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CONSCIENTIOUS OBJECTION BY SOUTH AFRICAN HEALTHCARE PROVIDERS TO INVOLVEMENT IN THE PROCESS OF ABORTION

INTRODUCTION

The South African ***Choice on Termination of Pregnancy Act 92 of 1996***, enacted December 11, 1996 and effective since February 1997, is generally regarded as one of the most liberal abortion laws in the world. The aim of this law is to uphold the rights of women as equal citizens and to give effect to their rights to healthcare, including right of access to reproductive healthcare. Conscientious objection by healthcare workers to providing abortion is allowed in terms of the act; but ensuring that pregnant women are aware of their legal right to an abortion (Strauss, S.A., 1999), and probably also referral to a willing health care provider, is obligatory (Dickson-Tetteh, K. and Rees, H., 1999). There have been challenges to the act, and amendments to the act were subsequently passed in parliament during August 2004.

In this research report I will consider the ***justification for the right of conscientious objection by the individual health care provider in the face of the conflicting rights of the pregnant woman seeking abortion***. The importance of the rights of both the pregnant woman seeking abortion and the health care provider will be addressed and an attempt made to balance these sets of rights, weigh priorities and offer possible solutions. South Africa is a nation consisting of several ethnic, cultural

and religious groups. How the right to conscientious objection is affected by the multicultural nature of our South African society, if indeed it is, will be investigated.

Although a focus on human rights makes sense, for according a (positive) legal right gives rise to a resulting obligation on the part of the state and its organs to implement that right, it does not capture the essence of my belief. According a legal right leads to a greater chance of success that the beliefs of the conscientious objector will be respected, and also a greater chance of achieving improved reproductive healthcare for women (Cook, R.J., 1998). When the primary focus is on claiming one's own rights, however, the potential for conflict is enormous. In order for individuals to co-exist harmoniously, and for our society to flourish, we need a compromise (for the manner in which we think about this particular moral dilemma will be a reflection of how we deal with ethical conflicts generally). I believe that the primary focus should be on the unique value of each individual (allowing that all lives may not be equally instrumentally valuable), and that each one should afford the other, on that basis, dignity and respect. Allowing each person 'human rights' stems from this prior value of individuals.

This report is divided into nine main sections. Section 1 examines the history, purpose, and literal content of *The Choice on Termination of Pregnancy Act of 1996.* The historical account includes discussion of challenges that were raised against the Act and amendments that have been made to it. Section 2 compares South African and International Abortion Laws with regard to the right to conscientious objection.

Section 3 considers moral theories about abortion and its implications for the right to conscientious objection to abortion in a multicultural society. Why is abortion a moral problem? This question will be discussed in relation to theories regarding the

personhood and potentiality of the foetus and the sanctity of human life. Concerns about the rights of the foetus and of the pregnant woman will be considered, as will the beliefs of the major religious groups in South Africa. I will also discuss the moral implications in a society with a plurality of beliefs and, indeed, seek to ascertain the belief of the majority of the population with regard to abortion. All this will have implications for the moral acceptability of the right to conscientious objection in South Africa.

Section 4 deals with the special importance of freedom of access to abortion facilities in South Africa. The reasons why it may be especially important, specifically for South African women, to easily access abortion facilities will be considered. The major reason for passage of *The Choice on Termination of Pregnancy Act* was to reduce the high numbers of illegal abortions and the accompanying disastrous consequences. This will be discussed, together with the effects of the human immunodeficiency virus and gender violence.

Section 5 examines the extent of achievement of the objectives of *The Choice on Termination of Pregnancy Act.* I will discuss the impact of conscientious objection in limiting access to abortion and address other possible reasons for sub-optimal achievement of the objectives. If other factors are significantly important, there may be several possible interventions that could be implemented in order to minimize the conflict between the rights of pregnant women and health care providers.

In section 6 the reasons for an appeal to the right of conscientious objection to involvement in the process of abortion will be addressed. Conscientious objection may not only be related directly to the active curtailment of a human life, but may have much to do with the circumstances in which the procedures are carried out. For

example, if the health care provider is not certain that the pregnant woman has received adequate counselling prior to undergoing the abortion, she may not be willing to be involved in the process. It may be simpler to opt out of involvement in the procedure altogether than to address these various issues. Further, it may be that health care providers who had not reflected carefully on their position might alter their stance if given education and support in relation to abortion issues.

Section 7 will examine the justification for the right to conscientious objection to involvement in the process of abortion. Justification will be discussed from the following view-points: respect for the wide range of religious and moral beliefs within a multicultural society such as South Africa; acting with moral integrity; respect for the autonomy of South African healthcare providers; and, lastly, respect for individuals, and freedom of choice.

Section 8 seeks to define what is meant by 'conscientious objection' in the context of abortion, and considers the reasonable constraints with respect to the following: defining 'conscientious objection'; duties of care; duties of referral; education of students; obstructive behaviour by conscientious objectors; institutional conscientious objection to abortion; 'values clarification'; and, finally, the requirement to justify an appeal to conscientious objection.

How may the objectives of *The Choice on Termination of Pregnancy Act* be achieved? Based on the preceding discussion, section 9 will seek a solution that minimizes the conflict of rights: between the right to terminate a pregnancy and the right to conscientious objection to involvement in the process. The solution will be considered as follows: achievement of the wider objectives of the act while seeking to limit the need for abortion; altering circumstances that limit access to abortion; and, limiting the appeal to 'conscientious objection'.

I will conclude that there are good reasons for believing that a pregnant woman's freedom of choice to terminate a pregnancy is important, generally, and particularly in our South African society. The foetus, though not self-aware and not the bearer of legal rights, is not inconsequential. There are also good reasons to respect the views of healthcare providers who object on the grounds of conscience to involvement in the process of abortion. Individuals who believe it is important to promote maximally flourishing communities (for we do not want to see the collapse of our society, or the undermining of freedoms for which many have worked so hard) will be persuaded that accorded rights result in obligations, not only to themselves, but also to others. It is possible to work together to find creative solutions that minimize the conflict of interests while, simultaneously, promoting respect for each individual. Our lives are interdependent.

1. The 'Choice on Termination of Pregnancy' act 92 of 1996

This act makes abortion legal on request of the pregnant woman, whose pregnancy may be ended by a medical doctor, or registered midwife who has completed training for performance of the procedure, until 12 weeks of gestation. Between 13 and 20 weeks of gestation only a medical doctor in consultation with another medical doctor or registered midwife may perform the abortion, and then only if the continued pregnancy would be a threat to the woman's mental or physical health or if there would be risk of severe foetal physical or mental abnormalities. Abortion is also allowed if the pregnancy resulted from rape, sexual abuse or incest, or if the pregnancy would adversely affect the social and economic status of the woman. After 20 weeks, abortion is allowed only if there is a threat to the life of the woman or if there is severe foetal malformation (PHILA LEGISLATIVE UPDATE, 1996, retrieved 19-10-2003 from www.).

Although young women who are minors should be advised to consult with their guardians before termination of pregnancy, they do have authorisation to undergo the procedure (upon their own consent) without the agreement or even knowledge of their parent or legal guardian. Married women are not required to obtain the consent of their husbands or to even consult with them prior to terminating pregnancy. The state is obliged to provide counselling to women both before and after termination of pregnancy, but women are not obligated to use this facility. The counselling must, however, be non-directive.

Healthcare workers may not be forced to participate in the termination of pregnancies, but those who refuse must provide referrals to others who are willing. Preventing terminations or obstructing access to abortion services is a criminal

offence. Abortions may only be performed at a facility designated by the Minister of Health, while abortions under any other circumstances constitute a legal offence.

The legal right of access to abortion implies an obligation by the state to provide free abortion services. This may conflict with the right of the health care provider to object on grounds of conscience to involvement in the process. It has been suggested (Van Bogaert, L-J., 2002) that under conditions of scarcity, exacerbated by a lack of willing healthcare providers, the right to conscientious objection may be inappropriate, for under these conditions it is possible that the shortage of medical practitioners may limit women's access to abortion.

The aim of the ***Choice on Termination of Pregnancy Act*** is to uphold the rights of women as equal citizens and to give effect to their rights to healthcare, including right of access to reproductive healthcare (Dickson-Tetteh, K. and Rees, H., 1999). It is also the intention of the law to redress the inequities of the past when, because of restrictive legislation, terminations were primarily accessible only to those who could afford to pay for them. Before 1997 the 1975 ***Abortion and Sterilization Act*** applied. This allowed for termination of pregnancy in the presence of a serious threat to the life of the pregnant woman, serious threat to her mental or physical health, after rape or incest and when severe malformation of the foetus was expected. The approval of two independent physicians, who were not permitted to perform the abortion, was required. The consent of a psychiatrist or magistrate was necessary in some cases, and all abortions had to be performed in state hospitals. Those who could afford it would often procure an abortion where it was legal, usually in England (Guttmacher, S., Kapadia, F., Te Water, J., de Pinho, H., 1998, retrieved 25-09-2004 from www.). As it was mainly white women who could afford to obtain abortions elsewhere and, indeed, even safe illegal abortions within South Africa, the law,

although applying equally to all, had the effect of discriminating against the poor, who were mainly black. The 1996 ***Choice on Termination of Pregnancy Act*** aims to rectify this injustice. Thus those healthcare providers who object to performing abortions on the grounds of conscience may be accused of perpetuating past injustices.

There have been challenges to the ***Choice on Termination of Pregnancy Act***. In 1998 the first challenge, to section 11 of the Constitution, presented by the Christian Lawyers' Association, was based on the fact that abortion violates the right to life of the foetus, while by law 'everyone has a right to life'. This was rejected on 10th July, 1998 on the grounds that under the Constitution the foetus is not a person with a bearer of rights and that there was no intention under the law to distinguish between 'everyone' and 'every person'. It was found that section 11 of the Constitution did not apply to the foetus (Sarkin, J., 2000).

The second challenge to the law was based on the Christian Lawyers' Association's concern that it was not in the best interests of a pregnant child under the age of eighteen to consent to her own abortion (LifeSiteNews.com, May 31st, 2004, retrieved 18-Aug-04 from www.). Legally she has the right to do this without even the knowledge of her parents or guardians, much less their agreement. The challenge was dismissed in Pretoria on 29th May 2004, the reason being that the legislation was indeed in the best interests of the young pregnant girl since, "it is flexible enough to recognize and accommodate the individual position of a girl child based on her intellectual, psychological and emotional make up, and actual majority" (In Women's Legal Centre document, p2, retrieved 19-09-2004 from www.). The Reproductive Rights Alliance (RRA) represents civil society organizations that have worked to

implement the ***Choice on Termination of Pregnancy Act*** and continues to oppose the challenges that are brought against the right of women to access safe abortions.

On 19th August 2004 Parliament approved an amendment to ***The Choice on Termination of Pregnancy Act 1996.*** This allows trained registered nurses, not only registered midwives, to perform abortions, and approves a wider range of abortion facilities. It empowers provincial Members of the Executive Council (MECs) for Health, not only the Minister of Health, to designate abortion facilities. It furthermore holds that termination of pregnancies up to 12 weeks may be performed at all public and private health facilities with a 24-hour maternity service without permission of the MEC (or Minister of Health). It is illegal to terminate pregnancy at an unapproved facility (South African Medical Association, August 2004, and LifesiteNews.com, August 19th 2004).

There is concern among several groups that no specific clause related to the right to conscientious objection was envisaged (Kahn, T., 2004, retrieved 18-08-2004 from www.). A further concern of some is that abortions may not be as safe any more due to less qualified and less experienced staff being employed. The worry is that they may not be well trained to handle complications in an emergency, thus undermining the goal of 'safe motherhood' to some extent.

2. A COMPARISON BETWEEN SOUTH AFRICAN AND INTERNATIONAL ABORTION LAWS WITH REGARD TO THE RIGHT TO CONSCIENTIOUS OBJECTION TO ABORTION

In a global review the laws relating to abortion in 152 countries were studied and the changes between 1985 and 1997 documented (Rahman, A., Katzive, L., Henshaw, S., 1998, retrieved 10-Oct-04 from www.). It was found that 61 percent of these countries have liberal abortion laws while in 25 percent of countries abortion is almost always prohibited. In Nepal abortion is considered murder and is punishable by imprisonment. Much of South America has extremely restrictive legislation; and abortion is illegal, with no exceptions, in Chile. Guyana has the least restrictive laws in South America, with conscientious objection not permitted if the life of the pregnant woman is threatened (Cook, R.J., Dickens, B.M., 1999). In almost all countries, even where the final choice as to whether to continue the pregnancy is left to the mother, some conditions apply. These include the length of gestation, consultation with third parties, obligatory counselling, waiting period before abortion and restrictions with regard to approved facilities and medical practitioners. No global consensus about the moral status of the foetus, or the legal or moral acceptability of abortion, thus exists.

Access of women to safe abortion has, however, been found to depend not only on its legal status but also on the way in which these laws are interpreted and enforced (Cook, R.J., Dickens, B.M., Bliss, L.E., 1999). Attitudes of the general community as well as of the medical establishment have profound effects on the opportunity of women to access abortion services. In Ireland, for instance, although abortion is permitted under severely restricted conditions, it is not performed. One

possible reason for this is that the Irish Medical Council does not admit that there are any existing circumstances that might medically justify abortion. Thus, in Ireland, performing an abortion might give rise to the charge of medical misconduct with resulting implications that the practitioner would prefer to avoid. Where the state entitles (as opposed to merely permits) abortion, structures are put in place to ensure that access is available. Under these circumstances facilities are provided and staff are trained. This occurs in Denmark and France and officially occurs in South Africa, albeit under resource constraints. The right to conscientious objection is less likely to be invoked where general acceptability by the population is high and health care providers are well trained in modern procedures.

This lack of acceptability has been found to be a problem even in the United Kingdom (International Planned Parenthood Federation, European Network, January, 2004, retrieved 09-10-2004 from www.). A survey of young doctors in Obstetrics and Gynaecology units in Britain found that objections to performing abortions were often unrelated to religious or ethical belief. Although they invoked the right to conscientious objection, the true reasons were thought to be a lack of training or commitment.

The British Abortion Act of 1967 allows that a registered medical practitioner shall not be guilty of an offence when he/she performs an abortion, if two medical practitioners are of the opinion that termination of pregnancy would be in accordance with the provisions of the law relating to abortion. There is provision in this law for conscientious objection to participation in treatment. It states that, " No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection". However, in case of litigation, the medical practitioner who refused to be

involved with termination of pregnancy would be expected to justify his conscientious objection. Any duty to participate in treatment essential for preserving life or preventing grave permanent injury to the physical or mental health of the pregnant woman remains (Abortion Law Homepage, Abortion Act, 1967, retrieved 08-Aug-03 from www.).

A medical doctor in Scotland was denied a General Practice training post at Glasgow University because of his insistence that he would not perform (or prepare patients for) abortion, on the grounds of his religious beliefs. It was later admitted that this occurred against the stated practice of the Royal Glasgow Infirmary (Barratt, H., 2001, retrieved 13-Jul-03 from www.). In practice, the British Medical Association advises that the completion of the statutory form for abortion would not be obligatory since it is covered by the conscience clause, but that there would still be the moral duty to refer to another practitioner. It seems that, generally, doctors are not required to authorise or perform abortions, but will be expected to be involved in preparation of patients for the procedure, and arrange referral (Saunders, P., 1996, retrieved 13-Jul-03 from www.). British law did not allow refusal by a secretary to type referral letters for abortions in the case of *Janaway vs. Salford Health Authority.* Interestingly, the European Court of Human Rights censured British ruling that would not provide funds for anti-abortion leaflets in election campaigns, as it was expected that courts should balance the claims of all parties who had an interest in the issue of abortion (Cook, R.J., Dickens, B.M., 1999). Thus this international court recognizes the claims of those who object, on grounds of conscience, to providing abortion.

American abortion law differs in many respects from the British law. In 1973 in the case of *Roe vs. Wade* the United States Supreme Court held that abortion was a constitutional right on the grounds of the 'right to privacy'. Although the court had an

interest in protecting foetal life it was held that this interest did not become compelling until foetal viability in the third trimester of pregnancy (Abortion law Homepage, Overview of American Abortion Law, retrieved 08-08-2003 from www.). Being a matter of constitutional law, this ruling (based on the 14th Amendment to the United States Constitution) can only be reversed by a majority ruling of the Supreme Court. The right to abortion does not imply an obligation on the state to provide abortion, but rather a right to non-interference in the private affairs of the individual, in this case to procure abortion. There is consequently no obligation on the part of health care practitioners to provide abortion – unless they have been employed on that basis by an individual institution. There is thus, legally, no conflict between the rights of pregnant women and individual health care providers. In some states there is the provision that objectors (often these are not health care providers but concerned members of the public) may not obstruct access to clinics (Rahman, A., Katzive, L., Henshaw, S., 1998, retrieved 10-Oct-04 from www.). It is also illegal in France to obstruct access to abortion clinics.

Abortion legislation in several European countries includes a 'conscientious objection' clause. These include Austria, Denmark, France, Italy, Luxembourg, Portugal, Slovak Republic, Spain and the United Kingdom. In several of these, notably Austria, Luxembourg, the United Kingdom and particularly Southern Italy, conscientious objection is believed to limit pregnant women's access to safe abortion (International Planned Parenthood Federation, European Network, January 2002, retrieved 09-10-2004 from www.). Poland is the only European country to have introduced more restrictive abortion legislation, which is made even more onerous for the pregnant woman seeking abortion because of the widespread reluctance of medical practitioners to perform abortion, on religious grounds. Denmark amended

its abortion law in 1989 to allow for the right of conscientious objection for health care providers and students. In countries where there is no explicit provision for conscientious objection, it is usually implied (Cook, R.J., Dickens, B.M., 1999). Thus, in spite of the fact that in most countries liberal abortion laws together with widespread community acceptance of abortion led to a decrease in the number of illegal, and even absolute numbers, of abortions (abortion often going hand-in-hand with counselling and contraceptive advice and education), it still remains that coercion of health care providers to act against the dictates of their own conscience is widely regarded, even by the European Court of Human Rights, as unacceptable – within reasonable limits which require definition.

3. THE MORALITY OF ABORTION AND ITS IMPLICATIONS FOR THE RIGHT TO CONSCIENTIOUS OBJECTION IN A MULTI-CULTURAL SOCIETY

The life of the foetus begins at conception, the twenty-four hour process of fusion of the sperm with the ovum. After approximately fourteen days that embryo will no longer have pluripotent cells, no longer be capable of twinning, will have the beginnings of a spinal column and will be implanted in the uterus of its mother. It will be a genetically distinct human individual, and yet simultaneously a part of its mother, in direct connection with her via the placenta and completely dependent on her for survival. This total dependence of the foetus makes the mother's choices critically important. By six weeks the foetus will have a heartbeat, at eight weeks a distinctly human form and by twenty weeks a fully developed nervous system and thus the capacity to experience both pain and pleasurable sensations. Babies have survived independently of their mothers from a gestational age of twenty-two weeks, with birth normally expected at around forty weeks.

Despite the fact that a genetically distinct individual is created at conception, or at the latest at about fourteen days post-conception, it has not been obvious to everyone, as we have seen in the discussion of international laws relating to abortion, that the individual should be regarded as a 'person' with the interests and rights accorded to a person living in our modern Western world. Even when it is accepted that the foetus has a right to life, that right may not be absolute. For many (if not most) individuals life is regarded as precious, something of great intrinsic (as well as instrumental) value that comes with obligations and responsibilities. Most individuals do not regard a foetus as an expendable body part, like hair that is cut off and thrown

away. Thus abortion is morally problematic. In some circumstances allowing the pregnancy to continue may be worse than abortion – for the mother, the foetus, or both.

The circumstances under which abortion might be regarded as morally permissible will depend, for the individual, on the belief or value system on which her life is structured. Health care providers, also, live their lives according to some set of internalised values or guiding principles so that, when these beliefs do not permit the abortion of a human foetus, the right to conscientious objection to this procedure is a very important legal concession. I will look briefly at the main ethical theories relating to abortion as well as the beliefs of the major religious groups in South Africa. All of these belief systems are to be found in a multicultural society such as the one in South Africa and therefore impact on the importance of the right to conscientious objection.

The Moral Status of the Foetus – Personhood

Under South African law the foetus is not regarded as a person and has no rights to life (Sarkin, J., 2000), that is, it is not a legal person until it has been born alive. However, after live birth, it has full human rights including the right not to have been harmed before birth (Dhai, A., Moodley, J., McQuoid-Mason, D.J., Rodeck, C., 2004). For many the moral permissibility of abortion hinges on just this concept of the status of the foetus and whether or not it is a 'person'. Michael Tooley (1972, A Defense of Abortion and Infanticide, in Feinberg, J., 1973, p. 89) defines a person as an individual who requires certain properties to have a right to life, stating that, "An organism possesses a serious right to life only if it possesses the concept of a self as a continuing subject of experiences and other mental states, and believes that

it is itself such a continuing entity". On this view of personhood no foetus is a person with a right to life because no foetus reaches this stage of development. A newborn baby does not fit this view of a person either, so someone with this belief might condone infanticide also.

On the other hand, someone who does not believe that the foetus is a person with rights might object to abortion on other grounds. Tooley argues that the absence of a right to life does not necessarily imply an absence of any rights whatsoever. A kitten, according to him, has a right not to be tortured but no right to life. In accordance with this view it might be considered that even if a foetus has no right to life it may have a right not to be subjected to pain. Certainly the mother and healthcare providers have a moral obligation not to cause unnecessary pain. This would be respected only by very early abortions, before the development of sentience. Some health care providers might thus object on grounds of conscience to being involved with a mid or late trimester abortion, but not with a very early one.

The Moral Status of the Foetus – Christianity and the teaching of the Roman Catholic Church regarding the Right to Life

The belief of the Roman Catholic Church is completely contrary to Tooley's position. The teaching of the church is that every living human individual is a person from the time of conception, with the grave consequence that any procedure intended to end the development of that individual is wrong, indeed a mortal sin (Pope John Paul II, 1995). The foetus has the same right to life as any other human individual, and abortion is murder. It is specifically directed that the life of the foetus may not be ended to save the life of the mother, for instance when the woman has life-threatening cardiac disease or breast cancer exacerbated by the advancing pregnancy, or,

commonly in South Africa now, acquired immune deficiency syndrome. However, a hysterectomy performed for uterine cancer would be acceptable according to the so-called '*doctrine of double-effect'* because the purpose of the procedure is to remove the uterus, with foetal demise an unintended consequence. Termination of pregnancy is not intended in this case. Even when both mother and child might die as a consequence of continued pregnancy, and when aborting the foetus would save the life of the mother, for example in cases of severe pregnancy-induced hypertension, abortion would be morally unacceptable according to Roman Catholic doctrine. In the event of rape a woman would be permitted to take measures to prevent the 'invasion of her ovum' by 'a foreign assailant' (Finnis, J., 1994, in Kuhse, H. and Singer, P., 1999). Self-defence measures would include the use of a 'post-coital pill', but abortion would still be forbidden, as the foetus is not responsible for the aggression of the father. Screening for, and abortion of, abnormal foetuses is not permissible.

It is seen, then, that a healthcare provider accepting, and living her life in accordance with these beliefs, could not be involved in procuring abortions without loss of personal integrity. She could not even agree that abortion should be a matter of personal choice or that referral to someone who would do the abortion is acceptable. The issue is stronger than conscientious objection. Abortion would not be considered permissible at all, for anyone, since it is not an issue of Catholics having a right to their own beliefs and other groups to theirs, but of the "rights of all unborn foetuses", Catholic or otherwise. The aim is to protect the lives of the innocent (Roger Wertheimer, 1971, Understanding the Abortion Argument, in Feinberg, J., 1973, p.36). However, according to the church, care for the pregnant woman remains obligatory, and peripheral activities related to abortion are

permissible as long as these are not seen to be promoting, and are not promoting, the termination of pregnancies (Treloar, A., Treloar, J., Williams, A., Au-Yeung, P., 1995, retrieved 08-Jul-03 from www.).

These views of the Catholic medical practitioner, if strongly held, may be problematic in South Africa where the single greatest cause of maternal mortality (about 30 percent) is AIDS (acquired immune deficiency syndrome), the second (about 21 percent) being pregnancy-induced hypertension (Moodley, J., 2003). Frequently, in the latter case, the mother's condition only improves by terminating the pregnancy prematurely, usually at an advanced gestational age. My view is that the Catholic medical practitioner needs to explicitly state his objections, in advance, to patients or to employing bodies. If even referral is a problem for him, he is morally obliged to inform the pregnant woman seeking abortion where she can get information about and access to abortion: in order to avoid paternalism, to respect her rights, and to respect her as an individual.

Rights of Autonomy of the Pregnant Woman

Judith Jarvis Thomson (1971, in Sher, 1996) insists that a foetus' right to life is less important than the right of a woman to determine what happens to her own body. She uses her well-known example of the talented unconscious violinist in renal failure, using another's kidneys against her wishes in order to prolong his life. This analogy is problematic in that, in most cases, the woman has been a willing participant in the creation of the foetus. Thomson believes (retrieved 26-Apr-03 from www.) that there should be no limitations surrounding abortion, because this would involve infringement of women's rights and insult to their moral integrity. This might be an overly optimistic assessment of the knowledge and capabilities of a large

proportion of the young women seeking abortions. Not all pregnant females are mature, reflective and well educated women; they are frequently frightened young girls who do not know where to turn. The requirement (in South African abortion law) that access to counselling and post-abortion contraceptive services be available (but availed of at the pregnant woman's discretion) is essential for provision of much needed education and support, whatever the eventual decision. These services are not always adequate, however, and their absence could be a major reason for objection by health care providers to involvement in providing abortions.

Joel Feinberg (in Sher, G., 1996) argues that a woman's autonomy with respect to her own body is limited by the responsibility that she has for the conception. He argues that a woman's 'property rights in her own body' does not outweigh the foetus' right to life, and neither could the foetus be regarded as an aggressor, even in the case of rape. He does, however, believe that the woman would be justified, morally, in defending herself against the threat posed by the foetus if her life was in jeopardy.

The Moral Status of the Foetus – A Future of Value

Another argument against abortion is the one propounded by Don Marquis (1989, in Kuhse, H. and Singer, P., 1999). He argues that the foetus would be deprived of all its future experiences, and that abortion thus involves the wrongful destruction of 'a future of value'. This view could result in conscientious objection not only to abortion, but also to supplying contraceptives, especially those that, like intra-uterine devices and post-coital pills, have their effect after conception. The foetus itself is not the one that will suffer from being deprived of its future – though society might. The pregnant woman should not (hardly ever) be expected to sacrifice

her rights for the sake of the interests of the society, though. One might also argue that not all foetuses have a 'future of value' and that this can be demonstrated in many cases by doing early tests to determine the presence of severe inherited or other disorders which are incompatible with life outside the uterus, or would only result in a life of extreme suffering for the child and its family.

Unborn humans do have a potential future of value, however. Brown, M.T. (2002) argues against Marquis that people do not usually have rights to what they need to achieve their potential. Children do, of course, have the right to the fulfilment of their health needs. But there are limits, even to those rights. As Cook, R. (1998) argues, parents are not obligated to provide organs, bone marrow or even blood transfusions in order to save the lives of their children! So a 'potential future of value' of the foetus might not (to my mind) be a sufficient basis for overriding the legal rights of the mother. It would be a reason for an appeal to a moral obligation, though. One would make great efforts to persuade a parent to donate blood for their child, if required (when no other, guaranteed disease-free, compatible blood was available); be more understanding if he felt unable to donate a kidney; and would not permit the gift of a heart (from a live parent) to a child requiring a heart transplant. In the same way, it would not be plausible for a conscientious objector to expect a pregnant woman to endanger her life or health, or, possibly, even expect very large sacrifices from her and other members of the family.

Ethical considerations – Irrespective of Rights

There are some very bad consequences that attend unavailability of access to legal abortion (Warren, M.A., in Singer, P., 1993). These include the cost to society of raising unwanted, abandoned children and 'backstreet' abortions with the attendant risks to the health of the pregnant woman. As we shall see this is one of the main reasons for the implementation of *The Choice on Termination of Pregnancy Act*, and may be a reason to attempt to limit conscientious objection.

The 'virtue theory' perspective (Hursthouse, R., 1991) focuses on the morally worthy course of action rather than on the rights of the foetus or the rights of the pregnant woman. Although the foetus may not have moral or legal rights, there is the belief that the mother is morally responsible for the foetus. As stated above, this is, legally, the case in South Africa, for although a pregnant woman has the right to termination of her pregnancy she is legally responsible for any harm caused if the foetus is born alive. She does, however, also have other responsibilities, and needs to consider those: in relation to her other children, an abnormal foetus, possible future children and all this in relation to her life as a whole. Although abortion is inherently bad, according to the virtue theorist, and feelings of guilt and remorse are appropriate, whether or not abortion is the morally right course of action is dependent on the motivation, and attitude to life in general, of the woman having the abortion. This again highlights the possibility that an objecting health care provider holding this view might be as concerned with the circumstances, under which the decision to abort is taken, as she is about the actual abortion. She may want to be convinced that the pregnant woman is certain (or at least sufficiently confident) that the correct choice has been made.

The Intrinsic Value of Life

Ronald Dworkin (1994) believes that abortion is morally problematic because of an almost universal belief in the 'sanctity of life'; that life itself has 'intrinsic' value. It is this belief that makes it regrettable when a life is lost, and makes the decision whether or not to have an abortion such a serious one. He rejects the notion of the foetus as a 'person with rights to life', arguing that virtually no one actually believes that a foetus is such an individual from the moment of conception. This conflicts with official contemporary Roman Catholic doctrine in 'Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation', (1987, in Dworkin, R., 1994. Life's Dominion. p.39). However, the older view of the Roman Catholic Church was that abortion could not be condoned 'because it insults God's creative gift of life'. The belief that human life itself is sacred, intrinsically of value, is independent of the value that an individual places on his life or on any specific purpose for that life. The foetus, that does not yet have any concept of its own value, has this intrinsic value.

Dworkin would not have us outlaw abortion, but his view is more complex than that of the moral permissibility of abortion being dependent on whether or not the foetus is a person with a right to life. On his view, belief in the intrinsic value of human life expresses itself across a spectrum where maximal weight is placed on 'natural investment' (and thus the life of the foetus) at one end, and maximal weight on 'human investment' (and so on the mother and her concerns) at the other. (If the mother's life were threatened, there would be concerns about the 'natural investment' in her life also, in addition to the 'human investment'.) Thus abortion may or may not be thought to be acceptable, depending on where one's beliefs fall, on this spectrum.

There are implications for the healthcare provider who takes this view of the value of life. Someone holding that the 'natural investment' in a human life is of prior importance would be reluctant to agree to abortion (possibly even abortion of a severely abnormal foetus), for it is life itself (regardless of purpose and length of survival) that is valuable. One who is convinced that 'human investment' in a life should not be frustrated would be more likely to believe that abortion is justifiable, in order not to impair the quality of life of a pregnant woman. The energy she has invested in her life is seen to have more importance than the fact of life itself. Usually it is not a simple matter of a choice between the importance of 'human investment' or 'natural investment'. It is a matter of striking the right balance. Thus, when considering abortion, it is necessary for the pregnant woman to evaluate all the circumstances and have full understanding of the procedure and options open to her. Lack of these provisions might lead to a decision by a healthcare provider to conscientiously object to performing abortion, just as it would for the individual subscribing to virtue theory.

My own belief is that life is a precious gift to be respected, treasured in oneself and others, and lived responsibly. Thus abortion of a severely abnormal foetus with extremely limited future prospects (if that is the pregnant woman's wish) seems to me to be an act of kindness resulting in gain (even though a life is lost) for all concerned. The foetus also gains, for it is, potentially, spared much suffering.

Islam

The 'sanctity of life' is a doctrinal concept taught by most of the major religions. It applies in Islam where according to Shariah, the Divine Islamic law, deliberately terminating a pregnancy is generally forbidden, as the right to live is

given by God alone. Life is the most highly prized gift of God. However, prior to four months gestation, before the formation of limbs, abortion is considered to be a major sin, but is not regarded as murder, and so exceptions are allowed on medical grounds. These exceptions are rape, incest, a mentally retarded mother, foetal abnormality and threat to the life and health of the mother. After four months abortion is considered to be murder except when the pregnant woman would die as a result of continued pregnancy. This exception is made because the mother is regarded as having pre-existing obligations that the foetus does not have, for instance to other children already born (in Christofides, P., 1996).

According to Khalifa, A.A. and Strickland, C. (1997 –2003, retrieved 09-12-04 from www.) these dictates do not demonstrate an acceptance that the life of the mother, and that of children already born, is regarded as having greater value than that of the unborn foetus, but are rare concessions made out of compassion for the pregnant woman. Thus, a devout Muslim healthcare provider could be involved in providing abortions under only very restricted circumstances, for the value placed on the life of the mother must be balanced by the belief that abortion would be an insult to God's creative gift of life, as demonstrated in the life of the foetus.

Judaism

Judaism upholds the sanctity of life and considers abortion, in principle, wrong, even though the foetus does not have the moral or legal status of a person with a right to life. There is one reference in the Torah, in Exodus, to what the consequences would be if a pregnant woman, accidentally injured in a fight between two men, had a spontaneous abortion. If the foetus died and the woman was not hurt, then the event would result in a fine. If the woman died, however, the one who

caused her death would be subjected to capital punishment. The conclusion drawn here is that the foetus is not considered to be a person with a right to life. The Talmud considers the foetus to be part of its mother's body and abortion is acceptable to save the life of the mother. After birth it has the same status as the mother, so infanticide would not be condoned. It may not, however, be legitimate to abort a deformed foetus, as it is problematic to attempt to calculate the value of a deformed child (in Christofides, P., 1996). The 1975 Biennial Convention of the United Synagogues of America (in Dworkin, R., 1994. Life's Dominion. p.38) stated, "abortions involve very serious psychological, religious and moral problems, but the welfare of the mother must always be our primary concern."

Christianity – Protestant Denominations

Protestant Christians acknowledge that Scripture does not deal specifically with the issue of abortion, but believe that God, who created man in His own image, is the initiator of life, and determines its end. Whether individuals have a right to life or not cannot be legitimately questioned, as it is God who determines the beginning and the end of a human life; life is not a 'right' but a gift from God to be respected and treasured. There are several references in Scripture to God "knowing" certain individuals even before birth while still in "his mother's womb" (Psalm 139, vs.13-16). The various denominational groups are divided about whether or not abortion should be permitted, for certainly there must be respect for the pregnant woman's life (also God-given) as well as that of her unborn child. Even when the option of abortion is condoned, though, it is generally considered to be disrespectful of God's gift of life and so a morally inferior choice, something to be avoided as far as possible.

Hinduism

Vedas, the Hindu Scriptures, strictly prohibit abortion. According to the Vedas the law of cause and effect, or the law of Karma, dictates that any action results in consequences and the act of abortion results in bad Karma. At the time of death the soul transmigrates from one body to another and the fate in a future life is determined by actions in the present one (Christofides, P. 1996). Suffering for sins, in the view of the Hindu, is not the result of action by a punitive God, but is an inevitable result of the law of cause and effect. So the foetus who is the victim of abortion is seen to be struggling to become human, and may be blamed for the failure to be born, this being seen as a result of sinful acts in a previous life. Dr.T.Naidoo (personal communication with Christofides, P., 1996) considers that the main reason for the acceptance of abortion and contraceptives is to enable individuals to gratify the senses, while the Vedas attempts to elevate man from the materialistic to the spiritual realm.

Buddhism

Buddhists do not share the concept of the 'sanctity of life'. They consider such concepts to be convenient ethical constructions created by man to solve existential problems; but they do hold that all forms of life are deserving of respect, including plants (Barnhart, M.G., retrieved 09-12-04 from www.). Buddhism started as a reaction against the attempt by religion and philosophy to seek ultimate solutions and 'to define the indefinable'. It attempts to strike a balance between materialism and religious speculation and is non-theistic (according to Buddhists at the Temple in Kensington, Johannesburg, in communication with Christofides, P., 1996). There is no rigid belief about the permissibility of abortion and, while life is regarded as

precious, difficulties and problems are accepted as an integral part of being human (Louis H.van Loon of The Buddhist Institute of South Africa in Overport, Durban, 1996 in Christofides, P., 1996). Keown, D. (1995, in Barnhart, M.J., retrieved 09-12-04 from www.) argues that most branches of Buddhist tradition are antiabortionist. Japanese Buddhism and some modern Buddhists in the United States are exceptions. Thus many Buddhist healthcare providers might object to abortion - out of respect for all life.

Quality of Life Considerations

Foetal rights to life, even when acknowledged as such, may not always be of prior importance. There are the interests of the foetus itself. Severe (genetic or other) foetal abnormalities are a strong indication for abortion on the grounds of prevention of a life of suffering, for example in the case of Tay-Sachs disease. Such conditions may often be diagnosed early in pregnancy, with the possibility of an early abortion that would not cause pain to the foetus and would involve only minimal physical and psychological suffering for the pregnant woman. In addition, abortion would prevent the suffering involved in watching the pain and demise of the severely handicapped infant.

Kuhse, H. and Singer, P. (1985, and Singer, P., 1994), reject the notion of life as ‘sacred’. Their reason for this view is that the concept of ‘sanctity of life’ is rooted in Judeo-Christian theology and applies only to human life, not to life in general. They find it implausible that there can be reluctance to abort a foetus whose handicap is so severe that it clearly is not compatible with life outside the uterus, while the same significance is not accorded to the life of non-human animals; especially ones such as dolphins and primates whose level of functioning is much higher than that of

a severely handicapped infant without significant potential for development. Peter Singer (1994) asserts that the fact of having human genetic identity is not, in itself, of moral significance. He agrees with Tooley's assessment that a person is an individual with a sense of self "as a continuing subject of experiences and other mental states, and believes that it is itself such a continuing entity" (Tooley, M., 1972, A Defense of Abortion, in Feinberg, J., 1973, p.89). Because a person is able to reflect on the meaning of his life as a whole, and consider his future in relation to his past, it is worse, according to Singer, to kill a person than to kill a creature who is not a person (Singer, P. 1994). As a foetus or infant would not fall within this definition of a person, abortion is not, for him, morally problematic and even birth is not a morally significant event.

Dworkin (1994) also believes (in relation to the question of euthanasia) that it is important for individuals to live their lives as a consistent whole. His conclusion differs, however. It is not that it is less bad to kill a creature who is not a 'person', but, rather, that it is important to make the decision that the individual would have made if he were still in possession of his faculties. But this is not the subject of this research report, and does not apply to foetuses that have never made any life plans. It does, however, indicate respect for the intrinsic value of human life, irrespective of whether or not the individual complies with Tooley's definition of what it means to a person.

Thus we see a spectrum of beliefs with regard to abortion, ranging from the insistence that the right of the foetus to life has priority, even over that of the mother who may not live to care for him, to the view that abortion is a totally insignificant procedure, merely a means of regulating fertility, as has been the norm in the Russian

Federation where as late as January 2002 six out of ten pregnancies were deliberately aborted (Russian Family Planning Association, retrieved 09-10-04 from www.). The belief that God is the creator of life and that this has consequences for one's attitude to all life, especially to human individuals, is not based on facts which have been proved (or disproved) to everyone's satisfaction (though many who have that belief accept the evidence that they find in nature and in their own scriptures). Even if one has that belief, however, there is no consensus, as seen above, that there is a resultant prohibition on all abortions. It does mean, though, that abortion is not morally insignificant.

My belief is that abortion is, on occasion, morally required: for instance, on the grounds of prevention of suffering of a severely handicapped foetus, its mother and family, and when the life of a pregnant woman is in jeopardy. On other occasions it may be morally permissible or morally questionable. This is where the dilemma of where to draw the line (Selgelid, M., 2001) affects the potential conscientious objector, together with the fear that allowing abortion in one instance may progress to an uncontrolled (and uncontrollable) slide down the slippery slope. This difficulty in setting limits will lead to many conscientious objectors (who might not object to the performance of all abortions) withdrawing altogether from providing abortions. In reality, in the hospital or clinic setting, where abortion is a legal right, it is probably not possible to agree to perform an abortion on one pregnant woman and refuse another, or even to make that judgement. So the spectrum of beliefs, all of which are held by groups of individuals in the Republic of South Africa, impacts on access to abortion, by way of the beliefs of health care providers who object on grounds of conscience to involvement in the process of abortion.

South Africa is a multicultural society with individuals representing all the major religions and moral belief systems discussed, as well as those who profess no affiliation. Seventy to eighty percent of South Africans profess to be Christians. Within this group falls twenty-five percent of the total population who belong to African Independent Churches, the largest group of four million being the Zion Christian Church. Muslims make up about two percent and Jews one and a half percent of the population, with Hindus being one of the other major religious groups. Most of the rest have no religious affiliation. This suggests that there is no consensus regarding the morality of abortion among individuals in South Africa. There is in South Africa a separation between mosque/ temple/ church/ synagogue and state, and yet our Constitution upholds the right to freedom of religion. From the above discussion it is evident that the right to conscientious objection to abortion is integral to the right to freedom of religious practice.

One of the major strengths of a pluralistic society is the freedom afforded to individuals. However, the right of health care providers to express their own beliefs by refusing to participate in abortion provision has been cited as a factor preventing pregnant women from accessing abortion services, thus impinging on their (positive) freedom. The response by the Minister of Health to this state of affairs was that health workers should 'place their duty before their beliefs' (Bateman, C., 2000). A further look at the statistics (to be done later in this report) demonstrates that there is no consensus in the population at large, or in the health care provider population, about the moral acceptability of abortion, thus reinforcing the view that the right to conscientious objection should be upheld. Paradoxically, the argument that conscientious objection be permitted on the grounds of toleration of religious and cultural differences adds strength to the requirement of referral to a non-objecting

practitioner, for it would be inconsistent to use this plea oneself while not accepting it on behalf of others with a different view. The conscientious objector could not expect that his claim (to a right to conscientious objection) be respected (on the grounds of toleration of a multiplicity of moral beliefs in a multicultural society), without himself applying that same principle to others; such as the pregnant woman who believes that it is right for her (in her specific circumstances) to have an abortion, or another healthcare provider (who may consider it right to perform abortions). Thus the right of healthcare providers to conscientious objection to abortion cannot be unlimited, for others (pregnant women seeking abortion) also have their rights. I will consider the issue of the origin of duties and obligations in relation to beliefs later in this report.

4. THE SPECIAL IMPORTANCE OF FREEDOM OF ACCESS TO ABORTION FACILITIES IN SOUTH AFRICA

Aims of *The Choice on Termination of Pregnancy Act*

As seen earlier, the present South African abortion law aims to firmly establish the autonomy of pregnant women regardless of income, age, or social and marital status. These conditions did not obtain in the past where the application of restrictive legislation discriminated against the poor, mostly black people, and so came to be associated with the racist policies of the previous government. So a further aim (of the present law) is to redress these grievances resulting from the past. Discrimination against poor pregnant women under conditions of severely restrictive abortion legislation is not peculiar to South Africa, but is usually based on social status rather than being a racial bias. It has been found to be the case in Chile and in Nepal where rich women have safe abortions in private institutions with small risk of prosecution. The poor, in these countries where abortion is illegal, run the risk of harm from unsafe (illegal) abortions and are often reported to the authorities when they then seek medical attention at public hospitals. In Nepal it has been estimated that two-thirds of the women presently serving prison terms have been convicted of having an abortion, regarded in that country as criminal homicide (Rahman, A., Katzive, L., Henshaw, S., 1998, retrieved 10-Oct-04 from www.)! South African legislation has ensured that women cannot be prosecuted for having an abortion accessed through the correct channels, using designated health care providers and facilities.

Present abortion legislation also aims to improve the lives and health of all women, particularly with regard to reproductive healthcare: on the basis of human rights. Unsafe, or so-called 'backstreet', abortions were a major problem in South Africa before the new legislation took effect. It was estimated that 44,686 women were admitted to South African state hospitals annually following incomplete abortions, with more than 30 percent showing signs of having submitted to unsafe abortion procedures. Approximately 425 women died each year in public hospitals as a result of these procedures (Dickson-Tetteh, K. and Rees, H., 1999). Statistics from the three-year period 1999-2001 indicate that there were 120 maternal deaths related to abortion, that is, on average 40 per year (4.9 percent of total maternal deaths). Of the deaths from complications of abortion, 30 percent were a result of illegal termination of pregnancy, that is, on average 12 deaths per year (Department of Health, 2002, in Moodley, J., 2003). Thus, according to the above statistics, there is a huge reduction in deaths related to self-induced abortions, with the number of deaths due to legal terminations and spontaneous abortions now outstripping those from unsafe abortions.

A further goal is to entrench gender equality. Although equal in law, many South African women have limited powers of negotiation. There are many reasons for this, of overwhelming importance being economic considerations. Women are far more likely to have the major share of household and childcare responsibilities and so usually earn less than their spouses and are often financially dependent on them. There is also the question of acceptability of abortion within a particular culture. A woman may decide to go against the norms of her culture and would risk being ostracised if consent from spouse or guardian were a prerequisite for abortion. Giving women access to abortions without charge and without requiring consent from a

partner or guardian frees them from this dependence. It then becomes their own choice as to whom they wish to consult.

This particular issue may be a very important consideration for a healthcare worker in deciding whether he can in good conscience agree to terminate a pregnancy. He might believe that the father of the human life to be terminated also has an interest, maybe even a right, in making the decision. He might similarly believe that the parents of a young girl who wishes to abort her pregnancy, and who is financially and emotionally supported by them, should at the very least be aware of the circumstances in order to provide support which would, in the event of abortion, become even more important. The potential conscientious objector is likely to require assurance that the pregnant woman has indeed been counselled and made aware of all these issues and the various options open to her.

Gender Violence

Related to the issue of the limited powers of negotiation of women is the one of abuse and rape of women and children, which has now reached epidemic proportions in South Africa. Even during pregnancy the incidence of domestic abuse (52 percent physical abuse) showed a prevalence of 35 percent during the current pregnancy in a study performed at King Edward VIII Hospital, Durban, during a six-month period in 2000 (Mbokota, M., Moodley, J. 2003). Six hundred and four women in a low-income population, attending the antenatal clinic, were interviewed in this study. This figure of 35 percent (abuse during pregnancy) compares with the much lower estimated figures, reported in the USA, that range from 4 – 17 percent. High levels of general violence are endemic in South Africa. Much of this aggression

is aimed at women and girls but only a small minority (7 percent) of offenders received a prison sentence for rape, according to Bowley, D.M., Pitcher, G.J., Beale, P.G., Joseph, C., Davies, M.R.Q. (2002). The Red Cross Children's Hospital, Cape Town, showed an increase in the number of children treated for injuries as a result of rape from 8 per year (1978 – 1989) to 22 admissions per year (1991 –1999) (Bowley, D.M., Pitcher, G.J., et al, 2002). In 1998 a countrywide figure of 47.1 cases of rape (per 100 000 inhabitants) or attempted rape of children under 17 years were reported. Victims personally know seventy percent of offenders, with schoolteachers forming the highest number (Jewkes, R., Levin, L., et al, 2002). During October 2004, in Mpumalanga province alone, there were 80 reported cases of rape of children, according to the provincial police commissioner. Approximately half of the perpetrators of these crimes were close relatives (Kuhlase, Z., Arenstein, J., 2004).

Although it is likely that few healthcare providers would object to aborting a pregnancy occurring in the above circumstances, it seems to me preferable to minimize the conflict of rights (and harm to the victims) from the outset. With the informed consent of the woman or young girl (together with her parents, if possible), I would agree to giving immediate prophylaxis for HIV (human immunodeficiency virus) together with a so-called 'morning after' pill that would prevent implantation of any fertilized ovum. This would be acceptable, even to most espousing the Roman Catholic faith, but the same moral dilemma remains as would obtain with an intra-uterine contraceptive device where it is possible that fertilization of an ovum may already have taken place. Even so (during the first fourteen days), it might not yet be a distinct human individual (the cell is pluripotent) but only have the potential to become an individual. When using a post-coital pill the woman would not become pregnant since implantation would not occur, and she would never know whether or

not conception had occurred: so resulting in much reduced psychological trauma for her. There is no issue about sentience of the foetus at such an early stage.

The Human Immunodeficiency Virus

The human immunodeficiency virus (HIV) with the resulting acquired immunodeficiency disease syndrome (AIDS) is of major importance, particularly in the type of setting described above. As seen earlier AIDS is now the leading cause of maternal mortality in South Africa (Moodley, J., 2003). It is not thought to have had a major impact on the number of terminations of pregnancy, though, for most women were reported not to have had an HIV test before abortion (Seepe, J., 2001, retrieved 08-Oct-04 from www.). There is an additional problem in South Africa related to myths surrounding HIV that could explain the increasing incidence of rape of young girls and even babies. Interviews with participants in a sexual health workshop in 2000 revealed that almost one third thought that sexual intercourse with a virgin could cure HIV (Bowley, D.M., Pitcher, G.J., et al, 2002).

There are a number of implications of HIV for the need to access abortion and thus also for the right to conscientious objection. A study in India assessed the impact of pregnancy on women living with AIDS (Kumar, R.M., Uduman, S.A., Khurrana, A.K., 1997). Fifty-six percent of the pregnant women died within 17 months of conception whereas twenty-six percent of the non-pregnant women died within 42 months of being diagnosed with AIDS. Only three babies from a total of thirty-two pregnant women survived more than six weeks after delivery – of a total of fourteen delivered. This is the result of the combined effect of both the HIV and pregnancy on the immune system. Both decrease immunity, thus leading to increased susceptibility

to opportunistic infections and malignant growths. However, pregnancy does not significantly affect the progress of HIV disease in the very early phase (Evian, C., 2000).

International guidelines insist that pregnant women living with HIV and AIDS should have access to safe abortion, should they so wish (Cook, R.J. and Dickens, B.M., 2002). This right is implied in abortion laws where abortion is permitted for reasons related to the life and health of the mother, according to Cook and Dickens (2002), and is specifically stated in the 1995 abortion law of Guyana. A medical practitioner may refuse on grounds of conscience to be involved in the process of abortion under these circumstances, but not for the reason that the pregnant woman is HIV positive. Healthcare workers may not discriminate against individuals because of their HIV status although they might refer them to another facility where they would be guaranteed to receive superior care. Indeed, the HIV positive status of a pregnant woman might be considered to be a morally valid reason NOT to object to performing an abortion, especially in resource poor settings where anti-retroviral agents are not supplied to pregnant women, or to their babies who have an approximately 30 percent chance of becoming infected. HIV positive infants seldom survive beyond the age of two years.

This tragic state of affairs can to a large extent be prevented, however, for one dose of Nevirapine given to the mother during labour together with a single dose to the newborn within 72 hours reduces the incidence of vertical transmission from mother to child of the HIV by 50 – 60 percent (Evian, C., 2000). The use of the drug Zidovudine (AZT) before and during delivery to the mother, and after delivery to the baby, was shown to reduce vertical transmission by 67 percent compared with

placebo in the 1994 ACTG 076 trial (Lurie, M., Lurie, P., Ijsselmuiden, C., Gray, G., 1999). The High Court in Pretoria, in December 2001, instructed the state (in South Africa) to implement a plan for HIV positive pregnant women to access Nevirapine in order to decrease the incidence of vertical transmission. Breastfeeding the infant increases the risk of transmission by approximately one third, but is still indicated when safe alternative feeding is not available, showing that the risk of death from malnutrition or infection, in the absence of breastfeeding, is even higher than the increased risk of transmission of the HIV.

One might argue that providing abortions (for those who want them) is a sensible solution with enormous benefits in resource poor settings, when the child has such a low chance of surviving beyond infancy. The South African cabinet on 9th May 2003 decided to make antiretroviral agents (ARV) available to the public. It has been estimated that if 50 percent of patients who need ARV treatment actually take it, then 10 –30 percent of new infections can be averted (Pawinski, R.A., Berkman, A., McNally, L.M., Lalloo, U.G., 2003), and for those already living with HIV, the disease can now be managed as a chronic illness (Orrell, C., Wilson, D., 2003). This changes the situation for the pregnant woman whose chances of a live, healthy baby are much increased, and whose own prospects for survival are much better. Pregnancy itself would still reduce the mother's immunity to disease, however, so it is essential that an HIV positive woman be aware of the consequences of her HIV status in relation to pregnancy and childbirth, and be aware of the option to abort.

Without anti-retroviral drugs (ARVs) it might be difficult to justify conscientious objection to an abortion, knowing that the life of a young woman (who possibly already has young children to care for) could be shortened by continuing her

pregnancy, especially when the chances for survival of the infant are also compromised. For the strict Roman Catholic this would still not justify abortion. With the availability of ARVs being a reality, the pregnant woman and infant have a significant chance of survival and even health, so abortion is now not the only plausible solution. Indeed, abortion is not the definitive answer to the pain caused by HIV and AIDS. It is hoped that pharmaceutical preparations may go a long way towards the alleviation of this suffering, but the real solution is, of course, prevention of the spread of the disease.

5. TO WHAT EXTENT ARE THE GOALS OF *THE CHOICE ON TERMINATION OF PREGNANCY ACT* BEING ACHIEVED?

A major factor leading to the acceptance of *The Choice on Termination of Pregnancy Act* was the statistics with regard to 'backstreet abortions' and consequent morbidity and mortality. A national study undertaken in 1994 (Department of Health Document, 2000, retrieved 27-July-2003 from www.) showed that 44 686 women with incomplete abortions were admitted to South African public hospitals each year with 34 percent of these showing signs of being unsafe abortions. Approximately 425 women, each year, died as a result of these unsafe procedures (Dickson-Tetteh, K., Rees, H., 1999).

In order to determine what progress had been made in implementing the act, and whether the goals of the act were being achieved, a national study of all women less than 22 weeks pregnant, attending public hospitals for threatened or incomplete abortions, was undertaken during three separate weeks in the year 2000 and a comparison made with 1994 statistics. The difference in incidence of incomplete abortions (49 653) was not statistically significant, though morbidity was less, but still not statistically significant (Jewkes, R., Brown, H., Dickson-Tetteh, K., Levin, J., Rees, H., 2002). There was one death in this study compared with the three in 1994. This result suggests that the rate of interference (with pregnancy) had decreased and that instead there had been more use of legal termination services. A problem with this study is that it excluded legally induced abortions, thus not providing total numbers of abortions or the complication rate of these legal abortions.

Department of Health statistics for the three-year period 1999-2001 (in Moodley, J., 2003) demonstrated an annual maternal mortality due to all abortions of 120 for the three-year period, or 4.9 percent of total maternal deaths (5.6 percent in 1998) (Moodley, J., 2000). Of these, thirty percent were due to self-induced terminations of pregnancy. That equates to an average annual maternal mortality due to all abortions of 40, and an average figure of **12 deaths per year** due to unsafe abortions. This is a significant decrease in comparison with the 1994 estimate of **425 deaths annually** as a consequence of illegal abortion in South Africa. Globally 13 percent (75 000 women yearly) of maternal deaths are estimated to be due to unsafe abortion (2001, Medical Research Council of South Africa, retrieved 09-12-04 from www.)

The increase in the total number of abortions would be of serious concern to healthcare providers objecting to abortion, as so many more human foetal lives are being lost. However, the substantial decrease in total maternal mortality due to abortion (despite an increase in overall maternal mortality, probably due to AIDS, in the period 1999-2001), might, for many, justify the cost in terms of foetal lives lost. One very positive result has been the decrease in the number of second trimester abortions, which for most individuals is considered a greater evil than a very early abortion, as well as more physically and psychologically traumatic for the pregnant woman (Larsen, J.V., 2000).

Statistics are available until 2001; those for 2002 not yet completed. According to one source, the average number of abortions per 1000 live births in South Africa increased from 27 in 1998 to 46 in 2001, with 100 per 1000 in Gauteng province (the most populous region of South Africa), almost 4 times the national

average (Johnston, R., 2004). The Western Cape 2001 figure is 81 abortions per 1000 live births while in the more rural regions, KwaZulu-Natal and the Eastern Cape, the figure is 19 per 1000. However, Health Systems Trust statistics (retrieved 22-10-04 from www.), show that, in 2001, 19 970 legal terminations of pregnancies (TOPs) were performed in Gauteng, forming thirty-seven percent of the total number (53 973) in South Africa, while in 1997 fifty percent of TOPs were performed in Gauteng.

Though the figures vary somewhat according to the source, they do indicate a trend. Firstly, total numbers of abortions increased with more freely available access to TOP facilities (even adjusting for the increased birth rate). Secondly, although there is a disproportionate number of abortions in the urban areas, that balance is altering, the increase in abortion ratio (abortions per 1000 live births) being mainly as a result of an increase in the rural areas. It has been a matter of concern that the poorest and least educated, that is, mainly the rural women, were still being discriminated against with regard to their right to access free, safe, legal abortion services. Though the discrepancy is diminishing, equity has not yet been attained with regard to the right to reproductive healthcare. Encouragingly, the abortion ratio actually decreased in Gauteng, this despite the fact that the percentage of designated TOP facilities that functioned increased from 44 to 60 percent (year 2000 and 2003). It is to be hoped that the decrease in abortion ratio in Gauteng may be attributed to education regarding contraceptive methods and better use and acceptance of these services, though it may be that demand has now outstripped capacity (Buchmann, E.J., Mensah, K., Pillay, P., 2002). Countrywide, the number of already designated TOP facilities which are functioning has increased from 31.5 percent in the year 2000 to 61.8 percent in 2003 showing much improved availability to the most disadvantaged in recent years.

Maternal deaths per 100 000 live births (MMR, or maternal mortality ratio) was given as 150 in 1998 (van der Westhuizen, C., 2001). Health Systems Trust statistics (retrieved 22-10-2004 from www.) report total maternal deaths as 676 in 1998 and 937 in 2001. Moodley, J. (2003) suggests that a realistic estimate (an accurate record of all births does not exist) of the MMR for 2001 is between 170 and 200/100 000 live births. These statistics display an absolute increase in the maternal mortality from 1998 to 2001 that could be attributed, partly, to better recording of information, according to Moodley. It is certain that the rise in numbers of pregnant women succumbing to Acquired Immune Deficiency Syndrome has had an impact on these statistics, for 31.4 percent died of infections not directly related to the pregnancy in 2001, while in 1998 the figure was 23 percent.

In 30 percent of women who died from complications of abortion, there were signs of unsafe interference with pregnancy (Moodley, J., 2003), this despite the fact that abortion is legally available, free of charge. Thus the majority (70 percent) of abortion-related deaths are not due to illegal procedures, but are a consequence of complications related to spontaneous abortion or legally terminated pregnancies. This is offset, as seen earlier, by the fact that the total numbers of abortion-related deaths have significantly decreased. The availability of blood for transfusion impacts hugely on maternal mortality in general, as does a lack of transport. The lack of transport may be a reason why women still resort to unsafe abortion procedures.

A study (Department of Health Document, 2000, retrieved 27-07-2003 from www.) was undertaken in Gauteng during the year 2000 to determine the reasons why so many women admitted to public hospitals with incomplete abortions still showed signs of illegal termination of pregnancy. This occurred, even in Gauteng province

where the provision of services should have been adequate. Almost one third of women admitted to interference, much the same proportion as obtained prior to the new legislation. The reasons given were that 55 percent did not know about their rights to legal termination of pregnancy, 17 percent were intimidated by hostile hospital staff, 15 percent did not know where to access the service, 7 percent feared disclosure to family and acquaintances, 4 percent were obstructed by too long a waiting list, and 2 percent were in too far an advanced stage of pregnancy. There were also many women who wished to be cared for by their general practitioners. On the basis of the above statistics, reluctance by health care providers to participate in pregnancy termination was deemed to be a significant obstacle to women seeking abortions, though it would seem that this is often not explicitly stated. This intimidation of pregnant women seeking abortion is morally and legally unacceptable: conscientious objection should be explicitly recorded and the woman referred to a willing provider.

Many women are given the abortifacient drug misoprostol by their general practitioners and then referred to designated facilities for completion of the process. This practice has been legal since 1997 (provided the general practitioner has been registered to provide this service), though surgical intervention may not take place outside a designated facility. Women (in the above survey) who had been given misoprostol would still, for statistical purposes, have been included in the 'unsafe abortion' group (although they were not exposed to those hazards) thus inflating the numbers attributed to actual unsafe abortion. A finding (Varkey, S.J., Fonn, S., 1999) nationwide was that women using legal abortion services were mainly educated, single, older, students, unemployed and multiparous. This contrasts with the finding, internationally and before the new abortion law in South Africa, that

women who have unsafe abortions are mostly young, single, unemployed and pregnant for the first time. So these younger women may still be having illegally induced abortions, accounting partly for the still high numbers.

The above factors leading (in the Gauteng survey) to the occurrence of unsafe abortions would be relevant also in rural areas. In addition, in 2000, there was still a severe shortage of facilities in these rural areas and lack of staff willing to perform abortions, leading to exhaustion of those who did. This was cited as a major reason for the few pregnancies legally terminated (Bateman, C., 2000). There was also found to be a lack of co-operation and communication between private general practitioners willing to perform abortions and public health institutions (Bateman, C., 2002). Conscientious objection by health care providers, sometimes expressed in the form of aggressive behaviour towards pregnant women, appeared to be a factor preventing them from availing themselves of their constitutional rights, in rural as well as urban areas. In response to this state of affairs the Minister of Health asserted that health workers should 'place their duty before their beliefs' (Bateman, C., 2000).

As stated earlier it has been found internationally, also, (Rahman, A., Katzive, L., Henshaw, S., 1998, retrieved 10-Oct-04 from www.) that the availability of safe abortion services is not determined solely by the legality of the procedure. In the Netherlands and parts of Belgium medical practitioners provided safe abortion even before the procedure was legalized and resisted performing the procedure in Poland despite it being lawful. Polish physicians in 1991 pronounced that abortion was unethical except in very restricted conditions, although abortions were legally permissible. The attitudes to abortion of health care providers appear to be a reflection of the beliefs of the community at large. A look at how *The Choice on*

Termination of Pregnancy Act, 1996 came to be passed will provide insight into the resistance of large sectors of the community, and that of many health care providers, to abortion and involvement in that process.

With a new government in power under the African National Congress in 1994, and their commitment to women's health and redressing past imbalances, the environment was conducive for the efforts (of those parliamentarians and members of non-governmental organisations committed to implementing women's rights and reducing the numbers of unsafe abortions) to bear fruit (Varkey, S.J., 2000). Data presented to the South African Parliament regarding the numbers of women admitted to public hospitals with incomplete abortions, 45 000 per annum, and deaths from the ensuing complications, 425 per annum, led to the passage of the act (Althaus, F.A., 2000). The leadership of the African National Congress ordered all their members of parliament to vote in favour of *The Choice on Termination of Pregnancy Act.* Thus, because of minimal research and negotiation (Sarkin, J., 1999), there was no general commitment to this law, among the public, healthcare providers, or even members of parliament, when the act was passed.

A survey undertaken by the Democratic Nurses Association of South Africa in 1997 demonstrated that 64 percent of their members were against *The Choice on Termination of Pregnancy Act* (Bateman, C., 2000). Two to three years later (Varkey, S.J., Fonn, S., 1999) healthcare workers had reservations about the act. Fifty-six percent of those actually conducting abortions found 'abortion on request' to be morally acceptable. Eighty-one percent thought that women should be free to consent without partner's approval, while only thirteen percent believed that no parental consent ought to be required for minors seeking abortion. Religious practice affected

the attitude towards abortion, with nurses believing that they were committed to saving lives, not ending them. As seen earlier the influence of religious practice in South Africa is huge. A recent survey (South African Press Association, The Star 05-11-2004) by the market research company, Research Surveys, found that only 24 percent of urban-dwelling South Africans are in favour of abortion on demand. There were racial differences, with 30-31 percent of whites and Indians in favour and only 16-20 percent of coloureds and Africans in favour. Amongst all females in favour of abortion on demand, only 21 percent accepted that specifically trained nurses should be permitted to perform abortions, unaided by a medical doctor. This very general lack of acceptance, by health care providers and the general public, of the right to minimally restricted abortion, is a powerful justification for maintaining the right of healthcare providers to object on grounds of conscience to involvement in the abortion process.

How might the conflict between the rights of pregnant women and health care workers be minimized? With epidemic proportions of abuse of women, and myths relating to HIV infections leading to the rape of increasingly younger girls, the availability of safe termination of pregnancies and emergency contraception has become extremely important. Shortage of antiretroviral supplies and inadequate education about their proper use (Sookha, B., Packree, S., 2004) make the option of abortion vital for the health of many women. There are few medical practitioners who would object to performing abortions under these circumstances, and yet, abortion should be a last resort, for there is no doubt that prevention of the pregnancy in the first place and control, even prevention, of the HIV infection is preferable. That is the ideal. Abortion is only one factor in the achievement of gender and social equity and the optimisation of reproductive health. It is a short-term solution for

some of the problems. Most individuals and, indeed, most nations do not favour termination of pregnancies as a means of contraception, for abortion is not innocuous.

Reardon D.C. (2000, retrieved 07-12-04 from www.) reports on a study undertaken by the statistical analysis unit of Finland's National Research and Development Centre for Welfare and Health. They studied the death certificates of all women (9,192 in total), aged fifteen to forty-nine years (who died during the years 1987-1994) in order to ascertain pregnancy-related events for one year prior to death. There were 281 women who had died during the year following pregnancy. Women who had induced abortion had 3.5 times more risk of dying than women who delivered at term and twice the risk of those with ectopic pregnancies or spontaneous abortions. The suicide rate was more than seven times higher than for those who gave birth to a live infant. This latter group had half the risk of suicide of the non-pregnant group. The point of this report was to demonstrate that maternal mortality statistics, which report deaths to six weeks after the end of pregnancy, do not tell the whole story. It does not, of course, demonstrate a causal relationship between death and the circumstances surrounding pregnancy.

Freely available abortion may even lead to the coercion of women (by partners, family and friends) to abort, so actually limiting their freedom. It has been found to be the case in South Africa (Medical Research Council and Reproductive Health Research Unit, in Thom, A., 2003, retrieved 09-12-04 from www.). This is, interestingly, addressed in the abortion laws of the Netherlands, where the medical practitioner is required to ascertain that the decision to abort was freely taken, before proceeding with the termination (International Planned Parenthood Federation, European Network, 2002, retrieved 09-10-2004 from www.).

Amartya Sen (1999) discusses the importance of women's agency in the reduction of fertility rates. He explores the circumstances of women in the state of Kerala, in India, the most socially advanced state with the highest level of female education and employment; where the fertility rate (number of children per couple) is now 1.7 while the national average is 3.1. India's 'Medical Termination of Pregnancy Act' allows abortion for social reasons related to psychological indications (Cook, R.J., Dickens, B.M., 1999). Problems with access to these facilities exist, though possibly these difficulties do not apply to the state of Kerala. There is no coercion to abort. Social development plays an even greater role than economic development with regard to the empowerment of women, Sen asserts, comparing the wealthier states of Punjab and Haryana with Kerala. These states have a higher fertility rate, and lower female literacy and employment, than is the case in Kerala.

China has no restrictions on the indications for abortion, no limit even with regard to gestational age (though minors require parental consent), but does have coercive policies promoting abortion (Rahman, A., Katzive, L., Henshaw, S., 1998, retrieved 10-Oct-04 from www.). Both the Indian state of Kerala and China have high levels of basic health care and education, with the advantage for women's empowerment in Kerala of the legal recognition of women's property rights. Kerala has a slightly lower fertility rate than China, with a more rapid decline from 1979 (when the one-child policy was introduced in China) until 1991, than that in China, thus indicating that better access and coercive policies have no additional benefit in terms of decreased fertility rate. Women's education and job opportunity is the factor that has been shown to have the greatest impact on fertility rate. In addition it has also been shown to have the most influence on reduction of mortality rates in children under the age of five years. There is an interesting connection here, with decline in

the mortality rates of young children being associated with a decrease in the number of births.

Dissemination of information about the legal right to terminate a pregnancy, and availability of abortion facilities, will help to achieve the goals of equity in reproductive healthcare in South Africa. Recent amendments in August 2004 will make more facilities and more healthcare providers available for legal termination of pregnancies, though it remains to be seen whether this will have a significant impact on maternal mortality, arguably the more important objective. I would argue that these goals of *The Choice on Termination of Pregnancy Act* would be better achieved by aiming to make abortion redundant, though realizing that there will always, even under ideal conditions, be occasions where abortion will be morally required.

As seen, the achievement of such conditions ought to be centred, largely, on the education and employment of women. In addition to literacy and numeracy, such education should include that related to contraception, childcare and general life skills, as well as more specific education for a job; so vastly improving the chances of women for a genuine choice with regards to their quality of living. Having these choices reduces the danger of exposure to disease, including HIV infection; and access to affordable general healthcare and medicines will further limit the wish to access abortion facilities. Societal causes of violence need to be addressed, particularly gender violence. It will be a long time before the need for safe abortion facilities is down to a minimum level in South Africa. Thus we still have the problem of a conflict between the rights of pregnant women to choose to terminate their pregnancies and the rights of health care providers who object to involvement in the process.

6. REASONS FOR CONSCIENTIOUS OBJECTION TO INVOLVEMENT IN THE PROCESS OF ABORTION

Objecting to abortion 'on grounds of conscience' implies that the individual does not wish to be involved in the termination of the life of a human foetus, usually for reasons related to beliefs about the moral status of the foetus. The reason may be, either a belief that the foetus is a genetically distinct human individual with a right to live and that abortion is murder, that the foetus has the potential to have a right to live, that the foetus has the potential to have a life of value, because it possesses a life that is 'sacred'; or any combination of these. Especially when abortion is performed for what is perceived to be frivolous reasons, there may be concern over wastage of life or unpleasant sensory experience for the foetus. (After all, many individuals who do not object to using animal products for food or clothing may nevertheless object to killing an animal, and especially a very young animal, for no very good reason at all.) These beliefs may be modified in some way or other by the competing interests of the mother and even of society in general, for instance in the case of a severely handicapped foetus which might be a burden on society, as well as on its family and itself.

There may also be other reasons for objecting to provide abortion. It may be that the health care provider finds the procedure unpleasant and distasteful, and, for emotional reasons, difficult to perform. She may consider that her time would be better spent on other health related matters. There may be concerns relating to the detail or interpretation of the legislation. We have seen that there are many health

care providers, and individuals in the population generally, who believe that women who are minors, should have parental or guardian consent, or at least knowledge, prior to abortion. Even in China (Rahman, A., Katzive, L., Henshaw, S., 1998, retrieved 10-Oct-04 from www.), although there is no restriction on the reasons for abortion, and there has even been coercion to abort, minors are required to have parental consent. Absence of a requirement of consent by the pregnant woman's partner is generally of less concern. The lack of a supportive environment, which non-participation by a third party suggests, is undeniably a factor in poor post-abortion physical and psychological adjustment (Varkey, S.J., Fonn, S., 1999). Coercion of abortion is also related to poor post-partum adjustment.

Access to counselling is obligatory in South Africa both pre- and post-abortion and is required to be non-directive. In reality this frequently does not occur or is inadequate. This may seem simple to rectify, but circumstances in a public hospital or clinic usually does not allow the individual performing the abortion also to provide the counselling (which needs to be done before consent is given). A concerned health care provider will want to be assured that the pregnant woman is familiar with all the options open to her and that she will have support following the procedure.

7. JUSTIFYING THE RIGHT OF HEALTH CARE PROVIDERS TO 'CONSCIENTIOUS OBJECTION'

Respecting the wide range of religious and moral beliefs within a multicultural society such as South Africa

We have seen that the majority of South Africans claim affiliation with a religious group, the overwhelming majority belonging to one or other denomination within the Christian faith. A full 25 percent are members of one of the African Independent Churches, who accept that abortion is permissible under very restricted circumstances only. The official Roman Catholic Church position remains that abortion is murder of an innocent human individual (Pope John Paul II, 1995). South Africa has espoused a secular democracy with separation of the affairs of church and state, yet freedom of religious association is a constitutional right. Each individual citizen lives his life according to his adopted set of moral and cultural values, be they based on religious belief or entirely secular theories. Also the atheist may be opposed to abortion, while the religious man may well consider abortion to be not only morally permissible, but even desirable or required under certain circumstances.

Wicclair, M.R. (2000) discusses 'toleration of moral diversity' as a justification for the right to conscientious objection. Engelhardt, H.T. (1986, in Wicclair, M., 2000) reflects on the absence of 'any common moral ground' in modern society where, in order to live harmoniously, it becomes essential not to impose our own beliefs on others in society. Jonathan Sacks (2003) also discusses this virtue of toleration of religious beliefs as foundational for the modern state. This, according to

Sacks, is not relativism, but the understanding that coercion of belief is not genuine belief at all. It is important in the pluralistic state, according to him, that individuals may choose to belong to a cultural, civic or political group that does not necessarily affirm the beliefs of the majority of the population. This seems particularly plausible in a truly multicultural nation such as South Africa, where there are eleven official languages and a wide range of religious and other socio-cultural beliefs; and especially in relation to an issue such as abortion that is still controversial.

There are implications for the conscientious objector of adopting this particular view, as justification for his stance towards abortion. It does not allow that it is morally impermissible for all health care providers to perform abortions. To be logically consistent this view demands acceptance that a pregnant woman also has the moral right to her beliefs and, additionally, that other healthcare providers have a right to theirs; since they may believe it is ethical to perform abortions. Referral to a non-objecting healthcare provider thus becomes obligatory, on the very same grounds of tolerating a wide range of religious, cultural and other moral values in a multicultural society, such as exists in South Africa.

There is a difference between accepting all beliefs as equally valid (ethical relativism) and respecting the right of each individual in a multicultural society to live according to his set of beliefs. The latter affirms cultural and religious freedom, which is a constitutional right in South Africa, while not ruling out the possibility that they could be mistaken in their beliefs. Inevitably there are limits even here, for one could, for instance, not condone human sacrifice in the name of religion. I do not believe that refusing to abort a foetus, particularly as abortion is a controversial issue, would fall into that category. Potential harm (to the pregnant woman) as a result of

not acting (when this harm is not intended by the objecting healthcare provider) would not be as bad as causing harm intentionally and actively. The utilitarian would disagree with this, however, for it is the state of affairs that matters, not how that state of affairs was achieved.

The South African Minister of Health demonstrated this consequentialist reasoning (Bateman, C., 2000) when she stated, in relation to the right of conscientious objection to abortion, that health care providers should place their duty before their beliefs. The same belief is echoed by Christie, R.J., and Hoffmaster, B.C. (1986, in Van Bogaert, L.J., 2002, p.134), who state that, "a physician's role is to subordinate moral beliefs to moral obligations, for the ultimate commitment is to the patient even if that necessitates the violation of one's moral views". Certainly the healthcare provider may expect to sacrifice his comfort, his time and even endanger his own physical health in the interests of commitment to his patients, but it seems to me questionable whether it ultimately would be in the interests of patients for their healthcare providers to act against their firmly held convictions. Even on utilitarian grounds it may not, ultimately, be favourable to coerce healthcare providers to act in a manner that they, themselves, would consider to be immoral. I will return to this.

Shuklenk, U. (2001, retrieved 19-09-04 from www.) makes the point that the ethical duty of medical practitioners in South Africa is to practice in accordance with the moral principles accepted by the South African Medical Association and the Health Professions Council of South Africa, who regard abortion services as part of normal medical care. The opinions of these bodies are not necessarily representative of the views of medical professionals in South Africa, however, and, as we have seen, certainly not of the views of the population generally. Shuklenk does concede that

health care providers would compromise their integrity by continually acting against the dictates of their own conscience. So the conflict remains.

Acting with moral integrity

Are 'states of affairs' and consequences of actions with regard to abortion all that matter? Bernard Williams (in Sher, G., 1996, p.353) asserts that utilitarianism may cause loss of integrity by demanding dissociation of the individual "from the projects and attitudes with which he is most closely identified", in the interests of maximizing utility. This is not because so much 'human investment' (as in Dworkin) has been spent on these projects, but because the individual is so closely bound to them. It is because they form part of his identity.

Are there principles involved that should not be violated? The religious person usually does believe that there are certain inviolable rules for living, or, at least, principles that should almost never be abandoned. When the statement is made that 'a physician's role is to subordinate moral beliefs to moral obligations' the obvious response is, "What is the source of our moral obligations, if it is not our moral beliefs?" Is it expected of health care providers, who do not accept the permissibility of abortion, that they should act merely as servants of the public, without reflecting on their own attitudes and beliefs about the ultimate good: good, not only for themselves, but also for their patients? The implication is that the obligation of the health care provider is to act **merely** as a civil servant, for the objecting health care provider does not believe that abortion is in the best interests of the pregnant woman. Such an authoritarian expectation goes against the Kantian principle of treating individuals as ends, not merely as means (to an end). However,

respecting the autonomy of the pregnant woman requires that she also have the option of making her own informed, rational choices, so it is morally obligatory that she have access to information, and referral, if that is her choice.

The problem for health care providers, in relation to abortion, thus exists, if indeed it does exist, because humans are, as Korsgaard (1996) says, reflective creatures. We reflect on good reasons for our beliefs and resulting actions, but may question our freedom to deliberate about choices available to us, even in the absence of external constraints, because of the genetic, psychological and experiential influences that affect the way we think, and the choices we make. Thus the religious and cultural influences to which an individual has been exposed will play an enormous role in the reasoning of that person, positively and negatively, even if he does not have the religious belief that rules, or guides for a maximally flourishing life, are dictated by a higher authority. In this way individuals assume identities, practical identities with resultant obligations.

It is the violation of these identities or self-conceptions that lead to a loss of integrity, the extent of this loss of integrity being dependent upon the centrality of the particular identity in the individual's life. Here Korsgaard's view and that of Williams' concur. Moral obligations are the consequence of valuing humanity in others as we value it in ourselves. Thus turning our backs on our practical identities and not valuing our own and others' humanity leaves us with loss of integrity, and, as Korsgaard says, possibly no reason to live and act all.

There may be conflicts that arise between our various identities. At least one of the practical identities of a medical professional is that of a member of her profession. The medical practitioner who believes absolutely that the foetus has

moral rights to life from the time of conception, and who is also required to perform abortions, is faced with the moral dilemma of unacceptable alternatives, conflicts between her practical identities (Cameron, N., 2000).

Aims of the medical profession include the holistic promotion of health, the prevention, management and cure of disease and the alleviation of suffering. Although abortion is legal and has been accepted by the Health Professions Council of South Africa and the South African Medical Association as a morally legitimate procedure, it is not generally accepted, by the public or by health care providers, as morally unproblematic. The healthcare provider objecting to involvement in the process of abortion may not see herself as being in conflict with the overall aims of the medical profession, and possibly not even with the ultimate goals of *The Choice on Termination of Pregnancy Act.* There is an obvious conflict with the immediate aim of achieving equitable and freely available access to abortion, but possibly not a conflict with the ultimate goals of non-discrimination on the basis of gender and socio-economic status, and freely chosen, safe motherhood. It is the means used to achieve that end that is at the heart of the battle. It would never be possible to eliminate abortion altogether, of course, for even in the ideal society with absence of violence and preventable disease, there would still be occasional contraceptive failure and severe foetal abnormalities.

There are adverse consequences for the individual healthcare provider, and potentially for the profession as a whole, of coercion to act against the dictates of one's own conscience. Even healthcare providers who do not have particularly strong objections, but only feel uneasy or perhaps fear negative reactions from the community, have been found to require debriefing sessions in order to function

optimally (Clarke, E., 2003, retrieved 14-08-2003 from www.). A loss of integrity has been associated with depression and even suicide. The profession as a whole, and therefore the public, may suffer, in accordance with the slippery slope argument, for the individual healthcare practitioner who perceives herself to have acted immorally in one situation may be less resistant to acting immorally on another occasion. Finally, the possibility of coercion of healthcare providers may influence them not to seek employment in the South African public service where there is generally a desperate shortage of staff. This shortage does not apply only to the provision of abortions, so the consequences of coercion may have a negative impact in other areas of healthcare provision also.

Respecting the Autonomy of South African Health Care Providers

Trained nurses have not generally been regarded as independent professionals who make decisions about the treatment of patients, but have traditionally been expected to implement the decisions made by a medical doctor in consultation with the patient. Thus they have not acted autonomously in their role as health care providers (Dickens, B.M., 2001). There has been a degree of change in this regard in South Africa in recent times with the training of primary healthcare nurses and specific training for abortion provision by qualified midwives. With effect from August 2004, general nurses without midwifery experience will also be enlisted for the purpose of pregnancy termination. These nurses are trained and required to make independent decisions. One would expect that registered nurses, who have completed the training programme specifically for the termination of pregnancies, have implicitly agreed that they would perform abortions, and that the only reason for

conscientious objection would be if they had altered their moral stance after the completion of this training. However, according to the head of the Reproductive Rights Alliance (RRA), Merckel, J. (2003, in Thom, A., retrieved 09-12-04 from www.), the trained midwives often were not subsequently employed in termination of pregnancy (TOP) services, and had been lost to follow-up.

Designated private abortion facilities, such as the Marie Stopes clinics, do function in South Africa. These exist specifically for termination of pregnancies and, as such, would quite legitimately employ only non-objecting staff, as this is a specific requirement for the job. In general hospitals in the public service medical practitioners are employed to provide a wide range of services and are independently responsible for the treatment their patients receive, even expected to be responsible for their own professional indemnity insurance. Thus they could be regarded as autonomous agents. They do receive a salary from the state, however, and the state, by virtue of the law enacted, is responsible for the provision of access to safe abortion (Dickens, B.M., 2001). The state may also be answerable to international bodies such as the Committee on the Elimination of Discrimination Against Women (CEDAW) that monitors equity of access to medical care required to promote health (Dickens, B.M., Cook, R.J., 2000).

Dickens addresses the comparison made between conscientious objection in medicine and that of conscripts in the armed forces who object to taking up arms. This comparison is flawed, he believes, as medical practitioners are volunteers, not conscripts. That is only partially true in the South African public service, notably in the case of permanently employed, relatively senior, staff and specialists in training. An analogy with conscription would be applicable to interns in their first year of

employment following graduation and community service medical officers, the second year after graduation, who are required to work for the state in these positions in order to register as independent practitioners. A second year of internship is envisaged, making three years of service, in state employ, obligatory. These doctors may well be expected to perform terminations of pregnancies as part of their duties, just as they would be required to evacuate products of conception in the case of spontaneous abortions. Community service medical officers are the ones who are allocated posts in rural areas with a shortage of staff, so the analogy of conscription is particularly apposite. They are, however, expected to work independently with very little, or no, supervision; that is, as autonomous individuals who are directly accountable for their actions. It is these doctors who are the most likely to suffer significant loss of integrity if the right to conscientious objection were removed. These are also the circumstances, in outlying areas with a shortage of facilities and staff, in which the right of pregnant women to choose to terminate a pregnancy would be most likely to be compromised.

With regard to those who have freely chosen a career in the public service there is another possible analogy with the armed forces, as described by Bertha, C. (retrieved 13-07-2003 from www.) in his discussion of selective conscientious objection. His belief is that an individual who believes that killing is permissible only in just wars, should not volunteer for the military at all, for the same army is involved also in wars that he considers to be unjust and is thus essentially an immoral institution. The analogy, to my mind, fails on the basis of this last phrase. The overall goal of public healthcare in South Africa, comprehensive health for the majority of the population who are dependent on the public service, is not immoral. So it is implausible to suggest that healthcare providers, who object to involvement in

the process of abortion, should not seek employment in the public health sector. On the contrary, the Department of Health wishes to attract medical personnel, for there is a general shortage of healthcare providers, not only of those needed to perform abortions.

Respect for Individuals and Freedom of Choice

Allowing conscientious objection is a demonstration of respect for the choices made by individuals, allowing them to live their lives in accordance with their strongly held convictions and their commitment to a life of integrity. It is not only the toleration of a diversity of beliefs, appreciating the importance of integration of values and actions, or promoting the right to independent decision-making, as discussed earlier, but it is also according value to each unique individual. Giving priority to the commitments of the state, in a sense, diminishes the individual. Using the services of an individual, without respect for his needs, in order to achieve maximum common good is contrary to the Kantian principle of treating people as ends and not merely as means. That person is then treated in a manner that shows disregard for the importance of his life (Dworkin, R., 1994).

Similarly, of course, each pregnant woman requesting the termination of her pregnancy is an individual with intrinsic value, not merely a member of a group representing 'the obligations of the state'. Treating people with dignity, according to Dworkin (1994, in Life's Dominion, p.239) requires individual freedom, with the freedom to act according to one's conscientious beliefs being at the very heart of that freedom. The importance of the dignity of the individual is central in a democracy, and, as Dworkin says, "Because we cherish dignity, we insist on freedom, and we

place the right of conscience at its centre, so that a government that denies that right is totalitarian no matter how free it leaves us in choices that matter less. Because we honour dignity, we demand democracy, and we define it so that a constitution that permits a majority to deny freedom of conscience is democracy's enemy, not its author." Does this help us to solve the conflict between the rights of the conscientious objector and the right of a pregnant woman to choose abortion? After all, it is both who need the freedom to choose to act in accordance with the dictates of their conscience. Maybe (requiring of conscientious objectors) provision of full information, referral, and non-judgemental behaviour towards pregnant women seeking abortion, would not violate their integrity; while a decision not to abort, when it is a matter of the pregnancy occurring just a few months earlier than planned (for instance), or travelling some distance to a referral centre, may be morally required of a pregnant woman.

There is no room for forcibly imposing the values of one group on another, or one individual on another. A compromise is required. We need to live in mutually acceptable ways in order to flourish and ultimately in order to survive at all, for moral behaviour just is behaviour in relation to other people (or plants or animals). It does not occur in isolation. Thus we must balance these competing human rights.

8. REASONABLE CONSTRAINTS ON THE RIGHT TO CONSCIENTIOUS OBJECTION TO INVOLVEMENT IN THE PROCESS OF ABORTION

Defining Conscientious Objection

There is a need to define the meaning of conscientious objection relative to the abortion process. The whole process would encompass pre-operative counselling, admission procedures, pre-operative preparation, the actual abortion procedure (whether pharmacologically or surgically induced), post-abortion care including necessary procedures and possible anaesthesia, together with supporting services. There is a strong case to be made for designated abortion facilities with staff assigned specifically and solely for this function, for then employment would legitimately be contingent on willingness to be involved in the process. It would be a requirement for the job. However, amendments to South African abortion legislation in August 2004 make it legal for both public and private hospitals and clinics with a 24-hour maternity service to terminate pregnancies up to a gestational age of twelve weeks, without special permission from the Member of the Executive Council (MEC) of the province concerned (news24.com, retrieved 18-08-2004 from www. and lifesite.net, retrieved 25-09-2004 from www.). In making this a part of the normal maternity services, it would be a matter of chance as to which health care provider would be available at any particular time.

Duties of Care

Pre-operative preparations are quite obviously undertaken specifically with the aim of abortion, thus a healthcare provider objecting to abortion in a particular instance must, to be consistent, also object to preparation for that procedure. Dickens, B.M. (2001) agrees with this assessment but also stipulates that emergency medical care following abortion is obligatory in the same way as is the care following any abortion, be it spontaneous or induced. The system can be manipulated, however, so that pregnant women seeking abortion are given an abortifacient, such as misoprostol, by one individual and then referred (possibly within the same institution), for evacuation of uterine contents by another healthcare provider, who is then expected to comply on the grounds that this has now become an emergency procedure (Ward, H., 1996, retrieved 08-07-2003 from www.). This latter medical practitioner may well consider that he should not be required to be involved in this procedure, if he has a conscientious objection to abortion.

Pharmacists face the same moral dilemma as other health care providers with regard to the use of the abortifacients RU486 and misoprostol (which is not registered for use as an abortifacient). It can be argued that supplying or prescribing these drugs leaves the responsibility for its use with the pregnant woman and so absolves the supplier of any moral accountability. This seems implausible for the reason that the intention is clearly to terminate the pregnancy. The professional association of South African hospital pharmacists' (SAAHIP) position is that, while they respect the legal and moral rights of their members, the autonomy of pregnant women takes priority over the legal rights of pharmacists to refuse to dispense drugs that cause abortion (SAAHIP, retrieved 14-08-2004 from www.). A further problem with prescribing

misoprostol is that, should the foetus survive, it could be born with Mobius' syndrome (facial nerve paralysis with or without limb defects), so self-administration by pregnant women, unless carefully followed up, is clearly a danger (de Muelenaere, C., 1999).

Duties of Referral

It is generally considered that it is a legal requirement in South Africa for health care providers objecting to involvement in the abortion process to refer to a willing provider (Dickson-Tetteh, K., Rees, H., 1999). According to Strauss, S.A. of the Law Faculty, University of South Africa (1999), section 6 of *The Choice on Termination of Pregnancy Act 92, 1996,* determines that the legal requirement is that 'a woman shall be informed of her rights under this act' by the healthcare provider she has approached. This requirement could be fulfilled by means of a pamphlet, he says. If the life or health of the woman is threatened, however, the situation changes, for then non-referral would leave the practitioner open to litigation.

As discussed earlier conscientious objectors differ in their beliefs with regard to the moral duty of referral. A healthcare provider, who believes that abortion is the murder of an innocent human individual with rights to life, could not in good conscience refer a patient for abortion. This would be an exceptional stance in South Africa, however, for most medical practitioners would consider that respect for the pregnant woman's right to make independent decisions would justify providing her with all relevant information, including information about access. When there is refusal to be involved with providing abortion, this should be explicit, and a record kept.

Education of students

All students aiming to provide holistic healthcare need to have knowledge of legal and practical requirements for the job. Medical students and nursing students who may be required to perform abortions also need technical expertise. They could not object to receiving theoretical information. The actual procedure is the same whether it is an inevitable spontaneous abortion, a legally procured abortion, or even an illegal situation where emergency care is necessary. Thus there is opportunity for acquiring practical skills in a setting where active termination of a pregnancy does not occur. There is thus no need to involve medical students in terminating pregnancies. If it is envisaged that students may be required to be involved with performing abortions, then it is also required that this expectation be made explicit before entering medical school or nursing college.

Obstructive Behaviour by Conscientious Objectors

Though illegal, this has proved to be a significant problem in South Africa. Many healthcare providers are reluctant to perform abortions because of fear of reprisals in the community (Clarke, E., 2003, retrieved 14-08-2003 from www.). According to the Department of Health document (2000, retrieved 27-07-03 from www.), as seen earlier, the main reason why women still have illegal abortions in Gauteng province, is due to a lack of knowledge of the law (55 percent). A further fifteen percent did not use legal facilities because they did not know how to access these. When they were aware of abortion services, however, the main reason for illegal abortion was anticipated staff rudeness (17 percent). Respect for each

individual makes intimidation of pregnant women seeking abortion morally impermissible.

Conscientious objection to abortion by Institutions

Internationally, this is regarded as unacceptable (Dickens, B.M., Cook, R.J., 2000). It would also be regarded as unacceptable for an institution to employ only medical staff that would claim conscientious objection. This was the case in a hospital in KwaZulu-Natal, South Africa, where the Medical Superintendent claimed that there was no staff willing to perform abortions, and furthermore the hospital would not attempt to influence their decisions (SAAHIP, retrieved 14-08-2004 from www.). They did suggest that they would allow a mobile abortion team to perform abortions on their premises.

Values clarification

During the year following the implementation of *The Choice on Termination of Pregnancy Act,* the Planned Parenthood Association of South Africa (PPASA), the Reproductive Health Research Unit (RHRU) and the Reproductive Rights Alliance (RRA) conducted 'Values Clarification Workshops' throughout South Africa (Dickson-Tetteh, K., Rees, K., 1999). This was done with a view to counter-acting resistance by health care providers to performing abortions, and altering their lack of acceptance of the fact that pregnant women have the right to termination of pregnancies. It was hoped that the opportunity for reflection on culturally determined beliefs about the morality of abortion, together with education about abortion, might,

in many instances, lead to an appreciation of the importance of pregnant women's rights, and maybe even to alter their moral stance. More than four thousand healthcare providers attended the workshops and a pilot study by the PPASA indicated that almost seventy percent felt that the workshops had been helpful in assisting them in relating to their patients. Although there is no indication here of actual alteration of belief, exposure to other beliefs, the chance for reflection on the individual's own beliefs, as well as reflection on the importance of respecting a pregnant woman's right to choose her course of action, may have helped to avoid conflict.

Amartya Sen (1999, in Development as Freedom, pp.273-274) considers the formation of ethical values in relation to policy making. He discusses four influences on the formation of values. Firstly, there is the influence of reflection and analysis; a Kantian notion which was considered earlier in relation to Korsgaard's (1996) belief that our normative values are grounded in our ability to reflect on our own desires, thoughts, and beliefs, and question them. Reflection on the practical identities so formed may lead to sufficient reason to maintain that identity, that is, a resultant duty.

Secondly, Sen considers 'our willingness to follow convention'. This encompasses not only what we have found good reason to do but also what others have found good reason to do. The influence of religion would fall into this category. It seems to me that this is likely to be prior to personal, independent reflection. As Sacks, J. (1997, in The Politics of Hope, p.176) says, when considering the Kantian notion (Kant, I., in Sher, G., 1996) of the morally praiseworthy individual, (one who grounds morality in reason itself, completely autonomously, and whose good acts result from duty alone, rather than inclination), "But this is not how we learn…. We

need to see how master-practitioners practice their craft." Aristotle suggested that virtuous acts are motivated, not by duty, but by a special kind of desire, namely, a settled disposition to do what is right (Aristotle, in Sher, G., 1996); that is, by good habits which have been developed (usually) due to the early influence of (important) others.

Thirdly, according to Sen, there is the influence of public discussion, with the implication that individual values can and do change in the process of decision-making. The perception by policymakers in South Africa, that conscientious objection to abortion is an unconsidered response and that education about the issues could alter the views of conscientious objectors (Dickson Tetteh, K., Rees, H., 1999), has prompted the conduction of 'Values Clarification Workshops'. Lastly, Sen states that evolutionary selection may play a part, with survival and flourishing of behaviour patterns because of their positive effects. Thus objection to abortion might be seen as originating in the need to promote the survival of the species.

Requirement to justify values that lead to conscientious objection

Should health care providers, who wish to object to abortion on grounds of conscience, be required to justify their beliefs or demonstrate the centrality of those values in their lives? This is very demanding, and one may not think it essential that persons should be required to justify their beliefs. Often religious and moral values have not been so carefully considered that individuals are able, clearly, to articulate their position. In this particular situation, however, where there is the possibility of harm to a pregnant woman who might choose to submit to an illegal, unsafe abortion if safe services are not available, there are good reasons for this requirement.

Beauchamp, T.L. and Childress, J.F. (2001) believe that medical practitioners should be free to refuse to provide treatment they consider morally objectionable as long as this is not part of their normal duties. Meyers, C. and Woods, R.D. (1996) are of the view that medical practitioners have the obligation to provide services that have been accepted by the community as being part of normal health care. Thus, according to Meyers and Woods, those who object to performing abortions should be required to demonstrate how coercion to perform abortions would have a serious negative impact on their moral or religious beliefs. They are concerned that appeal to the right to conscientious objection is a convenient way to avoid involvement with abortion provision, while true reasons, such as distaste, fear of social consequences leading to loss of income, or inconvenience, are hidden. Their reason for wishing to limit the rights of objecting healthcare providers is the same as exists in South Africa, namely that in the United States access to abortion services is declining for want of willing providers. They, just as Shuklenk, U. (2001, retrieved 19-09-04 from www.) in South Africa, are of the view that having a monopoly on the right to perform abortions leads to a resulting obligation to perform them. The monopoly exists, of course, in the interests of the public, not for the protection of the health care provider. It is there to prevent unsafe abortions that still do occur, so there has been no suggestion that the monopoly should be ended.

In South Africa there has been some compromise with regard to the qualifications necessary for providing abortions, for, just as trained primary health care nurses are authorized to provide certain medications, registered nurses trained for the job may provide abortions. As discussed earlier, there is a distinction between medico-legal sanction and socially and morally sanctioned services, which, of course, is the reason for the appeal to ‘conscientious objection’. Because the right to abortion

in the United States is a negative right (though in the case described by Meyers and Woods the state of California had the obligation to provide abortion for prisoners and mentally incompetent women), their dilemma is not nearly as great as the South African one, where the state is obliged to provide free abortion to all pregnant women wishing to avail themselves of this service. Dooley, D. (1994) considers that the dilemma of supply of willing health care providers is one that should have been worked out, bearing in mind the need to respect objection on grounds of conscience, prior to implementing abortion legislation.

This suggestion was also made in South Africa before the passage of the act through parliament in 1996 (Ward, H., 1996, retrieved 08-07-2003 from www. and 1997). Merckel J., of the Reproductive Rights Alliance (in Thom, A., 2003, retrieved 09-12-04 from www.), recently conceded that consultation with healthcare providers, prior to the implementation of abortion legislation, would probably have avoided some of the problems resulting from a lack of staff willing to terminate pregnancies. It seems to me that if abortion were truly socially and morally unproblematic, there would not be a severe shortage of health care providers willing to perform the procedure.

A requirement of demonstrating centrality of belief, or even stronger, demonstrating a negative impact on belief, in order to be permitted to object on grounds of conscience, would most likely be very difficult to implement objectively and fairly. Health care providers in South Africa should, however, be required to make their objections explicit, just as the hiring institution should be explicit concerning the job description in that institution. In a dedicated abortion facility non-objection would be a requirement for the job. At any other health care facility

requiring medical practitioners to perform abortions, the issue of conscientious objection ought to be raised prior to hiring. That would also be the appropriate time to assess whether there is genuine moral objection to abortion provision. It seems plausible that a conscientious objector could be required to receive education about the issues surrounding abortion, such as was provided in the 'values clarification workshops'. A questionnaire, to be specifically designed for the purpose, could clarify whether or not an individual is a true objector. True moral objection ought to be respected.

I believe that, although this would be the right course of action, it would be, practically, extremely difficult to reject the claim of conscientious objection even if it became obvious that this was not the true reason. I do not believe that, in the South African public health services, we would be able to refuse to hire someone whose conscientious objection was deemed to be false, while at the same time hiring and allowing conscientious refusal to be involved in terminating pregnancies for another, because her appeal was judged to be a reflection of her firmly held moral values. This would be likely to result in a charge of unfair hiring practice with resultant action on the part of employees. The requirement to explain reasons for conscientious objection might be worthwhile, however, for some might, on reflection, alter their stance.

It should be the responsibility of the institution to ensure that enough willing healthcare providers are hired. If no one is available to perform an abortion in a South African public health facility at a particular time when it is required (for the reason that those normally involved are on leave or ill, for instance), it must be the responsibility of that institution to inform the pregnant woman of alternatives, and, ideally, when she has received counselling and made a decision, to provide the

necessary transport. In remote locations in South Africa the lack of transport is a major obstacle to accessing health care facilities.

Circumstances in relation to Moral Limits to Conscientious Objection

Van Bogaert, L-J. (2002), argues that the right to conscientious objection to abortion should be limited in the developing world, where referral to another willing health care provider is not as simple as it is in developed countries. Transport, as seen above, is one obstacle. This situation leads to the increased likelihood that unsafe abortions, with subsequent risk to the pregnant woman, will continue to take place.

The many reasons why access to abortion is considered to be an important right, especially in a country like South Africa, have been addressed. However, the individual who believes that abortion is morally objectionable may not be persuaded by the fact that he is the only one who is in a position to perform the abortion. He will not believe that abortion is the best course of action for the pregnant woman, and, (resisting his wish to act paternalistically on her behalf) while maybe affirming the right of the pregnant woman to make her own considered choices, may not accept that he could be instrumental in actively ending the life of the foetus. (He may not even concede his obligation to refer. An institutional referral system, implemented when an objection to providing abortion is explicitly documented, could overcome this obstacle.) It would be preferable to focus on addressing and altering all the other circumstances, for the lack of healthcare providers willing to terminate pregnancies, should not alter (one's views about) the moral status of the foetus.

9. ACHIEVING THE OBJECTIVES OF *THE CHOICE ON TERMINATION OF PREGNANCY ACT, 1996*

Pregnant women in South Africa have the almost unrestricted legal right to choose to terminate their pregnancies. As shown earlier, there are many good reasons why this may be considered a hugely important right. The right to choose abortion is a positive right, obliging the state to provide the required facilities. Even more than that, in order to achieve the goal of equity, free access is required. Other goals of the act are to reduce abortion-related deaths and to improve the health and quality of life of all women in South Africa.

The right of health care providers to object, on grounds of conscience, to involvement in the process of abortion is one of several obstacles faced by women wishing to access safe abortion, and thus also a factor preventing achievement of the goals of *The Choice on Termination of Pregnancy Act.* Because the freedom of healthcare providers to choose not to be involved in the process of abortion is also important, for the reasons previously outlined, a means to resolve the conflict needs to be worked out. It is not simply a matter of one right being more important than the other, or one course of action resulting in greater utility than the other.

Individuals constituting our society have responsibilities towards each other as well as to themselves, so must seek a creative solution. What may be seen as resulting in maximum utility in the short term, sacrificing the right of (the relatively few) health care providers to conscientious objection in order to find sufficient numbers willing to provide (the many) abortions, may in fact not have ultimately best

consequences. Disillusionment and loss of integrity of the individual health care provider may impact on the whole profession (according to the slippery slope argument) with negative consequences for the broader public. Another possible scenario is that health care providers may choose not to be employed by the state, rather than act in a manner that they consider to be immoral. That would not affect numbers providing abortions, but would be detrimental in terms of all other services provided by these healthcare practitioners. On the basis of the earlier discussion, there are several strategies that may be employed in order to achieve the wider goals of abortion legislation while at the same time limiting the coercion of health care providers who object to abortion.

Achievement of the wider objectives while seeking to limit the need for abortion

The single most important factor (Sen, A., 1999) that alters the quality of life of women, and so also that of their families, is education; and, second, is employment. The subsequent empowerment of women filters through to affect every area of their lives, making them less vulnerable to abuse, giving them more actual choices and providing them with knowledge to make use of the facilities available; in order to protect their own health and that of their families. Facilities required would include reproductive health care clinics with freely available contraceptives and family planning advice, clinics for the treatment of HIV and other sexually transmitted diseases, counselling services for the prevention of these disorders and support for those who live with them. Counselling and support is required for women both before and after abortion, and for those who have given birth to babies resulting from unwanted pregnancies. This education of women should be an ongoing process,

starting in childhood, and including not only literacy and numeracy, but also self-discipline, and principles and skills for living maximally flourishing lives.

Gender violence, and violence generally, is endemic in South Africa. The need to reduce violence in the community and to provide refuge for those living in violent situations should thus be a top priority. As a consequence of these societal problems, the provision of emergency contraception and prophylaxis for HIV, in the event of rape, is an urgent necessity (McQuoid-Mason, D., Dhai, A., Moodley, J., 2003).

Altering circumstances that limit achievement of the goals

Much work has been done in this area with the recent (August, 2004) amendments to the act being directed towards minimizing obstacles to accessing abortion. A far wider range of health care facilities has been made available and registered nurses without midwifery experience are being trained to perform abortions. Training more willing healthcare providers should impact positively on accessibility of services, and result in less (perceived) need to coerce those who have conscientious objections. These trainees need to be carefully chosen and thought given to how they may be retained in termination of pregnancy (TOP) services.

In populous regions the most transparent and, because of the large numbers involved, probably most efficient manner to provide abortions would be in special units dedicated specifically for that purpose. This would have the advantage, apart from the fact that declaring conscientious objection would preclude employment, that all the necessary support services (such as counselling services) would be

immediately available. The unit may be housed in a community clinic, or, in the interests of confidentiality, as a separate unit in a hospital. One might wish to rotate staff through such a unit, for permanent employment there is likely to be particularly stressful. The Marie Stopes clinics in the private health sector are such specifically dedicated facilities.

As seen earlier, it has been found that individuals performing abortions require psychological support (Clarke, E., 2003, retrieved 14-08-2003 from www.). This may indicate stress because they find the work distasteful, due to fear of harassment by those who oppose abortion, because they have a moral dilemma that causes guilt and depression, or just due to the fact that they are interacting, daily, with women who are living through a period of crisis in their lives. There is significant stress attached to the destructive procedure necessary to terminate foetal life, particularly in the case of more advanced pregnancies; especially for a healthcare provider whose overriding reason for being in medical practice is to maintain life and promote health. Thus support for abortion providers, both practical and psychological, is essential. The provision of salary (or leave) incentives for healthcare providers and support staff in dedicated facilities could be justified on the grounds of the psychologically stressful working conditions.

Making explicit the conditions of service at the outset may go a long way towards reducing the number of conflict situations. Obstetricians, gynaecologists and anaesthesiologists, together with specialists in training and medical officers in the departments relating to those specialties, ought to expect the provision of abortion to be part of their duties. They should be required to state objections they may have, prior to starting employment. However, in a large department there is usually no

major difficulty in accommodating a few who object to involvement with abortion, unless they are required to rotate through special abortion units.

The case of medical officers not assigned to specific departments, usually in smaller hospitals and clinics, differs. If it is required of them to perform abortions this could be stated when they apply for the job. In the case of interns and community service doctors, a space on the application form (in which to indicate whether or not they find abortion to be morally objectionable) would allow for them to be allocated to a post where this would not be required of them, and so ensure that there are other healthcare providers available to do the job. They might be required to justify their position just as others with special circumstances are required to do. In a case where an objecting medical officer is confronted with a woman seeking abortion, he should record his refusal to perform abortion and make arrangements for referral. These records should be kept for statistical purposes so allowing for more accurate planning in the future. Avenues for referral must be put in place by the particular institution where there is shortage of staff. This has become particularly important since August 2004, as any health care facility that provides a 24-hour maternity service is now designated to perform abortion without specific permission from the MEC for health; which means that healthcare providers practising in those facilities will be expected to comply. Extra staff members have not necessarily been employed to cope with this additional workload.

Medical students and nurses in training may acquire the necessary skills for performing abortions without the necessity of performing elective pregnancy terminations. A requirement to obtain theoretical knowledge about abortion provision as well as knowledge about the related psychological, ethical and moral issues is

absolutely essential. This would ideally, in time, render such interventions as 'values clarification workshops' obsolete. At present that sort of intervention may be very useful and would continue to have a place for non-professional support staff.

A major obstacle to the provision of abortion in South Africa is the fact that it is not socially accepted. Public discussion by experts in the field, in the mass media, and in schools and community centres, would give the public opportunity to reflect on beliefs that are new to them, as well as on their own values. This is an avenue that may be exploited both for good and ill, but discussions giving all views about the status and value of foetal life, women's and healthcare providers' rights with regard to abortion (with an emphasis on the value of responsible decision-making), ought to be a positive intervention. It is hoped that this would reduce conflict by promoting better understanding of all points of view.

Limiting the appeal to 'conscientious objection'

The legitimate limits to conscientious objection have been discussed earlier. Addressing these issues may free some healthcare providers to become involved with providing the abortions requested by pregnant women, maybe because of altering their position about the moral permissibility of abortion. It is more likely, however, that consideration of all points of view will result in more respectful attitudes towards their patients and less reluctance to provide required information and referral. In addition, having had the opportunity to reflect on their own values, they will have less need to act defensively and be more confident to explicitly state their own objections (assuming they exist). This will be to the immediate benefit of patients, who are

treated with honesty, and ultimately to the system when there is improved availability of statistics.

As stated earlier, many women surveyed expressed a wish that they could have been cared for by their 'own' general practitioner. This would be desirable for many reasons, both from the point of view of the pregnant woman and that of the practitioner. The pregnant woman would benefit from being treated by a familiar person with pre-existing knowledge of her medical history. The practitioner might be willing to initiate an abortion, for instance with misoprostol, when he knows all the circumstances of the pregnant woman (and that she has freely made an informed and responsible decision), whereas without that information he might feel obliged to conscientiously object to involvement in the procedure.

CONCLUSION

There are, as we have seen earlier, many good reasons for believing that freedom to choose to terminate a pregnancy may be very important for pregnant women generally, and particularly in South Africa where there is a high incidence of gender violence and disease due to the human immunodeficiency virus. Respect for the pregnant woman, as a unique individual, requires that she be free to make decisions in accordance with the values that are central to her identity and with the obligations that she has to herself and others. This requires legal freedom of choice, even if the one legislating would almost never choose abortion. It, particularly, requires that she be treated with respect by all healthcare providers, whatever their personal beliefs.

The foetus, though not having any psychological concept of itself as an individual with hopes and dreams, and, in South Africa, having no legal rights, is still not inconsequential. Thus abortion should not be regarded lightly, for each foetus and born individual is unique. An aborted foetus cannot be replaced, for another one will be a separate and different individual. Foetal life itself, regardless of any instrumental value, may be of overwhelming importance for many: something to be treasured.

There are good reasons to respect the deeply held convictions (that abortion is morally impermissible) of many healthcare providers who object, on grounds of conscience, to involvement in the process of abortion. To begin with, it is an established legal right, accepted (at present) as such in South Africa and internationally. It is important in a multicultural democracy (that maintains a constitutional right to freedom of religious practice) that this right be upheld.

Abortion is also not the definitive solution to the societal ill of unwanted pregnancies with all of their causative factors, and should thus not be promoted as such. It is (only) one means to this end. The energies of conscientious objectors may be much better put to use in combating the sources of these problems than being coerced to act against the demands of their conscience. Demoralization (of the already insufficient numbers) of healthcare providers may lead to exodus from the public healthcare sector, with further undesirable consequences.

Objection to being involved in the process of abortion is most often based on beliefs which are widely held in South Africa and internationally: beliefs about the foetus as an individual with a moral right to life from the time of conception, with the potential to become a complete person, or that all human life is sacred. These are beliefs that cannot be proved to be true or not true. If believed to be true, and based on a system of beliefs central to the individual's identity, negation of that value system would be morally wrong, leading to loss of integrity.

There may be many good reasons for abortion. However, when the decision to abort is made on the basis of self-interest or convenience, this may possibly not legitimately be called a moral choice (Daniel Callahan, in Feinberg, J., 1973). It seems unjust, then, to require that the conscientious objector compromise his integrity for the sake of rights that are claimed (by the pregnant woman seeking abortion) for the sake of convenience. Not that this is always (or even mostly) the case. Thus full knowledge of the circumstances of the pregnancy and requested abortion may be especially pertinent to the healthcare provider who must decide whether or not he is able to justify a decision to comply with her request.

Lastly, for someone who holds a belief in the sanctity of life, a gift that comes with obligations and responsibilities, the freedom to choose whether or not to be involved in the process of abortion is important. These obligations to oneself and others require adherence to deeply held values and beliefs, maximally good use of allotted talents, and treating other individuals as one would want to be treated. Rather than concentrating on what may be claimed as a right (whether by foetuses or legal persons), it would be preferable for the focus, when thinking about abortion and conscientious objection, to be on the value of each individual's life and the interaction between individuals.

Coercion of healthcare providers to perform abortions, against their firmly held beliefs, shows a disregard for their value as distinct individuals. Freedom to act is limited by the freedoms of others, however, so limitations to the right to conscientious objection, as discussed earlier, seem to be morally required. These limitations would include the requirement to care for a pregnant woman pre-abortion (though not actual preparation) and post-abortion, including any surgical or medical procedures that may become necessary as a consequence of the procedure. There could reasonably be a requirement to demonstrate the importance of beliefs held (te Water Naude, J., London, L., Guttmacher, S., 1999), in the individual's life as a whole, as well as a demand to attend lectures or workshops that provide education about issues around the termination of pregnancies.

When a pregnant woman's life is in danger, as when the effects of pregnancy-induced hypertension are an acute threat, and the only means to save her is by delivering the foetus, then this must be done. Not doing so could cause the demise of mother and foetus, whereas inducing abortion might even save both their lives. In

other cases, such as when a foetus is severely deformed, or when there are compelling social indications, there would be no harm done by delaying the abortion for some hours (or even one or two days) so that the woman can be referred to another facility. Thus explicit recording of refusal to terminate pregnancy is essential, as is a clinic or hospital referral system; so there cannot be conscientious objection by institutions. This referral system needs to be functional for other emergencies also, so should in any case be in place.

Attempting to impose a belief system on others has historically caused great harm, and is not morally acceptable. Thus allowing each individual to act in accordance with his own conscientious beliefs, especially when there is no general acceptance about the morality of abortion, is, I believe, morally required. Planning, discussion and negotiation, at each institution, with all who may be required to be involved with performing abortions, is likely to produce the best results. It will promote optimal health and opportunity for all South African women to lead fulfilling lives, and provide freedom for healthcare providers to live their lives with integrity. They will then be more motivated to provide exceptional care – because they are treated with dignity and respect. So our communities may prosper.