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International human rights norms and the South African choice on termination of pregnancy act: an argument for vigilance and modernisation

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ABSTRACT

The right to access abortion services as an integral component of the right to sexual and reproductive health (SRH) has been increasingly recognised in the field of international human rights law. However, much more progress is necessary to realise this right in practice. The work of the United Nations human rights bodies and more recently the African Commission on Human and Peoples' Rights has been instrumental in signalling the importance of the legal framework and in setting clear guidelines to steer countries into reforming national laws in order to comply with their international obligations. This article explores the extent to which the Choice on Termination of Pregnancy and the amendment Bill submitted by the African Christian Democratic Party comply with International Human Rights Norms. Our analysis reveals that (i) the South African state has fallen short in adopting a legal framework that complies with the International Human Rights Norms and (ii) the proposed bill would constitute a retrogressive measure and its adoption would violate the state's obligations under international human rights law. In sum, this article makes an argument for the modernisation of the South African abortion law and for careful vigilance of the proposed legislative amendments.

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1. Introduction

South Africa stands out in the region for its robust rights framework on abortion and has been globally praised for the substantive protection given to reproductive rights in its 1996 Constitution, and its Choice on Termination of Pregnancy (CTOPA) Act, 92 of 1996. Albertyn notes that the latter transformed the legal framework for abortion from limited access, defined by race and class and policed by medical necessity and the

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criminal law, to a rights-based framework that allows for abortion on request.¹ While the Act undoubtedly represents a step in the right direction, 22 years have passed and it demands a closer look in light of the most recent human rights standards.

Removing the barriers to access to abortion services is a crucial step towards the fulfilment of the right to sexual and reproductive health.² The first step in that direction is – as Gruskin points out – their ‘identification’ and ‘careful analysis’ in order to proceed to their ‘subsequent modification through laws, policies and regulations that are consonant with human rights’.³ Accordingly, a critical analysis of the South African legal framework in light of human rights standards is essential for the further reform and advancement of this right in practice. This article will use a framework⁴ based on international human rights law – especially the recent General Comment No. 22 (GC 22) and the General Comments of the African Commission – to discuss the aforementioned Act and amendment Bill and whether the requirements contained therein form barriers to women’s access to reproductive health services, violating their basic rights.⁵ It will start with a brief overview of the international SRH framework so as to set the stage for the ensuing analysis of the South African CTOPA.

This article aims to contribute to the South African debate on access to termination of pregnancy services by critically assessing to what extent the CTOPA complies with the international obligations assumed by the state. Furthermore, it intends to provide a human-rights based analysis of the Bill proposed by the African Christian Democratic Party.

2. Human rights standards and legal barriers to access abortion services

2.1 International standards

In 1994, the International Conference on Population and Development (ICPD) transformed the existing discourse on reproductive health and rights from a strategy to meet demographic targets and control population growth to a more comprehensive and positive approach to sexuality and reproduction.⁶ Although the final conference documents failed to demand universal access to abortion services, the ICPD nonetheless stated that ‘in circumstances where abortion is not against the law, such abortion should be *safe*’.⁷ The ICPD recognised, in addition, that it is the responsibility of governments to legislate

¹ C Albertyn ‘Claiming and Defending Abortion Rights in South Africa’ (2015) 22 *Revista Direito GV* 430.

² S Gruskin, J Cottingham, AM Hilber, et al. ‘Using human rights to improve maternal and neonatal health: History, connections and a proposed practical approach’ (2008) *Bulletin of the World Health Organization* 591.

³ *Ibid.*

⁴ The framework of analysis used here was developed by Berro Pizarrossa and used to assess the Uruguayan Law on Voluntary Termination of Pregnancy in L Berro Pizarrossa ‘Legal barriers to access abortion services through a human rights lens: the Uruguayan experience (2018) *Reproductive Health Matters* 26(52) 1422664.

⁵ UN Committee on Economic, Social and Cultural Rights ‘General Comment No. 22, Right to Sexual and Reproductive Health’ (2016) UN Doc. E/C.12/GC/22.

⁶ See generally A Garita ‘Moving toward sexual and reproductive justice: A transnational and multigenerational feminist remix,’ in R Baksh and W Harcourt (eds), *The Oxford Handbook of Transnational Feminist Movements* (2014). UN International Conference on Population and Development. 1994a. Programme of Action of the International Conference on Population and Development. A/CONF.171/13. <http://www.policyproject.com/matrix/Documents/Cairo.html>

⁷ M Berer ‘The Cairo “compromise” on abortion and its consequences for making abortion safe and legal,’ in L Reichenbach and M J Roseman (eds), *Reproductive health and human rights: The way forward* (2009) 152; see also UN International Conference on Population and Development, ‘Programme of Action’ (1994) para 8.25. Emphasis added.

the matter and, when doing so, translate international commitments into national laws and policies.⁸ The CEDAW Committee affirmed that States parties should also remove punitive measures for women who undergo abortion.⁹

In March 2016, the Committee on Economic, Social, and Cultural Rights adopted a groundbreaking GC 22 on SRH, aiming to assist State parties with the implementation of their international obligations.¹⁰ GC 22 affirms that the right to sexual and reproductive health is an integral part of the right to health that has enjoyed longstanding recognition based on already existing international human rights instruments.¹¹ Furthermore, GC 22 contains four key components: it (a) adopts a life-cycle approach, therefore not reducing sexual and reproductive health to 'maternal health', (b) recognises that sexual and reproductive health and rights (SRHR) are indivisible from and interdependent with other human rights, (c) rejects all forms of coercive practices in SRHR and (d) recognises the particularly gendered experiences in SRHR, stating that due to women's reproductive capacities, the realisation of women's right to sexual and reproductive health is essential to the realisation of the full range of their human rights.¹²

From very early on UN bodies, such as the CEDAW Committee, have recognised that legal arrangements are key to realising SRHR and have cautioned countries of the harmful impact of 'inadequate' laws.¹³ For example, in one of its concluding observations to Namibia, the Committee notes how the 'inadequacy of the existing law on abortion contributed to the problem' of high rates of maternal mortality due to unsafe abortions being carried out.¹⁴ For that reason, the UN bodies have recommended states to be proactive in the adoption of a legal framework on SRHR, recommending countries to adopt laws and policies to guarantee the exercise of SRHR.¹⁵ Importantly, the Lancet Commission on Women and Health emphasises the need for 'an enabling social, legal, and regulatory environment' to respond to women's and girls' health needs and rights.¹⁶ The Commission on the Status of Women, likewise, continues to demand that states strengthen their normative, legal, and policy

⁸ J Cottingham, E Kismodi, AM Hilber, et al 'Using human rights for sexual and reproductive health: Improving legal and regulatory frameworks' (2010) *Bulletin of the World Health Organization* (2010) 551.

⁹ UN Committee on the Elimination of Discrimination Against Women 'Statement of the on Sexual and Reproductive Health and Rights: Beyond 2014 ICPD Review' (2014) UN Doc. CEDAW/C/2014/I/CRP.

¹⁰ UN CESCR 'General Comment No. 22' (note 5 above).

¹¹ The General Comment refers to General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) (2000) § 2, 8, 11, 16, 21, 23, 34 and 36. GC22 the following documents as examples: Convention on the Elimination of All Forms of Discrimination against Women (1979), article 12; Convention on the Rights of the Child (1989), articles 17, 23–25 and 27; and Convention on the Rights of Persons with Disabilities (2006), Articles 23 and 25; See also the Committee on the Elimination of Discrimination Against Women (CEDAW) General Recommendation No. 24: Women and Health (1999), paras 11, 14, 18, 23, 26, 29, 31(b); and the Committee on the Rights of the Child (CRC), General Comment No. 15: The right of the child to the enjoyment of the highest attainable standard of health (2013).

¹² L Berro Pizarrossa 'Legal barriers to access abortion services through a human rights lens: the Uruguayan experience (2018) *Reproductive Health Matters* 26(52), p.1422664.

¹³ UN Committee on the Elimination of Discrimination Against Women 'Report of the 20th and 21st Session' (1999) UN Doc. A/54/38/Rev.1 para. 228. Berro Pizarrossa (note 4 above).

¹⁴ UN Committee on the Elimination of Discrimination Against Women 'Report of the 16th and 17th Session' (1997) UN Doc. A/52/38/Rev.1, para 111.

¹⁵ See eg UN Committee on the Elimination of Discrimination Against Women 'Concluding Observations on the Fifth Periodic Report of Azerbaijan' (2015) UN Doc. CEDAW/C/AZE/CO/5 (2015) para 33.

¹⁶ A Langer, A Meleis, FM Knaul, et al 'Women and health: The key for sustainable development,' (2015) *The Lancet* 1178.

frameworks.¹⁷ In this regards, GC 22 affirms that states have an obligation to adopt ‘appropriate legislative’ measures in order to achieve the full realisation of SRHR.¹⁸

GC 22 determines that states have an obligation to repeal or eliminate laws, policies, and practices that criminalise, obstruct, or undermine individual’s or particular groups’ access to SRH facilities, services, goods, and information. This is considered to be a ‘core obligation’—one that is deemed two-fold in this analysis.¹⁹

2.1.1 Obligation to reform laws that impede the exercise of the right to SRH and immediate obligation to eliminate discrimination

On one hand, GC 22 affirms that states are under an ‘immediate obligation’ to eliminate discrimination against individuals and groups, and to guarantee their equal right to SRH.²⁰ The GC outlines that the realisation of women’s rights and gender equality requires states to repeal or reform any discriminatory laws, policies, and practices in this area. The CEDAW Committee has also previously recommended taking steps toward the decriminalisation of abortion, requiring countries to modify or repeal the existing abortion legislation in line with obligations assumed internationally.²¹

The former Special Rapporteur on the Right to Health, Anand Grover, has argued that laws criminalising abortion ‘infringe women’s dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health’.²² Grover states that ‘[c]riminal laws penalising and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realisation of women’s right to health and must be eliminated’.²³ In the same line, GC 22 lists laws that criminalise or restrict abortion as examples of laws that must be repealed by states.²⁴

2.1.2 Obligation to remove and refrain from enacting laws and policies that create barriers in access to SRH services

On the other hand, states are required to remove and refrain from enacting laws and policies that create barriers in access to sexual and reproductive health services.²⁵ GC 22 explicitly addresses states’ obligation to remove all barriers interfering with women’s access to reproductive health services.²⁶

¹⁷ UN Commission on the Status of Women ‘Report of the 60th Session’ (2016) UN Doc. E/2016/27-E/CN.6/2016/22 11–5.

¹⁸ *Ibid* paras 33 and 45.

¹⁹ CESCR, General Comment No. 22 (note 5 above), para 49(a).

²⁰ *Ibid* para 34.

²¹ See eg UN Committee on the Elimination of Discrimination Against Women ‘Report of 15th Session’ (1996) UN Doc. A/51/38 para. 131; UN Committee on the Elimination of Discrimination Against Women ‘Concluding Observations on the Combined Eighth and Ninth Periodic Reports of Haiti’ (2016) UN Doc. CEDAW/C/HTI/CO/8-9 para 33; UN Committee on the Elimination of Discrimination Against Women, ‘Report of the 13th Session’ (1994) UN Doc. A/49/38 para 492; UN Committee on the Elimination of Discrimination Against Women ‘Report of the 37th Session’ (2007) UN Doc. CEDAW/C/SUR/CO/3 para 30; UN Committee on the Elimination of Discrimination Against Women ‘Concluding Observations on the Combined Initial to Fifth Periodic Reports of Seychelles’ (2013) UN Doc. CEDAW/C/SYC/CO/1-5 para. 35(c); CESCR ‘General Comment No. 22’ (note 5 above) para 28.

²² UNCHR Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A Grover) ‘Interim Report of the Special Rapporteur’ (2011) UN Doc. A/66/254 para 21.

²³ *Ibid* paras 14–6.

²⁴ *Ibid* paras 28, 34, 40, and 49(a)(e).

²⁵ CESCR ‘General Comment No. 22’ (note 5 above) para 40.

²⁶ *Ibid* para 28.

Concretely, in relation to the tripartite typology in human rights, GC 22 establishes that the *duty to respect* requires states to refrain from interfering with individuals' right to exercise their sexual or reproductive health. Examples include limiting or denying access to health services and information, such as laws or practices that require third-party authorisation for access to abortion or contraception, among others.²⁷ Under the *obligation to protect*, states must protect individuals' right to SRH from interference by third parties, such as private health clinics, or insurance companies that impose practical or procedural barriers to health services.²⁸ The *obligation to fulfil*, requires states to take measures to eradicate practical barriers to the full realisation of the right to SRH, such as disproportionate costs and lack of physical or geographical access to sexual and reproductive health care.²⁹

Liberalizing abortion laws undoubtedly represents a step forward, but as the GC 22 affirms all barriers must be removed, including legal barriers. As noted in *L.C. v. Peru* by the CEDAW Committee, countries should establish an appropriate legal framework that allows women to exercise their right to access abortion services.³⁰ The Committee built on the considerations made by the European Court of Human Rights that read '[o]nce the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it'.³¹

Furthermore, the UN Human Rights Committee notes: 'in cases where abortion procedures may lawfully be performed, all obstacles to obtaining them should be removed'.³² For example, the latter has also called upon Argentina 'to eliminate all procedural barriers that would lead women to resort to illegal abortions that could put their lives and health at risk'.³³ Moreover, the UN Special Rapporteur on Torture has indicated that the denial of legally available health services – such as abortion and post-abortion care – can cause tremendous and lasting physical and emotional suffering that can amount to torture or ill-treatment.³⁴ The UN bodies also set guiding standards for the future, asking states to ensure no unduly burdensome restrictions to abortion services are adopted.³⁵

Evidence from the ground continues to confirm that restrictive abortion laws are proven to be associated with a high incidence of unsafe abortions and the consequential negative health outcomes.³⁶ Abortions in these restrictive settings contribute significantly to maternal mortality rates and preventable deaths worldwide.³⁷

²⁷ Ibid paras 40–1.

²⁸ Ibid paras 42–3.

²⁹ Ibid para 46.

³⁰ UN Committee on the Elimination of Discrimination Against Women 'Communication No. 22/2009' (2011) UN Doc. CEDAW/C/50/D/22/2009 para 8.17. Emphasis added.

³¹ Ibid.

³² UN Human Rights Committee 'Concluding Observations on Argentina' (2000) UN Doc. CCPR/CO/70/ARG; UN Human Rights Committee 'Concluding Observations on The Former Yugoslav Republic of Macedonia' (2015) UN Doc. CCPR/C/MKD/CO/3 para 11.

³³ Ibid.

³⁴ UNCHR Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (JE Méndez) Report of the Special Rapporteur (2011) UN Doc. A/HRC/22/53.

³⁵ UN Committee on the Elimination of Discrimination Against Women 'Concluding Observations on the Combined Seventh and Eighth Periodic Reports of Spain' (2015) UN Doc. CEDAW/C/ESP/CO/7-8 para. 31.

³⁶ L Ashford, G Sedgh, and S Singh 'Making abortion services accessible in the wake of legal reforms' (2012) *Issues in Brief* 1–4.

³⁷ Ibid.

The decriminalisation of abortion and the elimination of barriers in access thereto are therefore also crucial to ensure compliance with other core obligations set forth by GC: the obligation to prevent unsafe abortions.³⁸

2.2 Regional standards

In the regional setting, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) is the first human rights instrument in the world to explicitly set forth the reproductive rights of women to medical abortion. Art 14(2)(c) of the Protocol recognises the right to medical abortion when pregnancy results from sexual assault, rape or incest, or when the continuation of a pregnancy endangers the health or life of the mother, or when there is danger to the life of the foetus.³⁹

This right is two-fold and represents the approach to SRHR promoted by women from the South. On one hand, the Protocol adopts the classic approach to abortion that subsumes it into negative rights – such as privacy in the US context. In this interpretation, the right to abortion prohibits the state from interfering with the woman's decision to have a safe abortion in the permitted circumstances. On the other hand, the Protocol innovates by understanding that abortion entails a positive obligation of the state to take steps to fulfil the realisation of the right. In this line, Article 26 of the Protocol enjoins states parties to adopt all necessary measures, including budgetary measures, to fulfil the rights guaranteed by the Protocol. State obligations arising from article 14(2)(c) require implementation at the state level – not just in terms of merely recognising the grounds for abortion, but also establishing the infrastructure, including the dissemination of health information and provision of healthcare services for the termination of pregnancy under safe conditions.⁴⁰

In clarifying states' obligations under article 14(2)(c) of the Maputo Protocol, the African Commission in General Comment 2 (GC 2)⁴¹ explains the relevance of equality and non-discrimination to sexual and reproductive health and rights of women. In line with WHO's definition, GC 2 defines 'health' holistically to include physical and mental well-being.⁴² It premises the right to contraception/family planning and abortion on the state obligation to ensure access to reproductive health services that are available, accessible, ethically and culturally acceptable, and of good quality.⁴³ It calls on states to adopt purposive interpretation of grounds for abortion similar to the WHO

³⁸ UN Committee CEDAW 16th-17th Session (note 13 above) para. 49(e). L Berro Pizzarossa 'Legal barriers to access abortion services through a human rights lens: the Uruguayan experience (2018) *Reproductive Health Matters* 26(52) 1422664.

³⁹ C Ngwena and E Durojaye, 'Strengthening the Protection of Sexual and Reproductive Health and Rights in the African Region through Human Rights: An Introduction', *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014) 334.

⁴⁰ Center for Reproductive Rights *Briefing Paper: Reproductive Rights Violations a Torture and Cruel, Inhuman or Degrading Treatment or Punishment: A Critical Human Rights Analysis* (2010) <<http://reproductiverights.org/sites/crr.civicactions.net/files/documents/TCIDT.pdf>>.

⁴¹ African Commission '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' (adopted in the 55th Ordinary Session in Luanda, Angola 28 April–12 May 2014).

⁴² *Ibid* para 7.

⁴³ *Ibid* para 28.

Technical Guidance.⁴⁴ Further, it notes that where the risk to ‘mental health’ is relied upon, it is not necessary to first establish psychiatric evidence. The GC requires States to ensure access to health services on a non-discriminatory basis and in ways that are physically and economically accessible, and in which information is accessible.⁴⁵

Echoing the UN standards on states’ obligations to realise rights, GC 2 explains that the duty to respect rights requires State parties to refrain from hindering, directly or indirectly, women’s rights and to ensure that women are duly informed on family planning/contraception and safe abortion services.⁴⁶ The duty to protect requires State parties to take the necessary measures to prevent third parties from interfering with the enjoyment of women’s sexual and reproductive rights. It particularly cautions on the use of conscientious objection to hinder access to abortion services for women.⁴⁷ The GC further explains that the duty to promote imposes obligation on states parties to create legal, economic and social conditions that enable women to exercise their sexual and reproductive rights with regard to family planning/contraception and safe abortion, as well as to enjoy them. Regarding the duty to fulfil, it requires that States Parties adopt relevant laws, policies and programmes that ensure the fulfilment *de jure* and *de facto* of women’s sexual and reproductive rights, including the allocation of sufficient and available resources for the full realisation of those rights.⁴⁸

Ngwena *et al* have noted that GC’s 2 ‘human rights value goes beyond providing states with guidance for framing their domestic laws, practices, and policies to comply with treaty obligations’ but is also ‘invaluable in educating all stakeholders—including healthcare providers, lawyers, policymakers, and judicial officers at the domestic level—about pertinent jurisprudence’.⁴⁹

3. The South African legal framework

Cook *et al* note that ‘[n]o society, no religion, no culture and no system of national law has been neutral about issues of human reproduction’.⁵⁰ Indeed, SRH—including access to safe and legal abortion services—are intimately connected with issues of gender justice and dignity.⁵¹ The developments in South Africa are no exception to this rule. This section will outline the country’s legal framework on the topic.

The country has ratified all the relevant international human rights instruments that ground sexual and reproductive health as human rights, including the International Covenant on Economic, Social and Cultural Rights, the CEDAW, the International Covenant on Civil and Political Rights, and has signed and committed to implement both the ICPD and Beijing Platform for Action. South Africa is also a party to the

⁴⁴ *Ibid* para 30.

⁴⁵ *Ibid* para 31.

⁴⁶ *Ibid* para 42.

⁴⁷ *Ibid* para 43.

⁴⁸ *Ibid* para 44.

⁴⁹ C Ngwena, E Brookman-Amisshah & P Skuster ‘Human rights advances in women’s reproductive health in Africa’ (2015) 129 *International Journal of Gynaecology and Obstetrics* 184.

⁵⁰ RJ Cook, BM Dickens, and MF Fathalla, *Reproductive health and human rights: Integrating medicine, ethics, and law* (2004) 3.

⁵¹ RB Siegel, ‘Sex equality arguments for reproductive rights: Their critical basis and evolving constitutional expression,’ (2007) 56/4 *Emory Law Journal* 819.

African Charter on Human and Peoples' Rights and Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

Reproductive rights are warranted constitutional provision in the South African regime. The Bill of Rights mentions reproductive rights in two different sections. Section 12(2)(a) states that, 'Everyone has the right to bodily and psychological integrity, which includes the right [...] to make decisions concerning reproduction,' and section 27(1)(a) states 'Everyone has the right to have access to [...] health care services, including reproductive health care.'

Two years after achieving democracy, South Africa passed the Choice on Termination of Pregnancy Act, 92 of 1996. The law provides for abortion on request within the first 12 weeks of pregnancy. After the 12th week up to and including the 20th week the law requires the consultation with one medical practitioner that needs to certify 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 foetus 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.⁵² After the 20th week the procedure requires the consultation with two medical practitioners (or one medical practitioner and a registered midwife) that must be of the opinion that the continued pregnancy (i) would endanger the woman's life; (ii) would result in a severe malformation of the foetus; or (iii) would pose a risk of injury to the foetus.⁵³ There are limitations in terms of medical personnel authorised to provide abortion services and medical facilities in which such services can be provided. The CTOPA does not require a mandatory waiting period. The CTOPA does not remove all criminal penalties. Section 10 of the Act lists a number of offences relevant to '[a]ny person' who does not comply with the provisions of the Act when providing an abortion.

The passing of the CTOPA placed South Africa as a champion for SRHR in the region. The law granted access to safe and legal abortion managing to substantially reduce maternal mortality and morbidity by 91 per cent in the first years of implementation.⁵⁴

However, more than twenty years have passed and the enthusiasm for the transformative potential of the CTOPA has faded. Albertyn points at the deep problems of implementation in South Africa characterised by state inaction (eg failure to provide information, designate and staff clinics, procure drugs) and an absence of formal rules (eg no Guidelines or Protocols in place), as well as powerful and oppositional informal rules and practices (especially around stigma, moral judgments and conscientious objection).⁵⁵ For the period 2011–2013 the Sixth Confidential Enquiries into Maternal Deaths in South Africa indicated an alarming rate of illegal abortions and the South

⁵² See section 2 (1) of the Act.

⁵³ See section 2 (2) of the Act.

⁵⁴ R Jewkes, H Brown, K Dickson-Tetteh, J Levin and HRees 'Prevalence of morbidity associated with abortion before and after legalisation in South Africa' (2002) 324 *British Medical Journal* 1252–3; R Jewkes, H Brown, K Dickson-Tetteh, J Levin 'The impact of age on the epidemiology of incomplete abortions in South Africa after legislative change' (2005) 122 *International Journal of Obstetrics and Gynaecology* 355–9.

⁵⁵ C Albertyn 'Rights, Equality, Freedom and Reproductive Justice' Paper prepared for conference: Beyond Human Rights: Rethinking Gender Equality In Law And Politics 2017, University de los Andes Bogota, Colombia.

African government has identified ‘septic abortion’ as one of the most common causes of death among women.⁵⁶

The CTOPA has stood many challenges both at the judicial and legislative level. The latest challenge was a Bill proposed by Ms C Dudley from the African Christian Democratic Party on the 6 of December 2017. The Bill – was considered by the National Assembly and proposed a series of amendments to the CTOPA. In summary the proposed changes were related to (a) the participation of additional professionals in the abortion process (a social worker must also participate), (b) the elimination of the possibility to seek an abortion if it would pose a risk of injury to the foetus (c) the provision of mandatory counselling for women seeking abortion and (d) the new requirement of an ultrasound examinations and to repeal the Choice on Termination of Pregnancy Amendment Act, 2004 that provided – among other things – that mid-wives could terminate pregnancies up to the 12th week.⁵⁷

3.1 Legal barriers to access abortion services in the South African law

While the South African legal framework on SRH and abortion signified an important step towards the realisation of the right to access abortion services, a closer look reveals a number of burdensome requirements that must be fulfilled in order to access these services. This section will analyse some of the requisites set by the South African current CTOPA in light of the human rights standards discussed in [Section 2](#).

Besides the general obligations delineated above, the UN system has grappled with an extensive list of specific barriers and have provided clear guidelines to assist countries in enacting/modifying/repealing national laws so as to comply with their international obligations regarding SRH. This section will briefly describe the requirements set out in the South African CTOPA, which one needs to meet in order to lawfully access abortion services, and will assess those requirements in light of human rights standards. Moreover, it will analyse the draft bill filed by African Christian Democratic Party and requirements they proposed to introduce.

South Africa is not the only jurisdiction that reports difficulties in translating the legal norms into effective access to service. For example, evidence from Canada concluded that access to abortion services remained ‘practically illusory’ in 2007 due to restrictive practices and policies, even though it has been legally permissible since 1988.⁵⁸

In general, the World Health Organization (WHO) observes that laws, policies, and practices that restrict access to abortion services can deter women from seeking care and create a ‘chilling effect’ for the provision of safe, legal services.⁵⁹ These restrictions not only violate the obligations to eradicate barriers as we saw in [Section 2](#), limiting

⁵⁶ National Committee for Confidential Enquiries into Maternal Deaths ‘Saving Mothers 2011–2013: Sixth Report on Confidential Enquiries into Maternal Deaths in South Africa: short report’ <<http://www.kznhealth.gov.za/mcwh/Maternal/Saving-Mothers-2011-2013-short-report.pdf>>; Office on the Status of Women ‘South Africa’s National Policy Framework for Women’s Empowerment and Gender Equality’ http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=94056&p_country=ZAF&p_count=1051&p_classification=05&p_classcount=38.

⁵⁷ Choice on Termination of Pregnancy Amendment Bill (B34-2017) <<https://pmg.org.za/bill/748/>>.

⁵⁸ J Downie and C Nassar ‘Barriers to access to abortion through a legal lens’ (2007) 15/977 *Health Law Journal* 143.

⁵⁹ World Health Organization *Safe abortion: Technical and policy guidance for health systems* (2012) 95.

women's access to lawful services, but also result in inequities in access and create disproportionate risks for black, poor, young women and other women in vulnerable positions. These women often do not have the resources—time, money, transportation means—and knowledge to face all the obstacles required by law.⁶⁰ Moreover, these barriers make access unduly burdensome for women who experience gender-based violence or sexual violations, and who are twice more likely to need abortion services than women who do not experience such violence.⁶¹ The next subsections will assess four specific requirements and the issue of obstruction to access posed by 'conscientious objection' in light of the abovementioned human rights standards.

3.1.1 *Counselling and access to unbiased information*

The ICPD states that reproductive health care includes access to information, education, and counselling on human sexuality, family planning, and responsible parenthood.⁶² Likewise, General Comment 14 has framed the right to information on SRH as an essential component of the right to health.⁶³ Moreover, GC 22 refers to the Report of the Special Rapporteur on the Right to Education and iterates that the realisation of SRHR necessitates States parties to meet their obligations under other provisions of the Covenant, such as the right to accurate and scientific information.⁶⁴ Equally, GC 2 of the African Commission emphasises the need for states to 'ensure provision of comprehensive information and education on human sexuality, reproduction and sexual and reproductive rights'.⁶⁵ Also, General Comment 1 of the African Commission urges states to 'guarantee information and education on sex, sexuality, HIV, sexual and reproductive rights, which must be evidence-based, facts-based, rights-based, non-judgemental and understandable in content and language'.⁶⁶ It further requires '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'.⁶⁷

The CTOPA states that 'The State shall promote the provision of non-mandatory and non-directive counselling, before and after the termination of a pregnancy' (Section 4). However, the Regulations Under The Choice On Termination Of Pregnancy Act, 1996 state that the medical personnel involved are legally mandated to inform the women seeking abortions of (a) the available alternatives to the termination of her pregnancy (ii) the procedure and the associated risks of the termination of her

⁶⁰ See C Fiala and J Arthur 'Dishonourable disobedience' - Why refusal to treat in reproductive healthcare is not conscientious objection' (2014) *Psychosomatic Gynaecology and Obstetrics* 16.

⁶¹ See World Health Organization *Violence against women: A 'global health problem of epidemic proportions'* (2013).

⁶² 'Programme of Action' (note 6 above) para 7.6.

⁶³ UN Committee on Economic, Social, and Cultural Rights 'General Comment No. 14, The Right to the Highest Attainable Standard of Health' (2000) UN Doc. E/C.12/2000/4 para 11.

⁶⁴ UNHRC Special Rapporteur on the right to education (V Munoz) 'Report of the Special Rapporteur' (2010) UN Doc. A/65/162; see also CESCR 'General Comment No. 22' (note 5 above) para 21.

⁶⁵ African Commission 'General Comment No. 2' (note 45 above) para 32.

⁶⁶ See African Commission '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' (adopted during the 52nd Ordinary Session in Yamoussoukro, Cote d'Ivoire 9–22 October 2012) para 26.

⁶⁷ *Ibid.*

pregnancy.⁶⁸ The Regulations seem to override the provisions of the CTOPA going beyond what is legally mandated by providing for a sort of mandatory counselling on these aspects as the doctors are obliged to provide certain information (and omit other).

The Regulations require that women – additionally to giving their informed consent – are informed of the ‘associated risks’ of the termination of pregnancy. This has two major implications. Firstly, the CTOPA and more notably the Regulations present abortion – in contrast to the continuation of the pregnancy – as an exceptional and unhealthy procedure. Hence, while the decision to continue with pregnancy is construed as normal, natural, and unproblematic in the South African framework, the decision to terminate the pregnancy cannot be entrusted to women and requires the most careful thought – meriting not only the provision of informed consent but also this expanded advice/counselling instance.⁶⁹ Sheldon notes that modern medicine has shifted fundamentally away from ‘doctor knows best’ paternalism: today patients are routinely trusted, and indeed expected, to make medical decisions for themselves.⁷⁰ Pregnant women are not an exception to this fundamental legal principle except when the issue at hand is the termination of that pregnancy.

Secondly, undoubtedly, all individuals have the right to receive relevant, accurate and unbiased information prior to obtaining medical care so they can make sound decisions regarding treatment. The first point does not mean to indicate that those women are not entitled to receive ‘evidence-based, facts-based, rights-based’ information on any medical procedure they decide to undergo. However, abortion is a safe and legal medical procedure that does not require expanded counselling. The critique here lies in the legally mandated preference for maternity that requires medical personnel to inform the health consequences of the abortion procedure but not those that triggered by the continuation of pregnancy. This limitation on the information that doctors are legally obliged to provide – showing preference for one option over the other – neglects science-based information that evidences legally induced abortion to be markedly safer than childbirth.⁷¹ In fact, childbirth-related death is 14 times more likely than death resulting from abortion.⁷² Thus, this legally mandated preference for pregnancy violates states’ obligation to respect and protect SRH, including the obligation to refrain from withholding information or providing inaccurate figures.⁷³ In practice, this over-emphasis of abortion-related risks may unduly influence women’s decisions. In the words of Rebecca Cook, ‘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’.⁷⁴

⁶⁸ Regulations Under the Choice On Termination Of Pregnancy Act, 1996 <<https://srhr.org/abortion-policies/documents/countries/02-South-Africa-Choice-of-Termination-of-Pregnancy-Act-Regulation-168-1997.pdf>>.

⁶⁹ M Boyle *Re-thinking abortion: Psychology, gender, power and the law* (1997) 29.

⁷⁰ S Sheldon ‘The Decriminalisation of Abortion: An Argument for Modernisation’ (2015) 610 *Oxford Journal of Legal Studies* <<http://ojls.oxfordjournals.org/lookup/doi/10.1093/ojls/gqv026>>.

⁷¹ See EG Raymond and DA Grimes, ‘The comparative safety of legal induced abortion and childbirth in the United States’ (2012) 119/6 *Obstetrics & Gynecology* 1271–2.

⁷² *Ibid.*

⁷³ CEDAW Committee ‘20th–21st Session’ (note 13 above) paras 56 and 58.

⁷⁴ R J Cook, ‘International human rights to improve women’s health’ in R J Cook, *Women’s health and human rights: The promotion and protection of women’s health through international human rights law* (Geneva: World Health Organization, 1994) 26.

Moreover, the Draft Bill proposed by the African Christian Democratic Party introduces the requisite of mandatory counselling and intends to amend the CTOPA in this direction. This requirement can be critiqued on two grounds. Firstly, scientific evidence indicates that (a) pre-termination counselling is not wanted or needed by the majority of women because they are already certain of their decision and (b) policies aimed at mandatory pre-termination counselling would be a waste of resources and contrary to women's wishes. Indeed, 84 per cent of women interviewed in a study conducted in the UK said they did not need counselling because they were already sure of their decision.⁷⁵ In fact, there is extensive research indicating that most women make a decision on the outcome of unintended pregnancy at the time of taking a pregnancy test or even before taking a pregnancy test.⁷⁶ Secondly, international human rights standards demand elimination of this type of requirement. The CEDAW Committee, for example, has repeatedly denounced laws that provide for mandatory counselling and considers them as impermissible attempts to 'restricting women's access to abortion'.⁷⁷ The Committee has insisted in its recommendations that such requirements should be repealed.⁷⁸ As an example, the Committee urged Hungary to ensure access to safe abortion without subjecting women to mandatory counselling and a medically unnecessary waiting period as recommended by the World Health Organization.⁷⁹

The WHO follows a similar line considering that '[p]roviding information and offering counselling can be very important in helping the woman consider her options and ensuring that she can make a decision that is free from pressure'. The WHO recognises that many women have made a decision to have an abortion before seeking care, and explains clearly that 'this decision should be respected without subjecting a woman to mandatory counselling'. In the 2012 publication titled *Safe Abortion: Technical and Policy Guidance for Health Systems* the recommendation given by the WHO leaves no room for doubt '[p]rovision of counselling to women who desire it should be voluntary, confidential, non-directive and by a trained person'.⁸⁰

3.1.2 Barriers in terms of authorised medical professionals and facilities

The CTOPA requires the 'consultation' of medical professionals for cases of women seeking abortion services after the 12th week of pregnancy. Within the 13th week and up to the 20th week the abortion service can only be provided if a medical practitioner is of the opinion that any of the four circumstances provided in Section 2 (1) (b) of the

⁷⁵ C Baron, S Cameron, A Johnstone 'Do women seeking termination of pregnancy need pre-abortion counselling?' (2015) 41/3 *Journal of Family Planning and Reproductive Health Care* 181–5.

⁷⁶ S Rowlands 'The decision to opt for abortion' (2008) 34 *Journal of Family Planning and Reproductive Health Care* 175–180; S Brown 'Is counselling necessary? Making the decision to have an abortion. A qualitative interview study' (2013) 18 *European Journal of Contraception and Reproduction* 44–48; CL Cohan, C Dunkel-Schetter, J Lydon 'Pregnancy decision making: Predictors of early stress and adjustment' (1993) 17 *Psychology of Women Quarterly* 223–239.

⁷⁷ UN Committee on the Elimination of Discrimination Against Women 'Concluding observations on the eighth periodic report of the Russian Federation' (2015) UN Doc CEDAW/C/RUS/CO/8 para 35; 'Concluding observations on the combined fifth and sixth periodic reports of Slovakia' (2015) UN Doc CEDAW/C/SVK/CO/5-6.

⁷⁸ *Ibid* 'Concluding observations on the combined fifth and sixth periodic reports of Slovakia' para 31.

⁷⁹ UN Committee on the Elimination of Discrimination Against Women 'Concluding observations on the combined seventh and eighth periodic reports of Hungary' (2013) UN Doc CEDAW/C/HUN/CO/7-8 para 30.

⁸⁰ World Health Organization (note 64 above).

CTOPA are present.⁸¹ From 20 weeks of gestation onwards, abortions are available under limited circumstances. In this last case, two medical practitioners or a medical practitioner and a registered midwife need to be of the opinion that continued pregnancy would endanger the woman's life, pose a risk of injury, or result in severe malformation of the foetus.

Additionally, Section 3 of the CTOPA lists requirements that the health facility needs to comply with in order to be authorised to provide abortions. This section states that termination of a pregnancy may take place only 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 inpatient facilities; (h) has appropriate infection control measures; (i) gives access to safe waste disposal infrastructure; (j) has telephonic means of communication; and (k) has been approved by the Member of the Executive Council by notice in the Gazette.

The CTOPA was amended by Act No. 38 of 2004 and expanded the list of medical personnel that can perform abortion. Termination of pregnancies of 12 weeks gestation or less can be performed not only by a registered medical practitioner, but also by a registered nurse or midwife who has completed the prescribed abortion training course. Abortions in the second trimester (13–20 weeks) can only be performed by a registered medical doctor.

The CTOPA does not allow for self-managed abortion. As we pointed above, the CTOPA imposes a series of penalties to '[a]ny person' who does not comply with the provisions of the Act when providing an abortion. This – as noted by Pickles – has been used to criminalise women who self-induce abortions.⁸²

In terms of human rights standards, the WHO considers that restriction on the range of providers or facilities that are authorised to provide abortion reduce the availability of services and their equitable geographic distribution.⁸³ There is extensive evidence mifepristone and misoprostol capsules can be self-administered to safely induce a discrete and non-invasive medical abortion in pregnant women up to 12 weeks of gestation.⁸⁴ Research shows that self-managed abortion with pills is very effective, safe and acceptable, reduces the visits to the clinic – hence the burden on women and services – and does not require specific training or specialisation expanding the range of personnel that can prescribe the drugs.⁸⁵ Abortion after the 12th week entails a higher

⁸¹ The relevant section reads as follows: (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 foetus 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.

⁸² C Pickles Self-induced abortion in South Africa and Section 10 of the Choice on Termination of Pregnancy Act 92 of 1996. (2017) *South African Journal on Human Rights*, 33(3), 496–506.

⁸³ World Health Organization (note 64 above). para 4.2.2.4.

⁸⁴ Pehudoff, Katrina, Lucía Berro Pizarrossa, and Jelle Stekelenburg. 'Realising the right to sexual and reproductive health: access to essential medicines for medical abortion as a core obligation.' *BMC international health and human rights* 18, no. 1 (2018): 8.

⁸⁵ Thoa Ngoi D., Min Hae Park, Haleema Shakur, and Caroline Free. 'Comparative effectiveness, safety and acceptability of medical abortion at home and in a clinic: a systematic review.' *Bulletin of the World Health Organization* 89 (2011): 360–70.

risk for the pregnant woman which grants the intervention of a trained professional but does not justify the doctor(s) interference in women's health care decisions that will be discussed in [Section 3.1.4](#).

These restrictions are – as it was stated above – a violation of the obligation of the state to guarantee the right to SRH. GC 22 is very clear in this regard '[a]n adequate number of functioning health care facilities, services, goods and programmes should be available to provide the population with the fullest possible range of sexual and reproductive health care'.⁸⁶ Furthermore, the GC considers that ensuring the availability of trained medical and professional personnel and skilled providers who are trained to perform the full range of sexual and reproductive health care services is a critical component of ensuring availability. In the same vein, the African Commission has noted that states have the duty to remove restrictions that are not necessary for providing safe abortion services such as the requirements of multiple signatures, approval by committees before an abortion can be performed, or restricting performance of abortion to only medical practitioners.⁸⁷

The legal barriers mentioned above are exacerbated by the dire situation in terms of effective availability and accessibility to abortion services – and health services more generally. Despite the health care system reform and the efforts to invest in the public sector, inequalities persist in terms of infrastructure and resources. Regarding the availability and accessibility to train medical personnel, nearly 83 per cent of the population relies on the public health system, yet the private health care sector employs the majority of health care professionals and spends nearly 6 times more per patient.⁸⁸

In terms of the lack of sufficient health facilities, a recent report issued by Amnesty International indicates that only about 260 of the country's 3880 health facilities provide abortions. This number is not surprising giving the extensive list of requirements that facilities willing to provide these services need to meet and the high number of conscientious objectors. Effectively, less than 7 per cent of all the medical facilities in the country are able and/or willing to provide an essential life-saving medical procedure.⁸⁹

As mentioned above, these requirements aggravate the already existing inequalities in society and once again it is poor, rural, young and black women that bear a disproportionate burden of the lack of political will to realise the right to SRH. People living in rural areas—that represent the 43.6 per cent of the population—often experience the greatest adversities accessing quality health care.⁹⁰ It is reported that the multiple consultations that the process requires and the long distance that some women need to travel to access the scarce available medical facilities can require up to 3,000 South

⁸⁶ CESCR 'General Comment No. 22' (note 5 above) para 40.

⁸⁷ African Commission 'General Comment No. 2' (note 45 above) para 58.

⁸⁸ National Health Care Facilities 'Baseline Audit National Summary Report' (2013) <http://www.hst.org.za/sites/default/files/NHFA_webready_0.pdf> Department of Health 'Human Resources for Health South Africa' (2011); RSA Negotiated Service Delivery Agreement For Outcome Two: 'A Long and Healthy Life for All South Africans' 2010 cited by Amnesty International and UCT Women's Health Research Unit *Briefing Barriers to Safe and Legal Abortion in South Africa* (2017) <https://www.amnestyusa.org/files/briefing_barriers_to_safe_and_legal_abortion_in_south_africa_final_003.pdf>.

⁸⁹ *Ibid.*

⁹⁰ Amnesty International and UCT Women's Health Research Unit *Barriers to Safe and Legal Abortion in South Africa* (note 96 above).

African rand (USD 240 approximately) and severely hamper access to safe abortion (both medical and surgical).⁹¹ Amnesty International reports that rural women are served by only 12 per cent of the country's doctors and 19 per cent of nurses.⁹²

In addition, second-trimester abortions account for over 20 per cent of abortions performed in South Africa, which is greater than other countries with legalised abortion.⁹³ Delays due to inappropriate referrals evidenced by women attending numerous facilities before obtaining an abortion, waiting periods of over two weeks and difficulties locating a facility providing abortions are concerning and have been singled out as factors contributing to this high rate.⁹⁴ Concretely, women's access to abortion care services is being delayed by compromising their ability to access an earlier, less risky procedure.

All these burdensome requirements – only specific medical personnel can provide abortion services, the service may require the intervention of more than one medical practitioner or midwife, only special facilities that fulfil the long list of requisites can provide the service – force women to seek illegal and unsafe abortions. The existing requirements violate the State's obligation to fulfil the right to SRH that requires States to take measures to eradicate practical barriers to the full realisation of the right to sexual and reproductive health, such as disproportionate costs and lack of physical or geographical access to sexual and reproductive health care.⁹⁵ Clearly, it also violates South Africa's obligation to prevent unsafe abortions.

3.1.3 Mandatory ultrasound

Additionally, the Bill proposed by the African Christian Democratic Party demanded the addition of one more person (a social worker) to the process of termination of pregnancy. Furthermore, it requires that women undergo an ultrasound before an abortion and state that health facilities can only provide abortion services if they have such equipment. These additional requirements worsen the already burdensome process.

The requirement of a mandatory ultrasound would place even more restrictions in the already small number of health facilities that can provide abortion and evidence shows that it is not medically necessary and can add significantly to the cost of the abortion procedure.⁹⁶ The Guttmacher Institute considers that generally, such a requirement 'appears to be a veiled attempt to personify the foetus and dissuade a woman from obtaining an abortion'.⁹⁷ However, research on the effects of offering voluntary ultrasound viewing on women's experience with abortion provides evidence

⁹¹ J Harries, M Momberg, C Gerdt, D Greene Foster 'An exploratory study of what happens to women who are denied abortions in a legal setting in South Africa' (2015) 15 *BMC Reproductive Health* 21.

⁹² Amnesty International and UCT Women's Health Research Unit *Barriers to Safe and Legal Abortion in South Africa* (note 96 above).

⁹³ South African Department of Health 'Termination of Pregnancy Update Cumulative Statistics through 2004' (2005). See also Grossman, Daniel, Deborah Constant, Naomi Lince, Marijke Alblas, Kelly Blanchard, and Jane Harries. 'Surgical and medical second trimester abortion in South Africa: a cross-sectional study.' *BMC health services research* 11, no. 1 (2011): 224.

⁹⁴ J Harries, P Orner, M Gabriele and E Mitchell 'Delays in seeking an abortion until the second trimester: a qualitative study in South Africa' (2007) 4/1 *Reproductive Health* 7.

⁹⁵ UN CESCR 'General Comment No. 22' (note 5 above) para. 46.

⁹⁶ Guttmacher Institute 'State policies in brief: requirements for ultrasound' <http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf>.

⁹⁷ Guttmacher Institute 'State policies in brief: requirements for ultrasound' (note 90 above).

that ultrasound viewing does not dissuade women from abortion.⁹⁸ In summary, the requirement of ultrasound in order to terminate a pregnancy does not have any deterrent effect; it only makes the procedure more costly in terms of money, decreases the number of medical facilities that can provide the service.

This cannot be reconciled with the obligation of the state to remove all barriers interfering with women's access to comprehensive sexual and reproductive health services, goods, education and information.⁹⁹ By passing a law that adds these – and the other requirements – the South African government would be failing in its obligation to refrain from enacting laws and policies that create barriers in access to sexual and reproductive services.¹⁰⁰ GC 22 states that 'the imposition of barriers to sexual and reproductive health information, goods and services' is an impermissible retrogressive measure.¹⁰¹

3.1.4 Third party authorisation

Furthermore, if the woman is seeking a late-term abortion the CTOPA requires the intervention of two doctors or a doctor and a midwife in order for them to 'authorise' the abortion if in their 'opinion' any of the three grounds is configured (Section 2 (I) (c)). This is a form of third-party authorisation that women need to obtain prior to accessing the service. The CEDAW Committee's General Recommendation 24 notes that conditioning women's access to health services on the authorisation of husbands, partners, parents, or health authorities is a significant barrier to the pursuit of their health goals, deterring people from seeking and receiving the information and services guaranteed by law.¹⁰² The UN bodies have repeatedly called for the requirement's elimination and GC 22 explicitly requires its prohibition.¹⁰³

The Bill proposed by the African Christian Democratic Party added one more person (a social worker) that needs to authorise the termination of pregnancy for cases in which the decision is based on social or economic reasons. According to the arguments posed by the proponents of the Bill 'a social worker's expertise is [going to be] offered before pregnancy is terminated for social or economic reasons'.¹⁰⁴ As argued above, the introduction of another professional that needs to authorise the termination of the pregnancy aggravates an already uphill battle. This additional requirement feeds into the stereotype of women as irrational decision-makers incapable of making their own decisions and is based on the harmful understanding that the state, the doctors and/or the social workers know better than women do what they really want and need in matters of sexual and reproductive health and rights.¹⁰⁵

⁹⁸ UD Upadhyay, K Kimport, EK Belusa, NE Johns, DW Laube and SC Roberts 'Evaluating the impact of a mandatory pre-abortion ultrasound viewing law: A mixed methods study' (2017) 12/7 *PLoS one*.

⁹⁹ UN CESCR 'General Comment No. 22' (note 5 above) paras 28 and 34.

¹⁰⁰ *Ibid* para. 40.

¹⁰¹ *Ibid* para 38.

¹⁰² UN Committee on the Elimination of Discrimination Against Women 'General Recommendation No. 24, Women and Health' (1999) UN Doc. A/54/38/Rev.1 para. 14.

¹⁰³ Grover (note 21 above) para. 55; CEDAW Committee 'Slovakia' (note 76 above), para. 31; UN CESCR 'General Comment No. 22' (note 5 above) paras 40–1.

¹⁰⁴ Choice on Termination of Pregnancy Amendment Bill (B34-2017) can be accessed <<https://pmg.org.za/bill/748/>>.

¹⁰⁵ RB Siegel 'The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions' (2007) 1 *Yale Law School, Faculty Scholarship Series* 991.

This requirement enables doctors to act as ‘gate-keepers’ – in the sense used by Halliday – who control access to abortion and hold significant influence in determining what medical treatments are required to accept during pregnancy/birth.¹⁰⁶

The prerequisite is, in other words, contrary to the obligations set by both the regional and international legal framework. Indeed, GC 22 states that violations of the obligation to respect occur when states impose legal barriers that undermine the right to SRH and states’ failure to take the measures necessary to eradicate such barriers are seen as a violation of the right to fulfil.¹⁰⁷ Equally, the African Commission urges states to remove barriers that are not necessary to ensure access to safe abortion services.¹⁰⁸

3.1.5 Conscientious objection

The CTOPA does not include any provision explicitly regulating the exercise of conscientious objection (CO) which is seen as one of the shortcomings of the framework.¹⁰⁹ Nonetheless, as Ngwena pointed out, Section 15 of the South African Constitution of 1996, which inter-alia, guarantees the right to freedom of conscience, implicitly accommodates the right to conscientious objection to abortion.¹¹⁰ This is not an absolute right, but is subject to accommodating women’s constitutional rights and international human rights.¹¹¹

However, there are no clear guidelines to regulate the exercise of this right and this hinders access to abortion services by reducing the number of medical personnel and facilities that effectively provide these services.¹¹² In fact, a qualitative study by the WHO on abortion services in the Western Cape showed that ‘Providers’ reluctance to be involved in different aspects of abortion provision led to complex and fragmented levels of service provision in many healthcare facilities.¹¹³

Even more problematic is the lack of clear conceptualisation on behalf of the State and lack of understanding on behalf of the medical personnel of what constitutes conscientious objection. Conscientious objection is being used in an ‘ad hoc, unregulated and at times incorrect’ manner as a means to oppose abortion on very broad grounds – similar to the civil disobedience reported in Uruguay¹¹⁴ – resisting the application of the law and the objection became an all-encompassing opportunity for non-participation in abortion services.¹¹⁵ Furthermore, the right to refuse to provide abortion services applies only to the abortion procedure. Therefore, medical personnel that are not

¹⁰⁶ S Halliday *Autonomy and Pregnancy. A Comparative Analysis of Compelled Obstetric Intervention* (2016) 172.

¹⁰⁷ UN CESCR ‘General Comment No. 22’ (note 5 above) paras 57 and 63.

¹⁰⁸ African Commission ‘General Comment No. 2’ (note 45 above) para 60.

¹⁰⁹ C Ngwena C ‘Conscientious objection and legal abortion in South Africa: delineating the parameters’ (2003) 28/1 *Journal for Juridical Science* 1–8.

¹¹⁰ Constitution of the Republic of South Africa Act No 108 of 1996.

¹¹¹ C Ngwena ‘Decision T-388/2009. A Commentary on a decision of the Constitutional Court of Colombia from an African Regional Perspective’ in *T-388/2009: Conscientious Objection and Abortion, A Global Perspective on the Colombian Experience* (2014) <<https://www.law.georgetown.edu/oneillinstitute/research/documents/WLWT-388-09English-FINAL.pdf>>.

¹¹² J Harries, D Cooper, A Strelbel, CJ Colvin ‘Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study’ (2014) 11/1 *BMC Reproductive Health* 16.

¹¹³ World Health Organization *What health-care providers say on providing abortion care in Cape Town, South Africa: findings from a qualitative study* (2010) <http://www.who.int/reproductivehealth/publications/unsafe_abortion/rhr_hrp_10_18/en/>.

¹¹⁴ See L Cabal, M Arango Olaya and V. Montoya Robledo ‘Striking a balance: Conscientious objection and reproductive health care from the Colombian perspective’ (2014) 16/2 *Health and Human Rights Journal* 73–83.

¹¹⁵ Harries, Cooper & Strelbel (note 124 above).

directly involved with the abortion procedure cannot invoke conscientious objection as a reason to deny assistance to a woman seeking abortion services.¹¹⁶ More importantly, in terms of the constitutional right of all South Africans to emergency health care, conscientious objection cannot be used to refuse the provision of post-abortion and/or emergency services related to induced or spontaneous abortions.¹¹⁷

As Fiala and Arthur highlight, reproductive health is the only field in medicine where societies worldwide accept freedom of conscience as a valid argument to limit a patient's right to a legal medical treatment.¹¹⁸ In practice, the (ab)use of conscientious objection prevents patients from receiving accurate, scientific, and unbiased information about their options, and thus inhibits their ability to access such care.¹¹⁹

The WHO states that health-care professionals who claim conscientious objection must refer the woman to another willing and trained provider in the same, or another easily accessible health-care facility. Where a referral is not possible, the health-care professional who objects must provide safe abortion to save the woman's life, to prevent serious injury to her health and provide urgent care when women present with complications from unsafe or illegal abortion.¹²⁰

All in all, the South African lack of guidelines, monitoring and accountability mechanisms with regards to the exercise of CO clashes with the obligations assumed at the international level. Firstly, the obligation to protect the right to SRH requires states to prohibit and prevent private actors from imposing practical or procedural barriers to health services.¹²¹ In this regard, states must organise health services in a manner that ensures that 'the exercise of conscientious objection by health professionals does not prevent women from obtaining access to health services'.¹²² Secondly, the CEDAW Committee clarified that 'if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers'.¹²³ According to GC 22, states must appropriately regulate this practice to ensure that it does not inhibit anyone's access to SRH care, including by requiring referrals. Additionally, this referral must be done to an accessible provider capable of and willing to provide the services being sought.¹²⁴ And thirdly, states must guarantee access to abortion services in urgent or emergency situations.¹²⁵ The South African framework – or lack thereof – does not meet any of these standards.

¹¹⁶ See *Greater Glasgow Health Board v Doogan and Another* [2014] UKSC 68; see also African Commission 'General Comment No. 2' (note 45 above) para 26.

¹¹⁷ C Morroni, G Buga, L Myer 'Understanding aspects of the termination of pregnancy legislation' (2006) 24/1 *Continuing Medical Education* 37–8.

¹¹⁸ Fiala and Arthur (note 65 above) 13.

¹¹⁹ TA Weitz and S Berke Fogel 'The denial of abortion care information, referrals, and services undermines quality care for U.S. women' (2010) 20 *Women's Health Issues* 7–11.

¹²⁰ World Health Organization (note 64 above) para 4.2.2.5.

¹²¹ UN CESCR 'General Comment No. 22' (note 5 above) paras 43 and 63.

¹²² UNGA 'Report of the Office of the United Nations High Commissioner for Human Rights on Practices in Adopting a Human Rights-based Approach to Eliminate Preventable Maternal Mortality and Morbidity' (2011) UN Doc. A/HRC/18/27 para. 30.

¹²³ UN CEDAW Committee 'General Recommendation No. 24' (note 99 above), chap. I.

¹²⁴ UN CESCR 'General Comment No. 22' (See note 5) paras 43 and 63.

¹²⁵ *Ibid.*

4. Conclusions and perspectives for the future

Policies and laws that act as barriers to the availability, accessibility, acceptability, and quality of SRH remain a serious area of concern worldwide.¹²⁶ In September 2016, a group of experts from the UN reiterated that: '[r]estrictive legislation which denies access to safe abortion is one of the most damaging ways of instrumentalising women's bodies and a grave violation of women's human rights.'¹²⁷

This article shows the urgent call for vigilance and modernisation that the CTOPA and the proposed amendment elicit. There is no contention in terms of the international obligations assumed by the South African State: it must repeal or reform laws that impede the exercise of SRH – including laws that criminalise or restrict access to abortion services – and is required to remove and refrain from enacting laws and policies that create barriers in access to SRH services. As discussed above, a critical analysis of the existing framework and the potentially upcoming law reforms is key to ensure that the state complies with its obligations in the international sphere and effectively ensures women's access to abortion services.

This article reveals that – in spite of its acclaim at the international level and the adoption of a praiseworthy law on abortion – South Africa has fallen short of adopting a legal framework that complies with international standards and that guarantees effective access to abortion services. Although more than 20 years have passed since the enactment of the CTOPA, women still face serious barriers in access to lawful services, endangering their health and lives.

The proposed amendment Bill analysed in this article was rejected by the National Assembly in May 2018. It was stated that '[t]he Committee [National Assembly Public Health Committee] was unanimous in the view that the Bill was fatally flawed, not practical and would place huge financial burden on the Department of Health, which was already under-staffed and faced financial challenges – if the Bill was not implementable, there was no value in passing the legislation'.¹²⁸ The decision also indicated that '[f]rom a constitutional perspective, the proposed Bill places an unnecessary heavy burden on those who wish to terminate pregnancy'.¹²⁹

Although this represents a positive development that rejects the imposition of extra barriers to access abortion services it is important that law-makers, as well as health and human rights advocates, follow these kind of initiatives carefully in order to keep compliance with the international human rights framework in mind. Scholars report that anti-abortion activism has adopted a new so-called 'women-centred' agenda that given their lack of success in outlawing abortion completely, now support the imposition of burdensome barriers that effectively erode women's

¹²⁶ Cottingham et al. (note 8 above).

¹²⁷ Statement by Alda Facio, Chair-Rapporteur of the Working Group on the issue of discrimination against women in law and in practice; Dainius Pūras, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health; Juan E. Méndez, UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment; and Dubravka Šimonović, UN Special Rapporteur on violence against women; see OHCHR, 'Unsafe abortion is still killing tens of thousands women around the world – UN rights experts warn,' (28 September 2016) <<http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20600&LangID=E>>.

¹²⁸ Republic of South Africa, National Assembly Portfolio Committee on Health, Session 09 May 2018. pmg.org.za.

¹²⁹ Republic of South Africa, National Assembly Portfolio Committee on Health, Session 09 May 2018. pmg.org.za.

access to the legally recognised right.¹³⁰ Indeed, the draft Bill fits a pattern observed by the literature in which those opposing abortions use the tactic to introduce several burdensome requirements in order to ‘protect’ or ‘empower’ women.¹³¹ A shift has been noted in the South African context from a direct attack on the core right to abortion to attempts to narrow the ambit of women’s reproductive choice.¹³² States parties should be guided by contemporary human rights instruments and jurisprudence, as well as the most up-to-date international guidelines and protocols established by the UN agencies and must remain vigilant of initiatives that undermine women’s right to sexual and reproductive rights.

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¹³⁰ See for example L Canold ‘Understanding and responding to anti-choice women-centred strategies’ *Reproductive Health Matters* 10, no. 19 (2002): 171–9. L. Finer and J B Fine. ‘Abortion law around the world: progress and pushback’ *American Journal of Public Health* 103, no. 4 (2013): 585–9.

¹³¹ AE Yamin and P Bergallo, P ‘Narratives of Essentialism and Exceptionalism: The Challenges and Possibilities of Using Human Rights to Improve Access to Safe Abortion’ (2017) 19/1 *Health and human rights* 1. See MP Cheryllyn Dudley’s (promotor of the Bill) statement on the ‘empowering’ intention of the amendment in EWN, ‘Amendment to abortion law is about empowering women’ <<http://ewn.co.za/2017/12/08/amendment-to-abortion-law-about-empowering-women>>.

¹³² Albertyn ‘Claiming and Defending Abortion Rights in South Africa’ (note 1).