82 Tamale (n 10) 315.

83 C Zampas & J Gher 'Abortion as human right- International and regional standards' (2008) 8 *Human Rights Law Review* 252.

84 See C Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) *32 Human Rights Quarterly* 783-864.

85 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.

in 2003 and its subsequent General Comment No 2 on reproductive health rights in 2014.[86]

It is then surprising that African feminists have not produced much scholarly work on the abortion debate. It is important to note that while African feminists have made inroads in developing African feminist theories and addressing issues of discrimination against and oppression of women within the African context, there is a general lack of scholarly engagement. The issue of conscientious objection has been marginalised from mainstream debate. Western scholars continue to produce the bulk of studies conducted in this area, with exception of growing publication emerging from South Africa.

Kriemild Saunders aptly observes that feminists in developing countries including in Africa are more concerned with pressing issues of poverty and other harsh conditions including conflicts, which is different from their Western counterparts

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[86] African Commission on Human and Peoples' Rights 'General Comment No.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). Art. 14 of the Maputo Protocol states that:

> *1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:*
>
> *a) the right to control their fertility;*
> *b) the right to decide whether to have children, the number of children and the spacing of children;*
> *c) the right to choose any method of contraception;*
> *d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;*
> *e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices; g) the right to have family planning education.*
>
> *2. States Parties shall take all appropriate measures to:*
>
> *a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;*
> *b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;*
> *c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.*

who centre gender equality.[87] Despite the close link between poverty and lack of access to abortion, this might partly explain the dearth of research and academic work on abortion in African feminism scholarship. African feminists continue to insist that the realities of African women are animated with 'bread, butter, culture, and power issues.'[88] For example, in her book that exemplifies some of these issues, Senegalese novelist Mariama Ba provides a sweeping criticism of gender relationships in Senegalese societies.[89] In examining gender relationships, she highlights that in addition to men, women also should be held responsible for discriminating against other women through their usage of power offered by social hierarchies.[90] This line of thinking is particularly useful for this study, which examines the practice of conscientious objection to abortion as a representation of power relations and a site for contestation.

Second, Rachel Rebouché's description of the conflicting messages about women's roles that is exemplified in health and reproductive rights provided under article 14 of the Maputo Protocol might provide insights into such silences about abortion.[91] There continue 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.[92] African feminists' acknowledgment and embracement of the role of motherhood is in conflict with women's rights to autonomy.[93] This double-edged sword might perhaps explain their focus on the role

87 See K Saunders *Feminist post-development thought: Rethinking modernity, post-colonialism and representation* (2002).

88 G Mikell *African Feminism: The politics of survival in Sub-Saharan Africa* (1997) 4.

89 M Ba *So long a Letter* (1980).

90 As above.

91 R Rebouche 'Health and reproductive rights in the Protocol to the African Charter: Competing influenced and unsettling questions' (2009) 16 (79) *Washington and Lee Journal of Civil Rights and Social Justice* 104 & 108. On the drafting history of the Protocol see 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, at 10-12 (on file with the author).

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

93 S Tamale 'The right to culture and the culture of rights: A critical perspective on women's sexual rights in Africa' (2008) 16 *Feminist Legal Studies* 47-69.

of women in shaping and maintaining traditional societies coupled with the cult of domesticity.[94]

Finally, given the differences in the status of laws in African countries, there is under-theorisation of the concept of conscientious objection due in part to the fact that most African countries still have restrictive abortion laws.[95] Thus, it can be argued that feminists are busy with other practical questions and campaigning in abortion reform and ensuring greater access to abortion services for women. By engaging with the practice of conscientious objection from an African feminist lens, this study contributes to the scholarship on African feminist discourses on abortion and interpretation of African women's resistance, while drawing experience from other feminists' approaches. The premise of such an approach is to utilise relevant 'transcultural knowledge,' while optimising the African gaze through non-enforcement of hegemonic and universalising knowledge emerging from a 'Eurocentric canon.'[96]

Notably, this theoretical perspective is also useful to understanding the manifestation of micro-practices of power exercised by nurses as frontline providers, which draws on Foucault' work on power.

2.2 The concept of power: The Foucauldian background

The term power means different things to different people. Drawing from political theory, including both liberalism and Marxism, power is deemed to be connected to authority, domination or exploitation through the *"power as domination"* paradigm.[97] The state is conceived to exercise legitimate power over its subjects to ensure a stable state anchored on sovereignty. However, more importantly for this discussion, power is more than just state power, which is based on recent

94 See RJ Lesthaegh *Reproduction and social organization in sub-Saharan Africa* (1989); Amadiume. (n 47).

95 Center for Reproductive Rights (CRR) 'The world's abortion laws' https://reproductiverights.org/worldabortionlaws (accessed 15 August 2019).

96 Ngwena (n 7) 216-222.

97 B Hindess *Discourses of power: From Hobbes to Foucault* (1996).

conceptions of the notion of power as derived from Foucault's writings.[98] Foucault developed his thought in dialogue with Marxism but goes beyond it. From a Marxist perspective, no matter how complex or pluralist a state, power has a 'centre.' This implies that the exercise of power in society is the exercise of power of one class (the economically dominant) over another.[99] The doctrinal undermining of this superstructure (law, culture, morality, religion) mirrors and facilitate interests of those that hold power.[100] Marx in his seminal work, *the Communist Manifesto,* writes, 'the history of all hitherto existing society is the history of class struggles.'[101] For Marx, power cannot be legitimately exercised unless the working class, who form the majority, gain substantial control over means of production.[102]

Marxists also claim that power can be exercised through ideological means. Ideology is used to describe the systems of ideas that mirrors the interest of the economic ruling class. Marx puts it aptly, 'it is not the consciousness of men that determine their existence, but on the contrary their social existence that determines their consciousness.'[103] Through the notion of *reification*,[104] social relations come to be identified with the physical properties of things thereby appearing to acquire the appearance of naturalness and inevitability. Here, Marx claims, 'the ruling ideas of each age have ever been the ideas of its ruling class.'[105] Thus, the dialectical relationship between the base and the superstructure addresses the complex nature of class, power and hegemony.

The concept of hegemony or ideological domination, which illustrates how system of powers are constructed through knowledge was distinctively developed by the Italian-born political theorist, Antonia Gramsci.[106] Gramsci proposed that a socialist

98 M Foucault *The Archaeology of knowledge* trans AMS Smith (1969).
99 K Marx *Capital: A critique of political economy: Vol. 1* trans B Fowkes (1977) 712-713.
100 As above, 165-167
101 J Isaac (ed) Karl *Marx & Freidrich Engels*: *The communist manifesto* 1848 (2012) 74.
102 P Wetherly *Marxism and the state: An analytical approach* (2005).
103 K Marx 'A Contribution to the Critique of Political Economy' (1859) 3.
104 Emphasis added.
105 Marx (n 103) 90.
106 A Gramsci *Further selections from prison notebooks* (1971) trans Q Hoare & GN Smith (1995).

conception of domination under capitalism[107] was achieved through hegemony of ideas of the ruling class.[108] In illustrating the force of ideology serving the needs of the dominant classes, he asserted that subordinate groups do not have a consciousness to come to the realisation that their perception of the world is largely due to a number of factors including family, religion and society. [109] Given that hegemonic power is derived from ideas, knowledge then becomes power and consequently, knowledge penned by the person with the greatest power persuades individuals to 'subscribe to the social values, and norms of an inherently exploitative system.'[110] Through the usage of hegemonic power, individuals and social classes are convinced to ascribe to 'common sense,' which relies on volunteerism, rather than fear of paying for the consequences of disobeying such law.[111] This subscription is inherited and seen as acceptable, thereby producing docility and impassiveness.[112]

Foucault pointed out the binary opposition of ideology (such as the ruler and the rule); the lack of examination of the ideas of the dominant class due to its abstract nature; and blindness to discourses of disciplinary institutions and their effects on practice when critiquing the utility of ideology.[113] As a result of his reservations of ideology, Foucault provides an alternative account of power. That is, power is not something that is acquired, but exercised.[114] With a focus on the examination of how people subject themselves and others through systems and practices, he attempted

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107 Capitalism generally refers to an economic system where the factors of production (land, raw materials, labour, capital, technology) are privately owned.

108 C Mouffe 'Hegemony and ideology' in C Mouffe (ed) *Gramsci and Marxism* (1979) 169-170.

109 GA Williams 'The concept of 'Egemonia' in the thought of Antonio Gramsci: Some notes on Interpretation' (1960) 21(4) *Journal of the History of Ideas* 587.

110 M Stoddart 'Ideology, hegemony, discourse: A critical review of theories of knowledge and power' (2007) 28 *Social Thought and Research* 191-225 as cited in S Tamale 'Exploring the contours of African sexualities: Religion, law and power' (2014) 14 *African Human Rights Law Journal* 150, 155.

111 A Gramsci *Prison notebooks: Vol 1* trans JA Buttigieg (1992) 137.

112 As above. 333.

113 M Foucault *Power/ knowledge: Selected interviews and other writings 1972-1977* trans C Gordon (1980) 118.

114 M Foucault *The history of sexuality, Vol 2* trans R Hurley (1988) (originally published in 1976) 94.

to clarify the link between societal values, norms and relation of power through the analysis of systems of knowledge.[115] Thus, drawing a significant link between power relations and construction of truths that are transmitted through multiple sites and not in one direction.[116]

Foucault opines that power should not be simply viewed as oppressive, but also as productive. In other words, power evolves over time and manifests in discourses, knowledge and regimes of truth that are socially constructed.[117] Power is exercised through discourse categorise into 'normal' and 'abnormal', 'acceptable' and 'unacceptable.' He further maintains that power is more than just how knowledge is constituted, but also comprise of discourse.[118] In a similar vein, discourse is where power and knowledge combine.[119] The concepts of power and knowledge are not oppositional or in isolation, and although distinct they directly implicate one another.[120] Foucault contends that 'there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations'.[121] Relations of power thus constitute interwoven actions.[122] On expanding discourse, he noted that discourses can be conceived both as an instrument of power as well as an outlet for resistance.[123]

It would appear that in a Foucauldian sense, people participate in discourses that are not characteristically fully theirs.[124] Through a discursive constitution, they are 'subject to' and 'subject of' (or ways of being and understanding oneself and

115 Foucault (n 98).
116 J Rouse 'Power/knowledge' in G Gutting *The Cambridge companion to Foucault* (1994) 102.
117 As above.
118 R Pringle & S Watson 'Women's interest and the post-structuralist state' in M Barrett & A Phillips (eds) *Destabilizing theory: Contemporary Feminist debates* (1992) 65.
119 Foucault (n 114).100.
120 See S Hall *et al* (eds) *Representation* (2013).
121 M Foucault *Discipline and punish: the birth of a prison* trans AM Sheridan Smith (1977) 27.
122 HL Dreyfus & P Rabinow (eds) *Michel Foucault: Beyond structuralism and hermeneutics* (1982) 220.
123 As above, 100-102.
124 Butler (n 42).

others).[125] This encompasses a broad range of rules or regulations, methods of surveillance, processes, goals, normalisation and hierarchies.[126] To that extent, individuals use normalising techniques when they compare themselves and others to an ideal standard that must be adhered to and deemed as *normal or the ideal* to which subjects aspire to. This process enables the sanctioning and punishment of subjects who do not conform to the norm. Through discourse, the behaviour or activity is constructed and presented as one that majority of the population are engaged in. These techniques ensure that human groups are ordered accordingly while enhancing 'discipline' in people. For instance, culture, traditions and value-systems are used to exert control over women's bodies. These discourses further shape women's identity on what it means to be a woman to the point where women would behave according to these acceptable truths.

Hierarchical organisation of bureaucracy and surveillance occurs where people are constantly monitored to perform in a 'normal manner.'[127] For instance, during consultation between a health professional and a woman requesting an abortion, information obtained makes subjects 'knowable' wherein they become differentiated and categorised. The positioning and differentiation of women seeking abortion services based on justified or unjustified reasons; good or bad abortion, is a theme examined in chapter six.[128] The different positioning and monitoring by nurses have implicit implications for the woman seeking abortion services. This speaks to Sally Sheldon's assertion of 'paternalistic control,'[129] which may result in either influencing the woman not to end a pregnancy, or in the case of an objector, refusing to give details on alternative facilities that offer abortion services. This is a clear illustration of knowledge production and construction of identity as a way in which people discipline or govern others. Foucault believes that:

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125 Foucault (n 114).

126 As above.

127 Foucault (n 121) 27.

128 *Infra* chapter six: nurses' performative contradiction in abortion care: The limits of abortion reform.

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

> The discourse of discipline has nothing in common with that of law, rule, or sovereign will. The disciplines may well be the carriers of a discourse that speaks of a rule, but this rule is not the juridical rule deriving from sovereignty, but a natural rule, a norm. The code they come to define is not that of law but that of normalization. [130]

Foucault equates the use of surveillance to the use of power to rule individuals in a continuous and permanent way.[131] Constant surveillance is manifested in 'panopticism,' meaning 'all-seeing'.[132] Foucault discusses the use of the 'panopticon,' a 'surveillance' tool was created by Jeremy Bentham, the utilitarian theorist, to observe and keep an eye on prisoners.[133] The panopticon is mounted as a structural tower from which guards can see the prisoners below. Foucault uses the analogy of a modern prison to explain that 'the codified power to punish becomes the disciplinary power to observe.'[134] The underlying premise is that when one believes that they are being watched, they become submissive. An environment is created in which people perpetually feel exposed and thus, subscribe to self-surveillance. Foucault's analysis is quite instructive for understanding oppression of women, and in this case, how nurses who are mostly women can be a vehicle of oppression. Thus, power becomes something that is internalised by nurses who become compliant in producing societal norms.

Moral judgment, exclusion, discrimination and stigma are all forms of disciplinary strategies that are meted on women who seek abortion and those who provide abortion. Women seeking abortion are seen to be straying from norms that places a premium on of women's biological function of motherhood. This is because as Martha Nussbaum noted, women have largely been appreciated based on their reproductive roles rather than on the exercise of their agency.[135]

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130 M Foucault *Power: The essentials works of Foucault 1954-1984* in J Faubian (ed) (1994) 44.
131 Foucault (n 113) 106.
132 As above.
133 See J Bentham & M Božovič (ed) *The panopticon writings* (1995).
134 Foucault (n 121).
135 M Nussbaum *Sex and social justice* (1999) 63.

Martha Fineman and others further claim that, 'women will be treated as mothers (or potential mothers)' because 'social construction and its legal ramifications operate independent of individual choice.'[136] As these are deeply embedded traditions, nurses who perform abortion procedures are deemed to go against social norms and thus become labelled as 'enemies.'[137] Both Butler and Foucault helps our understanding of stigma as a tool of social relations reproduction that is premised upon distinction between what is 'normal' or deviant' through discourse. Negative attributes are not only ascribed to women seeking abortion, but also to nurses who provide abortion services and are thereby stigmatised.[138] Relatedly, stigma is conceptualised as actions experience by nurse providers that show biases against them, one path being through framing discourses. This thesis explores how nurses who are subjected to stigmatisation based on their professional identities are able to re-construct these into positive ones.[139] These discursive constructions of abortion providers are discussed in chapter seven.[140]

Furthermore, the study's attempt in illustrating how individuals (nurses) can be implicated in normalising structures (hospital) through the discursive constructions of women seeking abortion (as discussed in chapter five) speaks to Foucault's concept of governmentality.[141] In his definition of the concept, he notes that:

> The art of government … is essentially concerned with answering question of how to introduce economy — that is to say, the correct manner of managing individuals, goods and wealth within the family (which a good father is expected to do in

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136 MA Fineman *et al* (eds) *The neutered mother, the sexual family and other twentieth century tragedies* (1995) 51.

137 E Goffman *Stigma: the management of spoiled identity* (1963) 11. See A Kumar et al. 'Conceptualising abortion stigma' (2009) 11(6) *Culture, health and sexuality* 625-629.

138 See RJ Cook & BM Dickens 'Reducing stigma in reproductive health' (2014) 125 *International Journal of Gynecology and Obstetrics* 89–92; LA Martin *et al* 'Abortion providers, stigma and professional quality of life' (2014) 90(6) *Contraception* 581-587; LA Martin *et al* 'Measuring stigma among abortion providers: Assessing the abortion provide stigma survey instrument' (2014) 57(7) *Women Health* 641-661.

139 See R Parker & P Aggleton 'HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action' (2003) 57 *Social Science and Medicine* 13-24.

140 I*nfra* chapter seven: *nurses' abortion work: stories, agency and testimonies*

141 G Burcell *et al* (eds) *The Foucault effect: Studies in governmentality* (1991).

> relation to his wife, children, and servants) and making of the family fortune prosper- how to introduce this meticulous attention of the father towards his family into the management of the state. [142]

Governmentality's approach of power not only includes state-like institutions' exercise of power through policies and other regulatory frameworks, but also self-governance. This extends his work on the analysis of how power operates at multiple levels. Here, the tactics of governmentality aims to keep women domesticated even when they do not want to exercise their reproductive right as the law provides a framework to facilitate it. This sanctioning is grounded in gendered understandings of women ensuring that they accept their reproductive role if pregnancy occurs.[143]

It is argued that prior criminalisation of abortion in South Africa has created discourses and knowledge on gender and gender roles that people live by even in an environment of legalisation. Tamale contends that '[t]he law is an important instrument in shaping and scripting our gendered bodies. Society — reads women's bodies along the landmarks forged by the law'[144] In Catharine Mackinnon's view, 'gender is a question of hierarchy. The top and the bottom of the hierarchy are different, all right, but that is hardly all'.[145] That is, as abortion remains a continuous struggle among competing interests, the issue at stake is about 'power over the lives of [women].'[146] Thus, nurses find themselves in two competing positions. On the one hand, objecting or non-supporting nurses reinforce society's disciplinary actions within institutional organisations over nurse providers. On the other hand, guaranteeing women the right to have control over their biology becomes political action and a resistance strategy for nurse providers. Notably, we see that the enactment and organisation of power in nurses' provision of abortion services is

142 As above, 92.
143 Chiweshe (n 77) 79.
144 S Tamale 'Nudity, protest and the law in Uganda' Inaugural professorial lecture, Kampala: Makerere University (2016) 31.
145 Mackinnon (n 20) 635.
146 M Vatter 'Biopolitics: from surplus value to surplus life' (2009) 12 (2) *Theory Event* 1.

intricately interwoven with more general social and institutional forms of control. The implications of this is further explored in chapter 7.

2.2.1 Feminism's critique of Foucault

Despite the relevance of the Foucault's work on power, which gives feminist theorists a theoretical framework that aids in understanding the body as a site of political struggle, feminists have taken an issue with his neglect of gender. This negligence, they claim, results to making the female subject invisible as well as invisualising the location of women and the subjective experience arising out of that location.[147] Monique Deveaux notes that despite the value of Foucault's writings on power, his conceptualisation erases or obscures women's specific experiences of power.[148] Nancy Hartsock also argues that Foucault's theory of power was not designed for women because of the erasure of 'unequal power relations.'[149] She contended that this was mainly due to his positionality as a privileged white male, thereby arguing for the need of a feminist standpoint method.[150] Despite the shortcomings of gender blindness in Foucault's work, feminist have used his conceptualisation to stimulate feminist research such as Susan Bordo's work on female anorexia, which she considered as the crystallisation of cultural imperatives and practices of power.[151] Additionally, Sandra Lee Bartky highlights active dimension of female subjection by examining aesthetic practices as disciplinary tools.[152]

The second criticism against Foucault is his lack of an explicit normative foundation, prompting Nancy Frazer to label him as an 'antihumanist thinker,' arguing that his

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147 See EA Buker 'Hidden desires and missing persons: A feminist deconstruction of Foucault' (1990) 43(4) *The Western Political Quarterly* 811: See Butler (n 42).

148 See M Deveaux 'Feminism and empowerment: A critical reading of Foucault' (1994) 20 (2) *Feminist Studies* 223-247

149 N Hartsock 'Foucault on power: A theory for women?' in L Nicholson (ed) *Feminism/Postmodernism* (1990) 168.

150 As above, 164.

151 S Bordo 'Anorexia nervosa: Psychopathology as the crystallization of culture' in I Diamond & L Quinby (eds) *Feminism and Foucault* (1988) 87-118.

152 SL Bartky 'Foucault, feministy and the modernization of patriarchal power' in in I Diamond & L Quinby (eds) *Feminism and Foucault* (1988) 61-86.

refusal to engage in normative discussions led to the erasure of the difference between internalised domination and autonomy.[153] While it is possible to read in normativity in Foucault's work, Hartsock suggests that feminism needs to 'develop an account of the world which treats our perspectives not as subjugated or disruptive knowledge, but as primary and constitutive of a different world.'[154]

Limitations in Foucault's analysis regarding his orientation towards non-gendered formulations has also led to questions around sexuality and desire in the feminine form. According to Judith Butler, Foucault's constructivism of sex and his claim that regulation and control operate through discursive articulation of identities is problematic, as there are other alternative means through which the feminine can be excluded and erased.[155] However, in engaging with Foucault, she also suggests that it is possible to construct feminist politics without a feminist subject, which has an essentialist identity.[156] In Carol Smart's view 'what feminists have added to Foucault's work is the recognition of the gendered nature of patterns of [power] that are formed.'[157] These observations provide a good ground to argue that while Foucault's work on power has implications for this study, its shortcomings including an absence of a gender lens provides a basis to extend his work through feminist theories.

This study acknowledges that power relations play a critical role in deciding position and location of nurses, who are mostly women, and the subjective experiences arising out of that location. More importantly for this study, it is contended that Foucault's assertion of power is deemed too limiting as it depicts that because power is infused everywhere, it cannot be resisted. As this study illustrates, while women including nurses may act in collusion with patriarchal power because they are constituted in discourses that are complicated making it

153 N Fraser *Unruly practices: Power, discourse and gender in contemporary social theory* (1989) 49.
154 Hartsock (n 149).
155 J Butler 'Sexual inversions' in SJ Hekman (ed) *Feminist interpretations of Michel Foucault* (1996) 68.
156 Butler (n 42) 142.
157 C Smart *Law, crime and sexuality: Essays in feminism* (1995) 7-8.

difficult to escape indoctrination, on the other hand, nurse providers show resistance through their abortion work.

Thus, Foucault's work provides the study with a strategic framework for understanding power, knowledge and how it relates to power relations and discursive formulations. It serves as instructive resource for the study's focus on power dynamics and construction of the critical African perspective.

2.3 Constructing a 'critical African feminist perspective' analytical framework

The above discussion demonstrates the importance of going beyond Foucault whose work invisibilises gender. I proposed and utilised the construction of a critical African feminist perspective framework, incorporate aspects of African feminism and draws inspiration from the other strands of feminism for the purpose of this study.[158] As highlighted above, feminism constitute a multiplicity of theoretical positionings and ideologies that complement and contradict each other. However, despite the different approaches in understanding and addressing inequalities, they have one thing in common; to challenge inequalities within gendered societies. The variety of multidisciplinary methodological and theoretical repository provides a tool kit, to borrow from Sara Ahmed's formulation.[159] These are the starting points for this research work, which is closely related to standpoint epistemology and knowledge production in feminist discourse.[160]

There are seemingly two contradictory positions in relation to women and their positions in society. The first and probably more researched view, is that women themselves use existing mechanisms and ideologies that are premised on gender-based prejudices. Thus, reinforcing 'natural' assumptions about women's reproductive role and women as child-bearers. Rather than just focusing on women's role in subjugating other women, there is also the view that women are

158 B Davies & S Gannon 'Feminism/poststructuralism' in B Someth & C Lewin (eds) *Research methods in the social sciences 318-323.*

159 S Ahmed *Living a feminist life* (2017) 16

160 Barlett (n 20) 872.

able to articulate their viewpoints and assert a degree of autonomy. At a practical level, my constructed analytical framework provides the lens to examine nurses' abortion work and the exercise of conscientious objection as a gendered practice involving power relations. This study demonstrates that there exist examples of both these perspectives within the context of abortion provision. Even where nurses exercise power, it is gendered as their exercise of power is not the same as that of men. Therefore, working from a politics of difference and resistance, this study extends African feminist theory to centre the experiences of nurses both as abortion providers and non-providers or objecting nurses.

In examining how and why nurses make decisions on whether to provide or not provide abortion services, this analytical tool accounts for the discourses and practices that nurses draw on when women come to seek abortion services. Through discourse, which constructs and regulates subjects, a norm is created wherein a behaviour or activity is presented in a way that illustrates the engagement of majority of the population.[161] For example, the interaction between the nurse and woman seeking abortion might contain disciplinary technology. Choices maybe offered to the woman, however, because this is done within discourses, the nurse may convey either right or wrong choices premised on a particular discursive regime.[162]

In addition, through a critical African feminist lens, the study is able to capture narrated accounts of not only oppression, but that of resistance as illustrated in chapter 7. This tries to address the criticism on intersectionality analysis levered by Evelien Geerts and Iris van der Tuin, who argue that there is a 'lack a profound analysis of power and its affected subjects' due to the viewing of power only as

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161 C Macleod & K Durrheim 'Foucauldian feminism: The implications for governmentality' (2002) 32(1) *Journal for the Theory of Social Behaviour* 41-60.

162 *Infra* chapter 6: *Nurses' performative contradiction in abortion care: The limits of abortion reform.*

oppressive.[163] The use of this lens enables the use of Foucauldian conceptualisation of power, by paying attention not only to the ways in which nurses are positioned (and position themselves) as subjects who reinforce dominant discourses, but also nurses who claim their spaces as abortion providers thereby asserting resistance. Using various discursive strategies, this approach looks at the complex relationship between gendered norms, gendered practices and gendered ideals. This means that the study takes account of the messiness of nurses' everyday lives and relates that experience to theory.[164]

To borrow from Joan Williams, this study employs 'the model of lawyer as persuader in the realm of social discourse and focuses on how to reframe existing rhetoric to achieve feminist goals.'[165] Through this framework, I asked critical questions about power, knowledge, gender and laws on abortion and conscientious objection. The application of this lens is also aimed at deconstructing essentialism and recognising multiple identities.[166] In line with the goals of this study, the critical African feminist perspective is anti-essentialist, because it does not assume that all nurses are the same. As illustrated in chapters five and six, nurses' lived experiences and their structural contexts are multidimensional. Slyvanna Falcón on the concept of intersectionality having a transnational salience makes the point that 'an awareness of social local and power relationships must be incorporated into its application so that multiple understandings of intersectionality can meaningfully coexist.'[167] In this sense, the critical African feminist perspective is intersectional and serves as a practical model for paying attention to various intersecting

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163 E Geerts & I van der Tuin 'From intersectionality to interference: Feminist onto-epistemological reflections on the politics of representation' (2013) 41 *Women's Studies International Forum* 17.

164 MacKinnon (n 29) 543.

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

166 On the importance of such an approach, see KT Barlett 'Feminist legal methods' (1990) 103 *Harvard Law Review* 829.

167 SM Falcón *Power interrupted: Antiracist and feminist activism inside the United Nations* (2016) 128.

characteristics such as race, class, geographic location, socioeconomic status that allows for differences and similarities between nurses. [168]

2.4 Conclusion

The preceding attempts to illustrate the significance of an African lens when undertaking an analysis of power. An appraisal of western feminist theories shows that it is not sufficient on its own for this study as they do not adequately cater for a situated African context. The criticisms of Western feminism are well placed and highlights the dangers of applying one approach to the complex lives of all women. African feminist theory is a normative resource for understanding and unmasking power in its multiple forms and advancing an analytical framework that examines the lived experiences of nurses within the context of abortion. As this chapter shows, power is a complex and multifaceted phenomenon.

This study engages with a more refined analysis of power that is a situated perspective, which explores both the context of power relations as well as resistance where appropriate. The application of a critical African feminist lens to Foucauldian scholarship and general feminist theorising produces an analysis that avoids an essentialised and homogenised representation. Indeed, as I utilise this framework, attention is paid to how nurses occupy various and sometimes conflicting discourses and structures, which are constantly changing. A critical African feminist perspective provides the framework to explore how nurses understand and exercise conscientious objection to abortion which is seen as located in and products of discourse and discursive practices.

Before presenting the major findings of my study, I shall describe the methods through which data was collected.

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168 See K Crenshaw 'Mapping the margins: Intersectionality, identity politics, and violence against women of color' (1991) 43 (6) *Stanford Law Review* 1241-1299.

CHAPTER THREE

RESEARCH METHOD

As indicated in chapter one, there is considerable research demonstrating the norms and factors that influences nurses' provision of abortion services.[1] However, to date there is very little feminist research that examines how nurses understand and exercise conscientious objection related to abortion care. Moreover, existing research has mainly focused on nurses in the public sector. This study's focus on both public and private sector nurses and contributes considerably to existing scholarship.

The purpose of this study is to answer the following questions:

1. What is the scope and limitations of the right of nurses to exercise conscientious objection to abortion?

2. What discursive resources and framings were drawn on by key state and non-state actors in South Africa that contributed to the absence of a conscientious objection provision in the Choice on Termination of Pregnancy Act?

3. What practices of discretionary power influences nurses' exercise conscientious objection relating to provision of legal abortion? In particular, how and why do nurses exercise conscientious objection?

4. How do shifting dynamics including professional norms, socio-cultural values and wider political and legal factors underpin nurses' action or failure to act in the provision of legal abortion?

[1] See for example, S Rohrs 'The influence of norms and values on the provision of termination of pregnancy services in South Africa' ((2017) 6 *International Journal of Africa Nursing Sciences* 39-44*;* J Harries and others 'Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study' (2004) 11 (16) *Reproductive Health* 2-7; J Harries and others 'Health care providers' attitudes towards the termination of pregnancy: A qualitative study in South Africa' (2009) 9 (296) *BMC Public* Health 1-11.

To answer these research questions, a case study of South Africa with particular focus on nurses' lived experiences in two provinces Gauteng and Limpopo is conducted. Using an African feminist theoretical framework, the study examines the ways in which the legal, political and socio-cultural institutional contexts shape how nurses understand and exercise conscientious objection to provision of legal abortion services.

This study is a feminist project grounded in the theoretical approaches outlined in chapter two. This chapter discusses the methods deployed for study. First, it examines the research design. The data collection and analysis process are followed by a discussion of the ethical approval. I also engage in a dialogue that highlights my positionality and interpretation to explore the situatedness of knowledge production.

3.1 Research design

A qualitative design is appropriate for this study given that the identified problem relates to nurses' norms and perceptions in providing or not providing abortion services within a case study of South Africa.[2] The research incorporates qualitative social science research methods. Sandra Harding in *Feminism and methodology* defines research method as:

> A technique for (or way of proceeding in) gathering evidence … fall[ing] into one of the three categories: listening to (or interrogation) informants, observing behavior, or historical traces and records.[3]

Linda Smith further argues that 'research is about satisfying a need to know, and a need to extend the boundaries of existing knowledge through a process of systematic inquiry.'[4]

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

3 S Harding *Feminism and methodology* (1987) 2.

4 L Smith *Decolonizing methodologies*: *Research and indigenous peoples* (1999) 170.

A case study research strategy is used because my research questions are related to an empirical inquiry of how and why nurses exercise conscientious objection to abortion. A case study is an empirical inquiry to investigate an issue (in this case, conscientious objection) in depth within a contextualised environment.[5] A good case study relies on multiple sources of evidence that converges through triangulation.[6] This thesis relies on several sources of evidence including documents, archival records, interviews and participant observations. Thus, the study combines the examination of legal norms- formal, informal or background rules with lived experiences. This approach draws from Rachel Rebouché's functionalist methodology of studying abortion law in their functional capacity.[7]

To do a careful description of the trajectories that led to the absence of a conscience clause in Choice on Termination of Pregnancy Act,[8] I did process tracing. Process tracing 'begins not with observing change or sequence, but rather with taking good snapshots at a series of specific moments.'[9] For the process tracing of the absence of the conscience clause, archival records are mainly used to collect evidence on arguments and reasoning underlying the absence through parliamentary Hansards and submissions. These arguments were documented in parliamentary debates and minutes of parliamentary committees accompanying the promulgation of the Act and subsequent amendments. The validity of the data acquired from these archival records are triangulated with other evidence collected from documentation of news clippings and reports related to the events as well as interviews with relevant stakeholders. The goal of this process is to give a more nuanced view of the

5 RK Yin *Case study research: Design and methods* (2014) 16.

6 Yin (n 5) 14.

7 See R Rebouché 'A functionalist approach to comparative abortion law' in R Cook et al (eds) *Abortion law in transnational perspective: Cases and controversies* (2014).

8 Act 92 of 1996. I use the term abortion throughout the study, although, in instances where it is used by respondents or when quoting the Act, which provides for the term 'termination of pregnancy' (TOP), the term is used in the study.

9 D Collier 'Understanding process tracing' (2011) 44(4) *PS: Political Science* 823-830.

normative framework surrounding abortion as illustrated in the analysis in chapters four and five.[10]

Details on how these sources of evidence were applied into the process tracing of the absence of a conscience clause in the Choice on Termination of Pregnancy Act are as follows:

Table 1: Documents utilised in process tracing the absence of a conscience clause in the Choice on Termination of Pregnancy Act

Source	Documentation	Interview	Archival Records
The Choice on Termination of Pregnancy Act	News clippings on the bill	Interviews with key stakeholders	Choice on Termination of Pregnancy Bill- Second reading Minutes of the Portfolio Committee on Health
	Submissions to the Portfolio Committee on Health on the Termination of Pregnancy Bill		Minutes of public hearing on the implementation on the 1996 Choice on Termination of Pregnancy Act
	Manifestos of political parties		
Choice on Termination of Pregnancy Amendment Bills	News clippings on the bills	Interviews with key stakeholders	Minutes of public hearings on Choice on Termination of Pregnancy Amendment Bill
	Submissions to the Portfolio Committee on Health on the Termination of Pregnancy Amendment Bills		Reports of the Portfolio Committee on Health (National Assembly)
			Reports of proceedings of anti-choice workshops

For the purposes of the broader study, in-depth interviews, and focus group discussions with nurses in public and private facilities in Gauteng (urban province) and Limpopo (mixed urban-rural) province was used as the primary means for data

10 *Infra,* chapter four: *Scope and limitations of conscientious objection in South Africa* and chapter five: *abortion discourses and conscientious objection: an analysis of parliamentary debates on South African abortion law*

collection.[11] Interviews were also conducted with relevant stakeholders. I also collected observational data to further supplement the interview data. Each of these data tools provided opportunities to gain insights into the nurses' exercise of conscientious objection. This is discussed in depth below.

While these techniques of evidence gathering are not unique to feminist research as traditional methods of inquiry common in social sciences, the manner in which the interviews were formulated, utilised and analysed are based on general feminist theories of knowledge. Given that there is no distinctive feminist method of inquiry, any research method can be used in a feminist manner if the researcher's chosen methodology incorporates the critical analysis of the chosen method.[12] In this study, the research methods used to collect data and subsequent analysis were done from a feminist perspective. This feminist point of view is what Patricia Cain refers to as 'a point of view that is shaped by an understanding of women's life experiences.'[13] As a methodology, this study's focus on lived experiences, takes as a starting point from which to make a feminist analysis and ask new questions: who is telling the stories and whose stories are being told in the debate about this issue; and what population benefits the most out of this thinking?

Feminist research 'goes beyond documenting what is, to proposing an alternative and imaginative vision of what should be.'[14] Feminism 'problematizes gender and brings women and their concerns to the centre of attention.'[15] According to Clare Dalton, feminism is:

> the range of committed inquiry and activity dedicated first, to describing women's subordination – exploring its nature and extent; dedicated second, to asking both

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11 Attention was paid to saturation of themes to achieve diverse views. See G Guest et al 'How many Interviews are enough? An experiment with data saturation and variability' (2006) 18(1) *Family Health International* 59.

12 S Harding 'The method question' (1987) 2(3) *Hypatia: Feminism & Science* 19-35. See also S Harding *Feminism and methodology* (1987).

13 PA Cain 'Feminist legal scholarship' (1991) 77 I*owa Law Review* 20.

14 Maguire as cited in S N Hasse-Biber (ed) *Handbook of feminist research: Theory and praxis* (2007) 150.

15 As above.

> *how* – through what mechanisms, and *why*- for what complex and interwoven reasons- women continue to occupy that position; and dedicated third, to change.[16]

The way I decided to conduct the research is guided by my epistemology or theory of knowledge. This is in line with M. Jacqui Alexander's call to acknowledge the ways in which we come to know what we think we know, and how those practices are themselves constituted by all the experiences that have brought us to this point of knowing.[17] For instance, the epistemologies used in this study are feminist theories of knowledge partly based on the experiences of women who participated in this study. For its epistemological practice, this study lets intersectional categories emerge from the local contexts of the data sites, rather than assume to know what matters by interrogating the gaps and silences.[18] As an analytical tool, intersectionality,[19] within the framework of this study, is understood as more than identity, that it draws on complex subjectivities and experience of nurses providing or not providing abortion services from a simultaneous viewpoint of both privilege and oppression. Such an approach re-echoes Katherine Barlett's claim that 'victims do not have exclusive access to truth about oppression.'[20]

It highlights how lived identities, structural systems and forms of power intersect and change.[21] This feminist inquiry also notes the differences in experiences, knowledge and situatedness of nurses. It becomes a critical point in exploring the experiences of nurses who live in urban or rural areas; young or old; work in public, private or own their own clinics. The manner in which the narratives are recounted is important but not the most vital aspect of this study. The way in which I read the

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16 C Dalton 'Where We Stand: Observations on the Situation of Feminist Legal Thought' 3 (1) *Berkeley Women's Law Journal* 2.

17 MJ Alexander, *Pedagogies of Crossing: Meditations on Feminism, Sexual Politics, Memory, and the Sacred* (2005) 2.

18 See P McFadden 'Cultural practice as gendered exclusion: Experiences from Southern Africa' in A Sisask (ed) *Discussing women's empowerment: Theory and practice* (2001) 58-70. See also, D Lewis 'African gender research and postcoloniality: Legacies and challenges' in O Oyěwùmí (ed) *African gender studies: A reader* (2005) 381-382.

19 This concept was used by Kimberlé Crenshaw to describe the problems that black women experience with the law. *See*, S Cho et al 'Toward a field of intersectionality studies: Theories, applications and praxis' (2013) 38(4*) Signs: Journal of Women in Culture and Society 785-810.*

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

21 VM May *Pursuing intersectionality: Unsettling dominant imaginaries* (2015) 28.

narratives, understood them and disseminated this information from a feminist perspective is critical in my role as the researcher.

3.1.1 Research setting and case selection

The collection of empirical data was conducted between January 2019 and July 2019. Data was collected from both public and private health facilities in Gauteng (urban) and Limpopo (rural). Public sector facilities provided abortions free of charge, while private sector facilities charged fees ranging from 800 ZAR to 1,500 ZAR depending on the gestational age and type of abortion procedure.[22] Nurses were generally trained in manual vacuum aspiration (MVA) and not in medical abortion. Medical abortion was generally unavailable in public facilities and in the privately-owned abortion clinics of nurses. However, other private facilities offered medical abortions. These facilities provided a range of services from pre-abortion counselling to the provision of first trimester and second trimester abortions, post-abortion counselling and contraceptive services.

The rationale for having these two provinces was to allow for diversity as the data sites differ in location and in type. The goal was to understand the commonalities and differences deployed across the sites. The differential characteristics between the urban and rural landscapes might be due in part to the types of private health facilities available. For instance, certain private clinics such as Marie Stopes are only available in urban areas in Gauteng and not in Limpopo. However, nurses who owned their own private clinics were seen in both places. Additionally, certain cultural norms and beliefs were more predominantly used in rural areas. A broad review of the reproductive health indicators of the two provinces is done below:

22 These prices were culled from observations when I visited private abortion clinics.

a. Gauteng Province

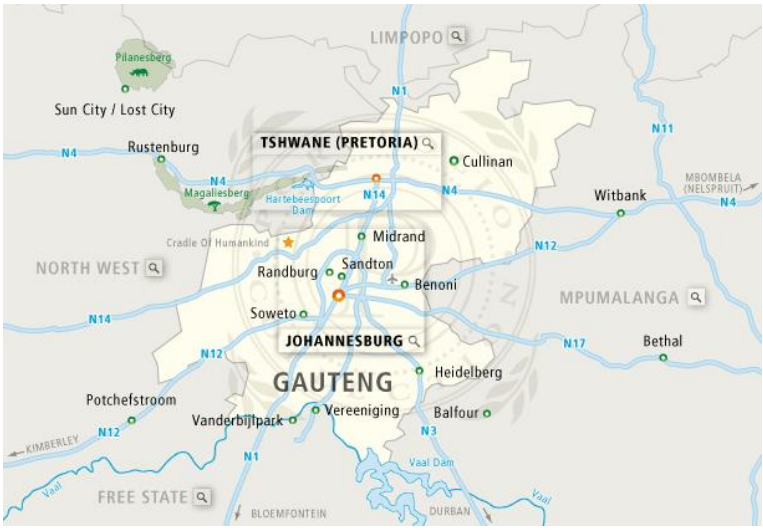

Figure 2: Map of Gauteng Province

Gauteng is the smallest in size of South Africa's nine provinces. It is highly urbanised comprising of the largest city, Johannesburg and the administrative capital, Pretoria. Its population is estimated at 14, 717 000 people, comprising 25.5 per cent of the national population, making it the most populous province in the country.[23] The SANC register shows that as of 1 January 2019, there were 37, 097 registered nurses in Gauteng of which 35, 031 were female and 2, 939 male s.[24]

Gauteng is considered to have a well-functioning primary healthcare system, which makes it an ideal province for the influx of migrants for accessing health services including abortion.[25] For example, Gauteng province had the largest proportion of abortions conducted in 2006, even though less than one-fifth of women of a

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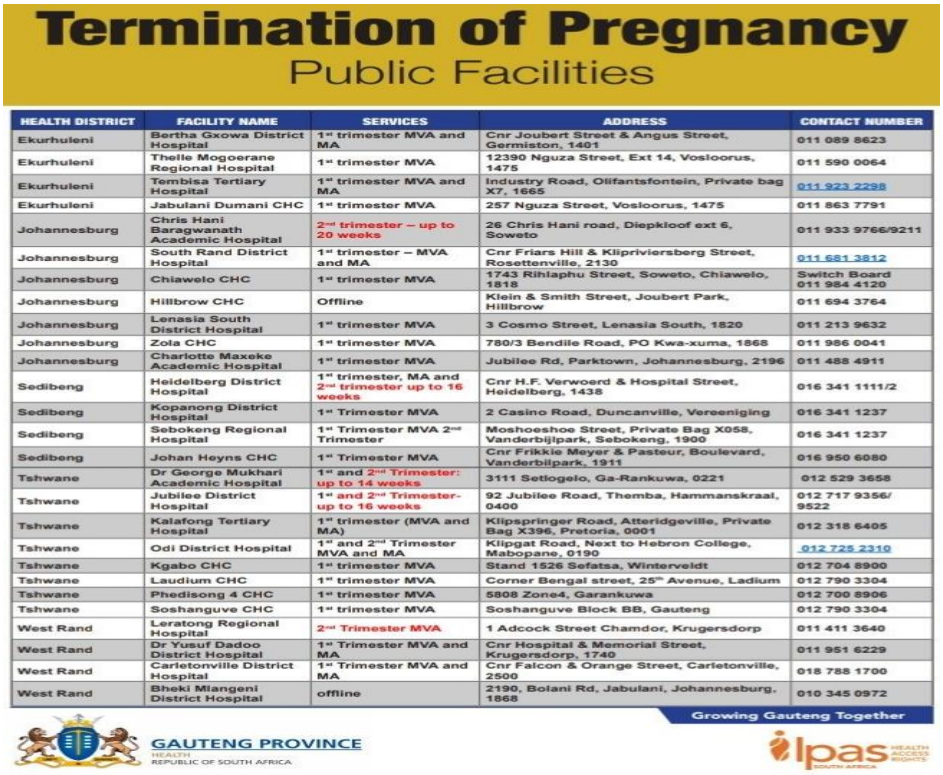
[23] Stats SA 'Mid-year population estimates, 2018' (2018) http://www.statssa.gov.za/publications/P0302/P03022018.pdf (accessed 10 June 2019) 2.

[24] Given that the SANC database is not linked to the employee database of the departments of health, these figures do not necessarily mean that these nurses are working in those provinces. But they serve as a good indication of the uneven spread of registration of nurses in provinces. See South African Nursing Council (SANC) 'SANC geographical distribution: Provincial distribution of nursing manpower versus the population of South Africa' (2018) https://sanc.co.za/stats/stat2018/Distribution%202018xls.htm (accessed 20 June 2019).

[25] Between 2011 and 2016, there was approximately, 479 461 (external migrants) and 1 459 549 (internal migrants). This is estimated to increase. See Stats SA 'Mid-year population estimates, 2018' (2018) 15.

reproductive age lived in the province at that time.[26] In 2016, Mantshi Teffo and Laetitia Rispel found that in Gauteng, 87.5 per cent (28 of 32 designated sites) were providing abortion services.[27] This is illustrative of the inequitable distribution of services in other areas in South Africa. In August 2019, the Gauteng Department of Health tweeted a list 27 public facilities that offer termination of pregnancy services across the province as provided in figure 3.[28] The list of functional abortion health facilities also shows that services remain concentrated at the highest level of health system with only eight out of the 27 sites being community health centres.



Termination of Pregnancy
Public Facilities

HEALTH DISTRICT	FACILITY NAME	SERVICES	ADDRESS	CONTACT NUMBER
Ekurhuleni	Bertha Gxowa District Hospital	1st trimester MVA and MA	Cnr Joubert Street & Angus Street, Germiston, 1401	011 089 8623
Ekurhuleni	Thelle Mogoerane Regional Hospital	1st trimester MVA	12390 Nguza Street, Ext 14, Vosloorus, 1475	011 590 0064
Ekurhuleni	Tembisa Tertiary Hospital	1st trimester MVA and MA	Industry Road, Olifantsfontein, Private bag X7, 1665	011 923 2298
Ekurhuleni	Jabulani Dumani CHC	1st trimester MVA	257 Nguza Street, Vosloorus, 1475	011 863 7791
Johannesburg	Chris Hani Baragwanath Academic Hospital	2nd trimester – up to 20 weeks	26 Chris Hani road, Diepkloof ext 6, Soweto	011 933 9766/9211
Johannesburg	South Rand District Hospital	1st trimester – MVA and MA	Cnr Friars Hill & Klipriviersberg Street, Rosettenville, 2130	011 681 3812
Johannesburg	Chiawelo CHC	1st trimester MVA	1743 Rihlaphu Street, Soweto, Chiawelo, 1818	Switch Board 011 984 4120
Johannesburg	Hillbrow CHC	Offline	Klein & Smith Street, Joubert Park, Hillbrow	011 694 3764
Johannesburg	Lenasia South District Hospital	1st trimester MVA	3 Cosmo Street, Lenasia South, 1820	011 213 9632
Johannesburg	Zola CHC	1st trimester MVA	780/3 Bendile Road, PO Kwa-xuma, 1868	011 986 0041
Johannesburg	Charlotte Maxeke Academic Hospital	1st trimester MVA	Jubilee Rd, Parktown, Johannesburg, 2196	011 488 4911
Sedibeng	Heidelberg District Hospital	1st trimester, MA and 2nd trimester up to 16 weeks	Cnr H.F. Verwoerd & Hospital Street, Heidelberg, 1438	016 341 1111/2
Sedibeng	Kopanong District Hospital	1st Trimester MVA	2 Casino Road, Duncanville, Vereeniging	016 341 1237
Sedibeng	Sebokeng Regional Hospital	1st Trimester MVA 2nd Trimester	Moshoeshoe Street, Private Bag X058, Vanderbijlpark, Sebokeng, 1900	016 341 1237
Sedibeng	Johan Heyns CHC	1st Trimester MVA	Cnr Frikkie Meyer & Pasteur, Boulevard, Vanderbijlpark, 1911	016 950 6080
Tshwane	Dr George Mukhari Academic Hospital	1st and 2nd Trimester: up to 14 weeks	3111 Setlogelo, Ga-Rankuwa, 0221	012 529 3658
Tshwane	Jubilee District Hospital	1st and 2nd Trimester- up to 16 weeks	92 Jubilee Road, Themba, Hammanskraal, 0400	012 717 9356/ 9522
Tshwane	Kalafong Tertiary Hospital	1st trimester (MVA and MA)	Klipspringer Road, Atteridgeville, Private Bag X396, Pretoria, 0001	012 318 6405
Tshwane	Odi District Hospital	1st and 2nd Trimester MVA and MA	Klipgat Road, Next to Hebron College, Mabopane, 0190	012 725 2310
Tshwane	Kgabo CHC	1st trimester MVA	Stand 1526 Sefatsa, Winterveldt	012 704 8900
Tshwane	Laudium CHC	1st trimester MVA	Corner Bengal street, 25th Avenue, Ladium	012 790 3304
Tshwane	Phedisong 4 CHC	1st trimester MVA	5808 Zone4, Garankuwa	012 700 8906
Tshwane	Soshanguve CHC	1st trimester MVA	Soshanguve Block BB, Gauteng	012 790 3304
West Rand	Leratong Regional Hospital	2nd Trimester MVA	1 Adcock Street Chamdor, Krugersdorp	011 411 3640
West Rand	Dr Yusuf Dadoo District Hospital	1st Trimester MVA and MA	Cnr Hospital & Memorial Street, Krugersdorp, 1740	011 951 6229
West Rand	Carletonville District Hospital	1st Trimester MVA and MA	Cnr Falcon & Orange Street, Carletonville, 2500	018 788 1700
West Rand	Bheki Mlangeni District Hospital	offline	2190, Bolani Rd, Jabulani, Johannesburg, 1868	010 345 0972

Growing Gauteng Together

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

ipas HEALTH ACCESS RIGHTS SOUTH AFRICA

Figure 3: Designated public health facilities offering abortion services in Gauteng

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26 See KE Dickson and others 'Abortion service provision in South Africa three years after liberalization of the law' (2003) 34(4) *Studies in Studies in Family Planning* 277-284.

27 WE Teffo & LC Rispel 'I am alone: factors influencing the provision of termination of pregnancy services in two South African provinces' (2017) 10 *Global Health Action* 3-4.

28 'Gauteng Department of Health urges women to have safe abortions' *@GautengHealth* 15 August 2019 https://twitter.com/GautengHealth/status/1162015173252657152?ref_src=twsrc%5Etfw%7Ctwcamp%5Etweetembed%7Ctwterm%5E1162015173252657152&ref_url=https%3A%2F%2Fwww.parent24.com%2FFertility%2FFAQs%2Fgauteng-department-of-health-urges-women-to-have-safe-abortions-20190816 (accessed 25 September 2019).

b. Limpopo Province

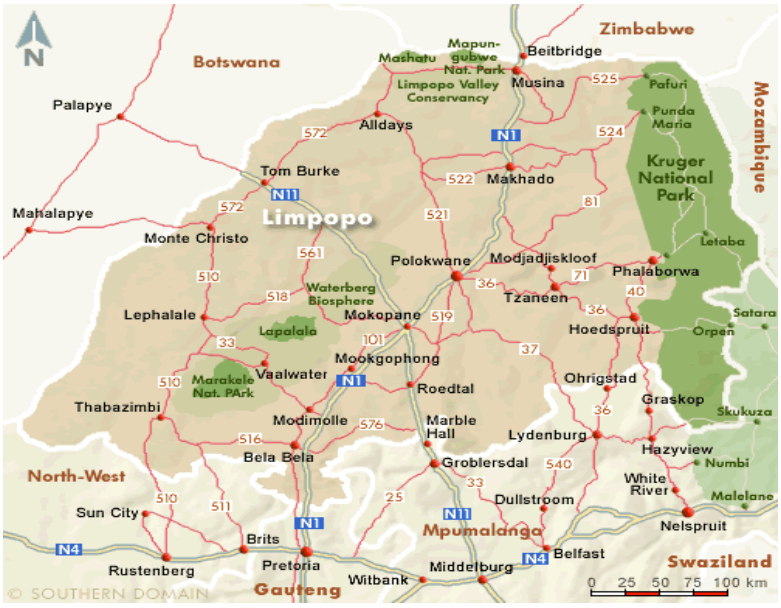

Figure 4: Map of Limpopo Province

Limpopo is located in the North East of South Africa sharing borders with Botswana, Zimbabwe and Mozambique with a diverse geographical and cultural landscape. It is home to approximately 10 per cent of the country's population with an estimated 5, 797 300 people in the province.[29] As of 1 January 2019, SANC's register shows that there were 12, 639 registered nurses in Limpopo comprising of 10, 988 female nurses and 1, 641 male nurses.[30]

Limpopo has a higher fertility rate compared to the more urbanised province such as Gauteng, which has lower levels of fertility.[31] Given its large rural population, a 2004 study found accessibility to health facilities to be a major challenge to provision of abortion services.[32] It further found that at that time, there were only 28 abortion sites available to meet the needs of nearly 1.5 million women of

29 Stats SA (n 23) 21.

30 South African Nursing Council (SANC) 'SANC geographical distribution: Provincial distribution of nursing manpower versus the population of South Africa' (2018) https://sanc.co.za/stats/stat2018/Distribution%202018xls.htm (accessed 20 June 2019).

31 Stats SA (n 23) 11.

32 EMH Mitchell et al 'A Facility Assessment of Termination of Pregnancy (TOP) Services in Limpopo Province, South Africa' (2004) Chapel Hill, NC, Ipas.

reproductive age.[33] Although, there is absence of updated data on the burden of unsafe abortion due to under reporting and record keeping, the situation seems to have worsened.[34] In May 2019, the Treatment Action Campaign (TAC) led a protest in the province demanding for termination of pregnancy services to be offered at all public health facilities in the region.[35] The Limpopo Department of Health claimed that that the low number of facilities is due to lack of resources and the irregular use of the service.[36] A 2018 assessment of public-sector safe abortion care in Limpopo by Ipas South Africa shows the acute need for expanded public-sector safe abortion services given that many women have to travel long distance to reach a public health centre.[37]

The provincial distribution of nursing manpower versus the population of South Africa is summarised in table 2 below.

Table 2: Provincial Distribution of Nursing Manpower versus the Population of South Africa

	National	**Gauteng**	**Limpopo**
Population[38]	57,7 million	14,7 million (25.4%)	5,8 million (10%)
Registered Nurses[39]	146, 791	37, 970 (13.2%)	12, 639 (4.4%)
Female	131, 579	35, 031	10, 988
Male	15, 212	2, 939	1, 641

3.1.2 Sampling, study population and recruitment

The population of interest was professional nurses: abortion providers and non-providers in public and private sectors in Gauteng and Limpopo provinces. The

33 As above, 5.

34 Limpopo Department of Health. 2002. Annual Report - Department of Health & Welfare for 2000 - 2001. http://www .limpopo.gov.za/docs (accessed 18 May 2019).

35 M Mojela 'Limpopo activists demand abortion services at all public health facilities' *IOL News* 28 May, 2019 https://www.iol.co.za/news/south-africa/limpopo/limpopo-activists-demand-abortion-services-at-all-public-health-facilities-24247528 (accessed 5 June 2019).

36 As above.

37 Ipas South Africa '2018 assessment of public-sector safe abortion care in Limpopo and Gauteng Provinces' (2018).

38 Stats SA (n 23) 2.

39 SANC (n 30) 1.

study participants were purposively chosen thereby representing a varied sample of respondents from different professional categories. These were as follows:

1. Nurse providers who were trained in to perform first trimester abortions in public or private health sector and were providing abortion services.

2. Nurse providers working in abortion services but not trained in abortion procedures. They are involved in abortion related processes including nurses who do pre and post counselling, referral, amongst others.

3. Nurses who are not involved in abortion provision.

4. Healthcare managers in public health facilities

5. Policy makers, academics, activists, researchers and legal experts

For the empirical focus on nurses, data was collected from nurses drawn from a sample of public and private facilities that offer abortion services in urban areas of Gauteng and rural areas of Limpopo. The goal was to understand the commonalities and differences deployed across the sites drawn from nurses in the interview context. In total, 32 nurses were interviewed (see table 3 below).[40] Nurses interviewed who were involved in a different aspects of abortion service provision were almost exclusively female and black as they form the majority.[41] This is true especially for nurses with termination of pregnancy certification and practice. For example, the South African Nursing Council (SANC) register shows that as of 1 January 2019, there were 101 nurses that had registered the certificate in termination of pregnancy as an additional qualification.[42] Of these, 96 were females

[40] 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).

[41] South African Nursing Council (SANC) 'Registrations and listed qualifications: Calendar year 2018' (2018) https://sanc.co.za/stats/stat2018/Year%202018%20Registrations%20of%20Practitioners%20Stats.pdf (accessed 10 May 2019).

[42] As above.

and 5 males. This figure went down from 2017 with 111 nurses (105 females and 6 male nurses).[43]

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 healthcare system.[44] Thus, this study focuses on the subjectivity of female nurses in terms of how their thoughts and actions are shaped by and reflect the predominant social norms and values. It is within these norms that they are raised as women and develop as nurses.

Table 3: Characteristics of the nurses interviewed (n = 33)

Characteristics	**Number of interviewees**
Sex of provider	
Female	32
Male	1
Race	
Black	32
White	1
Type of facility	
Public	22
Private	11
Geographical location	
Metropolitan	18
Rural	15
Religious affiliation	
Christian	11
Not specified	21
Range of number of years worked in nursing	4 months-22 years
Conscientious objection	
Providing TOP services	19
Practicing conscientious objection	7
Undecided	7

43 As above.

44 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(4) *Journal of Southern African Studies* 695-717. See WHO '*The world health report*' (2006) http://www.who.int/whr/2006/en/ (accessed 12 March 2018).

Service providers were targeted through the selection of potential informants by the hospital as well as scheduled interviews through referrals from other participants, a practice referred to in social science research as 'snowballing.'[45] Snowballing, which is relying on people interviewed to recommend others was very helpful considering the difficulty of access. A recommendation was helpful with motivating nurses to grant an interview and develop trust.

3.2 Data collection

This study relied on multiple data sources: mapping out the context and events,[46] discourse analysis,[47] and interviews to enhance both the internal and external validity of the data gathered.[48] The qualitative fieldwork entailed in-depth interviews which were guided and informed by the conceptual and theoretical frameworks of the study.[49] As noted above, fieldwork was done in two parts:

3.2.1 Semi-structured interviews with nurses

Prior to each interview, the participants signed a consent form. They were informed of their right to stop the interview at any time or not answer any question if they felt uncomfortable. The importance given to ensure confidentiality was reinforced. Nurses were assigned random numbers and subsequently assigned a pseudonym which has been used for quotes and discussions. After signing the consent form, they were asked to complete a short demographic survey (Appendix F). This included demographic variables: age, sex, race, marital status, religious preference, years of nursing, employment, income, roles relating to abortion work.

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45 On snowballing as a sampling technique, see L Mosley *Interview research in political science* (2013) 20-35.

46 J Gerring *Social science methodology: A unified framework* (2012) 173.

47 See LA Wood & RO Kroger *Doing discourse analysis: Methods for studying action in talk and text* (2000).

48 JF Lynch 'Aligning sampling strategies with analytic goals' in L Mosley *Interview research in political science* (2013) 37.

49 See Yin (n 5) 17 on the uses of interviews in social science research. The fieldwork also facilitated the collection of secondary sources such as organisational documents.

Data were collected using in-depth qualitative interviewing and focus group discussion tools. Interviews explored informants' day-to-day practice, their beliefs and the legal, professional, moral, ethical and religious factors that shape their abortion work. An interview guide was also used when interviewing nurses (Appendix C). Each participant was interviewed for 40 to 90 minutes. Some of the interviews were audio recorded with participant's permission.

3.2.2 Individual interviews with key informants

In addition, 9 semi-structured interviews were also conducted with key stakeholders in South Africa (see table 4). These included health administrators, reproductive rights activists, academics and legal experts. The purpose of the interviews was aimed at triangulating with other methods including the analysis of primary sources including the Constitution, laws and cases; and existing data sources such as health statistics and documents from government agencies, civil society, international actors and media. The objective of conducting these interviews was to provide contextual understanding of the historical circumstances and discourses that informs the absence of a conscientious objection provision; current regulatory framework and strategies to address the exercise of conscientious objection.

Due to the various locations of key informants throughout South Africa and beyond, interviews were primarily conducted via skype. Interviews were conducted at a time deemed to be convenient for the participants, which ranged from 30 to 60 minutes in length. An interview scheduled was utilised by the researcher while interviewing key informants (Appendix G).

Table 4: Professional domains of interviewees

Professional domain	Number of interviewees
Government officials	1
Healthcare managers in public facilities	3
NGO Staff*	3
Feminist or legal advocacy groups	1
Academics/Researchers	4

3.3 Data analysis

Data analysis is an integral part of the overall research design and is predominantly informed by the theoretical framework as outlined in chapter two, as well as the research questions.[50] This study adopted a "thick" analysis and utilised a particular type of evidence of textual and field research.[51] The data were analysed by means of thematic analysis approach to identify categories, themes and sub-themes influenced by the original research objectives. I drew on an analytical generalisation based on comparison of the responses from different participants across different thematic categories. From the different sources, I then drew patterns and linkages. As a feminist project, it was important to let intersectional categories emerge from the cases and contexts themselves.[52]

The analysis of the data was done with the aid of Atlas.ti to develop a case study database in order to facilitate data management and ensure reliability. The textual evidence that the interviews yielded were systematically coded and evaluated from a feminist methodological frame. Conducting a critical feminist analysis required a systematic way of organising, processing and synthesising the data, which are critical for a robust and thick analysis. Thus, data gathered was coded using themes guided by the theoretical framework. Key themes to emerge were: perceptions of

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* This includes international organisations.

50 The strategy for the data analysis is aimed at addressing the issue of internal validity.

51 Gerring (n 2) 17.

52 See D Lewis 'African gender research and postcoloniality: Legacies and challenges' in O Oyěwùmí (ed) *African Gender Studies: A reader* (2005) 381-382.

women seeking abortion; knowledge and understanding of the Choice on Termination of Pregnancy Act; the reasons why nurses were not willing to provide abortions including individual and health service related barriers; how providers conceptualised conscientious objection, how women's decision for seeking abortion influenced nurses' decision to be involved in abortion provision; the experiences of nurses providing abortion services and the barriers they face.

Three strategies to ensure the internal validity of the data are used. First, different data sources including interview data, court judgments, laws, minutes and bills from the parliament, organizational documents and scholarly works are triangulated to justify the analysis. Second, in order to minimise potential bias for all categories of participants, field notes were taken during and after the interviews to allow the researcher to reflect on the content, communication and tone of the participant. The journal reflections were useful helpful in clarifying findings and initial thoughts on emerging codes and categories. In addition, debriefs with one of my supervisors[53] were employed to increase accuracy of the interpretations of the data collected.[54]

3.4 Ethical considerations

Ethical approval for the study was obtained from the Research Ethics Committees of both the Faculty of Law, and the Faculty of Health Sciences, University of Pretoria respectively (Appendices A and B). The study has been structured in accordance with ethical considerations such as the protection of the identity of all participants. As this is a highly sensitive fieldwork, the researcher in following the 'do no harm' principle asked for informed consent; respected interviewees' confidentiality and anonymised all respondents' details and the data sites.

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53 Professor Siri Gloppen, a trained political scientist and researcher.

54 Strategy of involving others to ensure accuracy of interpretation increases study's validity. See AK Shenton 'Strategies for ensuring trustworthiness in qualitative research projects' (2004) 22 (2) *Education for Information* 63–75.

3.5 Positionality: Reflecting on the research process

Reflexivity is central to feminist research process as it is 'a continuing mode of self-analysis.'[55] As Sue Wilkinson puts it, reflexivity is 'disciplined self-reflection.'[56] I have been adequately trained in the skills necessary to carry out the designed study. In preparation for this study, I have undertaken doctoral coursework to deepen my understanding on the various theoretical and methodological considerations. Throughout the study, as a PhD Law Transform Scholar of the Centre on Law & Social Transformation, University of Bergen, I have attended the PhD course on *Effects of lawfare: Courts and law as battlegrounds for social change* and presented during the Bergen Exchanges in Norway. In November 2018, I attended a one-week intensive qualitative research as an African Doctoral Dissertation Research Fellow (ADDRF) of the African Population and Health Research Center (APHRC), Kigali, Rwanda. I have also presented preliminary results of this work at the 2019 ADDRF Research Symposium in Senegal and the 2019 Law and Society Annual Meeting in Washington DC, United States (US).

As the primary researcher for this study, it is necessary to clearly identify my personal values, assumptions and biases. As a researcher, I am aware of the importance of locating my position within this research project and question how I produce and contextualise knowledge.[57] I was raised in a predominantly Muslim society in The Gambia where abortion is highly restricted. While religion plays an instrumental role in my life, I identify as a feminist with strong pro-choice views and a dedicated record of activism and research on women's reproductive rights. I belong to several organisations who fight to ensure the fulfilment of women's right including reproductive healthcare services. The knowledge I produce as the researcher is directly informed and biased by the information I have shared above,

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55 H Callaway 'Ethnography and experience: Gender implications in fieldwork and texts' in J Okely & H Callways (eds) *Anthropology and autobiography* 33.

56 S Wilkinson 'The role of reflexivity in feminist psychology' (1988) 11(5) *Women's Studies International Forum* 493.

57 On the importance of reflexivity, positionality and identity in feminist fieldwork see, R Nagar *Muddying the waters: Co-authoring feminisms across scholarship and activism* (2014) 81-104.

and in many other ways that I have not yet been able to ascertain or understand. Standpoint is described as 'a social location from which one observes, relates to, and socially constructs, interprets and enacts, oneself and others.'[58] The production of this thesis is informed within my particular standpoint as a feminist researcher. This is in line with Alexander's call to acknowledge the ways in which we come to know what we think we know.[59] While I bring certain biases to this study, I have made efforts to ensure objectivity. For instance, during interviews, I did not disclose my own views on abortion, and I asked questions in an unbiased manner.

I am not a healthcare professional, and so I come to this research relatively as an outsider of the world of healthcare. While this gives me the opportunity to have a fresh perspective, it also limits my own personal understanding of the challenges faced by nurses in the field. In researching on abortion rights in South Africa, I am also an outsider, conscious that I am unable to provide a truth that is representative of all women living in South Africa, specifically of nurses. This is particularly pertinent given the context of an institutionalised racism which I have not experienced personally. I am not South African, and this is research is not an attempt to present a narrative of 'the' South African nurse. This feminist research is aimed for the benefit of women in general.

3.6 Difficulties encountered and limitations

In reflecting on conducting the research, I also faced certain challenges. For instance, I was unable to secure interviews with high-level actors[60] and representative of certain organisations.[61] Some of the publicly known anti-choice organisations were difficult to access. While they were keen on talking to me, these

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58 PY Martin 'Mobilising masculinities': women's experiences of men at work' (2001) *Organization* 592.

59 MJ Alexander *Pedagogies of crossing: Meditations on feminism, sexual politics, memory and the sacred* (2005) 2.

60 For example, I sent request for interviews to senior government officials and politicians including the Minister of Health, but some of these did not happen.

61 I was unable to have an interview with the South African Nursing Council (SANC) after several attempts.

organisations later dropped out after the interview was scheduled due to reasons surrounding confidentiality despite several assurances of anonymity. However, majority of non-state actors including non-governmental organisations, academics and researchers were quite welcoming of the research and interviews were immediately fixed. They were also very helpful in making referrals of other individuals who may be of relevance to talk to. In addition, there was also the challenge of access with regard to public health nurses. Despite approvals from particular hospitals, it was difficult to gain access and conduct the interviews. Ipas South Africa's ongoing research on conscientious objection to abortion in the two provinces under study was quite useful and timely.[62]

Conducting the interviews was very significant to how the thesis took shaped. This was evident in two ways. First, prior to conducting the interviews, my assumption was that nurses who object called themselves conscientious objectors, but they mostly did not understand the term conscientious objection. Second, the literature did not address a special group of nurses who I had the opportunity to speak to: nurse providers who run their own abortion clinics. This provided variation between public and private health nurses and within the same category.

There are several methodological limitations with the study. First, being a qualitative study, the results do not indicate the size and extent of the problem in South Africa as a whole, yet it is suggestive of the problem. Finally, while this study cannot be generalised, it resonates with other South African provinces and findings regarding the perceptions and experiences of nurses and practices have utility for ensuring access to abortion services.

3.7 Conclusion

[62] I am the South Africa country expert consultant in this research work on conscientious objection in South Africa which is part of a larger Ipas research project, which focuses on 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. (contract on file).

With this outline of the methodological approach guiding this thesis, this chapter sets the stage for an empirical scrutiny into the regulatory framework and exercise of conscientious objection by nurses in South Africa. A discussion of the procedure, study participants, data collection and analysis outlined the specifics of how the study was conducted. It also set out the ethical considerations. The position of the researcher was also a primary component of the chapter given the importance of reflexibility in feminist research. A feminist methodology as discussed in chapters one and two was used to develop theory on nurses' understanding and exercise of conscientious objection to abortion provision.

The goal of the next four chapters is to provide the study results and discussion.

CHAPTER FOUR

THE SCOPE AND LIMITATIONS OF CONSCIENTIOUS OBJECTION IN SOUTH AFRICA

Conscientious objection is a complex issue of competing rights: women's rights to safe, legal abortion are pitched against healthcare providers' rights to follow their conviction to refuse to provide abortion services on religious or moral grounds.[1] Deep religious and moral disagreement around abortion raises the question of how law should deal with freedom of conscience. Conscientious objection is widely practised around the world and has been enshrined in domestic laws and regulations. According to the World Health Organization (WHO), globally, a lot of countries have explicit conscience clauses within the context of reproductive healthcare services.[2] However, other countries including Finland and Sweden do not permit the exercise of conscientious objection to abortion care by any medical professional.[3]

South Africa has ratified all relevant international human rights instruments that guarantee women's reproductive health and rights including the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)[4] the International Covenant on Economic, Social and Cultural Rights (ICESCR)[5] and the

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1 J Harries *et al* 'Health care providers' attitudes towards the termination of pregnancy: A qualitative study in South Africa' (2009) 9 (296) *BMC Public* Health 1.

2 See generally, World Health Organization (WHO) 'Global Abortion Policies Database' https://abortion-policies.srhr.org/.

3 A Heino *et al* 'Conscientious objection and induced abortion in Europe' (2013) 18(4) *European Journal of Contraceptive Reproductive Health Care* 231-233. See, W Chavkin *et al* 'Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses' (2013*) International Federation of Gynecology and Obstetrics* S41.

4 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) GA Res 54/180 UN GAOR 34th session Supp 46 UN Doc A/34/46 1980.

5 International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 3 January 1976, in accordance with article 27.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).[6]

While South Africa's legal framework on abortion is hailed as radically liberal given the reproductive rights provisions in the 1996 Constitution and its Choice on Termination of Pregnancy Act,[7] there is a divergence between law and practice. One of the key challenges to the efficacy of the law is the refusal by healthcare professionals including nurses to perform or provide abortion care based on conscience grounds. The Act does not directly address conscientious objection. The consequences of such a gap serves as an obstacle to the implementation of a liberal abortion law in practice. Where there are no clear laws or guidelines, the environment is conducive to health care providers acting within their 'own' interpretation of the law.

South Africa's limited laws and jurisprudence on the exercise of conscientious objection has received considerable scholarly attention.[8] However, given recent evolving international norms and jurisprudence at the international and domestic levels, this thesis builds on legal ideation for regulating conscientious objection. Thus, this chapter aims to clarify 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.

The chapter has four sections. Section one sets out the reproductive rights framework with a focus on South Africa's 1996 Constitution and the Choice on Termination of Pregnancy Act. Section two examines international and regional

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6 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.

7 C Ngwena 'The history and transformation of abortion law in South Africa' (1998) 30 *Acta Academica* 32.

8 See for example C Ngwena 'Conscientious objection and legal abortion in South Africa: Delineating the parameters' (2003) 28(1) *Journal for Juridical Science* 1-18; J Harries *et al* 'Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study' (2014) 11(16) *BMC Reproductive Health* 3.

developments in relation to the implied right of conscientious objection to abortion. Through a rights-based analysis, I argue that the national legal framework plays a limited role in regulating the practice of conscientious objection and does not comply with South Africa's international human rights obligations. Section three focuses on delimiting by the legal scope of the exercise of conscientious objection by examining the limitation clause in the Constitution. Drawing from international human rights law and comparative law, the second part of section three further explores the approach the courts should take in developing judicial interpretations of the exercise of conscientious objection and reproductive rights. I suggest that the legal scope of conscientious objection ought to recognise the possibility of allowing a healthcare provider to refuse to provide care, but only while protecting women from harm. Section four concludes this chapter.

4.1 The South African legal framework

4.1.1 The Constitution

The Constitution recognises reproductive rights in section 12(2) and section 27 and other bundle of rights that protects abortion rights. The material words of section 12(2) of the Constitution are as follows:

> Everyone has the right to bodily and psychological integrity, which includes the right—
>
> (a) *to make decisions concerning reproduction*;
> (b) *to security in and control over their body; and*[9]
> (c) not to be subjected to medical or scientific experiments without their informed consent.

The section serves as a constitutional basis for reproductive choice thereby affirming women's right to bodily integrity, personhood and autonomy. This is envisaged within an inclusive and non-racialised and non-sexist democracy that is based on equality, freedom, dignity and social justice.[10]

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9 Sec 12(2) of the Constitution. Emphasis added.

10 Preamble of the Constitution.

Jurisprudential clarifications of section 12(2) on the right to 'physical and psychological integrity' was made in the 2016 case of *AB v Minister of Social Development* (*AB* case).[11] The Constitutional Court determined that the decision to have a child via a surrogacy agreement cannot be deemed as a constitutionally protected right of reproductive autonomy.[12] AB, an adult who wished to have a child of her own entered into a surrogacy agreement after failing to fall pregnant after undergoing 18 in vitro fertilisation (IVF) cycles between 2001 and 2011.[13] As a single woman, AB was informed that she was not legally entitled to enter into a surrogacy agreement pursuant to section 294 of the Children's Act[14] as she was a single woman and thus, cannot donate a gamete.[15] Given these circumstances, AB, joined the Surrogacy Group as the second applicant and the Centre for Child Law (hereinafter, "the petitioner"), filed a petition before the Gauteng High Court. The petitioner contended that section 294 of the Children's Act is inconsistent with the Constitution and should be declared invalid as it violated 'reproductive autonomy, privacy and access to healthcare.'[16] In response to the allegations, the Minister of Social Development noted that AB's need can be catered through the available adoption processes in South Africa and to prevent the phenomenon of 'designer' child and commercial surrogacy.[17] The High Court held that section 294 of the Children's Act violated AB's constitutional rights to equality, human dignity, reproductive autonomy, privacy and healthcare.[18] It accordingly declared the section constitutionally invalid.[19]

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11 (2016) ZACC 43.

12 As above, 309-315.

13 As above, para 5 & 8.

14 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."

15 *AB* case (n 11) para 10.

16 As above, paras 11-12.

17 As above, para 12.

18 As per *AB v Minister of Social Development* (2015) ZAGPPHC 580; 2016 (2) SA 27 (GP) (High Court judgment).

19 As above.

Subsequently, AB and the Surrogacy Group sought confirmation of the High Court's judgment from the Constitutional Court, which has the final judicial authority as stipulated in section 167(5) of the Constitution, which states:

> The Constitutional Court makes the final decision whether an Act of Parliament, a provincial Act or conduct of the President is constitutional, and must confirm any order of invalidity made by the Supreme Court of Appeal, the High Court of South Africa, or a court of similar status, before that order has any force.

On the one hand, the petitioner argued that one of the key values of the Constitution is autonomy, which entails the exercise of autonomy in a choice and manner in which one choose to reproduce that is not a prerogative of the state. While the petitioner did not argue for autonomy as a stand-alone right, it utilises it as a lens through which an alleged individual's right must be viewed when determining the scope.[20] On the other hand, the Minister submitted that the section 294 of the Children's Act did not violate AB's rights. The Minister further argued that even if the Court were to come to the determination that certain rights were infringed on, such infringement would constitute 'legitimate government purposes,' the limitations of which are reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom.[21]

In the majority judgement, Justice Nkabinde noted the need to give a broad interpretation to section 12(2)(a) of the Constitution, despite it being part of an amalgamation of rights relating to freedom and security of the person.[22] However, its interpretation of section 12 as a negative protection of physical integrity followed the Court's interpretation of section 11 of the Interim Constitution in *Ferrerira v Levin*,[23] which was focused on detention without trial, torture, inhumane and degrading treatment.[24] The Court's application of the section as a negative right thereby asserting that bodily integrity does not extend to 'psychological harm' due

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20 *AB* case (n 11), para 21.
21 As above, para 24.
22 As above, para 63.
23 1996 (1) SA 984.
24 A*B* case (n 11), paras 70-72.

in part to the fact that the applicant's body will not be physically affected by the anticipated pregnancy.[25] Thus, the decision to have a child via surrogacy would not be constitutionally viewed as protected under the reproductive right.[26]

While the Court's acknowledgment of the protection of bodily and psychological integrity as integral for women who decide to terminate a pregnancy is commendable,[27] its scope of the core meaning of section 12(2)(a) does not incorporate the intersectional context of women's reproductive decision-making. Section 27 contains the following proviso:

> (1) Everyone has the right to have access to—
>
> (a) *health care services, including reproductive health care*;
> (b) sufficient food and water; and
> (c) social security, including, if they are unable to support themselves and their
> dependants, appropriate social assistance.
>
> (2) *The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.*[28]
>
> (3) No one may be refused emergency medical treatment.

South Africa's Constitution guarantees socio-economic rights as highlighted. As such, the country has very progressive jurisprudence on holding government accountable for its obligations relating to the realisation of the socio-economic rights[29] including right to healthcare services.[30] The *Minister of Health v Treatment Action Campaign (TAC* case*)*[31] dealt with the failure of the government to provide Nevirapine for people living with human immunodeficiency virus (HIV) in public hospitals. Thus, the Constitution envisages equal access and enjoyment for health-

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25 As above, para 76.

26 As above, para 315.

27 *H v Fetal Assessment Centre* [2014] ZACC 34; 2015 (2) SA 193 (CC); 2015 (2) BCLR 127 (CC) para 1; *Christian Lawyers' Association v Minister of Health* 2005 (1) SA 509 (T) 518C-F.

28 Emphasis added.

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

30 *Minister of Health v Treatment Action Campaign* 2001 (5) SA 721 (CC);

31 As above.

related goods, services and facilities.[32] The judgment has been criticised for its marginalisation of reproductive autonomy of black women living with HIV.[33] 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.'[34]

The ambit of state's obligations relating to section 27(1) is addressed in section 27(2) of the Constitution. The Constitutional Court in *Soobramoney v Minister of Health* (*Soobrmoney* case),[35] held that section 27(2) of the Constitution places a positive duty on the state to progressively realise socio-economic rights based on available resources.[36] However, in order to evaluate whether the state is discharging its obligation to progressively realise socio-economic rights, in this case, reproductive healthcare, the courts can require the state to adopt concrete steps if it fails in doing a periodic review of its policies. In *Government of the Republic of South Africa v Grootboom* (*Grootboom* case),[37] the Constitutional Court identified three instances of unreasonableness in relation to this obligation: when the state has not adopted any measures; where the adopted measures and the policies are exclusionary or limited in scope; and the third, when state does not assess its policies to ensure progressive realisation of the socio-economic rights.[38] The Court further held that legislative measures are not in themselves sufficient to form compliance with constitutional obligations envisaged under section 27 of the Constitution.[39] 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

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32 C Ngwena 'Access to health care as a fundamental right: The scope and limits of section 27 of the Constitution' (2000) 25 *Journal for Juridical Science* 19.

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

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

35 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.

36 *Soobramoney* case, para 11.

37 2001 (1) SA 46 (CC).

38 As above, para 67.

39 As above, para 42.

> 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 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.[40]

This means that legislative measures must be backed by well-designed programmes that are implemented in practice. Given the changing nature and context of society, the state is further obligated to periodically review policies to ensure its relevance and practicability.[41]

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.[42] 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,[43] 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. The UN Working Group on the Issue of Discrimination against Women in Law and in Practice shares this same reasoning when it stated:

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40 As above, 42.
41 As above, 43.
42 C Pickles 'Lived experiences of the Choice on Termination of Pregnancy Act 92 of 1996: Bridging the gap for women in need' (2013) 29 *South African Journal on Human Rights* 525-527.
43 *S v Makwanyane* 1995 3 SA 391 (CC) para 313.

> 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 intimidate matters of physical and psychological integrity, and is a precondition for the enjoyment of other rights.[44]

Section 9 (1) of the Constitution guarantees the right to equality before the law and equal protection of the law. Equality includes the full and equal enjoyment of all rights and freedoms. In *President of the Republic of South Africa & Another v Hugo* (*Hugo* case)[45] the Constitutional Court noted:

> We need […] to develop a concept of unfair discrimination which recognises that although a society which affords each human being equal treatment on the basis of equal work and freedom is our goal, we cannot achieve that goal by insisting upon identical treatment in all circumstances before that goal is achieved.[46]

The premise is that equality is more than just formal equality, which requires the law to treat persons in similar situation alike. This formal discourse builds on the ideas of Greek philosopher Aristotle, who believed that 'things that are alike should be treated alike, whereas things that are unlike should be treated unalike in proportion to their unalikeness.'[47] Classical liberalism sees formal equality as one in which individuals exercise free choice based on the assumption that individuals are free to do so. However, this has been criticised by feminist theorists who point out that the concept of formal equality is not adequate as it does not address the larger societal contexts as it does not factor in differences.[48] Both in international case law of international courts and national jurisprudence, the notion of substantive equality has taken root. In General Comment No 18, the UN Human Rights Committee responsible for overseeing the implementation of the

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44 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.

45 1997 (4) SA 1 (CC).

46 As above, para 38.

47 Aristotle *The Nicomachean Ethics book V, III* (1980) trans D Ross 113a-113b.

48 M Becker 'Patriarchy and inequality: Towards a substantive feminism' (1999) 21 *University of Chicago Legal Forum* 32–33. On critics of the formal notion of equality see L Pojman 'Theories of equality: A critical analysis' (1995) 23(2) *Behavior and Philosophy* 1-27;

International Covenant on Civil and Political Rights (ICCPR)[49] noted that 'the enjoyment of rights and freedoms on an equal footing, however, does not mean identical treatment in every instance.'[50] It further added:[51]

> The Committee also wishes to point out that the principle of equality sometimes requires States parties to take affirmative action in order to diminish or eliminate conditions which cause or help to perpetuate discrimination prohibited by the Covenant.

The notion of substantive equality finds support in the works of Amartya Sen who argues that the determination of human capability must go beyond the examination of available goods and services, to scrutinise the social arrangements that shapes the capability of each person.[52]

The transformative potential of substantive equality has also been advanced by the Constitutional Court in several cases.[53] These jurisprudential developments are particularly important given the South African social and historical context of persisting inequalities arising from the remnants of structural oppression of apartheid.[54] In *Soobramoney,* the Constitutional Court describes this problem in the following terms:

> We live in a society in which there are great disparities in wealth. Millions of people live in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. These conditions already existed when the Constitution was adopted and a commitment to address them and to transform our

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49 International Covenant on Civil and Political Rights (ICCPR) adopted 16 December 1966, GA Res 2200A (XXI), UN Doc A/6316 (1966) 993 UNTS 3, entered into force on 23 March 1976.

50 Human Rights Committee 'General Comment No 18: Non-discrimination' (1989) HRI/GEN/1/Rev.9 (Vol. I) para 8.

51 As above, para 10.

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

53 These include: *President of the Republic of South Africa & Another v Hugo* 1997 6 BCLR 708 (CC); *National Coalition of Gay and Lesbian Equality v Minister of Justice* 1999 1 SA 6 (CC); 1998 12 BCLR 1517 (CC) para 74.

54 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* 748-769.

> society into one in which there will be human dignity, freedom and equality lies at the heart of our new Constitutional order. For as long as these conditions continue to exist that aspiration will have a hollow ring.[55]

The social and historical context was not only on the basis of race and class, but also gender. On the inequality suffered by women due to their gender roles, Justice Goldstone presented it as follows:

> For all that it is a privilege and the source of enormous human satisfaction and pleasure, there can be no doubt that the task of rearing children is a burdensome one. It requires time, money and emotional energy. For women without skills or financial resources, its challenges are particularly acute. For many South Africa women, the difficulties of being responsible for the social and economic burdens in circumstances where they have few skills and scant financial resources are immense. The failure by fathers to shoulder their share of the financial and social burden of child rearing is a primary cause of this hardship. The result of being responsible for children makes it more difficult for women to compete in the labour market and is one of the causes of the deep inequalities experienced by women in the labour market.[56]

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.[57] South Africa remains one of the most unequal societies in the world.[58] 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.[59] 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

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55 *Soobramoney* (n 35) para 8.

56 *Hugo* case (n 45) para 38.

57 As above, para 38.

58 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).

59 As above, xiv.

> time, such external control of reproduction and sexuality –– and thus of women and their place in society –– reinforces of inequality.[60]

Given this historical context of inequality, the quest for equality is not merely for political equality but also focuses on socio-economic status. The right to equality demands the articulation and implementation of state's obligations that addressed discrepancies based on racial and gender dimensions in accessing healthcare services.[61] This finds support in the 2018 report of the Guttmacher-Lancet Commission on sexual and reproductive health and rights, which affirms that the right to make decisions concerning one's body is a key component in the attainment of gender equality and economic development.[62] Access to safe abortion is a gender equality matter as a woman's control of her reproductive rights is key to her ability to equally contribute in society.[63] Equality is about the articulation of fairness amongst citizens. As for the struggle to safeguarding equality within a liberal polity, Charles Ngwena holds that:

> Taking equality seriously means taking steps to protect the equality rights of a vulnerable social group by countering discriminatory and obstructive barriers that are unconstitutional or superfluous and have the effect of delaying or ultimately thwarting the exercise of legal rights, thus perpetuating the status quo.[64]

In respect of access to healthcare, section 27 is also aimed at achieving substantive equality.[65] Control over one's reproduction as guaranteed in section 12(2) of the

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60 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

61 See C Ngwena 'Accessing abortion services under the Choice on Termination of Pregnancy Act: Realising substantive equality' (2000) 19 *Journal of Juridical Science* 25–26.

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

63 US Supreme Court Justice Ginsburg quoting *Planned Parenthood v Casey* 505 US 833 (1992) in *Gonzales v Carhart* 550 US (2007) 4.

64 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(1) *Journal of African Law* 133. See also C Ngwena *What is Africanness? Contesting nativism in race, culture and sexualities* (2018) 248-250.

65 C Ngwena 'Substantive equality in South African health care: The limits of law' (2000) 4 *Medical Law International* 2; F Freedman 'Understanding the right to equality' (1998) 115 *South African Law Journal* 243.

Constitution constitutes an important element of human dignity.[66] Section 10 of the Constitution provides that everyone has inherent dignity and the right to have their dignity respected and protected. The 'concepts of equality and dignity [are] closely intertwined, namely that all persons have the same inherent worth and dignity as human beings.'[67] Justice Chaskalson on the principle of dignity aptly elucidates that 'the relationship between equality and dignity is clear. It recognises a substantive content in equality, and this is the approach that the Constitutional Court has taken to the interpretation and application of the equality clause of our constitution.'[68] 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 will not be easy but that is the goal of the Constitution should not be forgotten or overlooked.[69]

My point here is that women's control over their reproduction cannot be analysed in isolation but rather, it entails a complex set of social and economic relationships that exists at all levels. This means, a move from just a focus on choice and individual rights to a more relation context of reproductive decision-making.[70] The realisation of such rights is dependent to a large extent on health professionals who have a vital role in protecting and promoting human rights including the right to abortion.

However, given that attitudes about abortion remain largely mixed or negative, healthcare workers with conscientious objection can find support in the Constitution. The South African Constitution recognises the implied right to

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66 On the link between women's reproductive control and dignity see Freedman (n x) 149-152.

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

68 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.

69 *Hugo* case (n 45) para 41.

70 This speaks to the reproductive justice framework see JC Chrisler 'Introduction: A global approach to reproductive justice- psychosocial and legal aspects and implications' (2013) 20 *William & Mary Journal of Women and the Law* 1-24.

conscientious objection. According to section 15 (1) of the Constitution 'everyone has the right to freedom of conscience, religion, thought, belief and opinion.'[71] 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.'[72] Like other constitutional rights, this right is not absolute. The right would be subject to the limitation clause as provided in section 36. It is submitted that in determining the limit on the exercise of conscientious objection, section 36 imposes a duty to provide medical care in case of medical emergency, as well as enshrines an obligation to provide information and is only applicable to those directly involved in the procedure.[73] Using section 36 to ensure a balancing act of competing rights is discussed in detail below.

4.1.2 Choice on Termination of Pregnancy Act

The Choice on Termination of Pregnancy 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.'[74] The key values espoused in the preamble include non-racialism, non-sexism and the advancement of human rights and freedoms.[75] It also recognises the state's responsibility to provide reproductive health to all, and to also provide safe conditions under which the right of choice can be exercised without fear or harm.[76] The Act is aimed at redressing past injustices as a result of the restrictive grounds for termination of pregnancy in the 1975 Abortion and Sterilization Act.[77] Abortion was only allowed in cases of serious threat to the life of the pregnant woman, or constituted a serious threat to the physical or mental health of the woman, malformation of the foetus or where the

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71 Sec 15(1) of the Constitution.
72 *Christian Education of South Africa v Minister of Education* (10) BCLR 1051 (CC) para 42.
73 See Ngwena (n 8) 11-15.
74 Preamble, para 7
75 As above, para 1
76 As above, para 5.
77 Act 2 of 1975. See SM Klausen *Abortion under apartheid: Nationalism, sexuality, and women's reproductive rights in South Africa* (2015).

pregnancy was a result of unlawful carnal intercourse.[78] In addition, for all these grounds, abortion could only be procured if certified by two medical practitioners in writing.[79] This had a disproportionate impact on poor black women leading to illegal abortion as white women were able to seek abortion elsewhere. [80]

The Choice on Termination of Pregnancy Act provides for abortion on demand up to twelve weeks of pregnancy and between thirteen to twenty weeks, in consultation with a medical practitioner on broad grounds specified in the Act. The relevant section of the Act reads:

> 2. (1) A pregnancy may be terminated-
>
> > (a) upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;
> >
> > (b) from the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that-
> >
> > > (i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or
> > > (ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality; or
> > > (iii) the pregnancy resulted from rape or incest; or
> > > (iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman; or
>
> (c) after the 20th week of the gestation period if a medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy-
>
> > (i) would endanger the woman's life;
> > (ii) would result in a severe malformation of the fetus; or
> > (iii) would pose a risk of injury to the fetus.

78 Sec 3(1)(a)-(d).

79 As above.

80 R Hodes 'The culture of illegal abortion in South Africa' (2016) 42 (1) *Journal of Southern African Studies* 80.

The Act further stipulates that pre-abortion and post-abortion counselling should be non-directive in nature and made available to women, which they can choose not to receive.

Since its enactment 22 years ago, attempts to challenge the Act and claw back on its provisions failed. As discussed below, jurisprudence affirms reproductive rights.

A. Defending abortion rights

While progress have been noted, there has also been a growing mobilisation of the pro-life movement rooted in morally based arguments and fuelled by right wing political parties including the African Christian Democratic Party (ACDP), Pan Africanist Congress (PAC) and the New National Party (NNP).[81] Within this context, the conservative voice merged vigorously and strategically to roll back the Act. The Act's constitutionality was first challenged in *Christian Lawyers Association v National Minister of Health & Others* on the grounds that the right to terminate a pregnancy violates the constitutional right to life of the foetus.[82] The Pretoria High Court dismissed the claim, holding that the foetuses were not rights-bearers, as the wording of the Bill of Rights provisions under the Constitution did not envisage this.[83]

The second case was in 2004 when the Christian Lawyers Association challenged sections 5(2) and 3 of Act, which allows adolescent girls to choose abortion without the consent of, or consultation, with parents.[84] The High Court dismissed the challenge, noting that girls who have the emotional and intellectual capacity to consent could do so.[85] The Court noted that enforcing a mandatory parental

81 Reproductive Rights Alliance 'Media coverage on termination of pregnancy over January to August 1999' (1999) 3 *Barometer* 15.
82 *Christian Lawyers Association v National Minister of Health & Others 1998 (4) SA 1113 (T).*
83 As above.
84 *Christian Lawyers Association v National Minister of Health & Others* 2005 (1) SA 509.
85 As above, 519.

involvement would infringe the constitutional rights of girls including their reproductive freedom, dignity, privacy and access to reproductive healthcare.[86]

In 2004, the Doctors for Life International challenged the initial attempt to amend the Act on the grounds that the amendment process did not adhere to the rules of consultation at the provincial levels. [87] This resulted in the decision of the Constitutional Court to suspend the implementation of the amended Act for 18 months in order for the state to follow due process. It was eventually returned to Parliament and the Choice on Termination of Pregnancy Amendment Act 1 of 2008 was passed. The 2008 amendment expanded the list of medical personnel that can perform abortions under section 10. Hence, termination of pregnancies during the first trimester (12 weeks of gestation) or less can be performed not only a medical practitioner, but also a registered nurse or midwife,[88] who has completed the prescribed abortion training.

B. Silence on the right to conscientious objection: A key shortcoming of the Act

A key shortcoming of the Act is that it does not have an explicit provision on conscientious objection by healthcare professionals.[89] This is a departure from the 1975 Abortion and Sterilization Act, which allowed physicians to refuse to perform an abortion. Section 9 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.

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86 As above. See also Pickles (n 42) 527.

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

88 According to the Act, a 'registered nurse' or 'registered midwife' means a person registered as such under the Nursing Act, 2005 (Act No. 33 of 2005), and who has in addition undergone prescribed training in terms of this Act

89 See Ngwena (n 8) 1-18.

This particular section allowed for conscientious objection without restrictions. From this premise, the debate on whether to include a conscience refusal clause or not during the drafting of the Choice on Termination of Pregnancy Act is discussed in the next chapter. The Council of Europe in its 2010 report on conscientious objection noted that the lack of regulation when it comes to the exercise of conscientious objection is a central element in effectively blocking women's access to abortion.[90]

However, while regulation of conscientious objection is vital, it is important to note that even where conscience-based refusals are enshrined in law, they do not always work in practice.[91] To borrow the words of Christian Fiala and Joyce Arthur:

> Even where a law or policy allows limited [conscientious objection], abuse of that right is common. This implies that objecting personnel cannot be trusted to exercise the right responsibly, and that those who abuse [conscientious objection] are not qualified to be healthcare workers.[92]

A widely held view is that the National Department of Health and its provincial departments have not engaged in any meaningful awareness campaign since the enactment of the Act, which has led to a lack of awareness, obscurity and vagueness about the obligations of healthcare providers resulting to ineffective implementation at the expense of women's access.[93] This is further compounded by National Department of Health's conceptualisation of conscientious objection in that there is no proof of the systematic use of conscientious objection, as healthcare

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90 Council of Europe (n 90) 'Women's access to lawful medical care: The problem of unregulated use of conscientious objection' Doc. 12347 (2010) http://semantic-pace.net/tools/pdf.aspx?doc=aHR0cDovL2Fzc2VtYmx5LmNvZS5pbnQvbncveG1sL1hSZWYvWDJILURXLWV4dHIuYXNwP2ZpbGVpZD0xMjUwNiZsYW5nPUVO&xsl=aHR0cDovL3NlbWFudGljcGFjZS5uZXQvWHNsdC9QZGYvWFJlZi1XRC1BVC1YTUwyUERGLnhzbA==&xsltparams=ZmlsZWlkPTEyNTA2 ((accessed 20 March 2017) paras 44 & 53.

91 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(1) *Global Bioethics* 1-15; F Minerva 'Conscientious objection in Italy' (2015) 41 *Journal of Medical Ethics* 170-173.

92 C Fiala & JH Arthur 'Dishonourable disobedience – Why refusal to treat in reproductive health care is not conscientious objection' (2014) 1 *Woman- Psychosomatic Gynecology & Obstetrics* 19.

93 Interview with pro-abortion activist, skype 21 February 2019.

providers are merely not participating in abortion services.[94] A study on the attitudes of healthcare providers in relation to abortion termination found that providers do not have a clear understanding of what constitute conscientious objection due in part to an absence of a comprehensive regulatory framework.[95]

Despite the need for more robust research, there is sufficient evidence to indicate that healthcare professionals' refusal to provide care is a substantial obstacle in accessing abortion services.[96] Unsafe abortions continue to take place outside the ambit of the Act as demonstrated by widespread lamppost advertisements for quick abortions.[97] The lack of accessibility is further compounded by the unavailability of statistics of unsafe abortions outside the formal health system, which are not documented or accounted for due in part to government's lack of political will.

4.1.3 Draft National Guidelines for Implementation of Termination of Pregnancy Services in South Africa

Currently, there are no clear guidelines on the exercise of conscientious objection to abortion. The environment becomes conducive for healthcare providers to act within their 'own' understanding of the law, which results to systemic abuse of what the right entails.[98]

Recognising the limitation of the law, the National Department of Health developed a Draft National Termination of Pregnancy Guidelines in October 2018.[99] This is part of a broader strategy of not singling out termination of pregnancy, but rather

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94 Interview with National Department of Health representative, telephone 22 February 2019.

95 Harries et *al* (n 1) 4-5.

96 See for example, Harries *et al* (n 8) 3.

97 R Jewkes et al 'Why are women still aborting outside designated facilities in metropolitan South Africa' (2005) *BJOG: An International Journal of Obstetrics and Gynecology* 1236-1242.

98 J Harries et al 'An exploratory study of what happens to women who are denied abortions in Cape Town, South Africa' (2015) 12(21) *BMC Reproductive Health* 2-5.

99 National Department of Health 'Draft National guidelines for implementation of termination of pregnancy services in South Africa (2018). There is also a draft National Integrated SRHR Policy (2018) that addresses the issue of conscientious objection. (drafts on file with author).

as part of a comprehensive reproductive health services package with the goal of addressing stigma.[100] The guidelines detail how the Act and its subsequent amendment should be implemented including conditions in which a pregnancy may be terminated; designation of facilities; counselling; consent; regulations and offences and penalties.[101] The aim of the guidelines is to:

> provide a clinical and operational framework for the provision of equitable, accessible, cost-efficient, and user-friendly TOP services. It aims to advance client's rights to the highest quality of safe TOP services whilst ensuring its integration into the comprehensive SRHR healthcare service package.[102]

Key clinical considerations include adequate training to provide termination of pregnancy services, site designation criteria, national standardize clinical referral algorithm, conscientious objection and appropriate protocol and provider's obligation in emergency settings.

Given that the Act does not stipulate conscientious objection, the guidelines regulate the practice as 'obstruction to access or an obstruction to care,' which is provided in the law. [103] Section 10 of the Act makes it 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. In line with international standards, 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. This has resonance in other countries, as majority of national laws that allow conscientious objection, do require health providers to refer to a volunteer colleague.[104] The client's right to information and access to health care

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

101 Interview with National Department of Health representative, telephone 22 February 2019.

102 National Department of Health (n 140 above).

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

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* 104-108.

services, including abortion, should always be provided for.[105] The guidelines affirm that such refusal should not be to the detriment of the client seeking an abortion.[106]

Additionally, 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. An individual's conscience-based refusal cannot violate the right of the other health care providers who are willing to provide abortion services.[107] In terms of standards that must be put in place for the proper regulation of conscientious objection, the guidelines affirm that:[108]

- 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:
    I. Explain their refusal to the client in a manner that does not stigmatise or judge the client
    II. Explain to the client their right to request a safe abortion

105 As above.
106 National Department of Health (n 99) 36.
107 BM Dickens 'Conscientious objection and professionalism' (2009) 2(4*) Expert Reviews in Obstetrics and Gynecology* 97-100; BM Dickens 'Reproductive health services and the law and ethics of conscientious objection' (2001) 20 *Medicine and Law* 283-193.
108 National Department of Health (n 99) 30.

III. Make the necessary arrangements to enable the client to be seen by a provider who will conduct the abortion
IV. Update the facility register to note the refusal to treat.

With the guidelines possibly addressing the scope of obligations arising from the Act, a key concern is how the National Department of Health and its provincial departments will ensure that that they are effectively implemented and monitored.[109] It is important to note that it is almost a year since completion of the draft guidelines and the Health Council of the National Department of Health has yet to approve it.

4.2 Conscientious objection in international and African human rights standards and medical ethical standards

In an attempt to understand the ambit and scope of relevant South African constitutional and legislative provisions to the exercise of conscientious objection, an alignment should be made to corresponding international human rights norms. According to section 39(1) of the Constitution, courts must promote the underlying values of an open and democratic society, must take international law into account and may also have regard to foreign law when interpreting rights in the Bill of Rights.

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 one one's personal conscience.[110] The Oxford English dictionary defines conscience as '(a) person's moral sense of right and wrong, viewed as acting as a guide to one's behaviour.' Freedom of conscience is heralded as a fundamental component of a democratic and pluralistic society.[111] Respecting the wide range of

109 Interview with public health professor and researcher, Skype 20 February 2019.
110 J Rawls *A theory of justice* (2005) 363.
111 Council of Europe (n 90) para 11.

religious and moral beliefs is considered a foundation for a pluralistic state.[112] John Rawls argues that the practice of conscientious objection is a breach of law but one in which the objector is exempted due to her[113] held beliefs.[114]

Although there is an overlap between conscientious objection and civil disobedience, the two concepts remain different. Civil disobedience is usually a public act, while on the other hand, conscientious objection is usually centred on the individual who invokes it and it is not designed to serve as a rallying point for others to join. [115] Hannah Arendt argues that 'the rules of conscience hinge on interest in the self,' as the individual accepts that 'the fear of being alone and having to face oneself can be a very effective dissuader from wrongdoing, but this fear, by its very nature, is unpersuasive of others'.[116] The two may overlap where a group of individuals for instance, join forces to defy a particular law based on conscience, religious or moral grounds. This becomes politically significant because as a collective, they make their voices heard in public.

Conscientious objection claims usually finds support in the Constitution where it has both supportive and conflictual relationships to other fundamental rights such as equality, dignity, and freedom of expression. As an example, the claims of the conscientious objector who refuses to provide abortion contrary to a patient's right to equality and liberty amounts to a clash between individual rights.[117]

This thesis works on the premise that there is an implied right to conscientious objection, which must be understood within the context of freedom of conscience. Freedom of conscience is guaranteed in international human rights instruments

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112 See M Rosenfeld 'The conscience wars in historical and philosophical perspective' in S Mancini & M Rosenfeld (eds) *The conscience wars: Rethinking the balance between religion, identity and equality* 58-101

113 Instead of using both the masculine and feminine pronouns, this study when referring generally to individuals will use only the feminine.

114 Rawls (n 110) 363.

115 As above, 368.

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

117 See R Dworkin *Taking rights* seriously (1977) 131-149.

ratified by South Africa including the International Covenant on Civil and Political Rights (ICCPR).[118]

4.2.1 International standards

Freedom of conscience is guaranteed in international human rights instruments. Article 18 of the Universal Declaration of Human Rights (Universal Declaration)[119] states that, '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.'[120] The spirit of article 18 of the UDHR is replicated in article 18(1) of the ICCPR.

The right to exercise conscientious objection precedes the decriminalisation of abortion laws.[121] Historically, the invocation of objection based on freedom of thought, conscience and religion was in association with compulsory military service.[122] In 1993, the Human Rights Committee adopted General Comment No 22 on article 18 of the ICCPR, aiming to assist state parties with the implementation of their international obligations relating to freedom of conscience, thought and religion.[123] General Comment 22 affirms that while the right to conscientious objection is not explicitly stated in the Covenant, such a right could be read into article 18 as the 'use of lethal force may seriously conflict with the freedom of conscience and the right to manifest one's religion or belief.'[124]

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118 Art 18. International Covenant on Civil and Political Rights (ICCPR) adopted 16 December 1966, GA Res 2200A (XXI), UN Doc A/6316 (1966) 993 UNTS 3, entered into force on 23 March 1976.

119 Universal Declaration of Human Rights (Universal Declaration) adopted 10 December 1948, UNGA 217 A (III).

120 Art 18.

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

122 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).

123 Human Rights Committee 'General Comment No 22: CCPR, art 18 on freedom of thought, conscience or religion' (30 July 1993) CCPR/C/Rev.1/Add.4.

124 As above, para 11.

It is in this disposition that the Committee found violations of article 18 of the Covenant in *Jeong et al v Republic of Korea,*[125] due to the country's non-recognition of conscientious objection and absence of an alternative to compulsory military service.[126] The Committee held that conscientious objection is a constituent element of conscience noting that conscientious objection to military service is inherent to the freedom of thought, conscience and religion.[127] 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. This means, in terms of freedom of conscience, there is an implication that a person should not be *prevented* from demonstrating one's belief but should also be able to exercise the right *not to be required to act* against her conscience.[128] The Human Rights Committee has affirmed that:

> While the right to manifest one's religion or belief does not as such imply the right to refuse all obligations imposed by law, it provides certain protection, consistent with article 18, paragraph 3, against being forced to act against genuinely-held religious belief.[129]

Article 18(3) of ICCPR provides that:

> Freedom to manifest one's religion or beliefs may be subject to 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.

It 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 UDHR, which states:

> In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the

125 UN Human Rights Committee (27 April 2011), CCPR/C/101/D/1642-1741/2007 (2011)
126 As above, para 7.2.
127 As above 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.
128 Emphasis added.
129 *Yeo-Bum Yoon and Myung-Jin Choi v. Republic of Korea*, UN Human Rights Committee (23 January 2007) CCPR/C/88/D/1321-1322/2004 (2007) para 8.3.

> just requirements of morality, public order and the general welfare in a democratic society.

Thus, the exercise of conscientious objection is not absolute, as the freedom to manifest one's religion or belief can be subjected to restrictions.[130]

While majority of jurisprudence emanating from the UN are on conscientious objection to military service, this is not the only context where objection takes place. Conscientious objection is also recognised in the medical sphere, especially within the context of reproductive healthcare services.[131] The provision of reproductive healthcare services has remained a highly contentious moral issue amidst a strengthening of women's sexual and reproductive health and rights paradigm.[132] Healthcare providers' conscience-based refusal to provide reproductive health services including emergency contraception and other forms of contraception, sterilisation, infertility treatment and abortion care has consequences for women's human rights[133] This is why some scholars have contended that conscientious objection not at all like in the military, should not be allowed in reproductive healthcare.[134]

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130 Dickens (n 107) 97.

131 MR Wicclair 'Conscientious objection in medicine' (2000) 14(3) *Bioethics* at 206.

132 Notably, the International Conference on Population and Development (ICPD) in 1994 in Cairo and the Fourth World Conference on Women in Beijing reaffirmed the right of women to have decide freely and responsibly on matters concerning reproduction. See UN 'Report of the International Conference on Population and Development: Cairo programme of action' (1994) A/Conf.171/13; UN 'Report of the Fourth World Conference on Women: Beijing platform for action' (1995) A/Conf.177/20.

133 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 Gynecology & Obstetrics* 12-23.

134 JH Arthur & C Fiala 'The FSRH guideline on conscientious objection disrespects patient rights and endangers their health' (2018) 44(2) *BMJ Sexual & Reproductive Health* 145; See B Johnson Jr *et al* 'Conscientious objection to provision of legal abortion care' (2013) 123 *International Journal of Gynecology & Obstetrics* S60.

Obligation to regulate the exercise of conscientious objection

UN human rights treaty monitoring bodies have called on states to ensure that the exercise of conscientious objection does not hinder access to reproductive health services.[135] The Committee on the Elimination of all Forms of Discrimination against Women (CEDAW Committee) responsible for monitoring implementation of CEDAW adopted General Recommendation No 24 on obligations relating to women's health.[136] General Recommendation No 24 affirms that states have an obligation to take steps to guarantee access to reproductive healthcare services for women, even where they permit health professionals to refuse to provide services.[137] In this regard, if healthcare providers invoke conscientious objection to perform such services, women should be referred to alternative providers.[138] This is on the basis that forced continuation of pregnancy may amount to torture and cruel, degrading and inhumane punishment.[139]

The Committee on Economic, Social and Cultural Rights (Committee on ESCR) issued General Comment No 22 to provide guidance to states' international obligations to realise the right to sexual and reproductive health.[140] States have an obligation to respect, protect and fulfil the right to health, through which the right to sexual and reproductive health is constituted.[141] According to General Comment No 22, the duty to protect includes state obligations to take measures to ensure that

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

136 CEDAW Committee 'General Recommendation No. 24: women and health' (1999) A/54/38/Rev.1, chap. I.

137 As above, para 11.

138 As above.

139 CEDAW Committee 'General Recommendation No. 35 on gender-based violence against women' (2017) CEDAW/C/GC/35 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).

140 Committee on ESCR 'General Comment No. 22 on the right to sexual and reproductive health' E/C.12/GC/22 (2016).

141 See Committee on ESCR 'General Comment No 14: the right to the highest attainable standard of health' UN Doc E/C 12/ 2000/4 (2000). On the normative framework for the realisation of the right to health see, O Oluduro & E Durojaye 'The normative framework on the right to health under international human rights law' in E Durojaye (ed) *Litigating the right to health in Africa* (2015) 13-42.

refusal to provide services based on conscience does not serve as a barrier to accessing services.[142] In this regard, states have to ensure that there are adequate number of trained healthcare providers available in both public and private facilities.[143] 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.[144]

The treaty monitoring bodies have likewise raised the issue of conscientious objection in their concluding observations on state party reports.[145] For example, the Human Rights Committee in examining the report of Poland reiterated its concern on the inappropriate invocation of the 'conscience clause' which serves as one of the impediments to women's access to safe abortion services, hence, the high number of unsafe abortions.[146] The CEDAW Committee in its concluding observations on Hungary noted that states need to ensure that 'conscientious objection is accompanied by information to women about existing alternatives and that it remains a personal decision rather than an institutionalized practice.'[147] 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.'[148]

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142 Committee on ESCR (n 140) para 14.

143 As above.

144 Human Rights Committee 'General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life' CCPR/C/GC/36 (2018) para 8.

145 See CEDAW 'Concluding Observations on the seventh periodic report of Argentina' (2016) CEDAW/ARG/CO/7.

146 Human Rights Commission 'Concluding observations on the seventh periodic report of Poland' CCPR/POL/CO/7.

147 CEDAW Committee 'Concluding observations on the combined seventh and eighth periodic reports of Hungary' (2013) CEDAW/C/HUN/CO/7-8 para 31(d).

148 Committee on ESCR 'Concluding observations on the initial report of South Africa' (2018) E/C.12/ZAF/CO/1 para 66(b).

4.2.2 Regional standards

At the regional level, article 8 of the African Charter on Human and Peoples' Rights (African Charter)[149] provides for freedom of conscience. 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.[150] 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. Article 14 (2) of the Protocol obligates state parties to take all appropriate measures to:

> protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

Furthermore, article 26 of the Protocol direct states to adopt budgetary measures in order to fulfil the rights provided in the Protocol.

As of November 2019, 42 out of the 55 African states have ratified the Maputo Protocol.[151] This is an indication of the favourable reception that the Protocol enjoys in the continent as the foremost legal instrument on women's rights.[152] However, it is important to note that some African countries such as Cameroon,[153]

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149 African Charter on Human and Peoples' Rights, OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

150 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.

151 The latest country to ratify was Sao Tome & Principle on 18 April 2019. There are 13 countries (Botswana, Burundi, Central African Republic, Chad, Egypt, Eritrea, Madagascar, Morocco, Niger, Sahrawi Arab Democratic Republic, Somalia, South Sudan and Sudan) 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/7783-sl-protocol_to_the_african_charter_on_human_and_peoples_rights_on_the_rights_of_women_in_africa_5.pdf (accessed 27 November 2019).

152 F Viljoen *International human rights law in Africa* (2nd edition, 2012) 50-59.

153 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*

The Gambia,[154] Kenya,[155] Rwanda[156] and Uganda,[157] entered reservations to the provision on abortion upon ratification of the Protocol.[158] While both the African Charter and the Protocol are silent on reservation, article 19 of the Vienna Convention on the Laws of Treaties (Vienna Convention),[159] which allows states to enter into a reservation to a treaty.[160] 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.[161]

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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.'

154 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.

155 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.*

156 Rwanda lifted its reservations in 2012 to allow women to access abortion services when the pregnancy is a 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) https://www.achpr.org/states/statereport?id=111 (accessed 20 August 2019) para 78.

157 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.*

158 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) http://www.peaceau.org/uploads/special-rapporteur-on-rights-of-women-in-africa-presentation-for-csw-implementation.pdf (accessed 10 January 2019) 3.

159 Art 19 of the Vienna Convention on the Law of Treaties (1969) 1155 UNTS 331.

160 J Dugard *International law: A South African perspective* (2011, 4th edition) 417-422.

161 Art 2(1)(d) of the Vienna Convention. Emphasis added.

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:

> none 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 interpretative declaration on article 31 of the Charter.[162] 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 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, assumption might be made that the Protocol has more favourable provisions. By making this interpretative declaration, South Africa makes the bold statement that its Bill of Rights has more favourable human rights protection for women in South African than what the Protocol offers. This is particularly true in the case of abortion, which as highlighted earlier, both the Constitution and the Choice on Termination of Pregnancy Act offers a more comprehensive set of rights than the Protocol's

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162 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 160) 418.

circumscribed abortion grounds.[163] Similarly, they followed this reasoning in making a reservation on article 6(h) of the Protocol to safeguard citizenship rights of children.[164]

Second, while reservations by ratifying states means that it remains bound to the treaty except to the provisions to which the state has made reservations, this cannot be construed as serving to restrict drawing upon other international and regional human rights treaties to which the state is a party to.[165] While ratification is desirable, implementation of the Maputo Protocol is absolutely imperative in order to impact the lives of women. The Guttmacher Institute estimates that majority of women of reproductive age in Africa live in countries with highly restrictive abortion laws that are found in different categories:[166]

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163 Ngwena (n 150*)* 843. 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).

164 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.'*

165 HJ Steiner et al *International human rights in context: Law, politics, morals: Text and materials* (2000, 2nd edition) 1125-1126.

166 Guttmacher Institute 'Factsheet: Abortion in Africa' (2018) https://www.guttmacher.org/sites/default/files/factsheet/ib_aww-africa.pdf (accessed 5 February 2019) 1. See also Guttmacher Institute 'Abortion Worldwide 2017: Uneven progress and unequal access' *(*2018) https://www.guttmacher.org/report/abortion-worldwide-2017 (accessed 10 March 2019).

Countries in Africa can be classified into six categories, according to the reasons for which abortion is legally permitted.

Reason	Countries
Prohibited altogether, (no explicit legal exception)	Angola, Congo-Brazzaville, Congo-Kinshasa, Egypt, Gabon, Guinea-Bissau, Madagascar, Mauritania, São Tomé and Príncipe, Senegal
To save life of woman	Côte d'Ivoire, Libya, Malawi, Mali (a,b), Nigeria, Somalia, South Sudan, Sudan (a), Tanzania, Uganda
To save life of woman/ preserve physical health*	Benin (a,b,c), Burkina Faso (a,b,c), Burundi, Cameroon (a), Cen. African Republic (a,b,c), Chad (c), Comoros, Djibouti, Equatorial Guinea (d,e), Ethiopia (a,b,c), Guinea (a,b,c), Kenya, Lesotho (a,b,c), Morocco (e), Niger (c), Rwanda (a,b,c), Togo (a,b,c), Zimbabwe (a,b,c)
To save life of woman/preserve physical or mental health	Algeria, Botswana (a,b,c), Eritrea (a,b), Gambia, Ghana (a,b,c), Liberia (a,b,c), Mauritius (a,b,c,d), Mozambique (a,b,c), Namibia (a,b,c), Seychelles (a,b,c), Sierra Leone, Swaziland (a,b,c)
To save life of woman/preserve physical or mental health/socio-economic reasons	Zambia (c)
Without restriction as to reason	Cape Verde, South Africa, Tunisia

*Includes countries with laws that refer simply to "health" or "therapeutic" indications, which may be interpreted more broadly than physical health. *Notes:* Some countries also allow abortion in cases of (a) rape, (b) incest, (c) fetal anomaly. Some restrict abortion by requiring (d) parental or (e) spousal authorization. Countries that allow abortion without restriction as to reason have gestational age limits (generally the first trimester); for legal abortions in categories 2 through 5, gestational age limits differ by prescribed grounds.

www.guttmacher.org

***Figure 5 Legality of abortion in Africa*, 2017**[167]

This means that majority of abortion laws of state parties to the Maputo Protocol are not in line with its provisions.[168] Thus, implementation of the Maputo Protocol has been admittedly slow as women continue to face barriers to access abortion services even in countries where abortion has been liberalised. Within the Africa region, the incidence rate during 2010 to 2014 is estimated at 26 per 1,000 for married women and 36 per 1,000 for unmarried women.[169] Women from sub-Saharan Africa constituted the highest incidence of deaths at 62 per cent (29, 000 out of 47,000) from unsafe abortions in 2008.[170] As a result, the African Commission on Human and Peoples' Rights (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 mandates the Commission to 'formulate and lay down principles and rules aimed at solving problems relating to human rights.' Towards this end, the African

167 As above, 2.

168 However, several countries such as South Africa have more generous provisions than the Maputo Protocol as outline in the figure above.

169 Sedgh G *et al* 'Abortion incidence between 1990 and 2014: global, regional, and subregional levels and trends' (2016) 388(10041) *Lancet* 258–267.

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

Commission adopted General Comment No 2 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.[171] This is the second general comment adopted by the African Commission which adopted its first General Comment in 2012 on Article 14 (1) (d) and (e) of the Protocol,[172] clarifying provisions relating to protection of the rights of women to protection against sexually transmitted infections, including HIV/AIDS.[173] It reiterates the need for states to

> provide 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.[174]

General Comment No 2 thus focuses on measures to promote and protect sexual and reproductive rights of women and girls in the African region and particularly on access to safe abortion.[175] General Comment No 2 serves as a valuable benchmark as a soft law instrument that consolidates international best practices on state's obligation to respect, promote, protect and fulfil rights specifically to the issue of abortion.[176]

Unprecedentedly, the Commission addressed states' duty to adequately regulate the practice of conscientious objection in the reproductive health sphere. As the

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171 African Commission on Human and Peoples' Rights 'General Comment No.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).

172 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).

173 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' 14(2) *African Human Rights Law Journal* 681-704.

174 *General Comment No 1* (n 172 above) para 26.

175 CG Ngwena *et al* 'Human rights advances in women's reproductive health in Africa' (2015) 129 *International Journal of Gynecology and Obstetrics* 184-187.

176 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(1) *Journal of African Law* 131.

General Comment observes, healthcare providers directly involved in providing abortions services may invoke conscientious objection but not in emergency situations.[177] 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.[178]

In addition, the General Comment 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.[179] 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, 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,[180] and the African Court on Human and Peoples' Rights (African Court)[181] have not yet had the opportunity to develop its jurisprudence on the scope of the right of conscientious objection within the sexual and reproductive health services sphere.[182]

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177 *General Comment No 2* (n 171) para 26.

178 As above, para 48.

179 *General Comment No 2* (n 171) paras 26 & 48.

180 When a right in the Charter has been violated by a state, another state, individual or organisation can submit a communication alleging such violations of the Charter. See art 47-59 of the African Charter.

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

182 Art 5 of the Court Protocol stipulates the parties that are entitled to submit cases before the court. It reads:

> *1. The following are entitled to submit cases to the Court*
> *a. The Commission*
> *b. The State Party which has lodged a complaint to the Commission*
> *c. The State Party against which the complaint has been lodged at the Commission*

The other regional human rights systems also recognise 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.[183] 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.'[184] 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.[185] In the inter-American human rights system, the American Convention on Human Rights[186] also guarantees freedom of thought, conscience and religion with limitations (article 12). Both the International American Commission on Human Rights (IACHR) [187] or the Inter-American Court[188] have not explicitly addressed the subject of conscientious objection in the context of reproductive healthcare.

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d. The State Party whose citizen is a victim of human rights violation
e. African Intergovernmental Organisations

2. When a State Party has an interest in a case, it may submit a request to the Court to be permitted to join.

3. The Court may entitle relevant non-governmental organisations (NGOs) with observer status *before the Commission, and individuals to institute cases directly before it, in accordance with article 34(6) of this Protocol.*

183 European Convention for the Protection of Human Rights and Fundamental Freedoms, opened for signature 4 November 1950, 213 U.N.T.S. 221, Eur. T.S. No. 5 (entered into force 3 September 1953).

184 As above.

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

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

187 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 & Others v Chile* Case 12219, Inter-Am. Comm'n. H.R., Report No. 43/05, OEA/Ser.L/V/II.124 doc. 5 (2005).

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

4.2.3 Abortion and freedom of conscience in professional guidelines

The right to conscientious objection has also been recognised in international professional codes of conduct from varied sectors.[189] According to the 2014 revised International Code of Ethics for Midwives of the International Confederation of Midwives (ICM), the aim of the midwifery profession is to 'improve the standard of care provided to women, babies and families'.[190] On the scope of practice, ICM notes that:

> The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the post-partum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.[191]

Abortion is not mentioned, though it recognises that education and counselling as vital for women's reproductive healthcare.[192] In its 2018 Essential Competencies for Midwifery Practice, ICM noted the need for the provision of care for unintended or mistimed pregnancy.[193] It provides that key competencies under this category include counselling women about options to main or end pregnancy while respecting their decision; providing information about access to abortion services;

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189 B Dickens & RJ Cook 'The scope and limits of conscientious objection' (2000) 71 *International Journal of Gynecology & Obstetrics* 71-77.

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

191 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 https://www.internationalmidwives.org/assets/files/definitions-files/2018/06/eng-definition_of_the_midwife-2017.pdf (accessed 15 February 2019) 1.

192 As above.

193 International Confederation of Midwives (ICM) 'Essential Competencies for Midwifery Practice' (2018) 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) 16.

and referral to provider and post-abortion care.[194] It seems that there has been a gradual shifting of the position of ICM of abortion-related care not deemed mainstream for midwives, to its consideration now as an essential component of midwifery. The Technical Guidelines on Safe Abortion of the World Health Organization (WHO) also includes precautionary measures that require the practice of conscientious objection to not delay care within the context of lawful abortion services.[195]

4.3 Delineating the legal scope of the exercise of conscience objection

4.3.1 The limitation clause and conscientious objection

While the exercise of conscientious objection finds support in section 15(1) of the South African Constitution on the right to freedom of conscience, religion, thought, belief and opinion, it is not an absolute right and therefore be limited. Fundamental rights in the Constitution are subject to the limitation clause. Section 36(1) provides that:

> (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.

194 ICM *Code of Ethics* (n 188).

195 World Health Organization (WHO) 'Safe abortion: technical and policy guidance for health systems' 2nd edition (2012) 96.

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[196] 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.[197]

A principal argument of this section is that the limitation clause in the Bill of Rights can be applied to balance constitutional rights in conflict. In determining the scope of the exercise of conscientious objection, limitation on healthcare providers' right to freedom of thought, conscience and religion must be determined to be justifiable and reasonable. The application of the limitation clause to make such a determination is through the exercise of proportionality. In the *Makwanyane* case, the then president of the Constitutional Court, Chaskalson P in his dictum on limitation of rights noted:

> 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.[198]

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196 H Cheadle 'Limitation of rights' in MH Cheadle et al *South African constitutional law: The bill of rights* (2002) 693- 733.

197 As above, 694.

198 Makwanyane case (n 43) para 104.

The balancing exercise in this approach as highlighted above means balancing the significance of the right in question with the significance of the purpose of the limiting law.[199] For instance, an argument can be made that the denial of abortion services in this case on the basis of conscience may infringe on the woman's right to life as provided in the Constitution as well as her rights as provided in the ICCPR.[200]

In making a determination as to what right is more important than the other given that the Bill of Rights does not have a hierarchy of rights, the Constitutional Court in *Makwanyane* held that 'different rights have different implications for [...] an open and democratic society based on freedom and equality.'[201] This reasoning was in line with section 33(1) of the Interim Constitution[202] that had explicitly differed rights into those that required rational explanation and ones that did not need justification.[203] This judgment formed the foundation for future developments in relation to the proportionality test including the content of section 36(1) of the Constitution.

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199 See IM Rautenbach 'Proportionality and the limitation clauses of the South African Bill of Rights' (2014) *17*(6) *PER: Potchefstroomse Elektroniese Regsblad* 2229-2267.

200 See General Comment No 36 (n 144).

201 As above.

202 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.*

203 Cheadle (n 196) 704. The approach in Makwanyane was applied in the *National Coalition of Gay and Lesbian Equality* case (n 67) para 34.

While bearing in mind that the application of proportionality approach varies case by case, with respect to the issue of conscientious objection, we can draw on Veronica Undurraga's proposed framework of proportionality, which has three consecutive tests: 'suitability, necessity and strict proportionality.'[204] The first stage is to determine whether the intervention contributes to a legitimate constitutional aim. The second is to examine whether there are other measures to achieve the goal of the intervention, which has the least impact on fundamental rights of affected individuals. Finally, the third stage of strict proportionality determines whether the benefits of a limitation of rights outweighs the disadvantages imposed by such restriction.[205] In the case of the exercise of conscientious objection, a proportionality analysis would allow judges to do a balancing act between provider's right to freedom of conscience and a women's right to reproductive autonomy and access to healthcare.[206]

On the first limb (suitability), in limiting the exercise of conscientious objection, the importance of the purpose of the limitation must be determined. It asks the question, what interests and rights does the limitation protect in 'open and democratic society based on human dignity, equality and freedom'? The second limb (necessity) addresses the question of whether there are less restrictive ways to achieve the purpose of the limitation. This is also to explore 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 it is determined that such measures exist, then that must be chosen.[207] The third limb (strict proportionality) determines the beneficial effects on imposing such a limitation.

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204 V Undurraga 'Criminalisation under scrutiny: How constitutional courts are changing their narrative by using public health evidence in abortion cases' (2019) 27(1) *Sexual and Reproductive Health Matters* 5.

205 As above.

206 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.

207 P De Vos & W Freedman (eds) *South African constitutional law in context* (2014) 371-373.

To determine whether a provider's refusal to provide abortion care is proportionate, it requires the that the refusal establishes the following:

a) Is the legitimate aim of limiting refusal recognised?
b) Are there any more reasonable measures of achieving these aims?
c) Can a fair balance be struck between the rights of the objector and the interests of the pregnant woman?

For the first determination, a limitation on conscientious objection means the enabling of rights of the pregnant woman to receive the full spectrum of lawful health care services, enjoyment of her right to life and not having to suffer physical or mental pain, discrimination and non-interfere with her privacy.

On whether there might be other reasonable means to deal with a conscientious objection, this can be accommodated with certain caveats including referral. On the question of how to strike a balance between the two competing rights, one can explore what benefits there are to denial of such a right. These might include accessibility and availability of healthcare services and the safeguarding of medical ethics. On the other hand, if a provider is accommodated in the exercise of conscientious objection, rights such as freedom of conscience and human dignity are upheld. While, healthcare providers have 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.[208] For instance, it follows that healthcare professionals cannot rely on conscientious objection in an emergency situation as risks to the health and life of the pregnant woman is evident. This serves as an exception to the invocation of conscientious objection.

Duty to save lives

Healthcare providers who are unable to exercise their duty of care due to personal conscience still have ethical responsibilities to their patients.[209] It is in this view

208 Ngwena (n 8) 11.
209 Dickens & Cook (n 189) 71-72.

that the International Federation of Obstetricians and Gynaecologists (FIGO) has set up criteria for conscientious objection, which includes giving notice of one's objection based on conscience ground, referring patients to colleagues and providing emergency care when needed.[210] The Code of Ethics affirms that:

> [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.[211]

The legality of this exception to conscientious objection finds support in the Constitution, which clarifies the rights of the healthcare provider. Section 36 of the Constitution would support the limitation of the right to conscientious objection where maternal life or health is in serious danger or there is a medical emergency.[212] 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. For instance, section 4(2) of the 1967 United Kingdom's Abortion Act states that:

> Nothing in subsection (1) shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to her physical or mental health of a pregnant woman.[213]

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210 FIGO Committee for the Study of Ethical Aspects of Human Reproduction and Women's Health 'Ethical Guidelines on conscientious objection' (2006) 14(27) *Reproductive Health Matters* 148–149

211 As above.

212 This is in line with GC No 36 (n 144).

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

The 2009 Mexico City's General Health Law allows for conscientious objection with limitations in emergency situations and obligates hospitals to have non-objecting personnel.[214]

The reasoning for this exception is that when a pregnant woman in need of emergency care is refused services, this might have devastating consequences including violations of her rights to life[215] and human dignity.[216] As the former President of the Constitutional Court, Judge Arthur Chaskalson explained, respect for human dignity is a foundational value that is crucial for addressing conflicting interests.[217] Whilst respecting human dignity includes the recognition of conscientious objection and notion of tolerance, it also espoused duties and responsibilities of individuals. This was also reaffirmed in the *Makwanyane* case.[218] The Court recognised the concept of ubuntu[219] as a constitutional value that emphasises respect for human dignity through the recognition of 'a person's status as a human being, entitled to unconditional respect, dignity, value', that also requires that '[t]he person has a corresponding duty to give the same.'[220]

In this regard, health professionals have an ethical duty to guaranteed that their action or inaction adheres to general principles of medical ethics. Professional ethical guidelines of South Africa's medical, nursing and midwifery societies while supporting and protecting their members' exercise of conscience, emphasise

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214 G Ortiz-Millan 'Abortion and conscientious objection: Rethinking conflicting rights in the Mexican context' (2017) 29(1) *Global Bioethics* 2.

215 Sec 11 of Constitution provides that everyone has a right to life.

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

217 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.

218 *Makwanyane* case (n 43).

219 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(1) *South African Journal on Human Rights* 146-188.

220 *Makwanyane* case (n 43) para 224.

providers' duty to ensure that their beliefs do not serve as barriers to their patients access to services and information.[221] The difficulties in determining the practicality of this legal requirement of life-threatening situation is demonstrated in the 2012 Irish case where a woman died from sepsis three days after she was refused an abortion because of the presence of a heart-beat of the foetus.[222]

Duty to provide information

At a minimum, section 36 imposes an obligation to offer the pregnant client with information about where she can obtain an abortion. This also finds support in the Choice on Termination of Pregnancy Act, which provides in section 6 that a woman seeking abortion is to be informed by a medical practitioner or registered midwife of her rights under [the] Act.[223] 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 pregnant 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'.[224]

It is contended that the act of refusing to provide such information, intended to frustrate the system unnecessarily, breaches their duty to provide care which might be closely aligned to an act of civil disobedience rather than conscientious objection. Although there is an overlap between conscientious objection and civil disobedience, the two concepts remain different. Civil disobedience is usually a

221 See South African Nursing Council 'Ethical standard' http://www.sanc.co.za/pdf/Learner docs/Standards - Ethical Standards.pdf (accessed 30 January 2018) 10 & 13; 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.

222 M Berer 'Termination of pregnancy as emergency obstetrics care: The interpretation of Catholic health policy and the consequences for pregnant women' (2013) 21(41) *Reproductive Health Matters* 9-17.

223 Sec 6 of the Choice on Termination of Pregnancy Act.

224 *P and S v Poland* ECHR (30 October 2012) App. no. 57375/08, para 111.

public act, while on the other hand, conscientious objection is usually centred on the individual who invokes it and it is not designed to serve as a rallying point for others to join.[225] Hannah Arendt argues that 'the rules of conscience hinge on interest in the self,' as the individual accepts that 'the fear of being alone and having to face oneself can be a very effective dissuader from wrongdoing, but this fear, by its very nature, is unpersuasive of others.'[226] A healthcare professional is therefore unlikely to have a legitimate claim of conscientious objection when he or she refuses to give women access to information as they make unsubstantiated assumptions about what the woman will do with that particular information. In General Comment No 14, the right to information is considered key element of the right to health.[227] The African Commission obliges states to guaranteed information that is 'non-judgmental and understandable on content and language'[228]

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 impose such as obligation. This is arguably not sufficient as objectors have noted that referral might also mean complicity. While this can constitute a hindrance for referral, which has implications for access to such services, section 7(2) of the Constitution on the duty of the state to 'respect, protect, promote and fulfil' the rights in the Bill of Rights can be used as a premise for a statutory duty to refer the pregnant woman seeking abortion to another provider or facility.

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

225 As above, 368.
226 Arendt (n 116) 64 & 67.
227 General Comment No 14 (n 141) para 11.
228 General Comment No 1 *(*n 172) para 26.

> d. Midwives with conscientious objection to a given service request will refer the woman to another provider where such a service can be provided.[229]

WHO has also noted that healthcare providers must refer women, or where referral is not possible, must provide these services to which they are legally allowed to.[230] However, it is necessary to clearly define the scope of healthcare professionals' duties. As well as the manner to balance competing rights between healthcare professionals and women. At such a time until the Act is amended accordingly, this responsibility would fall on the courts.

4.3.2 Developing a jurisprudential approach to conscientious objection

It is important to note that courts in South Africa have not yet clarified the issue of conscientious objection. In efforts to test the issue of conscientious objection in the courts and to get an authoritative ruling, the Doctors for Life International brought the civil case of *Charles and Others v Gauteng Department of Health (Kopanong Hostpital) and Others* in the Equality Court, which was transferred to the Labour Court.[231] The case concerns a nurse's refusal to prepare patients at the Kopanong Hospital in Vereeniging for follow-up treatment following a termination due to her religious beliefs, which led to her reassignment by the director to another department. She eventually quit in May 2004. [232] On the basis of the *Promotion of Equality and Prevention of Unfair Discrimination Act*,[233] 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

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229 As above, 2-3.

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

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

232 '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).

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

transferred her case to the Commission for Conciliation, Mediation and Arbitration (CCMA).[234]

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.[235] Such anti-abortion discourses materialising in these two cases shows a subtler means of deploying power. For instance, the pro-life movement utilises 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 worker's right to non-discrimination and utilising labour laws would mean setting legal precedent that would clawback on a liberal abortion law.

A similar approach was used in *FAFCE v. Sweden, the Federation of Catholic Families in Europe (FAFCE)*,[236] 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 found that the right to health nor the right to non-discrimination, which the Charter guarantees does not give a legal entitlement to healthcare workers to refuse to perform abortion services based on conscience claims.[237] 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

234 *Charles case* (n 231 above) 1. I was unable to find any relevant ruling from the CCMA.
235 'Anti-abortion doc reinstated' *News24* 8 March 2010 https://www.news24.com/southafrica/news/anti-abortion-doc-reinstated-20100308 (accessed 15 February 2019).
236 No. 99/2013 Euro. Committee of Social Rights (17 March 2015).
237 As above.

understanding of injustice, identity, righteousness for action, and a vision of the preferred future'.[238]

In addressing the contestation over freedom of religion and conscience versus the rights of women to access abortion services, one can engage in lawfare. According to Siri Gloppen, lawfare can be understood as the 'strategic use of rights, law and litigation by different breeds of actors to advance contested political and social goals.'[239] Here, my interest lies in *court-centred strategies* that seek 'change by working from within the existing law, changing the interpretation of laws, constitutional provisions and international treaties, their application and enforcement.'[240]

Courts in South Africa could be a useful, impartial, non-prejudicial arena in which to relay the difficulties women face as a result of refusal of abortion services. In its landmark decision in the *TAC case*, 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 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.[241]

Although it is beyond the scope of this study, the question of whether to undertake litigation so as to get guidance on the exercise of conscientious objection is very contextualised and would require an investigation into the opportunity structures[242] including resources and barriers (economic, social, political, legal,

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238 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(3) *Journal of Sociology* 751.

239 S Gloppen 'Conceptualizing lawfare' 2017 at 6 unpublished (file with author).

240 As above, 8.

241 *TAC* case (n 30) 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 Albertyn (n 3) 112- 117.

242 This refers to the sum of external factors that influence actors engaged in lawfare of their judgment of what is right, opportune or possible in the circumstances, S Gloppen 'Introducing

etc.) as done in other countries.[243] A foreseeable problem in litigating on refusal to offer abortion services based on religious beliefs or conscience is the need to show the systematic nature of the practice.[244] Nevertheless, feminist organisations such as the Women's Legal Centre, an African feminist law centre that focuses on variety of strategies to advance women's rights, believe that the court is the most important tool in holding 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.'[245]

In line with this thinking, litigation can be used as a strategy by the pro-abortion movement in South Africa to push for a regulatory system that enables women to access abortion in the circumstances where a healthcare professional refuses to provide abortion services. One can bring an application to the court to declare that the exercise of conscientious objection by healthcare providers is an infringement of section 27 of the Constitution. The court would apply its mind to the proportionality test by limiting the exercise of freedom of thought, conscience and religion through a section 36 analysis. This speaks to Wicclair's view that 'it is unwarranted to give [health professionals] more or less blanket permission to withdraw from patient care in such cases.'[246]

In order to regulate conscientious objection to abortion, there are certain conditions that need to be addressed. Questions that arise regarding the scope of the right include who is entitled to object and to what activities? When should it be raised? What the duties of the objectors are? As the South African courts have not yet had an opportunity to deal with the right to conscientious objection within the

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lawfare: Concepts and approaches' (presentation at PhD course 'Effects of Lawfare Courts and law as battlegrounds for social change' Bergen, Norway, 15-24 August 2018).

243 Interview with Colombian law professor, Skype 27 June 2019. See also P Bergallo & AR Michel 'Constitutional developments in Latin American abortion law' (2016) 135 *International Journal of Gynecology and Obstetrics* 135 228–231

244 The Sexual and Reproductive Justice Coalition is looking into possibilities of litigating on this issue.

245 Interview with legal practitioner, Email 29 March 2019.

246 Wicclair (n 131) 205-207.

context of abortion, it can borrow from the approaches of courts from other jurisdictions. I briefly outline key Colombian Constitutional Court cases, which address some of these key issues that need to be addressed in the South African context and whose findings have been described as having 'considerable significance and instruction nationally, regionally, and internationally.' [247]

The Constitutional Court of Colombia dealt extensively with the right to conscientious objection by healthcare professionals in the case of a 13-year old girl who became pregnant as a result of rape.[248] She was refused abortion by her healthcare provider based on conscientious objection by its physicians.[249] Referral was made to another hospital which refused to provide her the abortion procedure based on the institution's conscience refusal claims on behalf of its entire medical staff.[250] In delimiting the scope of the conscientious objection on who can object, the Court held the institutions cannot exercise conscientious objection as only natural persons are able to exercise such a right.[251] This affirms an earlier decision in 2006 in which the Court determined that:

> neither legal persons nor the State can claim the conscientious objection. Only natural persons can exercise this right; therefore, clinics, hospitals, healthcare centers or any institution with such a name, cannot claim a conscientious objection against performing an abortion when the pregnant woman falls into the grounds defined by is judgment. With respect to natural persons, it is worth noting that the conscientious objection references a duly supported religious conviction, and therefore, it does not apply when a physician disagrees with abortion, nor can it justify disregarding women's fundamental rights; thus, in the event that a physician claims the conscientious objection, he or she must immediately proceed to referring the woman who falls into the hypothetical conditions to another physician who can perform the abortion, without prejudice to a subsequent determination

247 R Cook *et al* 'Healthcare responsibilities and conscientious objection' (2009) 104 *International Journal of Gynecology and Obstetrics* 249.

248 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).

249 As above, para 1.

250 As above, para 2.

251 As above, paras 4.3-4.17.

> regarding whether the conscientious objection did apply and was pertinent, through the mechanisms established by the medical profession.[252]

A further jurisprudential standard setting is found in the case of *T-388/09*,[253] in which the Colombian Constitutional Court 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.'[254] This case focused on the determination of whether a judicial officer could invoke the right to conscientious objection in order to recluse himself from an application for injunction that compels 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.[255]

This juridical resource is vital given that the question of who can legally object is varied globally. The disparity in determining who can object is partly due to the differing values attributed to the two competing rights of health professionals and women respectively. Dickens and Cook argue that the right to conscientious objection protects the personal beliefs of healthcare workers who are directly involved in performing the procedure and this does not include individuals assisting or facilitating the procedure.[256] This position is supported in Zambia, where an objector can only be the 'abortion provider' and not the 'support staff.' [257]

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

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

254 As above, para 5.1. See also 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).

255 For a detailed analysis of this case, see 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* 183-209.

256 Dickens & Cook (n 187) 74-76.

257 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* 106-114.

However, some countries allow anyone who directly or indirectly participate in abortion procedure to be able to object in conscience. For example, in France, while the abortion law provides that healthcare providers including nurses and midwives, or other medical auxiliary are not obliged to perform or participate in an abortion, it limits it to these categories.[258] A sharp contrast to this is the Zimbabwean Termination of Pregnancy Act of 1972. Section 10 of the Act states: "[n]otwithstanding any law or agreement to the contrary, no medical practitioner or nurse or person employed in any other capacity at a designated institution shall be obliged to participate or assist in the termination of a pregnancy." This section does not limit the scope to only healthcare professionals but extends it to any person employed within a particular healthcare facility, thereby not adhering to international and regional human rights standards as stipulated above.

Moreover, enabling anyone even those that are have indirect or remote involvement would result to ineffective access to abortion services. 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.[259] In the case of *Greater Glasgow Health Board v Doogan*,[260] the United Kingdom's Supreme Court in clarifying what 'participation' means held that:

> 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…[261]

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258 Chavkin (n 3 above) S50.

259 Interview with National Department of Health representative, telephone 22 February 2019.

260 *Greater Glasgow Health Board v Doogan & Anor (17 December 2014)* UKSC 68 [2015] SLT 25.

261 As above, para 38.

In a previous British case, the House of Lords on the meaning of 'participation' for the purpose of the conscientious objection provision in the Abortion Act 1967, held that it would refer 'to actually taking part in treatment administered in a hospital or other approved place.'[262]

Determining state's obligation to ensure access to services

The duty to fulfil the right to sexual and reproductive health require states to ensure the provision of abortions services.[263] When a state allows the exercise of conscientious objection, it is responsible for ensuring that there is adequate number of abortion providers so as not to violate women's fundamental right to healthcare.[264] European Committee of Social Rights defended a similar line of reasoning in the *International Planned Parenthood Federation European Network (IPPF- EN) v Italy*,[265] decided in 2013. Italy was found to have violated the right to health and non-discrimination provisions of the European Social Charter[266] in its failure to address the high number of conscientious objectors, which renders access ineffective.[267] The Committee made these findings on the intersectional and multiple nature of the violations.[268]

Here I suggest that the courts should take a similar approach which 'places women's autonomy at the centre of reproductive health care.'[269] This will be in line with the constitutional goal of addressing inequalities in reproductive health.[270] The equality clause would affirm that the lack of proper regulatory oversight of the exercise of conscientious objection and inadequate accessibility to safe and

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262 See *Janaway v Salford Health Authority* [1988] 3 All ER 1079 1082.

263 *General Comment No 22* (n 140)

264 *T-209/08* case (n 248) para 4.16.

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

266 The European Social Charter (Revised) Eur. T.S. No. 163 (1996)

267 As above, para 174.

268 As above, para 190.

269 Albertyn (n 34) 114. See also C Albertyn 'Substantive equality and transformation in South Africa' (20017) 23 *South African Journal of Human Rights* 253.

270 C Ngwena 'Accessing abortion services under the Choice on Termination of Pregnancy Act: Realizing substantive equality' (2000) 25 (19) *Journal for Juridical Science* 24-30.

accessible abortion services disproportionately affects women based on class, race, age and geographical location. As Amnesty International noted in 2016, while 505 of the 3880 public facilities were designated to provide abortion services, only 264 did so.[271] This points to the failure of government to guarantee access to reproductive health services as provided in section 27(1)(a) of the Constitution.

Challenges in abortion provision due in part to the unregulated exercise of conscientious objection plays a major role in the continuity of back street abortions. Thus, the courts can mandate government to put in place proper procedures, policies and resources to meet their constitutional and legal obligation to provide safe and accessible abortion services. The European Court of Human Rights has on a number of occasions upheld limitations on conscientious objection,[272] explicitly affirming in *RR v Poland*[273] 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.[274]

A human rights-based approach ensures transformative jurisprudence that recognises the possibility for individual healthcare providers' right to refuse to provide abortion services on the grounds of conscience, but which does not absolve government from its obligation to provide services (including information and materials resources) arising from the fulfilment of an abortion right. The assumption here is that litigation will have *legal effects* (changes in legislation or jurisprudence) and *material effects* on policy and administrative practices.[275]

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

272 This in line with article 9 of the European Convention on Human Rights on freedom of conscience. See, *Pichon & Sajous v France*, ECHR (2 October 2001), App. No 49853/99.

273 *RR v Poland* ECHR App. No. 27617/04 (2011).

274 As above, para 206. Emphasis added.

275 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.

Indeed, it will be a signal that when the state does not effectively implement the right to safe and legal abortion by ensuring that this right is not impeded by the refusal to offer services, it fails to meet its assumed obligations in terms of ratified international human rights instruments.

4.4 Conclusion

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 health care 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. When the state fails to ensure access to this right, it fails to meet its assumed obligations in terms of these international human rights law instruments. 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.

In this chapter, I have demonstrated that the acceptance of a justifiable refusal to perform or provide abortion care involves the balancing of the right of healthcare professionals to conscientious objection (derived from section 15 of the Constitution on right to freedom of conscience, religion, belief and opinion) and the express right of women to access reproductive health services as provided in the Constitution and the Choice on Termination of Pregnancy Act. Conscientious objection would generally be reasonable except in medical emergency and that healthcare professionals are duty bound to provide information and refer patients to a facility where they can access the service. However, a comprehensive enumeration of the legal scope of the right to conscientious objection can only be adequately addressed by the Constitutional Court when it is seized of the matter in order to develop South African jurisprudence. Here is important to emphasise the

role of the professional medical bodies, human rights practitioners and non-governmental organisations to take the matter to the Constitutional Court.

The failure of the South African government to effectively 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. In order to ensure that women's right to exercise reproductive autonomy and access to timely legal abortion services in South Africa, the state's domestic laws must effectively regulate and oversee the practice. As Rebecca Cook *et al* succinctly puts it:

> law frames the setting within which ethical choices may be practically exercised, but ethics frames the limits within which law is voluntarily obeyed and respected as an expression of the values and aspirations of the society in which it applies in cases where law conflict with individuals' perception of morals and ethics, citizens.[276]

I have illustrated that section 36 of the Constitution provides a solid constitutional basis for placing limitation on the right to freedom of conscience as provided in section 15 of the Constitution. I argued that the implied right of conscientious objection for healthcare professionals should be overruled where their refusal would mean a de facto denial of access to care for women. Where there are no readily available and accessible alternatives to the patient, healthcare professionals should be compelled to provide care. It is essential that the law regulates the practice of conscientious objection by healthcare professionals including nurses.

Given that the lack of a regulatory framework on conscientious objection serves as one of the key challenges in the implementation of the Act, it becomes useful to examine the history and politics of abortion that led to the absence of a conscience clause. Catriona Macleod and Tracey Feltham-King define politics of abortion 'as the configuration of cultural and gendered power relations that discussions, practices

276 R Cook et al. *Reproductive health and human rights: Integrating medicine, ethics, and law* (2003) 89

and legislation with respect to abortion bring to the fore.'[277] Abortion as a contentious issue invokes a debates that are premised on laws, politics, ethics and morals. This is especially true for a country like South Africa, whose diversity of its people is recognised in the Constitution. As such the drafting and eventual enactment of the Act was met with both support and resistance. The next chapter describes the discourses used that exerted influence during the drafting and legislative reform processes.

[277] CI Macleod & T Feltham-King 'Representations of the subject 'woman' and the politics of abortion: an analysis of South African newspaper articles from 1978 to 2005' (2012) 14(7) *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care* 737.

CHAPTER FIVE

ABORTION DISCOURSES AND CONSCIENTIOUS OBJECTION: AN ANALYSIS OF PARLIAMENTARY DEBATES ON SOUTH AFRICAN ABORTION LAW

To understand the absence of conscience clause in the Choice on Termination of Pregnancy Ac,[1] this chapter does a legislative mapping of framings employed during debates on the abortion law and its subsequent amendments.

This chapter begins from the premise that politics (expressed in terms of legislative debates in this thesis) is a reflection of society and that it is important to determine how actors use the law-making process to advance their competing positions utilised the policy-making process, a contested enterprise, to achieve the presence or absence of certain normative prescriptions. Thus, I attempt to uncover the political forces that led to the absence of a conscience clause by asking two inter-related questions: (1) How did the ideologies of political parties influence the absence of a clause? (2) What were the available discursive resources that politicians and commenters used to achieve their goals? For this purpose, I do a process tracing[2] of conscientious objection discourse through archival records and documentations from online legal databases and media reports coupled with interviews with key stakeholders including policy makers, international Non-Governmental Organisations (NGOs), women's and human rights activists and institutions.[3]

This chapter represents an attempt to uncover and analyse the political discourses on abortion. I give a careful description of parliamentary debates, which can serve

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1 Act 92 of 1996.

2 Process tracing is a fundamental tool in qualitative research. See D Collier 'Understanding process tracing' (2011) 44(4) *PS: Political Science* 823-830.

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

as a foundation for process tracing.[4] David Collier writes: 'process tracing focuses on the unfolding of events or situations over time.'[5] This exercise is vital as the law plays a critical role in nurses' experiences, knowledge and perceptions on abortion. I make the assertion that the statements made by various Members of Parliament (MPs) provides the context to ascertain the absence of a conscience clause. Equally important, their framings when debating about abortion is reflected in discourses utilised by nurses as examined in chapters five and six.

I examine the extent of the interplay between gender truths (discourses) and political party practices that led to an absence of a conscience clause in the Act.

5.1 Historical backdrop

Given the complexity of abortion regulation, parliamentary debates which preceded the passing of the Choice on Termination of Pregnancy Act illustrated beliefs and perceptions about abortion based on the pro-choice and pro-life discourses that cut across political lines as shown below.

5.1.1 Pro-choice arguments

The former liberation movement and post-1994 governing party, African National Congress (ANC), its women's league feminist movement and civil society organisations (CSOs) spearheaded the abortion reform agenda. Prior to the 1994 elections, the ANC in its manifesto included legislative reform to ensure women's right to have a termination of pregnancy.[6] The ANC in its Reconstruction and Development Programme outlined one of its national goals: 'every woman must have the right to choose whether or not to have an early termination of pregnancy

4 See J Mahoney 'After KKV: The new methodology of qualitative research' (2010) 62(1) *World Politics* 120 - 147.
5 Collier (n 2) 824.
6 Choice on Termination of Pregnancy Bill- Second reading 4814.

according to her own beliefs.'[7] This goal was aptly captured during the reading of the bill:

> The ANC went to polls in 1994 on a platform that included the right of a woman to choose an early, safe and legal termination of pregnancy. We were voted into power on this basis. It is a mandate and a promise.[8]

The shift in political leadership ushered an era in which it was possible to pass the law supported by the development of international norms on reproductive health and rights. The journey to reproductive autonomy was closely aligned with the development of the South African Constitution and the recognition of women as 'citizens and right-bearers.'[9] The then Minister of Health Dr Zuma during the second reading debate of the Choice on Termination of Pregnancy Bill noted: 'This bill allows women to uphold their religious beliefs, their cultural and moral values, and to exercise their choice accordingly.' [10]

The Democratic Party (DP), now the Democratic Alliance (DA),[11] in expressing its support for the Bill affirmed that their vote was in line with the 'constitutional right of a woman to make choices about the private matter of reproduction.'[12] In the eyes of one of the Members of Parliament (MP):

> Denying a woman, the right to choose whether to have an abortion or not is similar to black South Africans having been denied the right to vote under apartheid.[13]

A female MP also made these sentiments clear in expressing that:

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7 ANC 'Reconstruction and development programme base document' (1994) https://omalley.nelsonmandela.org/omalley/index.php/site/q/03lv02039/04lv02103/05lv02120/06lv02126.htm (accessed 25 June 2019) 2.12.6.4.

8 Choice on Termination of Pregnancy Bill- Second reading 4766.

9 C Albertyn 'Abortion, reproductive rights and the possibilities of reproductive justice in South African courts' (2019) 1 *University of Oxford Human Rights Hub Journal* 105.

10 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) 4760.

11 The former Democratic Party (DP) now renamed the Democratic Alliance is the official opposition to the governing African National Congress.

12 Choice on Termination of Pregnancy Bill- Second reading 4778.

13 Choice on Termination of Pregnancy Bill- Second reading 4806.

> The right to control our bodies, the right to choose a safe legal termination of pregnancy is in the context of political, social and economic choices for women, in the context of moving our society towards equality, respect and healthy sharing of power and responsibility in the home and in society.[14]

The opposition honed on this when in expressing its dissatisfaction with the Bill, the Inkatha Freedom Party (IFP)[15] noted that the bill was 'largely a reaction to the apartheid past rather than an investment in the future.'[16]

The extracts above are signifiers that the abortion debate was within the struggle for reform from apartheid to a democracy. A nationalist discourse on abortion was utilised, which illustrates the link between reproduction and national identity. The use of women's issues to represent a symbolic momentum from apartheid is akin to what Geraldine Herg describes when she writes:

> Female emancipation – a power political symbol describing at one a separation from the past, the aspirations of an activist present, and the utopia of an imagined national future – supplies a mechanism of self-description and self-projection of an incalculably more than pragmatic value in self-fashioning of nations and nationalisms.[17]

Abortion, as a highly politicised issued, often plays out in the contexts of transitions.[18] Within the context of South Africa, the backdrop of the debate was the 'historically racist use of population control policies under the Nationalist Party government.'[19] To Susanne Klausen, 'Afrikaner nationalism had a fixation with sex,

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14 Choice on Termination of Pregnancy Bill- Second reading 4793.

15 The IFP party with predominantly isiZulu members, is one of the oldest competing political parties.

16 Choice on Termination of Pregnancy Bill- Second reading 4772.

17 G Heng '"A great way to fly": Nationalism, the state and the varieties of third-world feminism' in MJ Alexander & CT Mohanty (eds) *Feminist genealogies, colonial legacies, democratic futures* (1997) 31.

18 See for example A Halkias 'Money, god and race: The politics of reproduction and the nation in modern Greece' (2003) 10(2) *The European Journal of Women's Studies* 211-232; R Fletcher 'Post-colonial fragments: representations of abortion in Irish law and politics' (2001) *8* (4) *Journal of Law and Society* 568-589

19 S Guttmacher *et al* 'Abortion reform in South Africa: A case study of the 1996 Choice on Termination of Pregnancy Act' (1998) 24(4) *International Family Planning Perspectives* 193.

an obsession fuelled by the repressiveness of the ideology of Christian Nationalism.[20]

Proponents further justified the reform through the ideological narratives of rights-based, public health and feminist ideas of women's equality and freedom of choice.[21] The Pan Africanist Congress (PAC)[22] acknowledged the Bills potential reach of removing abortion 'from the ill-handled operations in half-lit and murky backrooms, surrounded by secrecy and fear, and susceptible to manipulation and exploitation by unscrupulous elements.'[23] Dr. Tshabalala-Msimang, the then Deputy Minister of Justice of the ANC government further stated that:

> Reproductive rights are particularly important to women, because only when armed with these rights can women effectively exercise the rest of their rights and act as full and equal members of society…. Reproductive rights require respect for women's bodily integrity and decision-making in an environment which is free from fear of abuse, violence and intimidation. [24]

These narratives focused on international norms and issues of reproductive rights and health finds support in the 1994 International Conference on Population and Development (ICPD)[25], the Cairo Programme of Action and Beijing Platform for Action.[26] These two agreements were instrumental to the entrenchment of women's reproductive rights as human rights.[27]

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20 SM Klausen *Abortion under apartheid: Nationalism, sexuality, and women's reproductive rights in South Africa* (2015) 59.

21 C Albertyn 'Claiming and defending abortion rights in South Africa' (2015) *Revisya Direito GV* 441-443.

22 The PAC is a former Pan Africanist movement now political party.

23 Choice on Termination of Pregnancy Bill- Second reading 4810.

24 Choice on Termination of Pregnancy Bill- Second reading 4789.

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

26 Report of the Fourth World Conference on Women, A/CONF.177/20 (1995). See also Choice on Termination of Pregnancy Bill- Second reading 4767.

27 C Zampas & J Gher 'Abortion as human right- International and regional standards' (2008) 8 *Human Rights Law Review* 252.

5.1.2 Pro-life arguments

Abortion as a moral controversy is visible in framings from within by the anti-abortion movement that depicted foetuses as human beings. The opposition to law reform was led by two political parties — the African Christian Democratic Front (ACDF) and the Freedom Front Plus (FF+) — mainly on religious grounds. This is not surprising given that the ACDF is based on Christian beliefs and principles,[28] while the FF is a conservative party that represents the Afrikaans-speakers in the country and espouses Christian values.[29] In pushing for the rejection of the entire Bill, the ACDP held the Bill as 'the most controversial, dangerous, irresponsible and undemocratic [Bill to] be tabled in this Parliament … even worse than any Bill that was ever debated during the apartheid era.'[30] The FF rejected the Bill 'because it amounts to the murder of innocent and defenceless unborn children.'[31] The MP from FF party further went on to tap into women's maternal instinct:

> I want to address myself to the women and mothers in this house, if this legislation has applied when they were expecting their children, which one of them would they have had aborted? Whether they have five or seven children today, which one of them that is playing out there would they have not wanted? [interjections] this is an important decision, because this is what the voter or the person to whom this Bill applies today, will have to decide on.[32]

The Choice on Termination of Pregnancy Bill was considered the 'most evil law ever passed in South Africa.'[33] The opposition espoused that the passing of the Bill will have immense consequences:

> [The Bill] will lead, as it is clearly intended to, to the barbaric slaughter of millions of unborn infants. The slaughter will be unimaginable catastrophe and punishment on South Africa and all its people [Interjections.][34]

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28 See generally, ACDP https://www.acdp.org.za/ (accessed 10 November 2019).
29 See generally, FF+ https://www.vfplus.org.za/who-is-the-vf-plus (accessed 10 November 2019).

30 Choice on Termination of Pregnancy Bill- Second reading 4783.
31 Choice on Termination of Pregnancy Bill- Second reading 4774.
32 Choice on Termination of Pregnancy Bill- Second reading 4777.
33 Choice on Termination of Pregnancy Bill- Second reading 4788.
34 Choice on Termination of Pregnancy Bill- Second reading 4788.

The flippant disregard to life was further buttressed by another MP who visualised the backyard of an abortion clinic to be scattered 'with hundreds of little bodies or pieces of bodies in buckets or waste bags.'[35] The National Party (NP) on expressing its opposition to abortion on demand during the twelve weeks of pregnancy noted that 'on moral and religious grounds … [abortion on demand is] objectionable and offensive to the right to life guaranteed in the Constitution.'[36]

The religious discourse employed by the anti-choice movement was done within the historic past of the relationship between the state in apartheid South Africa and the church.[37] According to Sally Guttmacher *et al*, the official church of South Africa, the Dutch Reformed Church 'not only opposed the new law but propagated the belief that the white population must grow to maintain its supremacy.'[38] This is why, according to Ngwena, the abortion law 'sought to reverse a system which, through a combination of the pater-familial traditions of Roman-Dutch law and the patriarchal orientation of African customary law, had inscribed into law a subordinate status for women.'[39]

The emotive debate illustrating both complementary and contested positions, speaks to how 'abortion is a publicly controversial issue because it speaks to and draws on, localized understandings of women's role, the role of the state, the sanctity of life and society's obligation to women and the right to privacy.'[40] In relation to laws, feminist legal theorists have argued that 'standards of what is

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35 Choice on Termination of Pregnancy Bill- Second reading 4788.

36 Choice on Termination of Pregnancy Bill- Second reading 4767.

37 See H Bradford *Herbs, knives and plastic: 150 years of abortion in South Africa: Science, medicine and cultural imperialism (1991)* 120-145.

38 Guttmacher *et al* (n 19) 191.

39 C Ngwena 'The history and transformation of abortion law in South Africa' (1998) 30 *Acta Academica* 46 when citing F Kaganas & C Murray C 'Law and women's rights in South Africa: an overview' in Bennett et al (eds) *Acta Juridica* (1994) 1-38.

40 CI Macleod & T Feltham-King 'Representations of the subject 'woman' and the politics of abortion: an analysis of South African newspaper articles from 1978 to 2005' (2012) 14(7) *Culture, Health & Sexuality: An International Journal for Research, Intervention and Care* 737-752.

rational reflect the interests of those who currently hold power.'[41] For example, it has been highlighted that due to opposition from members of the ANC on the basis of religion, members were requested to vote as a bloc and consequently denied a free vote.[42] The former ANC chief whip of Parliament spoke about their difficult dilemma they faced:

> I've been taught that abortion is wrong. But I am in Parliament as an ANC MP. People voted in 1994 for the ANC, not for Geoff Doidge. I'm not there as a Catholic MP, but as an ANC MP. In terms of that I must follow party discipline [...] It was a very difficult time, wrestling with one's conscience and party loyalty. You opened the paper in the morning and saw you were threatened with excommunication. My job is to ensure that MPs vote in favour of legislation tabled by the organisation.[43]

This meant that although the Bill was eventually passed with an overwhelming majority, it was marked by significant absenteeism.[44]

While there was an overall tolerant support of the Bill by the other opposition parties, this was qualified mainly on the issue of conscientious objection. As alluded to earlier, there is no express provision regulating conscientious objection in the Choice on Termination of Pregnancy Act, as is done in the Civil Unions Act.[45] The absence of a conscience clause in an abortion law is not unique to the South African situation, as in most African countries and elsewhere it is not addressed and hence,

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41 K Bartlett & R Kennedy 'Introduction' in K Bartlett & R Kennedy (eds) *Feminist legal theory: Readings in law and gender* (1991) 3.

42 B Klugman *et al* 'Developing women's health policy in South Africa from the grassroots' (1995) 3 *Reproductive Health Matters* 122-131.

43 'ANC to act over abortion vote' *Mail & Gaurdian* 15 November 1996 https://mg.co.za/article/1996-11-15-anc-to-act-over-abortion-vote (accessed 15 November 2019).

44 See Guttmacher *et al* (n 19) 191-194.

45 Act 17 of 2006 sec 6 states:

> *A marriage officer, other than a marriage officer referred to in section (sic) may in writing inform the Minister that he or she objects on the ground of conscience (sic) religion and belief to solemnising a civil union between persons of the same sex. whereupon that marriage officer shall not be compelled to solemnise such civil union.*

remains largely unregulated.[46] But what makes it particularly interesting in the South African context is that it was there but deliberately excluded from the new Act.

5.2 Conscientious objection and the Choice on Termination of Pregnancy Act

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.[47] Where healthcare professionals were concerned, a written input from the Women's Health Conference held in 1994 proposed to the Ad Hoc Select Committee on abortion to include 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 alternative persons or institutions who do provide abortion services. Health authorities must ensure the provision of accessible abortion services.[48]

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.

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46 For example, 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* 183-209; OR Gustavo 'Abortion and conscientious objection: Rethinking conflicting rights in the Mexican Context' (2017) 29(1) *Global Bioethics* 5.

47 Choice on Termination of Pregnancy Bill- Second reading 4763.

48 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).

> (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. [49]

The framers of the Act thought the clause was unnecessary as it was already implicitly provided for in the Constitution.[50] This was within the backdrop of the debates that accompanied the passing of the Act. During the second reading debate of the Choice on Termination of Pregnancy Act on 29 October 1996, the conscience clause became a contentious issue. 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.[51]

This amendment was partially in line with the proposal of the NP, the former governing Afrikaner party, which argued for the removal of the clause requiring doctors and midwives with a conscientious objection to performing an abortion to refer the patient as an infringement of their constitutional right of freedom of conscience and belief.[52] However, the party further raised concerns 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.[53]

The Inkatha Freedom Party (IFP) also noted that whilst it welcomed the removal of the clause, its preference would have been for the Bill to categorically state that

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49 C Ngwena 'Conscientious objection and legal abortion in South Africa: Delineating the parameters' (2003) 28(1) *Journal for Juridical Science* 8.

50 Interview with feminist lawyer, Email, 29 March 2019.

51 Emphasis added. Choice on Termination of Pregnancy Bill- Second reading 4764.

52 Choice on Termination of Pregnancy Bill- Second reading 4769.

53 Choice on Termination of Pregnancy Bill- Second reading 4769.

conscientious objectors would be respected and protected.[54] It made this on the basis that they remain 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?[55]

Even those that supported the Bill such as the DP remained worried over the removal of the clause on the basis that the Constitution makes provision for their objections.[56] They felt that doctors and midwives who object to termination of pregnancies on the grounds of conscience may find themselves severely pressured by the removal of this section from the Bill.[57]

The viewpoint of the ACDP's strong objection to the deletion of clause 8 on conscientious objection is summarised in the following statement:

> 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.[58]

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

54 Choice on Termination of Pregnancy Bill- Second reading 4774.
55 As above.
56 Choice on Termination of Pregnancy Bill- Second reading 4781.
57 As above.
58 Choice on Termination of Pregnancy Bill- Second reading 4784.

> pregnancy, I believe, will undermine the trust that women have in them, and such trust forms the cornerstone of medical and midwifery practice.[59]

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.[60]

Other reasons advanced as to why the clause was dropped included the contention that it was in exchange for a block vote by the ANC backed up by Congress of South African trade union, women's organisations and the South African Communist party.[61] The hope was that the non-inclusion of a provision on conscientious objection in the Act would circumvent controversy and legal challenges.[62] Instead, it has the effect of serving as a key impediment to the implementation of the law in practice.[63] The intervention by Hon Patricia De Lille speaking on behalf of Pan Africanist Congress (PAC) is noteworthy:

> 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.[64]

A feminist lawyer working on sexual and reproductive health and rights explained that the understanding at the time was that, 'there was no need for a conscience

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59 Choice on Termination of Pregnancy Bill- Second reading 4787.

60 Choice on Termination of Pregnancy Bill- Second reading 4785.

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

62 See C Ngwena 'An appraisal of abortion laws in South Africa from a reproductive health rights perspective' (2004) *International and Comparative Health Law and Ethics: A 25 Year Retrospective* 708.

63 MC Engelbrecht et al 'The operation of the Choice on Termination of Pregnancy Act: Some empirical findings' (2000) 23 (2) *Curatonis* 6.

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

clause based on the wording of the Act. Unfortunately, this has failed with time and place.'[65] The Reproductive Rights Alliance earlier on made submissions to the Parliamentary Hearings in June 2000 on the legal rights of health workers on the issue of conscientious objection.[66] The umbrella body argued that where a clause is included to give health workers a legal right to object, it should not obstruct women's access to termination of pregnancy services.[67] They also expressed that where there are insufficient staff to meet the demands for service at designated public health facilities, the state would be entitled to demand that health professionals perform abortion as an essential component of their jobs. Employment would then be contingent upon willingness to perform abortion procedure. [68]

It is worthy to note that opponents of the bill wanted the inclusion of conscientious clause but were partially against the requirement for referral by an objecting medical professional. John Smyth, legal advisor to Doctors for Life succinctly summarised it:

> 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.[69]

Hence, attempts were made to reintroduce the clause in 2004[70] and 2007 respectively.[71] In 2007, the inclusion of a conscience clause in the Bill was largely

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65 Interview with feminist lawyer, Email, 29 March 2019.

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

67 As above.

68 As above.

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

70 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).

71 See National Assembly Health Portfolio Committee 'Choice on Termination of Pregnancy Amendment Bill: Public hearings' (13 November 20o7) https://pmg.org.za/committee-meeting/8601/ (accessed 20 May 2019).

supported by 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).[72] This argument was made in two fronts.

On the one hand, along with other pro-life organisations, the Doctors for Life International in its submission supporting the bill, argued that healthcare professionals were often 'victimised, discriminated against and threatened with disciplinary action' when they voiced their objections to taking part in abortion services.[73] They proposed explicit provision for healthcare workers to exercise their constitutional right to freedom of conscience, as provided in other countries.[74] This was based on the argument that, 'health care practitioners have been set up in order to create pro-abortion propaganda around the issue of conscientious objection.'[75]

On the other hand, the medical bodies expressed the need to ensure that an opt-out provision would accommodate continuation of care through referral.[76] DENOSA also submitted that nurses who have an objection must be given that right, as well as provide opportunity to nurses who are willing to undergo the prescribed training.[77]

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72 As above.

73 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).

74 As above.

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

76 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).

77 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).

The proposed clause was not eventually included in the Bill based on the decision of the Chair of the Health Portfolio Committee that since a conscientious objection clause is found neither in the principal act nor the amendment, it cannot be introduced during the public hearings.[78] Since the attempts made to reintroduce the clause in 2004 and 2007 respectively, there has not been another attempt to include a conscience clause. For instance, in 2017, Cheryll Dudley of the ACPD introduced a private member bill that would require mandatory counselling, ultrasound and third-party authorisation by a social worker in case of abortion sought on socio-economic reasons.[79] While a conscience clause was not reintroduced with this bill, such attempt illustrates the effort of theanti-choice movement in trying to roll back women's right to reproductive autonomy.[80] In making a case for the Bill, MP Dudley stated that 'the amendment aims to ensure greater protection of a women's right to apply her mind to relevant facts and information in order to make an informed choice.'[81] Although the Bill was eventually rejected by Parliamentary Portfolio Committee on Health in May 2018, her sentiments reflect discourses utilised by nurses in the subsequent chapter.[82]

There generally remains a continuing absence of mainstream debate about the ways in which politics, ideology and political decisions affect the right to abortion even after legalisation. Generally, in South Africa, there appears to be a conspiracy of silence as politicians generally don't want to talk about abortion as it is too

78 National Assembly (n 109 above).

79 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).

80 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(1) *South African Journal on Human Rights* 50-69 where they argue that the Bill submitted by the ACDP did not comply with International Human rights norms.

81 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). See ACDP Manifesto

82 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).

controversial.[83] Political parties and their representative only seem to deal with the issue when it is tabled before Parliament. This was particularly telling during the 2019 elections held in May 2019. The Sexual and Reproductive Justice Coalition (SRJC) called on the three major political parties: ANC, DA and the Economic Freedom Fighters (EFF) to support increment to the 2020 budget for sexual and reproductive health budget.[84] This came on the heels of a review they conducted of the manifestos of these three major parties, which revealed that abortion was not addressed at all.[85]

5.3 Conclusion

This chapter addressed an important question about South Africa's abortion law: Why was a conscientious objection provision not included in the Choice on Termination of Pregnancy Act? What discursive resources and framings were drawn on by key state and non-state actors in South Africa that contributed to this absence? The mapping shows that the absence of a conscience-based clause in the Choice on Termination of Pregnancy Act was determined by the strength of political forces in Parliament and the pull of special interest groups. For instance, female members of the ANC through the women's wing along with women's rights organisations placed a high premium on favouring the prochoice bill.

The absence of a conscience clause is an important factor in women's access to safe abortion services. As Sylvia Tamale contends, 'law is an important instrument in

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83 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).

84 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).

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

shaping and scripting our gendered bodies. Society "reads" women's bodies along the landmarks forged by the law'.[86] As can be clearly deduced from the narratives identified above, political ideologies intertwined with other considerations including rights discourse, nationalist sentiments and religious framings were used in Parliament to push for legal change. However, these same discourses are continually used to stigmatise both women seeking abortion in South Africa and those that provide abortion services. In terms of religious commitment, it has been argued that powerful and wealthy American evangelical groups are amongst those pushing people pushing the hardest against abortion in South Africa, showing how conservative forces are working to curtain abortion rights beyond their borders. For example, such groups include Heartbeat International, which has more than 120 pregnancy service providers spread around South Africa.[87]

However, the abortion debates also highlight that unlike in places like the US, abortion is not merely an either-or-issue; there were also compromised positions.[88]

The rhetoric used in parliamentary debates is reflected in the gendered conceptions of women who seek abortion services as discussed in the next chapter. As Macleod and Feltham-King found in their study, the way women are positioned has tremendous impact on 'how debates, legislation and practices surrounding abortion unfold.'[89] This calls attention to how such framings can be utilised by implementers of the Act including nurses to align with patriarchal systems that privileges male interest and are structurally male dominated. Political debate can mirror that of the discourses utilised by healthcare professionals.

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86 S Tamale 'Nudity, protest and the law in Uganda' Inaugural professorial lecture, Kampala: Makerere University (2016) 31.

87 Davies (n 72).

88 For example, J Castle 'New Fronts in the culture wars? Religion, partisanship, and polarization on religious liberty and transgender rights in the United States (2019) *47*(3) *American Politics Research* 650–679;

89 Macleod & Feltham-King (n 40) 749.

CHAPTER SIX

NURSES' PERFORMATIVE CONTRADICTION IN ABORTION CARE: THE LIMITS OF ABORTION REFORM

6.1 An introduction to the context in which (some) South African nurses provide abortion care*

Sister Mary
Yes, there was this day that I met a young girl while I was just sitting at the information desk. She came and wanted to do the termination. Then, I told her my views about the termination of pregnancy. I was objecting, but then I was not convincing her not to do it. I just gave her advice. Ultimately, she was convinced, and she started at the antenatal clinic, because she just wanted to do it because her friend was once pregnant, and she did the abortion. "Why did you have sex before marriage?" I asked. She responded: "peer pressure." I then asked her why she wanted to terminate her pregnancy? She did not seem to have any valid reason. Then I asked her about the complications that came, after she has done it. She didn't know about the complications. "This 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?" I told her. She was shocked that there are complications after a termination of pregnancy. She didn't know, because she was told it is completely safe. Then I told her, "the only safe part is that you won't be hurt like those ones that are doing it at the backstreet, but there are always complications." She now has a baby!

* These are derived from the interview data. The names are pseudonyms.

Nurse James

Ok, on my own experience, I had a healthy baby girl, she was born in 2018 December and apparently the baby mama wanted to do abortion and I was objecting to it and she did not consider my objections. She even wanted me to support her and accompany her to where she would terminate the pregnancy. Eh, I did accompany her just to support her and my aim was that eh, everything must go wrong, I wanted everything to fail but with my own instinct, it went the way I wanted, they kept on postponing the termination until the baby reached the viability [stage] of which she was 26 weeks so the termination was not possible anymore. And on the other side, I did secretly communicate with her family members that she is pregnant because she did not tell her parents and the parents made sure that she does not go anywhere, she was always kept.

Very little is known about how nurses in South Africa exercise conscientious objection; how they interpret guidelines; and how they perceive the intersection and tensions between their refusal versus their role as health professionals and care givers.

In this chapter, utilising the critical African feminist perspective, I explore nurses' opinions, attitudes to and practices of conscientious objection to abortion. Based on empirical data, the chapter assesses how nurses interpret and implement abortion law in practice and their construction and perceptions of women seeking abortion. It also examines the factors that shape nurses' motivations on conscientious objection relating to termination of pregnancy services. The data presented here were mainly based on semi-structured interviews and focus group discussions with nurses. I have described the methodology and research methods in chapter 3. Respondents provided written informed consent and were guaranteed confidentiality. Therefore, quotes presented from the interviews are without attribution.

The chapter has five sections. Section one gives an overview of abortion training for nurses and general abortion provision in public and private facilities. Section two illustrate the nature of the practice of conscientious objection to abortion provision by nurses. Section three explores the discourses utilised that pertains to how they make decisions to provide or not provide care. Second four gives an overview of the findings of the chapter while section 5 concludes the chapter.

Below, I present an anonymised representative of the narrative patterns that emerged from the research. The selection of the data is based on the extent to which the quotations are able to expand our understanding of the practice of conscientious objection. Based on the interview schedule, nurses were asked their views about abortion and women's reproductive rights; perceptions about women seeking services; their professional backgrounds including trainings done; and their understandings of conscientious objection. The goal was to explore legal, professional, moral, ethical and religious factors that shape their abortion work. While an account of nurses' understandings and behaviours are quite insightful, this does not in any way represent the experiences of women seeking abortion services, which has been studied elsewhere.[1]

6.2 Nurses' abortion work

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 twelve 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.

[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(16) *BMC Reproductive Health* 1-7.

Although, nurses are unable to perform the procedure after the first trimester, they are able to administer medication and are responsible for management of care during these procedures. They assist through preparation of patients for abortion procedure including asking women about their medical histories, drawing blood, providing abortion counselling or administering drugs for examination of the cervix. They are additionally in charge of post-abortion care. A majority of the nurses I 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).[2]

The training of nurses is in some cases partial and incomplete, or in need up updating. 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.[3]

The trainings for abortion providers employed in the public facilities are sometimes combined with values clarification and attitude transformation (VCAT) component. Ipas South Africa[4] mainly conducts VCAT trainings in Gauteng and Limpopo, which includes a variety of activities to engage participants in open dialogue to explore their values and attitudes about abortion and other related reproductive health issues, often leading to increased understanding and ease with the delivery of non-

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2 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 a self-administered paper questionnaire among women attending four clinics, Cape Town, South Africa' (2015) 22 (44 Suppl 1) *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.

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

4 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.

judgmental care.[5] The workshops are focused on moving providers through a progressive scale of support for abortion and reproductive rights.[6] A Support Staff nurse – previously an abortion provider until being transferred to a different department noted the usefulness of 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 the service that they require, irrespective of how I feel about it and not being judgemental.

Nurses noted that due to the 2008 amendment that extended eligibility to them, reactions were mixed as some supported it, while others resisted. A nurse reported that:

> 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.

That nurses who are trained stop providing abortion care is reported as a problem. It was noted by a Facility Manager that 'there are people out there who have been trained, but when they are supposed to provide the service, they reverse.' The reason for this varies. For instance, a nurse reported:

> 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.

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5 Ipas 'Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences' (2018) 3.

6 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, Ipas).

The inadequate uptake of abortion provision after training contributes to the shortage of trained abortion providers. This means that, the designated facilities will be unable to provide abortion services thereby leading women to resort to private or backstreet abortions. Effective service provision depends on willing and qualified healthcare providers.

For patients in private facilities depending on the state of pregnancy, medical abortion is mostly favoured. A client can make an online or telephone appointment to come in for the procedure. For public health facilities, surgical abortion is the main method rather than medical abortion, thereby impacting access to services. Thus, the client's pathway to access abortion services in public facilities depicted in figure 6 is impacted and looks very different from that of the private sector. The disjointed and complex ways in which abortion is provided – often in hidden spaces are not incorporated in the everyday life of the medical clinic. Figure 6 illustrates the different roles of healthcare personnel, including nurses in the process. This fragmentation of services due to variations in provider's preparedness for what they can offer is common in South Africa.[7]

[7] Harries (n 1) 1-9.

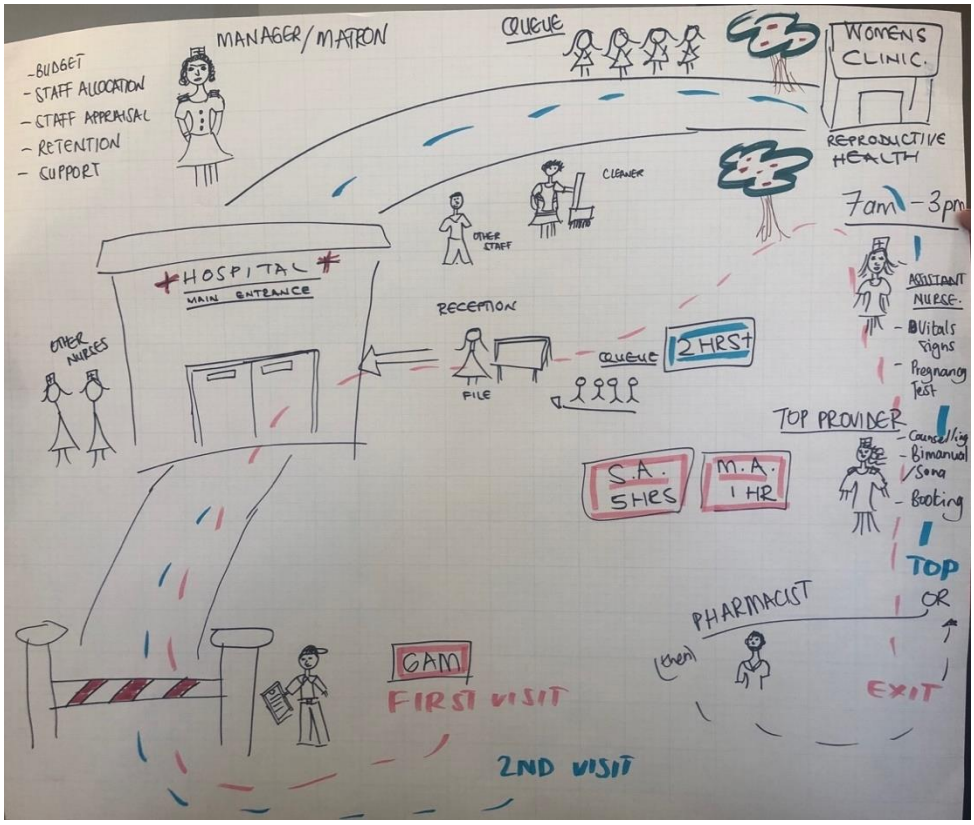

Figure 6: Client pathway for abortion access in public health facility

Thus, there are different levels of provision or involvement in abortion care by nurses, which in turn have implications for conscientious objection.

First, there are nurses who are trained as termination of pregnancy providers and are directly involved in the abortion procedure providing first trimester abortions. They conduct manual examination,[8] or alternatively perform ultra sound to determine gestation age.[9] If within the nine weeks window, they will administer Cytotec which causes the uterus to contract and expel the foetus,[10] but the majority

8 This is part of the standard pelvic examination, in which the healthcare provider uses their hand to evaluate pregnancy.

9 Given that not all facilities have a sonar (ultrasound machines), clients would be referred to another facility that performs ultrasound.

10 See D Grossman *et al* 'Surgical and medical second trimester abortion in South Africa: A cross-sectional study' (2011) 11(224) *BMC Health Services Research* 1-9.

use the manual vacuum aspiration also for these early pregnancies.[11] They also assist in the operating room when there is a surgical procedure.

Second, there are registered nurses who are not trained as abortion providers and thus cannot perform the procedure but are able to execute other abortion-related services such as referral to an authorised abortion facility, or pre- and post-counselling. They might also be responsible for taking vital signs, conducting pregnancy tests and booking of an appointment.[12] Third, there are nurses who absent themselves from all these aspects and only perform general nursing duties. Some might be involved in post-abortion care and contraceptive counselling while others will excuse themselves from this aspect as well.

6.3 Practices of conscientious objection

As discussed in chapter 4, while the Choice on Termination of Pregnancy Act does not provide for conscientious objection, healthcare providers are able to utilise the constitutional provision on freedom of thought, belief and opinion, if they do not wish to perform abortion services based on their religious or moral beliefs. However, they do have the obligation to not obstruct access by informing the woman seeking abortion of her right, as well as, to refer her to another provider or facility. The right to refuse to provide abortion services in South Africa is not applicable in case of a medical emergency, which is provided under section 27(2) of the Constitution.[13] A nurse cannot refuse to assist in this case

There are no explicitly available data on the prevalence of conscientious objection to abortion. In 2013, it was estimated that less than 50 per cent of the approximated

11 See WHO 'Safe abortion: technical and policy guidance for health systems' 2nd edition (2012).

12 Services are provided within a time frame during the day and in some of the facilities they are not provided on a daily basis. One is usually given a booking based on the availability of the provider and the capacity of the facility.

13 See also Human Rights Committee 'General comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life' CCPR/C/GC/36 (2018).

260 designated facilities provided abortion services.[14] In 2018, it was estimated that only 264 out of the 505 designated health facilities (7 per cent) actually performed abortions.[15] The shortage of health workers leads to increase the number of women seeking informal or backstreet abortion.[16]

It is important to note that this study was not designed to estimate the prevalence of conscientious objection. However, the data provides insights into understanding the means through which conscientious objection is practiced. Out of the 33 nurses interviewed in this study, seven noted that they do not support the provision of abortion as provided for in the law, while seven were categorised as undecided as their decision making was on-going and non-linear. For the private facilities and probably due to their nature as abortion clinics, there were no objectors. From the analysis of the data in the study, a general lack of understanding of the concept and practice of conscientious objection was evident. Similar to this study, Jane Harries and colleagues in a research conducted in Western Cape highlighted that conscientious objection was also not clearly understood by health professionals.[17]

Nurses were unfamiliar with the concept and practice.[18] If they absent themselves from the procedure, they did not use the term 'conscientious objection.' Only one facility manager was prepared to describe her understanding of conscientious objection:

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14 '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*(3) *American journal of public health* 397–399.

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

16 R Hodes 'The culture of illegal abortion in South Africa' (2016) 42(79) *Journal of South African Studies* 79–93. See also KE Dickson et al 'Abortion service provision in South Africa three years After liberalization of the law' (2004) 74(2) *Studies in Family Planning* 374-401.

17 Harries (n 1) 3.

18 Similar findings found in J Harries *et al* 'Health care providers' attitudes towards the termination of pregnancy: A qualitative study in South Africa' (2009) 9 (296) *BMC Public Health* 4-5.

> Meaning it's when you say I won't do it. I won't allow it to be done. I think it's up to an individual. Yes, I wouldn't change their mind-set or how they feel about it. But I believe we are living in a free country. People are free to object or to say their views. I wouldn't judge them and say they are nurses; they took an oath. It's a free country.

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 BCUR 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 managers anecdotally spoke of how nurses would not engage in abortion services but noted that there was no formal system for recording such objection. Those that object did

not have to register as conscientious objectors. There also seemed to have been a conflation between what constitute obstruction to abortion services as provided in the Act 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 probed regarding how those who object to termination of pregnancy (TOP) expressed their objections, respondents' answers were vague, unsure and unsubstantiated. The overall impression gained was that if someone – including an abortion provider – who objected to delivering or supporting termination of pregnancy wanted to be excluded from the services, they would inform their department head, the facility manager, a union representative, or the District Department of Health, in an informal manner. It appears that there are no policies or procedures for conscientious objection as this exchange with a facility manager suggests:

> Interviewer: Has anybody mentioned, previous management, how that process happens? Let's say, for example, you have a [Choice on Termination of Pregnancy] provider, and she becomes a born-again Christian, for example. What does she do, what happens? Does she go to… who does she speak to? Is there a form? Is there a procedure?
>
> Respondent: 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?
>
> Respondent: No … But we are guided by ethics.
>
> 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 appeared to be a general consensus that those who are trained as providers and later withdraw do so on religious grounds. For instance, a facility manager described how some nurses were sent for advanced training – which included training in termination of pregnancy – and when trained, refused to deliver abortion services because they found 'God':

> 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.

As the data extracts presented above suggest, understandings and implementation of conscientious objection remains uncertain. In some instances, conscientious objection seems to appear be used in creating space for resisting abortion law and the provision of legal abortion. This is coupled with the fact that facility managers and nurses reported that there is no formal process of recording the objection and reasons given. There are no standardised policies and procedures on managing the practice which creates more confusion.[19] It is difficult to get estimates of the number of objectors or the ground for objecting, but many materials indicate that it is common to refuse based on varied reasons. Poor knowledge of laws and regulations play key roles in nurses' perception of abortion, even where the law is liberal.

6.4 Discourses pertaining practical decisions to provide or not to provide abortion services

6.4.1 On professional duty and responsibility

On factors that influence nurses to provide abortion services, the majority of abortion providers considered it a professional duty, which also stems from personal experiences. Nurses' decision to perform abortion services or support in the procedure was mainly premised on the belief that termination of pregnancy

[19] This is aligned to findings in MC Engelbrecht et al 'The operation of the Choice on Termination of Pregnancy Act: Some empirical findings' (2000) 23 (2) *Curatonis* 4-14.

services save women's lives, otherwise, women will resort to backstreet abortion. A public sector nurse underscored the need for her involvement in this way:

> 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 reported that they were largely motivated to provide abortion care because of the devastating consequences of unsafe abortion, which is related to morbidity and mortality. This is reflected below:

> 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.

For others, their personal life intersected with their professional career choices in ensuring that women have the right to make decisions about their bodies and reproduction. This was the motivating factor for a private abortion clinic owner:

> 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.

The commitment to save lives and provide safe abortion services resonates with health providers in restrictive settings risking their lives and freedoms to address the consequences of unsafe abortion including morbidity and mortality.[20] These nurses are aware of the devastating consequences of unsafe abortion methods used and abortion pills sold by street vendors. Providers reported that they have seen instances of insertion of sharp objects into the vagina, physical manipulations of the

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20 See CM Payne *et al* 'Why women are dying from unsafe abortion: narratives of Ghanaian abortion providers' (2013) 17 *African Journal of Reproductive Health* 118-128.

womb and drinking of herbal concoctions to induce an abortion. These local abortion practices and folklores were the methods used over the past 150 plus years in South Africa.[21] My interviews show that this is still the case. 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 that 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 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.

In addition, the larger political and legal landscape also influenced their perception around reproductive rights as guaranteed in the South African Constitution. Among abortion providers, there was also a general understanding of medical norms which requires one to serve clients. Abortion providers constructed women seeking

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21 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.

abortion services as having agency and a right to make reproductive healthcare decisions.

6.4.2 Religious and cultural beliefs about abortion

From conversations with nurses, the study finds that religious convictions and beliefs systems which are sometimes based on ones' culture, have an impact on the decision of providers to not engage in abortion procedures. For objecting providers, this was mainly premised on Christian belief that abortion is against 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 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.

These extracts indicate a Christian discourse that views abortion as a sin, which echoes with pro-life views that abortion is murder and destroys the sanctity of life.[22] Furthermore, the religious arguments were also not just Christian-based, but also centred on traditional African religions. In Limpopo, unlike Gauteng province, the belief in traditional African religion and mythologies was apparent. A nurse provider commented:

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

A distinct difference between perceptions of people based in urban area and those in the rural area was evident when these Limpopo-based nurses shared as follows:

> 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 above quotations illustrate the immorality arguments used by objecting nurses, which equate abortion with religious and cultural anomalies. Cultural and traditional beliefs do govern views about abortion. This is akin to the findings of a 2017 study where the author stated that:

> The African traditional epistemology views abortion as a taboo and its transgression is known to be punished by the earth spirit through shortage of

22 See J Daire *et al* 'Political priority for abortion law reform in Malawi: Transnational and national influences' (2018) 20(1) *Health and Human Rights Journal* 225-236.

> agricultural products, famine, infertility, draught and illness. This punishment may befall particular clan members, the whole family or everyone living in the village. [23]

Although nurses were of the belief that abortion was an unacceptable practice and often cited religion, abortion providers also used religious convictions differently, arguing that Christianity's ethos includes compassion, humaneness and community. A nurse provider– a pastor in her church explains:

> 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:

> […] before I came for training I spoke to my reverend and he said to me because this thing is legalized 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 traumatized by what we see on TV or what is reported on daily basis.

These two narratives are very insightful examples of how discourse can be repurposed since it is socially constructed. Here, these two nurse providers re-positioned the issue of abortion as a moral issue in trying to address unsafe abortions. Such moral discourse is usually utilised by the prof-life movement.

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23 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).

Understanding ideologies whether political or religious helps in illustrating how it is used to further the interests of those in power. Patriarchal societies embody power structures including institutions, belief systems, ideologies and behaviours that maintain men's control over women's power of agency over their own bodies.[24] The traditional view of patriarchy is premised on the subordination of women by men through the family structure with men as the head of the household. The patriarchal discourse is often synonymous with the subordination of women within the context of religious and traditional beliefs and practices.[25] This categorisation is illustrative of the dichotomy between non-western states and western states.

Marxist-feminism sees patriarchal ordering as the premise on which capitalism as an economic class system is driven.[26] Bell Hooks 'use[s] the phrase "imperialist white supremacist capitalist patriarchy" to describe the interlocking political systems that are the foundation of politics.'[27] In *The Will to Change,* Hooks further argues that:[28]

> Patriarchy is a political-social system that insists that males are inherently dominating, superior to everything and everyone deemed weak, especially females, and endowed with the right to dominate and rule over the weak and to maintain that dominance through various forms of psychological terrorism and violence.

This sees the discourse on the subordination of women moving from its relegation in the private sphere, to both the political and public dimensions. Tamara Braam and Leila Hessini offer this definition of patriarchy:

> The systematic, structural, unjustified domination of women by men. It consists of those institutions, behaviours, ideologies, and belief systems that maintain, justify and legitimate male gender privilege and power. Men are viewed as the norm, and

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24 T Braam & L Hessini 'The power of dynamics perpetuating unsafe abortion in Africa: A feminist perspective' (2004) 8(1) *African Journal of Reproductive Health* 45-47.

25 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.

26 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.

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

28 As above.

> their life experiences and approaches are most often used as the basis on which to determine social needs, articulate policy requirements and assign resources. [29]

The anti-essentialist view of patriarchy is that it is not applicable the same way across cultures thus challenging the white/imperial feminist understandings of the concept. This perspective pays attention to the interrelated and constantly changing components of the concept and not just an oversimplification of complex social and economic systems.

The focus is that patriarchy is a system rather than individuals, though it can be practiced and supported (as well as challenged and resisted) by anyone. The role of religious ideology and practices in the institutionalisation of male control over women including making reproductive decisions is evident; championed on the authority of religious and cultural leaders who are often men. For example, the Catholic Churches relies on priests, who are exercise religious authority and many Protestants churches still identify fathers and husbands as spiritual heads.[30] While Islam recognises that all humans are equal before Allah,[31] women and men are expected to fulfil specific roles: such as men as the head of household and women responsible for child rearing.[32]

Notably, using a feminist lens, it is observed that religious and cultural arguments about the sanctity of life and not killing the unborn are based on expectations about the role of women, reproduction and motherhood. Gender norms are rules that governs what is acceptable or unacceptable behaviours based on one's gender.[33] Gender norms are restrictively constructed to allow behaviours that are conventional for men and women respectively. Women who do not conform to

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29 Braam & Hessini (n 24) 45.

30 KA D'Souza 'Abortion and the three bodies: An interpretive understanding of barriers to abortion access in South Africa' (2013) 1(3) *Journal of Undergraduate Anthropology* 8-19.

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

32 Quran verse 4:34. See SS Ali 'Women's human rights in Islam: Towards a theoretical framework' (1997) *Yearbook of Islamic & Middle Eastern Law* 117-152.

33 GL Darmstadt 'Why now for a series on gender equality, norms, and health?' (2019) 393 (10189) *The Lancet* 2375.

these standards are sanctioned. Consequently, the construction of abortion as sinful is premised on the conception of women's primary responsibility as that of childbearing and childrearing.[34] In other words, being a mother is considered a key element of status in societies and becomes the highest achievement of women.[35] Reva Siegel argues that when a woman decides whether to have an abortion, this often equates to whether she can and should be a mother.[36] Huma Ibrahim affirms that the sanctioning of motherhood is part of patriarchal discourse.[37] Thus, women who decide to have an abortion are deemed to be going against societal beliefs and norms about motherhood.

Abortion, as Kate Cockrill and Adina Nack write, 'can signal multiple transgressions, including participating in sex without a desire for procreation, an unwillingness to become a mother, and/or a lack of maternal-fetal bonding.'[38] This is a discourse that centres abortion as incompatible with the idea of motherhood. Beth Min-Ahlberg and Asli Kulane write that women have always been viewed as mothers rather than people with reproductive choices.[39] Martha Fineman and others described motherhood as a 'colonized category' arguing that what constitute motherhood is rooted in 'male norms and male understandings fashioned legal definitions.'[40] Historically, discussions within African reproductive regimes reflected ideals of marriage, high premium place on large families and the strong desire for many children.[41] In concert with other African feminists, it is my

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34 P*lanned Parenthood v. Casey*, 112 S. Ct. 2791, 505 U.S. 833, 120 L. Ed. 2d 674, 1992 U.S. LEXIS 4751, 60 U.S.L.W. 4795, 92 Daily Journal DAR 8982, 6 Fla. L. Weekly Fed. S 663 (U.S. 1992) 168-169. See also BR Grossman *Gender and Law: Theory, Doctrine & Commentary* 692.

35 K Luker *The politics of motherhood* (1984) 160.

36 R Siegel 'Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection' (1992) 44 *Stanford Law Review* 261 274.

37 H Ibrahim 'Ontological victimhood: "Other" bodies in madness and exile toward a Third World feminist epistemology in O Nnaemeka (ed) *The politics of (M)othering: Womanhood, identity, and resistance in African Literature* (1997) 155.

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

39 B Maina-Ahlberg & A Kulane 'Sexual and reproductive health and rights' in S Tamale *African sexualities* (2011) 326-329.

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

41 See RJ Lesthaegh *Reproduction and social organization in sub-Saharan Africa* (1989).

contention that the regulation and control of sexuality and reproductive capacity ensures that women are kept as good mothers.[42] In this vein, Amina Mama further argues that the assigned roles of childbearing and homemaking is shrouded within the dichotomy between the public and private spheres.[43] The dichotomisation of the public and private spheres is partly anchored on women's reproductive autonomy.[44]

In contrast, other African scholars caution against the viewing of motherhood in purely western gender discourse as women's autonomy can be celebrated both in the public and private spaces.[45] Women's role of wife or mother does not necessarily limit women's agency.[46] It is in this line that Ifi Amadiume in *Male Daughters, Female Husbands* writes:

> Maternity is viewed as sacred in the traditions of all African societies. And in all of them, the earth's fertility is traditionally linked to women's maternal powers. Hence the centrality of women as producers and providers and the reverence in which they are held.[47]

While the presentation of maternity as reproductive autonomy within the context of a 'balanced precolonial gendered institutions' is useful, there is need for caution against overly romanticising African women's agency during precolonial times.[48] It is troubling that Amadiume's depiction of motherhood paints a very peaceful

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42 This is in line with Tamale's arguments. See S Tamale 'The right to culture and the culture of rights: A critical perspective on women's sexual rights in Africa' (2008)16 *Feminist Legal Studies* 58.

43 A Mama 'Heroes and villains: Conceptualising colonial and contemporary violence against women in Africa' MJ Alexander & CT Mohanty (eds) *Feminist genealogies, colonial legacies, democratic futures* (1997) 46-62.

44 S Tamale 'Gender trauma in Africa: Enhancing women's links to resources' (2004) 48 *Journal of African Law* 52-53.

45 As above, 50-61.

46 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.

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

48 KA Hoppe 'Ifi Amadiume. *Male daughters, female husbands: Gender and sex in an African society*' (2016) 18(3) *International Feminist Journal of Politics* 499.

picture. Notions of tradition and gender may constrain women when asserted in a very uncompromising way. The reified and revered historic view of motherhood being a sacred duty does not sufficiently see this discourse as a double bind on women who seek to terminate a pregnancy. While protection for women's reproductive functions is evident, it has led to the confinement of women to that particular role. It is in the name of tradition that this feminist discourse contributes to conservative sexual morality, which shames and punishes women that engage in non-procreational sexual activity. Cultural norms, Fitnat Naa-Adjeley Adjetey claims:

> keep African women in cultural subordination and put them in such a low bargaining position that they have little, if any, control over decisions which affect their bodily integrity. This is because their reproductive labor is responsible for keeping the family bloodline alive, and because this responsibility is of the essence to Africans, they have not been permitted the freedom to make their own reproductive choices.[49]

Viewing motherhood as reproductive autonomy should also entail the exploration of it as a mode for the subjugation of women that sees abortion as a gender transgression. As Rebecca Cook elucidates motherhood can result to consideration of a woman 'a vehicle for human reproduction.'[50]

The South African Constitutional Court explains women's gender roles of being mothers as a source of inequality noting that while 'parenting may have emotional and personal rewards for women, [it] should not blind us to the tremendous burden it imposes at the same time.'[51] 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.

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49 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* 1352-1353.

50 R Cook 'Gender, health, and human rights' in JM Mann et al (eds) *Health and human rights: A reader* (1999) 253.

51 *President of the Republic of South Africa & Another v Hugo* 1997 6 BCLR 708 (CC) para 38.

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.

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

While personal, moral and religious beliefs about abortion are often cited by objectors, it is worth noting that the number of respondents who were unequivocally against abortion under all circumstances were in the minority. The majority of objecting nurses shared that they determine their involvement or non-involvement in abortion provision based on the reasons for women seeking an abortion. This points to the complexity of abortion provision decision-making and how nurses navigate their conflicting views towards abortion. 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% 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.

It is important to point out that the nurses' consideration was only for physical health and not the mental health of the woman seeking abortion.

These extracts highlight varied reasons why nurses who object to abortion work generally will be empathetic and deeming grounds of rape or risk to health as appropriate use of the services. Based on the extracts above, these nurses could be categorised as situational objectors as they would generally object but would make exceptions when they deem the reason for a woman asking an abortion to be justifiable. A feminist critical analysis of the reasoning that situational objecting nurses use to ascertain whether the reasons women give are justifiable or not, reveals stereotypical attitudes about women.[52] Gender stereotype is premised on the perceive roles that one should play based on their gender.[53] In this case, if women do not have exceptional reasons for having an abortion, they would be put in their place.[54]

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52 See Office of the High Commissioner for Human Rights (OHCHR) 'Commissioned report: Gender stereotyping as a human rights violation (2013). Arts 2 and 5 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) obligates states to modify gender stereotypes based on the inferiority of women in all spheres of life, including sexual and reproductive health and rights.

53 RJ Cook & S Cusack *Gender Stereotyping: Transnational Legal Perspectives* (2010) 9.

54 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.

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.[55] 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.[56] 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*.[57]

Nursing as a profession entails specialised knowledge and clinical practice which produces actions of power.[58] This speaks to Foucault's position that power and knowledge are inextricably linked in a complementary relationship.[59] Knowledge is not neutral but embodies perspectives which can serve as the vehicle for the exercise of power. Based on this premise, nurses construct women who seek termination of pregnancy differently and distinctly based on the reasons for seeking an abortion. Gender stereotypes permeate the reasoning of objecting nurses in determining under what circumstances women deserve access to abortion services. For instance, women who have been raped or have medical conditions are considered *deserving* and are portrayed as victims.

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 it is rape or sexual abuse. This has resonance with both

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

56 SW Salmond & M Echevarria 'Healthcare transformation and changing roles for nursing' (2017) 36(1) *Orthopedic Nursing* 21.

57 Emphasis added.

58 RR Sepasi *et al* 'Nurses' perceptions of the concept of power in nursing: A qualitative research' (2016) 10(12) *Journal of Clinical and Diagnostic Research* LC10.

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

the discourse used to support the enactment of the Choice on Termination of Pregnancy Act,[60] as well as the pro-choice movement's approach for abortion reform in restrictive settings.[61] 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*.[62] 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 I acknowledge that this victimhood argument might be seen as a good leverage for empathy amongst nurses who do not support abortion to make exceptions, it also stigmatises women who seek abortion based on other grounds. It must also be noted that the majority of women *do not* seek abortion based on reasons of being 'victims of sexual crimes.' For example, a Pretoria-based study found that women's reason for seeking abortion included inadequate finances, inconvenient timing, problems relating to their partner, non-completion of education and contraceptive failure.[63] Indeed, women who do become pregnant as a result of rape or sexual assault should not just be considered victims, as they are taking decisional autonomy of their reproductive health. Additionally, the inclination of nurses to make exemptions based on medical indications does not

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60 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.

61 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) *International Journal of Qualitative Methods* 1-9. See also M Berer "Abortion Law and Policy Around the World: In Search of Decriminalization" (2017) 19(1) *Health and Human Rights Journal* 13-27.

62 Emphasis added.

63 C Steyn *et al* 'An exploration of the reasons women give for choosing legal termination of pregnancy at Soshanguve Community Health Centre, Pretoria, South Africa' (2018) 60(4) *South African Family Practice* 129.

necessarily support the autonomous right of women, but rather is geared towards protecting the future reproductive capacity of these women, thus, reinforcing women's roles as mothers. The discourse of victimhood produces discursive practice that excludes women who have not experienced rape or sexual violence and medical reasons as not having a justifiable reason for abortion.

6.4.4 On contraception and 'repeat abortions'[64]

One of the major recurring themes in the narratives for non-involvement in abortion provision was the link between contraception and abortion. Nurses were less inclined to compromise on their value systems due to their perceptions of women seeking abortion services.

> 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

64 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.

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

There was a general inclination that women sought abortion as a method of contraception. Women suspected of 'repeat abortions' were perceived to be using abortion services as a contraceptive method.

> 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.

An often-cited example was of young women seeking abortion on multiple occasions and refusing education on contraception, who were deemed to be sexually promiscuous.

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

This belief was reflected in the response of a non-providing nurse when asked whether she would refuse to deliver post-termination of pregnancy services:

> 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.

From the narratives, there was a general belief that due to refusal to correctly use contraception, there has been an increase in 'repeat abortions,' which they found quite unacceptable:

> 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.

> […] it 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.

This was the concern for another:

> What I feel it's not fine is in the case where TOP is used as a tool for prevention, to prevent pregnancy and that is what I am seeing happening in today's life. Many of the young people, instead of attending ah, family planning, they would rather go for TOP. The reason could be because of family planning that has got some side -effects and also some of them due to medical problems they cannot use certain types of family planning. So that

> could be one of the reasons. Another reason could be TOP is something that is done there and then and it's over, but to come back for it, that is what I do not agree with.

However, there were counter- views to this narrative. Some nurses took a cautionary tone in that health providers need to pay attention to the circumstances of women seeking repeated abortions. They highlighted that due to constant movement, there might be instances in which these women have lost their cards and do not remember the dates. Other factors include inadequate access to family planning methods especially long-standing ones, untrained providers and general negative attitudes of health professionals.

> 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.

Another provider noted that she has seen several situations in which a woman sought to terminate only to find out that she is not pregnant. This might be due to the fact that lower rank nurses generally do pregnancy test and might have not followed proper procedures. An independent provider also noted that she had to

turn away a client after coming for the fourth time. This was after she was counselled to use contraceptives and referred to a social worker.

Additionally, some of the providers believed that abortion was encouraging young women to be promiscuous and that they were not concerned with the consequences of unprotected sex, including pregnancy and human immunodeficiency virus (HIV). An objector noted this as the reason why she objects:

> 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:

> […] because 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.

A related concern was couched in post - abortion rhetoric. Nurses were concerned that abortion threatens fertility and the possibility of a woman not being able to fall pregnant at a later date:

> [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.

An example of situations when they step in to address these future concerns, a nurse presents her experience in this regard:

> 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?'
>
> What did she say?
>
> 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 mainly illustrate the consequential arguments focused on contraceptive misuse and implications of undergoing the procedure. Women seeking abortion due to non-contraceptive use or for multiple times are considered *irresponsible and deviant*. This rests on and reproduces negative stereotypes about women as people who should not engage in non-procreational practices of sexual pleasure and desire. As such, nurses are less sympathetic to women seeking abortion if the reasons are due to contraceptive failure or is a result of the incorrect and inconsistent way that women use family planning methods.

Given the assertion by adolescents involved in non-procreated related sex are underserving of abortion services, these negative constructs are especially true for young, unmarried black women who are considered irresponsible and immoral.[65] There is an underlying presumption that availability of abortion causes promiscuity and irresponsibility, which are socially unacceptable behaviours especially for adolescents.[66] Objecting nurses believe that teenagers should not have sex before marriage because it is morally wrong. Nurses who do not provide abortion services also believed that young women ought not be entitled to abortion, as it would promote early sexual debut and HIV transmission.

In addition, women who have had abortion/s or multiple abortions were regarded as 'distinct from other women, including women who have a single abortion.'[67] The use of "repeat abortions" while signalling that people exist who have ended more than one pregnancy also makes it easy to separate people into two distinct groups or silos, which leads to harmful stereotyping. Women who have multiple abortions are then "othered" and considered bad and deviant by nurses. This position is largely due to debate around abortion used as a form of a contraceptive method. A nurse summarises the problem noting that there is 'no excuse' for abortion because of family planning and emergency contraception.

Whilst emergency contraception is considered a useful method to prevent unwanted pregnancy, there were varied positions. On one hand, there were nurses who seem to struggle in understanding why women do not comprehend that emergency contraception would address the need to have an abortion. On the other

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65 See CO Izugbara et al. 'Providers, unmarried young women and post-abortion care in Kenya' (2017) 48(4) *Studies in Family Planning* 344- 358; JN Dressler et al. 'The perspective of rural physicians providing abortion in Canada: Qualitative findings of the BC Abortion Providers Survey (BCAPS)' (2013) 8(6) *PLoS One* 1-5.

66 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* 71-78; K Wood et al 'Blood blockages and scolding nurses: Barriers to adolescent contraceptive use in South Africa' (2006) 14(27) *Reproductive Health Matters* 109-118.

67 Discussion on this, see L Hoggart et al ''Repeat abortion', a phrase to be avoided? Qualitative insights into labelling and stigma' (2017) 43 *Journal of Family Planning and Reproductive Health Care* 26-30.

hand, there were nurses who felt that if they promoted emergency contraception, women would stop using longer term available contraceptive methods. This might point to the reason why there is a general perception of emergency contraception as an abortifacient, hence, it is not widely promoted leading to misinformation about its use.

The contradictory contraceptive debate is more complex than the portrayal of these women by nurses as irresponsible, which might be rooted in the economic and structural conditions that these women face.

6.5 General discussion

The starting point of this chapter is the premise that legal changes, which permit women to access abortion do not necessarily remove barriers imposed by the attitudes of healthcare professionals including nurses.[68] Hence, the chapter extend insights into the lives of nurses and to the many subjective fields they navigate relating to provision of legal abortion care. Such a combined strategy integrated the multiple dimensions of their realities: relations of power and inquiring into many spheres of their lives (actions, feelings, and perceptions).

The Democratic Nursing Organization of South Africa (DENOSA) during its submission to the Parliamentary hearings on the Choice on Termination of Pregnancy (CTOP) Amendment Bill,[69] 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

68 See S Sheldon Beyond control: Medical power and abortion (1997).
69 Act 21 of 2007

> providers, are women who also have the right to choice about their own reproductive health.[70]

Interactions emanating from such abortion work constitute the creation of space that reifies the manifestation of multitude of power relations.[71] Hospitals serve as space for both vertical and horizontal power relations that keep in place the social and bureaucratic hierarchies in the hospital setting.[72] Nurses are in a position in which they have powers of not only disciplining patients but also subjecting them to surveillance and normalisation.[73] Margareta Dahl calls it the 'oppressed group behaviour.'[74]

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.[75] Nurses through the act of performance of their duties, enact the convention of reality. As Butler notes:

> 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.[76]

What the above findings illustrate is that nurses reflect and reproduce norms societies in which they live and work as depicted in the differences between multiple discourses deployed by nurses who provide and those who object (and

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70 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).

71 SW Salmond & M Echevarria 'Healthcare transformation and changing roles for nursing' (2017) 36(1) *Orthopedic Nursing* 12 25.

72 M Manojlovich 'Power and empowerment in nursing: Looking backward to inform the future' (2007) 12(1) *OJIN: The Online Journal of Issues in Nursing* 2.

73 See M Foucault *The history of sexuality, Vol 2* trans R Hurley (1980) 139.

74 M Dahl 'Nurses: An image change still needed' (1992) 39(4) *International Nursing Review* 12

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

76 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.

within that particular group).[77] Nurses' articulation of these illustrated discourses is tied to power relations.[78] For non-providers, this chapter mapped out their often-contradictory motivations and reasoning behind their decision. As discussed above, nurses' willingness to be involved or not involved in abortion provision is influenced by religious beliefs and their perceptions on whether they are "good" or "bad" abortions based on the reasons for which women are seeking the services. The themes and sub-themes are summarised in the table 2 below:

Table 5: Overview of findings

Reported Positions	**Sub-category of position**	**Broad category of reasons**	**Sub-theme For providing/supporting abortion**	**Sub-theme For not providing/supporting abortion**
Provider		Religious reasons	Religious ethos including compassion, which permits abortion	
		Professional ethics	Job was chosen due to calling	
		Moral beliefs	Prevents maternal mortality and morbidity	
		Legal right	Reproductive right	
		Institutional reasons		Inadequate incentive
Conscientious objectors	Deontological Objectors	Religious reasons		Religion does not permit abortion
		Safeguarding women's sexuality		promotes promiscuity prevention of early sexual debut
	Situational objectors	Women's Health/ consequences		infertility
		Deserving/ undeserving clients (Reasons for women seeking abortion)	rape/sexual assault medical reason	non-contraceptive use repeat abortions

77 SW Salmond & M Echevarria 'Healthcare transformation and changing roles for nursing' (2017) 36(1) *Orthopedic Nursing* 21.

78 Foucault (n 73) 131

While this study had a small sample, it provides insights into understanding the complexities relating to abortion practice. This study suggests that what we see practiced by nurses in relation to abortion provision is not what we would predominantly define or think of as conscientious objection. Nurses identified as "non-providers" not "conscientious objectors" and viewed abortion services differently. Given that morality is not a static concept, from the narratives, non-providing or objecting nurses can be described from two main viewpoints.

Firstly, the few nurses totally opposed to termination of pregnancy services assert the absolutist doctrine that abortion is immoral based on religious beliefs (for instance, that God commands us not to kill any human life). Hence, "Thou shalt not kill" constitutes moral law, which prohibits abortion.[79] This is reflective of major world religions, which views abortion as murder. The moral duty of these nurses to act out of respect for this moral law finds it foundation in deontological ethics that regards humans as rational beings.[80]

According to Kantian theory, the moral agent is only 'preoccupied with the nature of right, or the content or moral action.'[81] These moral values hold that one is not justified in doing something that is intrinsically wrong even if it produces good consequences. An important feature for these nurses is the total disregard of the consequences of their decision not to provide or assist in abortion procedures. For these non-providers, their answer to the question "is abortion always wrong?" is yes. It is never morally permissible to either perform the procedure or to have an abortion.

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79 Exodus 20: 2 –17, *Ten Commandments*, Old testament. However, the distinguishing from a secular approach, Immanuel Kant argues that divine will is not the source of moral law but rather the determination of whether any particular action is moral or not follows the rules of logic. See I Kant *Fundamental principles of the metaphysic of morals* trans TK Abbott (2005).

80 See HJ Gensler 'A Kantian argument against abortion' (1986) 49(1) *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 83-98.

81 LC McDonald 'Three forms of political ethics' (1978) 31(1) *The Western Political Quarterly* 7.

Consequently, these nurses apply the universality principle, which demands that ethical or value-based judgments are applicable to the same situation (pregnancy) regardless of the circumstances surrounding that pregnancy. Whatever the particular circumstances or outcomes, it does not have a bearing on the ethical decision-making process. Thus, there is no justifiable reason or good results in providing abortion, which is intrinsically bad, even, for instance, if abortion was needed by a rape victim. Their argument is that in such a case, there is no need to resort to abortion as the baby can be given away for adoption.

In contrast, the majority of non-providing abortion nurses interviewed in the study could, based on their narratives that exemptions should be made, be categorised as "situational objectors." This categorisation is based on two aspects: backward-looking stance (of who deserves an abortion) or the consequentialist position, which is based on forward-looking reasons for not having an abortion. This category of nurses applies situated moral judgments to determine when abortion is appropriate or not appropriate.[82] Decision-making of who deserved an abortion or not points to nurses' contextualisation of morality. What the data reveals is that decision-making for abortion provision is affected not by individual nurses' religious beliefs and cultures, but to a larger extent, it is affected by the context of the woman seeking an abortion. In applying relational ethics of care, women who have been raped or have a medical condition that is risky to the life or health of the woman were deemed 'deserving' of support, contrary to women who have weak reasons, including contraceptive failure. This narrative is reflective in the statement by a member of parliament (MP) during parliamentary debates on the Act when he expressed:

> The Bill challenges the legal rights of parents, guardians and husbands, it promotes promiscuity and irresponsibility amongst our teenagers. It destabilises trust

82 On how one assumed occupational identity can substantially influence moral judgement, see *LK et al* 'Different hats, different obligations: Plural occupational identities and situated moral judgments' (2012) 6 *Academy of Management Journal* 1316-1333.

> between married couples, and I foresee a great degeneration in family life as we know it today.[83]

Nurses were less willing to assist in these cases. Surprisingly socio-economic reasons did not come up as a reason for when they are more willing, though, this has been reported in other studies.[84]

The consequentialist position affirms the view that one should avoid an abortion because it can lead to undesirable consequences. This has been illustrated earlier from the alleged post-abortion rhetoric of abortion as an unhealthy procedure that has associated risks including infertility as highlighted in the prologue of Sister Mary's narrative. There is this general idea that abortion could have negative impact on the future fertility of the woman seeking the services, and thus contributing to the general climate of fear that women will not be able to conceive in the future.[85] This is also contrary to the obligation to ensure that information on sexual and reproductive rights is 'evidence-based, facts-based, rights-based, non-judgmental.'[86]

The emphasis on the risks related to having an abortion has undue influence on whether women terminate a pregnancy or not. Rebecca Cook notes that:

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83 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.

84 See J Harries *et al* 'Health care providers' attitudes towards the termination of pregnancy: A qualitative study in South Africa' (2009) 9 (296) *BMC Public* Health 1-11.

85 There is currently ongoing debate about whether induce abortion is safe and its health consequences. There has been some evidence to show that that induce abortion can be relatively safer than compared to childbirth as found in a US based study. See EG Raymond & DA Grimes 'The comparative safety of legal induced abortion and childbirth in the United States' (2012) 119(2) *International Journal of Obstetrics & Gynecology* 215- 219.

86 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.

> the role of health professionals is to give the individual decision-maker medical and other health-related information that contributes to the individual's power of choice and does not distort or unbalance that power.[87]

The paternalism displayed by these nurses is a shifting back to the analogy of medical professionals knowing it all.[88] Women who seek abortion are not trusted to make decisions for themselves. This is based on a gendered view that women who seek to terminate a pregnancy are not fully aware of the implications and likely consequences of their decisions.

For these nurses, indiscriminate access to abortion is a slippery slope. As highlighted previously, a major concern for nurses throughout the study is that despite the availability of family planning methods, women use abortion as contraception. This framing is reflective of the parliamentary debates during the passing of the Choice on Termination of Pregnancy Act when a member of parliament (MP) from the National Party (NP) noted:

> 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.[89]

For non-providing nurses, women were irresponsible in their ineffective or non-use of contraception methods, hence, resort to abortion. For most of these nurses, an abortion is acceptable, while more than one abortion is deviant and triggers a need for the 'bad behaviour' of the pregnant person to be corrected.[90]

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87 RJ Cook 'International human rights to improve women's health' in RJ Cook *Women's health and human rights: The promotion and protection of women's health through international human rights law* (1994) 26.

88 S Sheldon 'The decriminalization of abortion: An argument for modernisation' (2015) 610 *Oxford Journal of Legal Studies*

89 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.

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

Additionally, while a woman having more than one abortion seem to indicate that women use abortion as family planning, it is not clear whether this is due to reluctance, inadequate knowledge or limited access to contraceptive methods.[91] During the study, some nurses were willing to accept their responsibility in the contraceptive problem. Older and more experienced providers remarked that younger nurses were not sufficiently competent in family planning provision, delivery and counselling. Other providers also highlighted the limited role that the state is playing in ensuring the provision of effective and comprehensive family planning services. Public facilities do not always have adequate family planning products and therefore regularly experience stock-outs. In light of this, the nature and effectiveness of the family planning and post-abortion counselling sessions should be examined.[92]

This thesis illustrates the fact that due to nurses' moral or religious positions; they contribute to the stereotypical notion of 'womanhood as motherhood' that has an impact on women's health, particularly in accessing safe and legal abortion services. The value judgments illustrated earlier are a clear indication of nurses' exercise of paternalistic control, which may involve influencing women not to have an abortion, or exercise discretionary decisional autonomy as to when to 'allow' women to terminate their pregnancies.[93]

The research conducted for this thesis provides evidence in asserting that in addition to the law, social and institutional factors perpetuate and shape the perception of nurses on womanhood and interconnection within the context of abortion. The findings in this chapter acknowledge the ways in which nurses (in this case women) can be agents of patriarchal power against other women.[94] Power

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91 F Lang et al 'Is pregnancy termination being used as a family planning method in the Free State?' (2005) 47(5) *South African Family Practice Journal* 52-55.

92 A Ndwambi et al 'Characteristics of women requesting legal termination of pregnancy in a district hospital in Hammanskraal, South Africa' (2015) 30(4) *Southern African Journal of Infectious Diseases* 129-133.

93 Sheldon (n 88) 66.

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

can be viewed as an operating network at all levels.[95] This speaks to Foucault's point about power being everywhere, because power emerges from social interaction.[96] Since power is dispersed and relational, any group or individual can exercise it.

Hence, the nursing profession, which includes specialised knowledge and clinical practice becomes a vehicle for the production of actions of power.[97] The patient-nurse relationship is already fraught with gendered assumptions based on the patient's assumed role as a mother, thus, constituting a situated power relationship. Through the act of performance, nurses enact the convention of reality (for example, being a mother; not having pre-marital or transactional sex) making them appear natural and necessary.[98]

It would appear that in a Foucauldian sense, nurses participate in discourses that are not characteristically fully theirs. To that extent, they use normalising techniques when they compare themselves and women who seek abortion services to an ideal standard that must be adhered to and deemed as *normal or the ideal* to aspire to. This process as noted from the narratives, enables the sanctioning and punishment of women who do not conform to gender norms. Such tactics of organised mentalities aim to keep women domesticated even when they do not want to exercise their perceived reproductive role of procreation within a framework facilitated by law.[99] For instance, the construction of women seeking abortion services as sexually irresponsible by nurses has a punitive stance: to punish women for their promiscuity. Nurses' actions are contrary to the argument that that access to abortion rests on the free choice of women.[100]

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95 S Walby 'Post-Post-Modernism? Theorizing social complexity' in M Barrett & A Phillips (eds) *Destabilizing theory: Contemporary Feminist debates* (1992) 36.

96 Foucault (n 73) 93.

97 Foucault (n 59) 27-28.

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

99 G Burchell *et al* (eds) *The Foucault effect: Studies in governmentality* (1991) 92.

100 I Gilbert & V Sewpaul 'Challenging dominant discourses on abortion from a radical feminist standpoint (2014) 30(1*) Journal of Women and Social Science* 83-95.

Overall, the way nurses viewed women and their reasons for seeking abortion was premised on the concept of the 'universalised woman,'[101] that pays little attention to the range of women's circumstances and reasons for seeking abortion services. Nurses did not acknowledge that the reasons for women seeking abortion services are often dependent on multifaceted factors, especially given the primacy of race, gender and class in South Africa.[102] Women in South Africa are not a homogenous group and to borrow from Ebenezer Durojaye and Olubayo Oluduro, there is need to pay attention to intersectional categories such as age, socio-economic status, sexual orientation, disability, rural/urban dichotomy, and so forth.[103] In this study, it is particularly interesting that African mythologies and cultural norms about the family also manifested as influential settings that govern the outlooks of black women nurses.[104] Thus, illustrating that intersectional effects must be nuanced and contextualised.

6.6 Conclusion

This chapter focused on understanding the practice of conscientious objection amongst nurses in public and private facilities in Gauteng and Limpopo. The data reaffirms the study's assertion that the practice of not providing abortion services is common. However, as highlighted earlier, it is difficult to ascertain the prevalence of the practice given that there are no standard registers to keep track of the objection.

As claimed in chapter 2 when developing the critical African Feminist perspective, I demonstrate in this chapter the discourses and practices that nurses draw on when they make decisions about women's right to access safe and legal abortion.

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101 D Lewis 'Feminism and the radical Imagination' (2007) 21 (72) *Agenda: Empowering Women for Gender Equity* 18; and P Gqola 'Ufanele uqavile: Blackwomen, feminisms and postcoloniality in Africa' (2001) 16(50) *Agenda* 17.

102 See S Makgentlaneng 'Race, class and transformation in South Africa' *Pambazuka* 2011.

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

104 See C Macleod *et al* 'Culture as a discursive resource opposing legal abortion (2011) 21(2) *Critical Public Health* 237-245.

Along with the portrayal of women seeking abortion as victims and being irresponsible, value judgments by nurses who seek abortion services oversimplify the realities of women's lives in South Africa. This chapter highlights that nurses' conscience-based refusals are not only motivated by conscience, but also political beliefs, culture, inaccurate medical knowledge and evidence, stigma and discrimination and other factors. This highlights the importance of distinguishing claims of conscience from that of other types of claims.

The findings of this study show that despite abortion being liberalised more than 20 years ago, nurses continue to be gatekeepers in controlling who can access abortion services based on whether the reasons women are seeking abortion are good or bad reasons. Thus, reifying patriarchal norms of motherhood and exercising paternalistic control over women.

While this chapter generally focused on nurses' attitudes regarding abortion and practices of conscientious objection, the next chapter focuses on the structural conditions in which abortion - providing nurses perform their abortion services.

CHAPTER SEVEN

NURSES' ABORTION WORK: STORIES, AGENCY AND TESTIMONIES

Nurses constitute the 'largest single group of health-service providers' in South Africa.[1] According to the most recent available data, as of 31 December 2017, there were 146, 791 nurses registered with the South African Nursing Council,[2] of which, female nurses constitute the largest at 131, 579.[3] The bulk of nurses are employed in the public health sector.[4] Nurses perform a central role in the promotion and provision of essential health services, including safe abortion care.[5] Although, nurses remain a critical resource for the provision of health services, it has been argued that the South African nursing profession is 'in peril and characterised by shortages' and an apparent conflict between the needs of nurses and those communities they serve.[6]

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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 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 South African Nursing Council 'Persons on the Register: Stat 2/2017(b)' (2018) NRSCSTAT71 http://www.sanc.co.za/stats/stat2017/Year%202017%20Registrations%20of%20Practitioners%20Stats.pdf (accessed 20 June 2019) 3.

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

5 For instance, in 2016, the updated regulations to enable the effective operation of section 56 of the Nursing Act allows certain nurses to prescribe medicines, *see* Director-General of Health. Policy for issuing of authorisations to professional nurses to perform functions provided for in terms of section 56(6) of the Nursing Act 33 of 2005 (4 May 2016). See also 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) 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) 8.

6 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.

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.

Despite their essential functions in abortion provision, research on the shifting construction of nurses' abortion work largely remains under-theorised.[7] This chapter therefore broadly focuses on the health system context and how nurses are located within their work environments. This focus acknowledges that hospitals produce, enact and display a multitude of power relations and medical discourses in general. The findings are based on primary research with nurses who provide abortion services combined with observational data, which explores the ways the health system is set up and how that supports or restrains nurses' abortion work. The chapter explores the ranges of nurse providers' experiences of and the differences within the public/private dimension.

This chapter has two parts. Part 1 focuses on the challenges faced by nurses who work in public facilities in providing abortion services. Part 2 provides an overview and analysis of the multiple barriers that nurses face in running their own independent abortion clinics.

7 See M Thomson 'Rewriting the doctor: Medical law, literature and feminist strategy' in S Sheldon & M Thomson *Feminist perspectives on health care law* (1998) 174.

Part 1: Work experiences of nurses who provide abortion services in the public sector

From the interviews with nurse providers on their work experiences with regard to abortion provision, the lack of an enabling environment was the main theme that emerged. This had three inter-related sub themes: unsupportive management and deficiencies in the health system; non-specialty of abortion service; and attitudes of colleagues and stigma.

7.1.1 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 said the following:

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

The majority of nurses considered limited support of facility management as one of the major barriers that they face in providing abortion services in public facility. A public sector – turned- independent - nurse recalled her experience on her first day.

> 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 stated:

> Personally, I feel like most of the people that are in management are Christian people, who are like strong believers, who are against the service, and somehow it seems like they are for the service to be closed or shut down.

> 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,[8] 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.[9]

> 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.

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

9 This is contrary to the Democratic Nursing Organization of South Africa (DENOSA) position. 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).

Limited support is further exacerbated by major deficiencies in the public health system including inability to retain nurses as abortion providers, a lack of conducive space within the facilities and inadequate and a general lack of prioritisation of the services by facility managers. A nurse revealed:

> Shortage of staff is the biggest excuse ever. It will forever be a challenge. There is shortage of staff everywhere, and it's something we cannot change. So, unfortunately, they use that as their main excuse.

A nurse who was interested in getting trained shared her experience.

> [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.

Nurses also revealed that there was a general atmosphere of inability to retain trained nurses due in part to the lack of support from management leading to feelings of rejection and inadequate appreciation.

> 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 lack of prioritisation of abortion services evident in small and 'dingy' workspaces which undermines women's experiences of seeking abortion services.[10] Nurses shared 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

[10] This finding is in line with other studies in which women seeking abortion services lamented about the lack of privacy. See R Jewkes *et a*l 'Why are women still aborting outside designated facilities in metropolitan South Africa' (2005) *BJOG: An International Journal of Obstetrics and Gynecology* 1240.

> 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.

However, facility managers were quick to describe how they have made concerted efforts to ensure that termination of pregnancy services were reinstated after the departure of abortion providers.

> 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 to here. Then we also opened the clinic there to run even at night, because services were not being done at night. So, 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.

Another stated that she ensures that abortion providers receive the equipment they need because:

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

One facility manager identified budgetary constraints for the shortage of abortion providers.

> 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.

> 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.

The provider shortage, combined with no apparent succession plan to train and replace retiring providers, leads to high workloads for abortion providers and a high likelihood of burnout. From the above quotations, this study found that nurse providers do their abortion work in ill-equipped, short-staffed and unsupportive environments. This is similar to previous studies, which have highlighted that the bad working conditions of providers makes the provision of abortion services very challenging.[11] Inadequate human resources resulting to shortage of providers leads to burnout and high stress levels.[12]

7.1.2 Non-specialty of abortion service

A major theme relating to abortion work that emerged in the study was the lack of incentives and show of appreciation. My understanding from the nurses

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11 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* 73-86.

12 See similar findings in A Norris *et al* 'Abortion stigma: a reconceptualization of constituents, causes, and consequences' (2011) 21(3) *Women's Health* S49–S54.

interviewed was that some of them sought abortion training on the basis that it was a specialty. This assumption was based on the belief that it was the initial intention of the Department of Health.

> 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.

Nurses withdrew from providing termination of pregnancy services when the Department of Health decided that it would not be regarded as a specialty, and that abortion provision would not result in higher remuneration.

> 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.

7.1.3 Attitudes of colleagues, stigma and burn-out[13]

Nurse providers spoke of negative and judgmental attitudes from colleagues. They reported that they were judged harshly and stigmatised by colleagues who often label them "baby killers," "lucifer," "mortuary" and "murderers." As one said:

> 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:

> 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.'

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13 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.

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 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.[14]

Providers' experiences of stigma and discrimination takes a huge emotional toll on them evident by burn-out, sometimes leading to them leaving the services for other departments or going into the private sector. Due to negative comments and attitudes from colleagues, nurse providers felt isolated, victimised and stigmatised. A number of studies have highlighted that even where abortion is legal, providers continue to deal with stigma and lack of an enabling environment, which hinders

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

their provision of quality abortion services.[15] Both women who seek abortion and for those who provide such services are stigmatised.[16]

Stigma is defined as 'an attribute that links a person to an undesirable stereotype leading individual to reduce the bearer from a whole and usual person to a tainted discounted one.'[17] Bruce Link and Jo Phelan further defined stigma 'as the co-occurrence of its components – labelling, stereotyping, separation, status loss, and discrimination', arguing that "power [is] exercised" when stigma occurs.'[18] Building on Goffman's conceptualisation of stigma, Anuradha Kumar, Leila Hessini and Ellen Mitchell define abortion stigma 'as a negative attribute ascribed to women who seek to terminate a pregnancy that marks them internally or externally, *as inferior to ideals of womanhood*.'[19] Stigma operates within the individual, organisational and societal structures.[20] As this study focuses on nurse providers, abortion stigma would relate to the negative attributes ascribed to those nurses who provide termination of pregnancy services. Nurses who provide abortion services are stigmatised by colleagues, often not seen as lifesaving but been involved in unethical service.

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 have had an abortion. Nurses who provide abortion services are stigmatised based on the 'dirty work' that they do which is deemed to be contrary to the conception 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 to

15 LA Martin *et al* 'Abortion providers, stigma and professional quality of life' (2014) 90(6) *Contraception* 581-587; LA Martin *et al* 'Measuring stigma among abortion providers: Assessing the abortion provide stigma survey instrument' (2014) 57(7) *Women Health* 641-661.

16 See A Kumar *et al* 'Conceptualising abortion stigma' (2009) 11(6) *Culture, health and sexuality* 625-629.

17 E Goffman *Stigma: the management of spoiled identity* (1963) 11.

18 B Link & J Phelan 'Conceptualizing stigma' (2001) 27 *Annual Review of Sociology* 363.

19 Emphasis added. Kumar *et al* (n 16) 628.

20 As above.

continuous exposure to stigma.[21] Abortion provision becomes *an isolating and stigmatising profession.*[22]

Nonetheless, providers reported that they have coping mechanisms to counter the stigma and name-calling. These included the belief that they are 'helping women and girls' and providing respectable nursing care. Professional responsibility for them outweighed the judgmental attitudes from colleagues. 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.

Another stated:

> 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

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21 On professional responses addressing stigma, see, RJ Cook & BM Dickens 'Reducing stigma in reproductive health' (2014) 125 *International Journal of Gynecology and Obstetrics* 89–92.

22 Emphasis added.

> trimester, formation until the end. So, what do we expect the offspring will be like?

Support systems were also important in their line of work. Facilitation of group get-togethers amongst abortion providers seem beneficial for safeguarding against the stigma.

> We talk to each other about our feelings as a way of coping.

In addition to fellow abortion providers, nurses also identified family members, boyfriends or husbands and friends. The presence of such support helps in dealing with the stress and stigma that they encounter. It was interesting to note that through an analysis of the demographic survey, the youngest nurse interviewed and who only worked in private sector reported that she has not personally experienced any stigma relating to her work. This was quite different with the experiences of the older nurses who especially worked in public health facilities. The young nurse noted that the absence of feeling stigmatised was due in part to her work environment in the private sector and the open-mindedness of her family and friends who mostly hold pro-choice attitudes.

For nurses working in public facilities that are supported by Ipas South Africa, they also have debriefing and social engagement sessions. One provider described her coping mechanism thus:

> 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.

However, apart from the de-briefing sessions organise by Ipas South Africa for public sector nurses in Gauteng and Limpopo, DENOSA has noted that this is not provided overall in public hospitals despite extreme work conditions.[23]

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[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).

The above analysis of the existing health system difficulties and its effect on the termination of pregnancy services reflects concerns raised during the early years after the enactment of the Choice on Termination of Pregnancy Act. Rachel Rebouché argues that ineffective implementation of the Act is reflective of the problems in the broader health care system.[24] In 2002, the Reproductive Rights Alliance, an umbrella body formed by Non-Governmental Organisation (NGOs) working in the field of abortion noted their concerns around the unwillingness of facility staff and district managements to offer or support termination of pregnancy services despite designation.[25] Similarly, Ames Dhai in the 2002 National Parliamentary Health Portfolio Committee's hearing on abortion services commented:[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.

Issues during the hearing focused on the exercise of conscientious objection, the resistance of hospital managements to implement the services and continued stigmatisation of providers.[27] Unsupportive management continues to obstruct the ability of nurses to effectively render services. The South African case study is a good illustration of the argument that even when abortion is decriminalised, it continues to generate negative societal attitudes towards the practice, leading to ostracisation and discrimination.[28] This is manifested in the general lack of sufficient information on services; and lack of investment in public health services, making access to health dependent on social status and financial capacity.[29]

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24 R Rebouché 'The limits of reproductive rights in improving women's health' (2011) 63(1) *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 N Ziyamba 'Hearing on abortion services' (2002) *Women Health Project* 19.

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

29 As above, 12.

During the study, nurses often underscored that despite the negative attitudes meted by colleagues, some of these individuals will often come to them for support when they or someone they know has an 'unwanted' pregnancy. This points to the dualism of morality in that those that do not support providers for doing their job would bring someone to them for the procedure. Opposition to abortion dwindles when the unwanted pregnancy is closer to them, thereby justifying the need for an exception. A similar study in Brazil reported that the attitudes of health professionals changed drastically when the unwanted pregnancy affected them directly.[30]

[30] A Faúndes *et al* 'The closer you are, the better you understand: The reaction of Brazilian obstetrician-Gynaecologists to unwanted pregnancy' (2004) *Reproductive Health Matters* 47-56.

Part 2: Shifting construction of nurses' abortion work

7.2.1 Why don't they leave us alone?

To illustrate the shifting construction of nurses' abortion work, I have included a focus on nurses who have stand-alone private abortion clinics. I present two personal narratives from Gauteng and Limpopo provinces respectively to highlight the key emerging issues. These personal narratives underscore the multiple barriers that nurses face in running their own independent abortion clinics, including, difficulties with designation, lack of support and victimisation.

Sister M

This personal narrative provides the historical context of abortion during apartheid and after legalisation in 1996 in Gauteng. These extracts from Sister M's interview highlight the difficult process that providers have to go through to obtain designation for private facilities. Sister M was the oldest nurse I interviewed. She is 65 years old, started nursing in 1974 and had her midwifery certificate in 1982.

> 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 country side every three months, where black women could get an injection, sometimes without knowing what the injections were for.[31] 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.

On how she got involved:

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31 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.

> 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.

On her motivating factor of becoming a provider. She recalled:

> 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.

Years later, she left the public sector and worked for a private abortion clinic. She stated:

> 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 stand-alone abortion nursing practise, she describes it as:

> 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.

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 stats:[32]

> 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. 30 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 above are instructive of the shifting constructions of the identity of nurses, especially as it relates to abortion provision. The health system is inherently female in South Africa: powered by women (as indicated by earlier figures of female nurses). This has historical roots, as during World War II due to

32 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.

shortage, most black women were trained as nurses, but few were trained as doctors.[33] Within the South African context, Cecilia Makiwane is said to be the first black professional nurse registered in 1908, after her education at an experimental nurse's training school for black nurses based at the Lovedale Mission Hospital.[34] Such an opportunity arose because of the 'growing need for Xhosa people in King William's Town to have nurses who shared their cultural background.'[35] Gradually overtime, more black nurses were trained nationwide and currently form the majority of nurses registered 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 theoretical specialised knowledge and practical experience, which result in power being held and exercised by nurses.[36] 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.[37] The dispensation of power through complex social networks includes not only 'agents but also instruments of power,' such as documentations, infrastructures, equipment and ways of doing things through which power is used.[38]

However, power is not static but constitutes power relations that are re-enacted or reproduced over time.[39] For nurse providers, what emerges is that they became

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33 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(4) *Journal of Southern African Studies* 695-717.

34 South Africa Nursing Council "Born to be a nurse - Cecilia Makiwane" (2019) 3 *#SANCNews* 4.

35 As above.

36 RR Sepasi *et al* 'Nurses' Perceptions of the Concept of Power in Nursing: A Qualitative Research' (2016) 10(12) *Journal of Clinical and Diagnostic Research: JCDR* LC10–LC15.

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

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

39 Foucault (n 37 above) 98.

empowered through the Act to perform first trimester abortions, which invariably changes the construction of their professional identities and related opportunities arising out of that.[40] Through the construction of their own agency, it encompasses what Bell Hooks called, fluctuating between the 'margin and the center.'[41] Consequently, nurses are creating their own social locations and spaces by setting up their own specialised abortion clinics independent from public hospitals, thereby leading to a steady increase in service provision by nurses owning their own clinics in Gauteng and Limpopo. Private clinics become catchment for those unable to access public service due to stipulated times and the booking system. Some private abortion clinics even provide abortion services after-hours, which makes it more accessible.

Yet, for private nurse practitioners, especially those with their own private abortion clinics, one of their biggest hurdles is the burdensome designation process. Section 3 of the *Choice on Termination of Pregnancy Amendment Act* lists the requirements that health facilities need to comply with for designation to provide abortion. 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;

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40 M Berer 'Provision of abortion by mid-level providers: International policy, practice and perspectives' (2009) 87 *Bulletin of the World Health Organization* 58-63.

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

(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.[42] 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 depicted 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.

While private sector service provision has played a key function in complementing abortion services provided by the public sector, it is expensive. Due to the extensive bureaucratic process of accrediting facilities that takes a very long time, nurses lamented about their situations. This has invariably impacted on decentralisation of services where the majority of authorised public health facilities do not perform the procedure. Nurses have also suffered continued abuse and disempowerment in the hands of public health officers responsible for the designation of facilities compared to doctors running their own abortion clinics.

7.2.2 Doctor- nurse relationships: Negotiating roles and power

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:

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42 See, sec. 3 of the Act, No 38 of 2004.

> 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 5000, 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.

From conversation with nurses, there is an apparent tension and distinct professional boundary between nurses and doctors forged along lines of labels: 'I am a doctor and you are a nurse.' This is exemplified by gendered[43] and professional hierarchy in terms of qualifications and licenses.[44] Through professional codes and trainings, doctors and nurses are distinct professions.

Globally, senior positions of power are mainly occupied by men while front-line health professionals such as nurses are usually women.[45] Despite increase of women in the medical profession, men continue to constitute the majority. There is patriarchal authority of predominantly (male) doctors as the head of the team primarily composed of (female) nurses providing opportunity for performing hierarchical observation. The nursing profession has been stereotyped as being feminine.[46] The gendered division of labour within the health system mirrors that of society.[47] Nurses are conditioned by the health profession to play the deferential

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43 See S Porter 'Women in a women's job: The gendered experiences of nurses' (1992) 14(4) *Sociology of Health and Illness* 510-527.

44 G Andrews "Nursing as emancipatory practice" in JD Jansen (ed) *Knowledge and power in South Africa* (1991) 165.

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

46 M Takase *et al* 'Does the public image of nurses matter? (2002) 18(4) *Journal of Professional Nursing* 196.

47 P Hartigan 'The importance of gender in defining and improving quality of care: Some conceptual issues' 16 (Suppl 1) *Health Policy and Planning* 7-12.

role.[48] As the hospital mirrors that of society, power relations are maintained through the social and bureaucratic hierarchy in hospital settings.[49] Nurses are trained to conform to the traditional setting and dictates of hospital designed to ensure that she stays in her place, normalises and maintains it.[50]

Nonetheless, I observed a questioning attitude among some of the independent nurses with regard to assumptions of their occupational roles compared to doctors. Similar to Nawal El Saadawi's fictional character in *Memoirs of a Woman Doctor*,[51] these nurses, due to the experiences of women seeking abortion and their own experiences, no longer see doctors (mostly men) as 'priests of the body'.[52] This might be due to the fact that they no longer work within the hierarchical structures of public hospitals. It is hardly surprising, therefore, that nurses find the selective crackdown on private clinics run by nurses compared to doctors discriminatory. Private nurse practitioners running their own abortion clinics described the continued harassment and victimisation that they face from government officials, which doctors do not face. This is well illustrated in the news story below about how the provincial Department of Health raided a clinic that was ran by a professional nurse in May 2018.[53]

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48 CM Chapman 'Image of the nurse' (1977) 24 *International Nursing Review* 166.

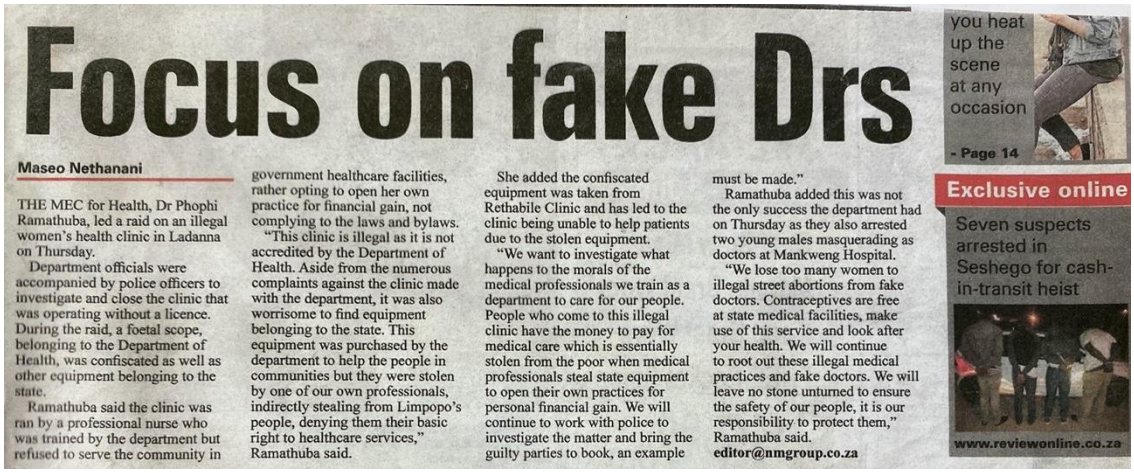
49 M Manojlovich 'Power and empowerment in nursing: Looking backward to inform the future' (2007) 12(1) *OJIN: The online journal of issues in nursing* 2.

50 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.

51 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).

52 M Foucault, *The Birth of the Clinic: An Archaeology of medical perception* (2003) 32.

53 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).



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 ran 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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you heat up the scene at any occasion

- Page 14

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Seven suspects arrested in Seshego for cash-in-transit heist

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Figure 7: News story (Raid on a women's health clinic)

Nurses contend that they provide abortion services in the first trimester that is of better quality to that of doctors at substantially reduced cost. They levelled criticisms against doctors by pointing out that majority of general practitioners offering abortion services in their own clinics do not follow proper procedures. What the above discussion portrays is the ways in which power works in the health care system.

7.3 Conclusion

This chapter highlights the complexity of nurse providers' experiences in providing abortion services. It demonstrates that abortion work for nurses is complex and difficult, especially for those that support abortion rights and perform termination of pregnancies. Throughout the study, we have witnessed the overt dedication of many abortion providers, despite the acute challenges which compromise the quality of their service delivery. To borrow from Michel Foucault, providing abortions services for these nurses have become 'a point of resistance and a starting point for an opposing strategy.' [54]

In this chapter, I have tried to elucidate the lived experiences of nurses working in abortion. The chapter demonstrates the shifting constructions of professional

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

nursing identity and nursing work resulting from the amendment to the Choice on Termination of Pregnancy Act. This observation serves as essential foundation from which to critically examine the conditions and challenges of nurses' contemporary role in abortion service provision.

For public health nurses, this study found several factors that constrain their abortion work including lack of an enabling environment, unsupportive management, exacerbated by the negative attitudes of colleagues. The lack of enabling environment, which includes availability of medicines, infrastructure and equipment affects the quality of care. World Health Organization (WHO) has pointed out the importance of well-equipped facilities and trained health providers for ensuring availability of safe abortion services.[55] Stigma and discrimination that abortion providers face leads to the encumbrance of care.[56] Nurses expressed overwhelming feeling of lack of support from colleagues and judgemental attitudes. Notwithstanding the gratifying reward of being able to provide a highly needed service, the name-calling and labelling combined with the health system barriers take a huge toll on abortion providers in the public sector.[57]

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 differential treatments between doctors and nurses is a good illustration of the role that power

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

56 A Kumar *et al* (n 16) 11.

57 See RJ Cook & BM Dickens 'Reducing stigma in reproductive health' (2014) 125 *International Journal of Gynecology and Obstetrics* 89–92; LA Martin et al (n 15) 581-587; LA Martin *et al* (n 15) 641-661.

plays in constructing the discourse of competence and regulatory effects in limiting the skills and knowledge of nurses to challenge and uncover truths.[58] 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.[59] The doctor-nurse relationship in this context is power relations that are built on knowledge.[60]

The findings reiterate the changing nature of the multiplicities of positions nurses occupy and shows issues of power and knowledge and its interplay with race, class, gender and others relating to reproductive issues.[61]

As this discussion shows the barriers and resources that nurses face in the context of abortion work is influenced by power dynamics. Nurses who do abortion work continue to face immense challenges in delivering quality abortion care. This paints a picture of the lived experiences of nurses who do abortion work and highlights their needs. In listening to their different narratives of their abortion work, I recognised the individuality of their stories while paying attention to common themes through which they display varied acts of resistance and responses to their experiences

58 NJ Ford *et al* 'Conscientious objection: a call to nursing leadership' (2010) 23 (3) *Nursing Leadership* 46.

59 A Lipp 'Challenges in abortion care for practice nurses' (2008) 19 (7) *Practice Nursing* 326-329; G Andrews 'Nursing as emancipatory practice' in JD Jansen (ed) *Knowledge and power in South Africa: A critical perspectives across the disciplines* (1991) 163.

60 R Pringle & S Watson 'Women's interest and the post-structuralist state' in M Barrett & A Phillips (eds) *Destabilizing theory: Contemporary Feminist debates* (1992) 65.

61 A Mama *Beyond the masks: Race, gender, and subjectivity* (1995) 145.

CHAPTER EIGHT

CONCLUSION

> 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]

Abortion has been legalised in South Africa for the past 23 years. South Africa's radical legal framework provides for reproductive rights through the 1996 Constitution[2] and the Choice on Termination of Pregnancy Act.[3] The Act was enacted to guaranteed access to safe and legal abortion.[4] Unfortunately, in spite of this lofty goal, women continue to face major barriers to accessing safe abortion services. This is due in part to the exercise of conscientious objection to abortion by health professionals including nurses. The Act does not explicitly provide for the right to conscientious objection nor is there a national guideline regulating the practice.

These issues triggered my study, and the analysis was guided by my research question: *In what ways do the legal, political, social and institutional contexts shape how nurses understand and exercise conscientious objection on provision of legal abortion?* Through the theoretical and normative frameworks in chapter two and four respectively, I attempted to do the following:

1. describe the scope and limitations of the exercise of the right to conscientious objection to abortion under the Choice on Termination of Pregnancy Act;

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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*(3) *American journal of public health* 397.

2 No 108 of 1996.

3 Act 92 of 1996

4 Preamble of the Act.

2. provide a better understanding of the discursive resources and framings drawn on by key state and non-state actors in South Africa that contributed to the absence of a conscientious objection provision in the Choice on Termination of Pregnancy Act;

3. offer insights into how nurses understand and exercise conscientious objection to abortion; and

4. capture how shifting power dynamics, operate to support or constrain nurses' provision of termination of pregnancy services.

As both a lawyer and feminist, I attempted to answer these pressing questions using both normative and empirical approaches.[5] To this end, I utilised a feminist lens by constructing and applying an analytical framework: 'critical feminist perspective'. The critical African feminist perspective framework incorporates aspects of African feminism and draws inspiration from the other strands of feminism for the purpose of this study.[6] This lens was applied to Foucauldian scholarship on power to understand how nurses exercise conscientious objection to abortion, which is seen as located in and products of discourse and discursive practices. Working from a politics of difference and resistance, this study extends African feminist theory to centre the experiences of nurses both as abortion providers and non-providers or objecting nurses. This component builds on gaps in the literature on abortion within African feminist theory.

Overall, this thesis builds upon a growing body of scholarly literature on access to safe, legal abortions as an important component of women's right and reproductive autonomy. In addition to the examination of legal doctrines, I was concerned with understanding discourses. Thus, they study provides an original contribution by employing feminist socio-legal methodologies to identify the complex and interwoven legal, political, and socio-cultural contexts. I utilised doctrinal and empirical research methods to draw conclusions on how we think about

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5 See K Abrams 'Feminist lawyering and legal method' (1991) 16 *Law & Social Inquiry* 373-404.

6 B Davies & S Gannon 'Feminism/poststructuralism' in B. Someth & C Lewin (eds) *Research methods in the social sciences 318-323.*

conscientious objection. Through interview data with nurses and information gathered from government officials, academics and members of civil society such as women's rights organisations and litigators, this thesis determines a number of strategies to improve the transformative potential of sexual and reproductive health and rights of women and girls. I consistently used triangulation as a strategy to ensure that I find and examine different data sources to justify the emergence of themes in this thesis, as well as interrogate assumptions that underpin the study.
My personal identity and social locations including my gender, class, religion, occupation amongst others shaped the selection of this topic and the focus on nurses, the research questions, the approaches taken to answer the questions and the way I read and interpreted the data. Although, I continuously made the effort to be reflexive throughout the research process, ultimately the thesis is from my own feminist standpoint based primarily on African feminism and other feminist theories as discussed in chapter two. The data extracts presented from the interviews are what I believe are worthy of presentation, ones I analytically engaged with and made conclusions on. But they do not fully capture the views of the interviewees, some of whom were articulate while others were minimalist. Instead of ascribing to particular individual interviewees and what they said, the data is now neatly grouped in different headings and chapters.

Consequently, this current account of the research is not fully reflective of the human interactions, emotions and motivations. What you can see is an abstract view of the research conducted. The thesis is a report that is entirely centred on my understandings of the available data and the vast materials I utilised. I have taken steps to ensure that I do not just highlight extracts that are supportive of my arguments and interpretations through my explanation of how I arrived at my ideas. As can be seen from previous chapters, I referred to work done by other researchers to help me draw conclusions.

My findings are also biased given that despite several attempts; I was unable to conduct interviews with some of the publicly known anti-choice organisations. They did share institutional documents that showcases their position, which I have

used in the thesis. Additionally, given that the study is qualitative in nature, the findings cannot be generalised to the broader South African society. This thesis does not attempt to describe the extent of the practice of conscientious objection in South Africa as a whole given that this is a small case study that was conducted in Gauteng and Limpopo respectively. However, to ensure that contextualisation of the findings and ensure validity, I collected and used materials from different sources, combining primary sources (including constitutions, laws, cases) and secondary materials (including government and civil society reports, survey and census data documents, demographic and health reports and media sources).

With this background, what then does my findings say about how we understand the practice of conscientious objection? In interrogating a liberal abortion law, I argue that ambiguity in the law on conscientious objection makes accessing abortion services unpredictable in light of competing rights claims –– to reproductive autonomy and to freedom of conscience. The fluctuation between politics, legal duty, ethics and practices is playing out currently. The issue of conscientious objection in South Africa has been the subject of recent public debate. In August 2019, a doctor who has been prohibited from practicing medicine is currently facing six-member disciplinary inquiry panel the Health Professions Council of South Africa (HPCSA).[7]

This followed an incidence that occurred at the 2 Military Hospital in Wynberg when he uttered to a patient that he believed that abortion constitutes the killing of an unborn human being.[8] He faces four counts of transgressions. First, he is accused of dissuading a patient from terminating her pregnancy. Second, he failed to respect

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7 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).

8 K Brandt 'Doctor barred from practicing over abortion view to face HPCSA Panel' *EWN Eyewitness* 27 August 2019 https://ewn.co.za/2019/08/27/doctor-barred-from-practising-over-abortion-view-to-face-hpcsa-panel?fbclid=IwAR0mq91OduwEuPIt16pdJ_dTdF9pGMVvMHupMib0KEjBUJHU9f1C27axqxY (accessed 1 September 2019)

the patient's autonomy. Third, he distributed pamphlets that imposed his religious beliefs on colleagues, patients and members of the public. Additionally, he attempted to influence his colleagues to adopt his views by sending them text messages. Finally, he failed to remain objective when advocating for contraceptives, thereby not acting in the patient's best interest. This means that he is also liable to the legal consequences set out in the Choice on Termination of Pregnancy Act.[9]

On 29 October 2019, the panel dismissed his appeal to drop the charges. If found guilty, he could potentially be sanctioned with a warning, a fine, suspension or termination of his registration with HPCSA.[10] The matter has been postponed to 6 December 2019. It is important to note that the decisions of the Committee are subject to review by high court upon an appeal.[11]

There is a general drive to make this doctor a martyr and politicise the issue as evidenced by the statement of the African Christian Democratic Party (ACDP) MP Marie Sukers in praising the doctor as having taken 'a bold and unpopular stand in choosing to be a voice for the voiceless.'[12] She further goes on to say:

> The ACDP believes in the sanctity of human life, and we look forward to a time when the life of an unborn child will be given the reasonable protection it deserves. Dr de Vos is to us an indication that the time for that is not far off. His statement, which has landed him in hot water with the HPCSA and 2 Military Hospital, shows that

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9 K Mafolo 'Anti-abortion doctor' to face charges of dissuading patient from terminating pregnancy *Daily Maverick* 29 October 2019 https://www.dailymaverick.co.za/article/2019-10-29-anti-abortion-doctor-to-face-charges-of-dissuading-patient-from-terminating-pregnancy/ (accessed 23 November 2019)

10 D Adriaanse 'Pro-life doctor Jacques de Vos' bid to have charges dropped dealt a blow' *IOL News* 30 November 2019 https://www.iol.co.za/capetimes/news/pro-life-doctor-jacques-de-vos-bid-to-have-charges-dropped-dealt-a-blow-36291824 (accessed 23 November 2019).

11 Sec 20 of the Health Professions Act 56 of 1974 substituted by s. 13 of Act 18/95, sec 66 of Act 89/97 and sec 56 of Act 29/2007.

12 '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 1 September 2019)

> there are people who know that we cannot value human rights without valuing human life.[13]

In an op-ed in the Guardian newspaper, Dr. Tlaleng Mofokeng, the former vice chairperson of the Sexual and Reproductive Justice Coalition (SRJC) 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.[14]

The discussion of the key findings, identification of proposals and finally suggestions for future research is outlined below:

8.1 Major findings of this thesis

8.1.1 Legal scope of conscientious objection

In order to ensure that women's right to exercise reproductive autonomy and access to timely legal abortion services, domestic laws must effectively regulate and oversee the practices of healthcare professionals in relation to their implied right to conscientious objection. In the thesis, I traced the historical trajectory of the absence of a conscience clause in the Choice on Termination of Pregnancy Act. An analysis of the legislative discourse during the debates around the enactment of the Act and its subsequent amendments were analysed. The findings of this exercise showed the various framings that emerged from parliamentary debates. It was believed at the time that the absence of a conscience clause would lessen legal assaults on the Act as well as ensure that providers are not coerced into getting

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13 As above.

14 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 1 September 2019).

involved in abortion provision contrary to their rights as guaranteed in the Constitution.

However, South Africa's failure to provide an effective legal framework to regulate the exercise of conscientious objection has resulted to it serving as a major barrier to women's access to safe, legal abortion. Carol Smart aptly describes law as site for multiplicities of struggles, which 'is not a free-floating identity, it is grounded in patriarchy.'[15]

As noted previously, it was reported that less than seven per cent of designated healthcare centres in South Africa provide abortion services, due in large part to the invocation of conscientious objection by medical personnel.[16] 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.

South Africa as a member of both the United Nations (UN) and the African Union (AU) have signed and ratified core international human rights treaties. Freedom of conscience is guaranteed in international human rights instruments such as the Universal Declaration of Human Rights (UDHR)[17] and the International Covenant on Civil and Political Rights (ICCPR).[18] At the regional level, the African Charter on Human and Peoples' Rights (African Charter)[19], American Convention on Human Rights,[20] and the European Convention on Human Rights contain a guarantee of

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15 C Smart *Law, crime and sexuality: Essays in feminism* (1995) 4 & 88.

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

17 Art 18. Universal Declaration of Human Rights (Universal Declaration) adopted 10 December 1948, UNGA 217 A (III).

18 Art 18. International Covenant on Civil and Political Rights (ICCPR) adopted 16 December 1966, GA Res 2200A (XXI), UN Doc A/6316 (1966) 993 UNTS 3, entered into force on 23 March 1976.

19 Art 8. African Charter on Human and Peoples' Rights, OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

20 Art 12. American Convention on Human Rights, 22 November 1969.

freedom of conscience.[21] Nevertheless, the right to conscientious objection is not absolute.[22] International and regional human rights treaty bodies have found that the freedom to manifest one's religion or belief can be subjected to restrictions.[23]

Given that the South African courts have not decided on the exercise of conscientious objection to abortion, I recommend borrowing from international human rights norms and comparative law, to ensure better interpretation of the constitutional rights to reproductive autonomy (section 12(2)) and guarantee access to healthcare services as provided in section 27(1)(a) of the Constitution. I demonstrate in chapter 4 that section 36 of the Constitution provides a solid constitutional basis for placing limitation on the right to freedom of conscience as provided in section 15 of the Constitution. In addition, I argue that this must be underpinned with the right to equality as guaranteed in section 9 of the Constitution in order to address the disproportionate burden faced by women due to their race, class, age and geographical location.

Ultimately, litigation and judicial interpretation on a human rights-based approach could help advance the law with regard to conscientious objection and abortion rights. This could ensure transformative jurisprudence that applies the proportionality framework to protect provider's right to refuse while guaranteeing that women are able to exercise their right access abortion services. Human rights-based judicial interpretation, while recognising individual healthcare providers' right to refuse to provide abortion services on the grounds of conscience, would not absolve government from its obligation to provide services (including information and materials resources) arising from the fulfilment of the right to safe abortion and

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21 Art 9. Convention for the Protection of Human Rights and Fundamental Freedoms Rome, 4.XI.1950

22 Art 18 (3) of the ICCPR. *See also* BM Dickens 'Conscientious objection and professionalism' (2009) 4(2) *Expert Reviews of Obstetrics and Gynecology* 97.

23 The European Court of Human Rights (*R.R v Poland* App. No. 27617/04, para 206) upheld limitations on conscientious objection stating that states are obliged to ensure that the exercise of a conscientious objection right does not prevent patients from having access to services. See also, Human Rights Committee *General Comment No 22: CCPR, art 18 on freedom of thought, conscience or religion* (1993) CCPR/C/Rev.1/Add.4, para 1.

related services. The assumption here is that litigation processes to regulate conscientious objection could have significant *legal effects* (changes in legislation or jurisprudence) as well as *material effects* on policy and administrative practices, given the obstacles that the current lack of regulations represent.[24] Indeed, it would be a signal that when the state does not effectively implement the right to safe and legal abortion by ensuring that this right is not impeded by the refusal to offer services, it fails to meet its assumed obligations in terms of ratified international human rights instruments. It is essential that the law regulates the practice of conscientious objection by healthcare professionals including nurses and midwives.

8.1.2 Conscientious objection in practice: A focus on nurses

Information is scant on the extent and nature of the practice of conscientious objection, which makes it difficult to establish the extent to which there is systemic abuse. This study has attempted to answer how and why nurses exercise conscientious objection. Different dimensions of nurses' views and experiences have been explored to show how their decisions are influenced by specific conceptualisations of conscientious objection, with a rage of underlying reasons. While the findings of this study cannot be generalised given the small sample, it provides important insights into understanding the practice of conscientious objection by nurses. Due to lack of understanding of the concept, nurses did not identify themselves as conscientious objectors. They self-identified as 'non-providers' to describe their refusal to be involved in providing abortion services in line with their assigned professional roles. A number of nurses (n = 7) out of the 14 self-identified as non-providers described their position as undecided.

A main reason given by nurses for their non-involvement in abortion services is their Christian religious beliefs, premised on the value for respect of the life of the

[24] 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.

unborn, with abortion being seen as killing. However, for a majority of the nurses, their willingness to be involved in abortion provision is influenced by their perceptions about the women seeking abortion services and their reasons for doing so. They cannot be categorised in the binary status of objector or provider. Their narratives highlight that their decision making was not static but exist in a continuum determined by whether women's reasons for seeking abortion is seen as justified or unjustified. Non-providers highlighted that they will be more willing to assist if abortion is sought because of a sexual crime or a medical condition. They were less inclined to help the woman if the pregnancy was as a result of non-use of contraception or its failure or extra-marital sex. They were also concerned with the consequences of abortion on the future ability of women to bear children. Their determination of 'good' or 'bad' abortion was based on gender stereotyping[25] of women into victims and deviants.

What this data illustrates is that, although abortion is not criminalised in South Africa, nurses exercise paternalistic control through normalisation and surveillance based on the differentiation, which have implicit implications for the woman seeking abortion services. [26] In addition, nurses seem to homogenise all women as they did not pay attention to the multifaceted reasons that women have for seeking abortion in relation to their intersectional situation including race, gender, class and geographical location.[27]

The findings of these thesis illustrate that in addition to the legal and medicalised discourse, it is important to examine the relational and social context in which nurses make decisions about providing or not providing abortion care.

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25 RJ Cook & S Cusack *Gender Stereotyping: Transnational Legal Perspectives* (2010) 9.

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

27 K Crenshaw 'Mapping the margins: Intersectionality, identity politics, and violence against women of color' (1991) 43 (6) *Stanford Law Review* 1241-1299. See also S Makgentlaneng 'Race, class and transformation in South Africa' *Pambazuka* 2011.

8.1.3 Power dynamics that support or constrain nurses' abortion work

The thesis has examined the conditions and challenges of nurses' contemporary role in abortion service provision. The findings of the study demonstrate the complex and difficult nature of abortion work. The study found that for public health nurses, their abortion work is constrained due to the lack of an enabling environment. They generally experience inadequate support from management and insufficient medical supplies and lack of a conducive workspace, which has an impact on availability of services.[28] In addition, this is exacerbated by stigma from colleagues.[29] The name calling has a negative effect on their provision of abortion services. The stereotyping of nurses' abortion work as 'tainted work,' deters some of them from continuing to offer services or care, thereby contributing to provider shortage.

One of the most interesting findings of this thesis is the lack of monetary and other incentives for specialising as an abortion provider and for performing abortion services. Given that the National Department of Health does not consider abortion services as a specialty, this limits the motivation of nurses to choose that route. There were nurses who pointed out instances where trained providers transferred to other departments because abortion was not regarded as a specialty, and thus not remunerated as a specialty. In order to improve abortion service delivery, as there is need to explore possible options for making it a specialty, which would guarantee providers higher remuneration and benefits.

In addition, nurses who own stand-alone private abortion clinics faced unique challenges. In addition to the cumbersome designation process, power dynamics

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

29 On stigma, see E Goffman *Stigma: the management of spoiled identity* (1963) 11. See A Kumar et al. 'Conceptualising abortion stigma' (2009) 11(6) *Culture, health and sexuality* 625-629; RJ Cook & BM Dickens 'Reducing stigma in reproductive health' (2014) 125 *International Journal of Gynecology and Obstetrics* 89–92; LA Martin *et al* 'Abortion providers, stigma and professional quality of life' (2014) 90(6) *Contraception* 581-587; LA Martin *et al* 'Measuring stigma among abortion providers: Assessing the abortion provide stigma survey instrument' (2014) 57(7) *Women Health* 641-661.

comes to play as they are treated different from the doctors. The differential treatment is imbued in how nurses and doctors are viewed based on the discourses of competence and regulations, contributing to the continuation of hierarchies within the health system.[30] The narratives further demonstrated strategies employed by these nurses and their resistance to the gender and power relations in the health system.

What this study shows is that though abortion providers work within the law, they continue to face stigma and harassment and poor material condition. However, despite all these challenges, nurse abortion providers continue to perform abortion procedures and offer care, mainly because their core ethical values compel them to do so. They see their work as saving women's lives, and they believe in the reproductive autonomy of women. The nurses see their abortion work as important and morally right thereby making conscience-based claims. In exercising the positive duty to do something, they reflect what Bernard Dickens and Rebecca Cook refer to as *conscientious commitment*.[31]

8.2 Concluding reflections and agendas for future research

The thesis demonstrates the willingness and dedication of abortion providers in Gauteng and Limpopo respectively despite the lack of an enabling environment coupled with the stigma they face from colleagues. Abortion remains highly polarised even among nurses. There are nurses who articulate defence of abortion and are willing to provide services, and there are nurses who are not willing to provide abortions services or care, thereby contributing to the discourse of conservative sexual morality. In the middle are nurses who are willing to provide

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30 See NJ Ford *et al* 'Conscientious objection: a call to nursing leadership' (2010) 23 (3) *Nursing Leadership* 46; A Lipp 'Challenges in abortion care for practice nurses' (2008) 19 (7) *Practice Nursing* 326-329; G Andrews 'Nursing as emancipatory practice' in JD Jansen (ed) *Knowledge and power in South Africa: A critical perspectives across the disciplines* (1991) 163.

31 See RJ Cook & BM Dickens 'Reducing stigma in reproductive health' (2014) 125 *International Journal of Gynecology and Obstetrics* 89–92; B Dickens 'The art of medicine: Conscientious Commitment' (2008) 371 *Lancet* 1240 - 1241.

or not provide care based on their determination of 'deserving' and 'undeserving' abortion seekers.

For those potential providers, who can be nudged towards providing or assisting in abortion services, there is need for more awareness-raising about the law as well as improvement of remuneration and conditions of service. A useful future research agenda would entail exploring strategies that can move a non-providing nurse to provide or assist in abortion services. Perhaps most important to nudge those who are not conscientious objectors but just do not see termination of pregnancy as an attractive specialisation as well as the removal of barriers to training.

It is also critical to explore what moves nurses the other way, towards becoming less supportive or conscientious objectors in light of conservative activism. This would entail getting more systemic information on resistance at the levels of managers, which seems to be widespread.

This thesis serves as a first step in exploring influences whether and how the legal, social, and economic environment and power dynamics influence nurses' decisions on whether to provide abortion services. The findings can provide useful insights for efforts to devise strategies and interventions to limit non-provision, and thus increase access to abortion services.

While ample research has been dedicated to conscientious refusal, there is need for further contribution to the scholarship of conscientious provision. As bio-ethicist Mark Wicclair notes, current conscience laws do not adequately provide for and protect conscientious provision.[32] In relation to this, there is also need to study more in-depth the unique situation of nurses running their own abortion clinics and what strategies can be implement to assist these stand-alone clinics that would provide the needed environment for both providers and women seeking the services. I therefore suggest a prospective comparative study of legal mobilisation

32 MR Wicclair *Conscientious objection in healthcare* (2011).

and judicialisation processes (including in Latin America and Europe), that aim to provide guidance on the regulation of the practice of conscientious provision to ensure that women are able to their exercise their constitutional rights and are not denied abortion care.

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. One of the main findings of this thesis is that the lack of clear legal or policy guidelines serve as a main obstacle for the delivery of abortion services. I therefore suggest that the regulation of the exercise of conscientious objection should be in line with its international and regional human rights obligations.[33] Several of the respondents called for the prompt adoption of the Draft National Guidelines for Implementation of Termination of Pregnancy Services in South Africa,[34] that is yet to be adopted by the National Department of Health, and its subsequent implementation in all the provinces.[35] However, public health researchers and activists are not optimistic in this regard, with one of the interviewees resignedly noting: 'conscientious objection cannot be overcome in this country.'[36] Others suggested that stricter rules be put in place including barring objectors from specialising in women's health specific domains such as gynaecology, as well as effective enforcement of laws relating to those that obstruct access as provided for in the Choice on Termination of Pregnancy Act. Addressing the Parliamentary Portfolio Committee on Health on the problems faced by women when they are refused access to abortion services might also be one way of addressing the issue.[37]

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33 C Zampas 'Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings' (2013) 123(3) *International Journal of Gynaecology & Obstetrics* S63–S65.

34 National Department of Health 'Draft National guidelines for implementation of termination of pregnancy services in South Africa' (2018) (on file with author).

35 Interview with pro-abortion activist, skype 21 February 2019; Interview with public health professor and researcher, Skype 20 February 2019.

36 Interview with women's health researcher, Skype 12 February 2019.

37 Interview with legal practitioner, Email 29 March 2019.

Additionally, nurse-providers recommended that in order to ensure quality care provision and retention of providers, there is need for more conducive work environments, both materially and in terms of supportive management and colleagues, which would stem the stigma they face. Better training and simplification of the abortion regimen by making use of technology to make medical abortion more readily available will also help in addressing the problems of the overburdend health system and disrupted abortion services thereof.[38]

Finally, this study was sparked by the question of why there is still so much resistance to abortion rights even after the enactment of a liberal law. This thesis is an attempt to understand how legal doctrines and discourses can be reoriented to strengthen women's access to safe abortions. What I hoped to do with this study is to modestly contribute to theoretical and methodological considerations that provide some insights into the articulations of power and how ideological positionings of nurses can have real consequences for women's access to safe and legal abortion.

[38] Interview with women's health researcher, Skype 12 February 2019.

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APPENDICES

Appendix A: Ethical approval (Faculty of Health Sciences)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 22 May 2002 and Expires 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.

1 February 2019

Approval Certificate
New Application

Ethics Reference No.: 636/2018
Title: Power dynamics in the provision of legal abortion: Afeminist perspective on nurses and conscientious objection in South Africa

Dear Ms S Nabaneh

The **New Application** as supported by documents received between 2019-01-24 and 2019-01-30 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 2019-01-30.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2020-02-01.
- Please remember to use your protocol number (636/2018) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers
MBChB MMed (Int) MPharmMed PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag X323
Arcadia 0007, South Africa
Tel +27 (0)12 356 3084
Email deepeka.behari@up.ac.za
www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

Appendix B: Ethical approval (Faculty of Law)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Law

RESEARCH ETHICS COMMITTEE

Tel: + 27 (0)12 420 5778
Fax: +27 (0)12 420 2991
E-mail: annelize.nienaber@up.ac.za

MS SATANG NABANEH
CENTRE FOR HUMAN RIGHTS
FACULTY OF LAW
UNIVERSITY OF PRETORIA
PRETORIA
0002

7 October 2018

Dear Ms Nabaneh

ETHICS CLEARANCE CERTIFICATE

The Research Ethics Committee of the Faculty of Law at the University of Pretoria has reviewed your application for ethics clearance entitled **"Power dynamics in the provision of legal abortion: A feminist perspective on nurses and conscientious objection in South Africa"** and granted ethics approval for your project.

Please note that, as this constitutes health research in terms of the National Health Act 61 of 2003, you need to apply for research ethics approval from the Faculty of Health Sciences' Research Ethics Committee.

We wish you success in your application to the Faculty of Health Sciences.

Yours faithfully

(PROF) A G NIENABER
CHAIR: RESEARCH ETHICS COMMITTEE (FACULTY OF LAW)

Appendix C: Interview participant information

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

PARTICIPANT'S INFORMATION AND INFORMED CONSENT DOCUMENT

Dear Participant

Title of project: Power dynamics in the provision of legal abortion: A feminist perspective on nurses and conscientious objection in South Africa.
Introduction

You are invited to volunteer for a research study. This information leaflet is to help you decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about all the procedures involved.

What is the purpose of the study?

The study is aimed at contributing to knowledge on how nurses and midwives understand and exercise conscientious objection to the provision of abortion services in South Africa. The overall objective of this study is to identify challenges in terms of reproductive rights law implementation.

The study is for a Doctorate in Law thesis under the Faculty of Law, University of Pretoria. This information is expected to be helpful to health professionals, reproductive rights activists and academics.

How will the study be conducted?

This study will employ qualitative research methods including in-depth interviews with nurses and midwives, as well as, elite interviews with key stakeholders comprising of reproductive health and legal experts, academics, local or state-level health administrators, reproductive rights activists, and other interest groups. Owing to the sensitivity of the subject matter, and respect for privacy of

participants, individual interviews are deemed the most appropriate method for data collection.

In this study, semi-structured and open-ended interviews will be conducted with nurses and midwives who work in facilities that provide abortion services in the public, private and NGO sectors in urban and rural South Africa. The interviews are meant to solicit why nurses practice conscientious objection to abortion provision. Interviews will explore informants' day-to-day practice, their beliefs and the legal, professional, moral, ethical and religious factors that shape their abortion work. Socio-demographic data will also be collected prior to the interview including gender, religious affiliation, income, training and qualifications, category of provider and years of experience as a provider.

The interview will take place for approximately one hour, during which time, with your consent, the interview will be recorded. All nurses and midwives interviewed will remain anonymous. Your name will not be attached to the data we collect from you.

What is the duration of the study?
The study will be conducted for a duration of six months (February 2019-August 2019).

Has the study received ethical approval?

This research protocol was submitted to the Faculty of Law Research Ethics Committee, and the Faculty of Health Sciences, University of Pretoria, and written approval has been granted. The study has been structured in accordance with ethical considerations such as the protection of the identity of all participants.
This study was also submitted to the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria, Medical Campus, Tswelopele Building, Level 4-59, telephone numbers 012 356 3084 / 012 356 3085 and written approval has been given by that committee.

What are my rights as a research participant in this study?

Your participation in this research is entirely voluntary and you can refuse to participate or stop at any time without stating any reason. If you do decide to withdraw, you'll be given the option to have any gathered data involving your participation in the project destroyed. The investigator also retains the right to withdraw you from the study if considered to be in your best interest.

May any of the research procedures result in any discomfort?

We do not think that taking part in the study will cause any physical or emotional discomfort or risk. If questions feel too personal or make you uncomfortable, you do not have to answer them.

What are the benefits involved in the study?

The study will help to contribute to knowledge on how nurses understand and exercise conscientious objection to abortion. It further explores how shifting power dynamics operate to support or constrain nurses' provision of termination of pregnancy services in South Africa. The results of this research will be used in a doctoral degree thesis. Additionally, this research may be used in publications in peer-reviewed journals and research reports, as well as in conference presentations. At a personal level, there may not be any direct benefit for the individual respondent. There will also be no financial benefits for participating in this study.

Are there any restrictions concerning my participation in this study?
There are no restrictions concerning your participation in this study provided you freely consent to participate even after reading and having the information provided here explained to your satisfaction.

Source of additional information

The study will be conducted by way of interviews by Satang Nabaneh, the researcher. Should you have any questions, please do not hesitate to contact her. The telephone number is (+27) 789-147-538, through which you can reach her or another authorised person.

Confidentiality

All information obtained during the course of this research is strictly confidential. Data that may be reported in law or scientific journals will not include any information which identifies you as a participant in this study. Data / information will be published anonymously. No information will be disclosed to any third party without your written permission.

Appendix D: Consent Form

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

INFORMED CONSENT CLAUSE

I hereby confirm that I have been informed by the researcher, Satang Nabaneh, about the nature, conduct, benefits and risks of the proposed research. I have also received, read and understood the above written information (informed consent) regarding the study.

I am aware that the results of the study, including personal details regarding sex, age, marital status etc (state) of myself will be anonymously processed into the research report. (See in particular the definition of "personal information" in the Promotion of Access to Information Act 2 of 2000.)

I may, at any stage, without prejudice, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

Participant's name: _____

Participant's signature: _____

I, _____ herewith confirm that the above participant has been informed fully about the nature and scope of the above study.

Investigator's name: _____

Investigator's signature: _____

Date: _____

Appendix E: Interview guide: Nurses

IN DEPTH INTERVIEW GUIDELINES

- **INTRODUCTION**

Read the INFORMED CONSENT DOCUMENT and provide a copy to the participant. Record the verbal consent of the participant in the audio recording and start the interview.

- **BACKGROUND INFORMATION**

1. Could you tell me a little about your working life and the work that you do?
2. Could you describe the kinds of training you have undergone? (*probe for abortion training*)
3. Could you describe your understandings around abortion/TOP?

– **DEEPENING**

1. Do you provide information and/or health services to women who seek abortions or need post-abortion care?

2. Have you attended any values clarification workshops, if so, how did you find these workshops?

If respondent does not know what values clarification is, please say: "Values clarification aims to separate the personal from the professional."

3. What are your thoughts about emergency contraception?

4. What are your thoughts about first and second trimester abortions?

5. What are your general feelings about working in a facility that provides / refers women for TOPs?

6. I would now like to ask you broadly how you feel about TOPs and what factors might have influenced your decision to provide or not provide TOP services?

7. What or who was an important influence in deciding to provide TOPs / refer to TOP services?
   Or

What or who was an important influence in deciding not to provide TOPs / refer to TOP services?

8. What role do you think religious or moral beliefs, or other personal reasons could play towards decisions to be involved in abortion services?

If explicit about refusal, probe reasons for refusal.

9. Are there any laws/ policies with regard to refusing to provide abortion care?

10. Referrals: Would you feel comfortable or willing to refer a woman to a facility that provides TOPs: if yes, why, if no, why not?

11. There might be different reasons why women seek a TOP. In what ways would you be or have been influenced by a woman's particular reason or reasons for seeking a TOP? [*Rape or incest Fetal abnormality, Socio-economic reasons, Oth*er].

12. Have there been any experiences that were particularly challenging to you?

If non-objector, ask: Have you ever being ostracized or stigmatized by other colleagues / health care workers in the workplace, and if so, how does this influence your decision to become involved in abortion services?

13. Sometimes health service managers or administrators influence opportunities to become involved in TOP services? What has your experience been in this regard?

Probe: If respondent has not had any experience, ask: Do you know of anyone else who has experienced this?

- **CLOSING:**

Summarize what was discussed and value the contributions of the participant. Ask for feedback and solve doubts or questions of the participant. Collect demographic data (gender, age, mother tongue, religion) [use demographic questionnaire]. Thank the participant for their collaboration and say goodbye.

Appendix F: Demographic survey

Demographic Questionnaire

1. What is your gender? _____ Woman _____ Man _____ Transgender _____
   (If these categories do not accurately represent you, please fill in your response) _____

2. What is your relationship status?
   _____Single/not living with a partner
   _____Cohabitating/living with a partner
   _____Married
   _____Dating
   _____Other (please specify): _____

3. Are you a parent (stepparent, biological, adoptive, foster)? _____Yes _____No
   If yes, to how many children? _____

4. What is your current age? _____

5. What is your race/ethnicity? _____

6. What is your home language? _____

7. What is your religion?
   _____Christian
   _____Muslim
   _____Other (please specify): _____

8. What is your current work status?
   _____Full-time
   _____Part-time
   _____Other (please specify): _____

8. What is your primary workplace?
   _____Government hospital
   _____Government health center
   _____Private hospital
   _____Private clinic

9. What is your annual household income from all sources?
   _____
   _____I prefer not to answer

10. What is the highest level of licensure you maintain?
    _____Professional (registered) nurses with 4 years of training
    _____Enrolled nurses with 2 years of training
    _____Nursing assistants or auxiliaries with 1 year of training

11. Where do you work? Please indicate province:
    _____ _____Metropolitan area/ Large City
    _____Small City
    _____Rural
    _____Other (please specify): _____

Appendix G: Interview schedule for key informants

INTERVIEW GUIDELINES: KEY INFORMANTS

- **INTRODUCTION**

Read the INFORMED CONSENT DOCUMENT and provide a copy to the participant. Record the verbal consent of the participant in the audio recording and start the interview.

All Participants

1. Do you want to speak on behalf of X organization, or do you want to speak in an individual capacity? Is it alright to audio-record this conversation?
2. What is your role in X organization?
3. What is the nature of organisation – aims of work?

Group One: Pro-abortion /Anti-abortion activists/organisations

1. What is your view, or if representing an organization, the organization's position regarding abortion?
2. What are your strategies for advancing the cause (political advocacy, legal strategies, mass mobilization, international mobilization etc…) [*Explore for most useful strategy*]
3. In your opinion, or if representing an organization, the organization's position, what are the barriers limiting women's access to reproductive health services? [Explore for the role of culture, religious beliefs or influence of family or religious leaders]
4. How have your advocacy influence abortion provision?

Group Two: Policy makers

1. What are your party's views on abortion?
2. How important is this for you/your party?
3. What are your views on health provider refusal to provide abortion?
4. What are your main strategies for advancing your position?

5. Who are your allies (domestic, regional, international) and how do you work with them to advance the cause?

Group Three: Researcher/legal expert

1. What are the main arenas in which contestations over abortion are played out?
2. Who are the main actors on the different sides, what are their motives and strategies?
3. What are your views regarding conscientious objection to abortion in South Africa?
4. How should the contestation over freedom of religion and conscience and the rights of women to access abortion services be addressed?

Group Four: Bureaucrats: Ministry of Health

1. Is objection to providing abortions regulated? (laws/policies)
2. Does this in any way affect your work with regard to the development and implementation of health policy? If so: how?
3. How have provider reluctance (including conscientious objection) been addressed? Did these strategies evolve over time?
4. Are there any workload adjustments/compensation/incentives to incentivize potential abortion providers?
5. What actions should be implemented to improve the quality of the health services?

Group Five: Professional nursing body

1. Is objection to providing abortions regulated? (laws/policies)
2. What are your views on nurses' right to refuse to provide abortion services based on religious grounds?
3. How, and to what extent if any, does the state coordinate with you to develop education and training materials?
4. What actions should be implemented to improve the quality of the health services?