

**Conscientious objection and South African medical
practitioners' constructions of termination of pregnancy and
emergency contraception**

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Abstract

Aim: The 1996 Choice on Termination of Pregnancy Act decriminalized abortion in South Africa and the South African Medicines Control Council in 2000 approved the dispensing of emergency contraceptive methods by pharmacists to women without a doctor's prescription. This legislation has been hailed as among the most progressive in the world with respect to women's reproductive justice. However the realisation of these rights in practice has not always met expectations in part due to medical practitioners' ethical objections to termination of pregnancy and the provision of related services. The aim of this study was to interpret the varying ways in which medical practitioners frame termination of pregnancy and emergency contraceptive services, their own professional identities and that of their patients/clients.

Methods: Sample of 58 doctors and 59 pharmacists drawn from all nine provinces of South Africa. Data collected using an anonymous confidential internet-based self-administered questionnaire. Participants were randomly recruited from online listings of South African doctors and pharmacists practicing in both private and public sectors. Data were analysed using theoretically derived qualitative content analysis.

Results: Participants drew on eight frames to justify their willingness or unwillingness to provide termination-of-pregnancy related services: the foetal life frame, the women's rights frame, the balancing frame, the social justice frame, the do no harm frame, the legal and professional obligation frame, the consequences frame and the moral absolutist frame.

Conclusion: Health professionals' willingness or unwillingness to provide termination of pregnancy related services is highly dependent on how they frame or understand termination of pregnancy, and how they understand their own professional identities and those of their patients/clients.

Keywords: conscientious objection, women's reproductive rights, justice, abortion, South Africa

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Glossary of terms

Abortion

The World Health Organization (WHO) defines abortion as “the termination of an already established pregnancy (in other words, a method that acts after implantation)” (2003).

Unsafe abortion

Unsafe abortion is “an abortion taking place outside of health facilities (or any other place not recognised by law) and/or provided by an unskilled person” (WHO, 1992).

Medical abortion

Medical abortion is an alternative to traditional surgical abortion, in other words, it is the termination of pregnancy through the use of a drug or a combination of drugs which may include misoprostol or mifepristone (Bateman, 2011:304).

Abortion on demand/request

Abortion on demand or on request, also known as elective abortion is an abortion that is not justified by a matter of health, life or rape, but by the free will of the woman.

Therapeutic abortion

Therapeutic abortion, popularly referred to as abortion for medical reasons is an abortion induced when pregnancy constitutes a threat to the physical or mental health of the pregnant woman or if there is foetal malformation (ACOG, 2007).

Maternal death or mortality (MM)

MM is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (Hurt and Ronsmans, 2005). Maternal mortality is measured using the ‘maternal mortality ratio, that is the “number of maternal deaths during a given time period per 100 000 live births during same time period” (Ronsmans and Graham, 2006:1190).

List of abbreviations

ACDP	African Christian Democratic Party
ANC	African National Congress
AIDS	Acquired Immunodeficiency Syndrome
ACOG	American College of Obstetricians and Gynaecologists
APhA	American Pharmacists Association
AHPRA	Australian Health Practitioner Regulation Agency
BMA	British Medical Association
CTOP	Choice on Termination of Pregnancy Act
CLA	Christian Lawyers Association
CE-RPSGB	Code of Ethics of the Royal Pharmaceutical Society of Great Britain
CO	Conscientious Objection
CCA	Conventional Content Analysis
DCA	Directed Content Analysis
DDE	Doctrine of Double Effect
ECOHR	European Court of Human Rights
FDA	Federal Drug Administration
FWCW	Fourth World Conference on Women
FOCA	Freedom of Choice Act
GPhC	General Pharmaceutical Council

HPCSA	Health Professions Council of South Africa
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ICM	International Confederation of Midwives
ICPD	International Conference on Population and Development
FIGO	International Federation of Gynaecology and Obstetrics
MTP	Medical Termination of Pregnancy Act
MEDUNSA	Medical University of Southern Africa
MCC	Medicines Control Council of South Africa
MLPs	Mid-Level Providers
MDGs	Millennium Development Goals
MAP	Morning After Pill
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NCCEMD	National Ministerial Committee on Confidential Enquiries into Maternal Deaths
NMMU	Nelson Mandela Metropolitan University
OTC	Over The Counter
PFLI	Pharmacists for Life International
PLDP	Protection of Life During Pregnancy
RDP	Reconstruction and Development Programme

RCOG	Royal College of Obstetricians and Gynaecologists
SAQ	Self-administered Questionnaire
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
SPUC	Society for the Protection of Unborn Children
SAMCC	South African Medicines Control Council
SANC	South African Nursing Council
SAPC	South African Pharmacy Council
TOP	Termination of Pregnancy
UN	United Nations
UNICEF	United Nations Children's Fund
VCWs	Values Clarification Workshops
WHO	World Health Organisation
WMA	World Medical Association

Dedication

This thesis is dedicated to my parents, Mr Gladman Chiwandire and Mrs Joyce Chiwandire and my brother Harry. I would like to thank you for realizing my potential all the way back from High School and grooming it up to now. I love you dearly, and always will, because without your motivation this thesis would not have been possible. I am happy that I have reached this far because of your faith in me.

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Chapter one: the study

Following the International Conference on Population and Development (ICPD) held in Cairo in 1994 and the Fourth World Conference on Women (FWCW) held in Beijing 1995, there have been tremendous efforts made worldwide for the development of reproductive and sexual rights for women, including abortion (Ngwena, 2004:708; see also Yanda *et al*, 2003:275). Both conferences contributed to the emergence of a dominant approach that equates the denial of safe abortion services on request to women with a serious human-rights violation. This approach gained hold after the 1994 ICPD in Cairo where nations agreed to the need for the classification of reproductive rights as a crucial element of human rights (United Nations, 1994, para. 7.3:40). According to Rebecca Cook who is the leading advocate of this approach, the application of a human rights framework can effectively reduce the burden of unsafe abortion as it seeks to ensure women's rights to equal protection of the law and non-discrimination on the grounds of sex and race (2006:15-16).

For Yanda *et al*, abortion is a 'basic reproductive right' that ought to be respected and promoted by governments (2003:276-277). Thus, in the event of an unintended pregnancy, every woman should be able to exercise full control of her body (Correa, 2010:112) and be able to make autonomous sexual and reproductive choices concerning either to continue or discontinue her pregnancy (Yanda *et al*, 2003:277; see also Pearson and Sweetman, 1994:46). Thus, "if she chooses to terminate it, it is the responsibility of healthcare providers, and good government policy, to ensure her safety" (Yanda *et al*, 2003:277).

The ICPD stressed the need to address unsafe abortion as a public health concern (Cook, 2006:27) and acknowledged that women need sexual and reproductive health services to preserve their health and lives. From this perspective, good public policy is that which seeks to prevent mortality and morbidity from unsafe abortions especially in countries where these remain high (Berer, 2002:31). Several authors suggest that by investing in abortion safety and availability governments can feasibly lessen abortion related mortality (Okonofua *et al*, 1994; World Health Organization, 2004; Alan Guttmacher Institute, 1999 cited in Grimes *et al*,

2006:1916; Grimes, 2003:100; Fathalla, 2006; Fathalla, 2007). However, the provision of these services is contingent upon the availability of medical personnel who are willing to provide them. One of the obstacles to the provision of safe abortion services to women in some countries is the invocation on the part of medical personnel of their right to conscientiously object to the performing of medical procedures such as abortion.

The post-apartheid South African government has an enviable international reputation with regards to enacting policies aimed at advancing women's sexual and reproductive rights. To further promote these rights, the government has also ratified many international and regional treaties aimed at advancing women's sexual and reproductive rights. However, the practical implementation of abortion and emergency contraceptive services has not yielded the expected results with respect to the unequivocal advancement of women's reproductive rights, particularly the rights of the poor who rely on public sector health services, because both services fall into the category of controversial reproductive services which health professionals may legally conscientiously object to providing if doing so would conflict with their religious, ethical and personal beliefs.

In the healthcare field, conscientious objection (CO) can be defined as an individual's refusal in principle to perform a legally required or permitted practice (Boyd *et al*, 1997:54-55). Ethical guidelines which regulate the health professional/client relationship with regards to termination of pregnancy (TOP) and morning after pill (MAP) services in countries where these are legal include the doctor's unconditional obligation to terminate a pregnancy in cases of emergency -- usually when continuation of pregnancy poses a serious danger to the life or health of the pregnant woman (Dickens and Cook, 2000:72). The right to CO is confined only to those who are directly involved in abortion procedures such as doctors and not nurses, hospital administrators and secretaries. In other words, staff indirectly involved in the provision of TOP-related procedures such as delivering of pre-operative and post-operative care duties to patients should not invoke CO to deny patients access to care (McCafferty, 2010:8). These ethical guidelines are recognized by the South African Nursing Council (SANC) (Harries *et al*, 2009:2).

Moreover, the right to CO is a prerogative of individuals and not religious affiliated or any other health care institutions (Cook and Dickens, 2003:50). Medical personnel conscientiously objecting to performing abortions have an ethical and legal obligation to refer their patients to other non-objecting medical personnel (Cook and Dickens, 2009:108). The same also holds true for pharmacists' duty to provide emergency contraceptive methods (Cantor and Baum, 2004 cited in Card 2007:9). And finally, medical students or trainees may only invoke the right to CO when they have been requested to participate in abortion procedures; they cannot conscientiously object to learning about abortion as an academic or scientific exercise (Dickens and Cook, 2000:76).

Despite the legality of abortion and emergency contraceptive methods under the South African legal framework, section 15 (1)¹ of the South African Constitution protects health professionals' right to CO to the provision of both services. Given this clash of women's rights to access both legal services and health professionals' rights to CO which is also protected under the South African Constitution, this study discusses the views of 117 doctors and pharmacists from across South Africa regarding the question of conscientious objection to the provision of controversial reproductive services, including abortion and emergency contraceptive methods particularly the morning after pill (MAP). Data were collected using an anonymous confidential internet-based self-administered questionnaire (SAQ). James Wolf has defined the latter as "a questionnaire that has been designed specifically to be completed by a respondent without intervention of the researchers (e.g. an interviewer) collecting the data" (2008:804). One of the advantages of using a SAQ, as Jennifer Egan points out is that it is "both economical and time-efficient by reducing travel costs and transcription time (as email transcripts are copied directly into data files)" (2008:244).

A SAQ is ideal for reaching a large, geographically dispersed sample and is a particularly useful way of canvassing the views of those who might not wish to be questioned face-to-face (see Payne and Payne, 2004). Given that abortion and emergency contraceptive methods are sensitive topics, the use of a SAQ allowed health professionals to respond more openly than might have

¹ Everyone has the right to freedom of conscience, religion, thought, belief and opinion.

been the case if the study was conducted using face-to-face interviews. Moreover, given that doctors and pharmacists are busy professionals, a SAQ was deemed to be the most effective tool for collecting data as it gave them the flexibility to respond in their own spare time. Questions in both doctors' and pharmacists' SAQs were informed by the existing literature on the international debate on CO with respect to the provision of controversial reproductive services which for the purposes of this study included abortion and MAPs.

The request to participate in the study was sent to health professionals randomly recruited online from various websites which provide comprehensive listings of South African doctors and pharmacists practicing in both private and public sectors. Doctors' email addresses were retrieved from such search databases or websites as Map-A-Doc, Easy Infor.com and South African Medical Specialists. Pharmacists' email addresses were retrieved from the Yellow Pages website which is the largest online database of South African businesses and services. While the study does not make any claim to the sample being representative of all pharmacists and doctors in South Africa there is considerable diversity in the sample such that it is able to provide insight into the possible ways of framing CO that circulate in South African medical practitioners' abortion discourses.

Ethical approval to conduct this research was granted by the Rhodes University Ethical Clearance Committee. The informed consent of the participants was obtained by way of a consent form which stressed the voluntariness of participation in the study and that answering and returning the SAQ served as adequate indication that the responding health professional had read and understood the aims and objectives of the research and had decided of their own free will to participate. The consent form stipulated that participants would not receive any form of incentive for participation in the research. Participants were assured that their responses would be anonymous in that all identifying information would be removed from their interview transcripts so that no particular response can be linked to a specific person. Participants were instructed to feel free to leave answers blank if they felt uncomfortable with some of the questions. Data collection began on 22 August 2013 and ended on 30 July 2014 when, through a process of constant comparison of the emerging data, it became apparent that a sufficient level of

saturation had been achieved in the sense that no further themes were emergent from the responses being received. Theoretical saturation, as Margarete Sandelowski suggests “is the point in data collection when no new or relevant information emerges with respect to the newly constructed theory. Hence, a researcher looks at this as the point at which no more data needs to be collected (2008:875-876).

Of the 2 292 SAQs emailed to practicing doctors, 58 were completed and returned. Of these responses, 15 doctors practice in the Western Cape Province; 15 in Gauteng; 10 in KwaZulu-Natal; eight in the Eastern Cape; three in Mpumalanga; three in the Free State; two in the Northern Cape Province and two in Limpopo. Questionnaires were completed by 42 male doctors and 16 female doctors. Respondents’ ages ranged from 28 to 84 years and their duration of practice ranged from five to 52 years. Almost all doctors acquired their tertiary education at South African universities including the University of Cape Town; the University of KwaZulu-Natal; the University of Pretoria; the University of Witwatersrand; the University of Limpopo (Medical University of Southern Africa (MEDUNSA)); the University of the North West; the University of the Free State; Walter Sisulu University and Stellenbosch University. A minority in the sample acquired their tertiary education abroad, in Scotland, Canada, the United Kingdom, the United States, Zimbabwe and Nigeria.

Of the 782 SAQs emailed to practicing pharmacists, 59 were completed and returned. Of these respondents 25 practice in the Western Cape Province; 18 in Gauteng Province; seven in the Eastern Cape; six in KwaZulu-Natal ; two in North West Province and one in the Northern Cape. These included 43 males and 16 females. Their ages ranged from 21 to 66 years and their duration of practice ranged from one to 43 years. Almost all pharmacists acquired their education at South African universities including the University of Cape Town; the University of KwaZulu-Natal; the University of Pretoria; the University of the Witwatersrand; the University of Limpopo (Medical University of Southern Africa (MEDUNSA)); the University of the North West; Walter Sisulu University; Nelson Mandela Metropolitan University (NMMU); the University of the Western Cape; Stellenbosch University and Rhodes University. A minority had

studied abroad and some had acquired their pharmacy diplomas through the South African Pharmacy Council (SAPC) or through the Clicks Pharmacies Programme.

Completed SAQs were returned by e-mail, processed, and analysed using qualitative content analysis. According to Cole, content analysis is a method used to analyse written, verbal or visual communication messages (1988). For Heidi Julien, “content analysis is the intellectual process of categorising qualitative textual data into clusters of similar entities, or conceptual categories, to identify consistent patterns and relationships between variables or themes” (2008:120-121). As Julien points out, content analysis can be used for “analysing a wide range of textual data, including interview transcripts, recorded observations, narratives, responses to open-ended questionnaire items, etc.” (2008:121). In health studies, content analysis has been widely employed in research on sensitive topics including abortion (Elo and Kyngas, 2008:114)

In the present study, responses were coded using the ‘directed’ content analysis (DCA) approach. DCA aims to validate or extend a conceptual framework or theory and this is why it is used where there is already (incomplete) existing theory or prior research about a phenomenon which could benefit from further description (Hsieh and Shannon, 2005:1281). In this study, the content analysis was directed by a survey of international literature and comparative experience in countries where abortion and emergency contraceptive methods are legal. Having established the major themes and significant issues from that survey I sought to interpret my data in order to examine whether these same themes and/or different themes emerged in the South African context.

In my analysis I employed the conceptual device of ‘framing’ as a way of understanding and grouping the themes that emerged in the data. Framing refers to the “way events and issues are organised and made sense of” (Reese, 2001:7). Gamson and Modigliani have defined a frame as a “central organising idea...for making sense of relevant events, suggesting what is at issue” (1989:3). Framing analysis has been chiefly employed in describing how public opinion is shaped by media messages. But framing theory has not *only* been employed in the analysis of

media messages. Similar processes of selection and exclusion in order to achieve specified social agendas can be seen with regard to how some social movement organisations employ specific ways of framing an issue to suit their agendas (Rohlinger, 2002:479). This enables a social movement or organisation to control the terms of a debate and to win legitimacy for its cause (Gamson and Wolfsfeld, 1993; McCarthy and Mayer, 1994; Walgrave and Manssens, 2000; Meyer, 1995).

For Kuypers, this is often achieved by “making some information more salient than other information” (2009:181). As Robert M. Entman points out, this process of selection of what is and is not most salient, acts to “promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation” (1993:52). For Erving Goffman, frames play an important role in structuring which parts of reality become noticeable (1974). Reese highlights also the importance of ‘omissions’ in the production of frames which are ‘naturalised’ so that their exclusion seems logical and common-sensical (2001:11). What is of particular importance from the point of view of the present thesis is the idea that frames “generally imply a policy direction or implicit answer as to what should be done about an issue” (Gamson and Modigliani, 1987:144). As Entman points out, frames play a fourfold role, defining problems, diagnosing causes, making moral judgments and suggesting remedies (1993 cited in de Vreese, 2005:53; see also Kuypers, 2009:185).

In the present study, doctors’ and pharmacists’ SAQ responses were analysed with specific attention to how they draw on various frames in invoking or not invoking CO to the provision of TOP and MAP services. As a starting point for data analysis I drew upon prior research by Myra Marx Ferree and her colleagues in their comparative study of abortion discourse in Germany and the United States (Ferree *et al*, 2002). In that study, these scholars grouped hundreds of different idea elements that came through in the way in which abortion was spoken about and referred to in the two countries by a variety of speakers, into eight frames (Ferree *et al*, 2002:106-107). These were: the foetal life frame (focuses on the sacredness of human life; sees the foetus as an unborn child and abortion as the taking of human life), the balancing frame (emphasis on the need to balance two rights that are in conflict with one another – that of the foetus and that of the

pregnant woman; neither is absolute and must be weighed as equally legitimate), the women's rights frame (emphasis on the woman's right to control her own body which affects other rights such as participation in the labour force and in political life), the individual versus state frame (emphasis on the importance of not allowing state intrusion into the private sphere – abortion is seen as a private not a state concern), the social morality frame (emphasis on the idea of moral decline and trend towards permissiveness in society – abortion seen as symptomatic of this overall moral drift), the effects on society frame (abortion seen as inevitably divisive and contested, no ideal solution is possible therefore it is necessary to compromise and find ways of defusing conflict), the pragmatic consequences frame (criminalising abortion does not reduce the number of abortions, but rather results in such negative social consequences as forcing women with unwanted pregnancies into obtaining abortions under conditions that greatly increase their health risks, both physical and psychological and this also increases social costs on the part of the public health system), and the social justice frame (emphasis on asking whether the costs and burdens of existing policies fall unequally on the poor and whether the ability to choose an abortion is unfairly dependent upon social location) (Ferree *et al*, 2002:106-107).

Taking these frames as a starting point for data analysis I aimed to determine if my respondents drew upon these frames to frame their willingness or unwillingness to invoke CO to the provision of TOP and MAP services. Heidi Julien points out that “content analysis can be accomplished using very low-tech materials such as a pencil and paper, coloured sticky notes, or coloured felt pens” (2008:121). Following Julien's suggestion, I did not use any advanced computer-assisted data analysis software to code my data. Having printed all the doctors' and pharmacists' SAQ responses I first familiarised myself with the entire data set by reading the SAQs repeatedly to achieve a sense of the whole (see Hsieh and Shannon, 2005). In qualitative research this is referred to as the researcher's immersion in the data (see Braun and Clarke, 2006:84). I used eight different colour highlighters which were equivalent to the eight frames found by Ferree *et al* in their study. I then undertook line-by-line coding of all the SAQ responses to identify whether or not the responses reflected Ferree *et al*'s eight frames. My finding based on this initial line-by-line coding was that only four of Ferree *et al*'s frames were relevant to my data. These included the foetal life frame, the women's rights frame, the balancing frame and the social justice frame.

Studies which apply a DCA approach have been criticised for the likelihood of encouraging researchers “to force fit observations into existing categories” (Benaquisto, 2008:89). To avoid running this risk I took a holistic approach by attempting to do justice to the entire data set and being open to accommodating responses which could not be coded in line with Ferree *et al*’s eight frames. For this reason, I undertook a second phase of data driven analysis: coding the responses using the method of conventional content analysis (CCA) (Kondracki and Wellman, 2002) in order to allow for additional frames to emerge that differed from those identified by Ferree *et al*. Following this process four additional frames distinct from those found by Ferree *et al* emerged from the data. These included what I shall refer to as the ‘do no harm frame’, the ‘legal and professional obligations frame’, the ‘consequences frame’ and the ‘moral absolutism frame’.

My interpretation of the frames was aided by an understanding of how to analyse discourse drawing on the work chiefly of James Paul Gee. In his book, *How to do Discourse Analysis: A Toolkit*, Gee provides 27 tools for doing discourse analysis (2011). In the present study I drew on five of these including: the ‘why this way and not that way tool’ used to determine what the speaker is trying to achieve by using certain language “in the way in which he or she did and not in some other way” (2011:54), the ‘fill in tool’ used to determine what the speaker is assuming of listeners (2011:11-12), the ‘figured worlds tool’ which enjoins the discourse analyst to ask what figured worlds the speaker is assuming and inviting listeners to assume; used to distinguish between what is regarded as ‘normal’ or ‘abnormal’ (2011:168), the ‘deixis tool’ normally used in research on racism and noticing for instance the use of such terms as ‘they’ and ‘us’ (2011:7) and the ‘subjects and predicates tool’ which enjoins the discourse analyst to “ask what socially recognisable identity or identities the speaker is trying to enact or to get others to recognise” (Gee, 2011:18).

As defined by Gee, “discourse analysis is the study of language-in-use [or in other words] it is the study of language at use in the world, not just to say things, but to do things” (2011:ix). It follows from this that Gee enjoins the discourse analyst not to take for granted what people say,

rather he or she ought to go beyond the intention of what people say and resurface what they have not directly said in their communication. For this reason, in this study, I use Gee's five tools to unearth hidden assumptions in what some of the participants have indirectly said or left unsaid in their SAQ responses which in turn plays an important role chiefly in determining their willingness or unwillingness to provide termination of pregnancy related services.

In the chapters that follow I describe each of these frames in more detail and then, in separate chapters go on to show how the personal attitudes of health practitioners to their right (or non-right) to invoking conscientious objection to the provision of TOP and related services is legitimized by how they choose to frame abortion, how they choose to frame their legal and professional identities and obligations, how they frame women's rights (for example, as absolute or confined to certain circumstances), how they frame the nature of the foetus (for example whether or not foetuses are rights-bearing subjects and whether or not life begins at conception), how they frame who does and does not deserve these services (based for instance on moral attitudes towards promiscuity, teenage sexuality and the like) and so on. Having described each frame in more detail the individual chapters of the thesis draw on exemplars from the primary data to show how these frames are invoked in practice in the words of the respondents. While all South African women have the legal right to abortion on demand the right to the MAP without limitation based on frequency of request or the age of the requesting client, the thesis shows that these rights are severely restricted depending on how the nature of the right is constructed by those who are responsible for securing its provision in practice.

Chapter two: approaches to the right to conscientious objection in medical practice

CO and termination of pregnancy

While supporters of the right to abortion on demand hold that women have the right to dispose of their bodies as they choose and that the unborn have neither rights no moral standing (van

Bogaert, 2002:139), the alternative view which supports the right of medical practitioners to conscientiously object to the provision of abortion and related services rests “its case on the inalienable right to life of the unborn; no right is granted to the woman” (van Bogaert, 2002:139). The Roman Catholic Church upholds this view as its teachings associate abortion with murder because of the belief that the life of a human being begins at conception (Collins, 2006:45; see also Deckers, 2010:1-2; Williams, 1958:181). In this respect, the Roman Catholic Church unconditionally opposes laws which legitimise abortion because under its teachings, it is a crime and thus, it enjoins its followers to invoke CO if requested to participate in abortion procedures (Whitcomb, 2010:772; see also Catholics for Choice, 2010:1). The origins of these teachings date back to 1869 when Pope Pius IX held that “abortion at any time during the pregnancy is punishable by excommunication” (Collins, 2006:45). To participate in abortion in any way, in this view, would be to collude with murder (Whitcomb, 2010:795).

The right to CO has long been protected under several international human rights instruments, conventions and treaties as a component of the right to freedom of thought, conscience and religion (Catholics for Choice, 2010:2). Since it is acknowledged that some medical practitioners may subscribe to the view that life begins at conception and that participation in, or collusion in any way with, abortion is tantamount to murder, the right to CO is seen as a mechanism to protect medical personnel from being coerced into actions which violate their deeply held religious, moral and ethical beliefs (Collins, 2006:47). For instance, both the Universal Declaration of Human Rights,² and the International Covenant on Civil and Political Rights protect an individual’s freedom of conscience³ (Ngwena, 2003:5). Similarly, on a regional level, the European Conventions on Human Rights⁴ and the African Charter on Human and Peoples’ Rights⁵ also contain conscience clauses.

² Article 18.

³ Article 18.

⁴ Article 9.

⁵ Article 8.

There are scholars who defend medical professionals' right to CO while not necessarily themselves taking the view that abortion is murder. They base their argument on the fact that medical professionals are individuals whose moral integrity deserves serious consideration (Wicclair, 2007:21; see also Wicclair, 2000; Brock, 2008 cited in Magelssen, 2012:18; Gerrard, 2009 cited in Magelssen, 2012:19; Childress, 1979:327; Matheny Antommara, 2011:82; Stein, 2006). As such, they should not be forced to act against their conscience as doing so will be putting their moral integrity at stake. In sum, these proponents of conscience are strongly in agreement with the position that "the health care professional's right to CO concerning abortion is never overridden by patient interests" (Stein, 2005 cited in Strong, 2007:32). Examples of this approach are the Mississippi Health Care Rights of Conscience Act 2004,⁶ and California's Health and Safety Codes.⁷ Both these Acts allow health care professionals to subordinate the wishes of their patients to their own preferences (Dickens, 2008:1240-1241).

Research in Africa and primarily in Sub-Saharan countries such as Zambia (Ngwena, 2004:714) and South Africa highlights the concern that where claims to CO are permitted as a reason to refrain from providing legal medical services, while empowering medical personnel this is at the expense of the interests of their patients and particularly of those who lack the economic means to secure private medical services (Harrison *et al*, 2000:429). In this context, while the right to freedom of conscience is protected under international law, some (see Whitcomb, 2010:773) argue that this right cannot be viewed as an absolute right. As such, to prevent the patient's right to access to lawful abortion services from being jeopardised by the healthcare professional's right to freedom of conscience, courts are now enjoined to impartially balance these competing rights (Dickens, 2006:515).

The healthcare professional-centred approach is criticised by those who favour a professional ethics approach to CO. This approach is aimed at limiting health care professionals' right to CO in order to ensure that women can have effective access to abortion services. Rather than making

⁶ MISS. CODE ANN. § 41-107-1 (West Supp. 2005).

⁷ Section 2595 allows health care workers to opt out of providing abortion services if they sign a written declaration stating they hold "a moral, ethical, or religious objection".

the health care worker's right to conscience pre-eminent, this approach emphasises limiting health care professionals' right to CO to ensure the delivery of effective healthcare services in a way that is respectful of patient autonomy to choose legal services of their choice. This view advocates for medical professionals to place the welfare of their patients at the heart of their professional obligations (Wicclair, 2007:21; see also London and Baldwin-Ragaven, 2008; Brody and Miller, 1998; Dickens and Cook, 2006).

Health care professionals' obligation to prioritise patient care is thought, in this view, to be derived from the obligations that rightfully flow out of the nature of the professional-client relationship (Cannold, 1994:80; see also Emmanuel, 1991:14; Meyers and Woods, 1996). Some have argued, along these lines, that individuals not prepared to implement legal medical services on the grounds of CO should not be medical professionals (see Savulescu, 2006 cited in Curlin *et al*, 2007). Savulescu bases this strong view on the fact that claims of conscience are not always genuine and may be invoked to avoid disagreeable professional duties (2006:294; see also Cook and Dickens, 2009:108). Meyers and Woods advocate the need to distinguish genuine from not genuine claims of conscience (2007; see also Meyers and Wood, 1996). They recommend "a system similar to that used for exemption from military service, one that incorporates a review board for evaluating claims of genuine conscientious objection" (Meyers and Woods, 1996:118-119; see also Meyers and Woods, 2007:20).

Those who express concerns about the invocation of CO by health care professionals on whichever grounds, argue that these practitioners illegitimately deny patients lawful medical services and as such violate their professional duty to respect the patient's autonomy (Frader and Bosk, 2009:66). According to this view, "physicians who fail to act in their patient's interests breach the fundamental duty of care of a physician" (Savulescu, 2007:22; see also Amado *et al*, 2010:123, CEDAW, 1998; Cook *et al*, 2003). This is because given that women possess a positive right to abortion in countries where abortion is legal, as Savulescu further argues, "health professionals have an obligation to provide abortion services, irrespective of their personal views" (2006). Cook and Dickens add that medical personnel conscientiously objecting to performing abortion procedures violate women's rights to reproductive health (2009:108). To

prevent this from happening, many authors have emphasised the need for human rights education regarding abortion which they believe would empower health care professionals to fulfil their legal responsibilities (Newman and Helzner, 1999:463; see also London and Baldwin-Ragaven, 2008; Freedman, 1995:314).

A somewhat moderated version of this approach attempts to take into account both the right to legal medical services on the part of patients and the right to act in accordance with deeply held ethical commitments on the part of medical personnel. While the right of medical personnel personally to conscientiously object to performing abortions is upheld, according to this position these medical personnel nevertheless have an ethical and legal obligation to timeously refer their patients to other willing or non-objecting medical personnel in order to ensure that their patients' health is not jeopardised (Cook and Dickens, 2009:108; see also; Dickens and Cook, 2000:72; Card, 2007:13; McLeod, 2010:30; McCafferty, 2010:6-8; Berer, 2002:32; Wicclair, 2000:226; Charo, 2005:2471; Blustein, 1993). Mandatory referral is thus seen as central to the fulfilment of healthcare professionals' obligations (Curlin *et al*, 2007:597) and as a reasonable and viable alternative to the outright denial of abortion services to women as a result of CO.

This has become a popular approach to managing CO in medical contexts but some authors have criticised mandatory referral as ineffective from the perspective of women's rights to reproductive health. Robert Card for instance advocates forcing health care professionals to provide abortion services irrespective of their personal or moral views (2007 cited in Strong, 2007:32; see also Deckers, 2010:5; Charo, 2005; Savulescu, 2006; Cantor and Baum, 2004). Card blames referrals for causing delays to access to abortion care – and notes that such delays disproportionately negatively affect economically disadvantaged patients in particular and primarily those living in rural areas (2007:9-10). Savulescu points out that in many settings referrals compromise the quality, efficiency, or equitable delivery of a service to which women are legally entitled (2006:296).

The compromise position of referral is also rejected by those who support the absolute right to CO (see Edmund Pellegrino, 2008:297; John Peppin, 1997:40) and totally reject not only the actual performing of abortion procedures but also mandatory referral, and even the provision of information about TOP services. In this view, since abortion is thought to be murder, there are no moral imperatives to participate in any way in an act of murder, however indirect that participation may be.

Conscientious objection and emergency contraception (EC)

Until recently, much of the literature on CO has focused on medical personnel's right to conscientiously object to performing or participating in any way in controversial procedures such as abortion and euthanasia. But pharmacists have not been exempt from the debate thanks to the increasing availability of EC. The construction of EC as an abortifacient emerges as a crucial definitional contention in the CO debate with conscientiously objecting pharmacists and judges joining forces with anti-abortion proponents to oppose the provision of EC on the grounds that it induces abortion.

Post-coital emergency hormonal contraception (EC) also popularly known as "Plan B" or the "morning-after pill" (MAP) has clinically been defined as "the use of a drug or device as an emergency measure to prevent, or reduce the risk of an unwanted pregnancy" (Cheng *et al*, 2004). Trussell *et al*, have defined ECs as "ordinary birth control pills containing the hormones oestrogen and progestin" (1998:52). EC works up to 72 (although most effectively up to 24) hours after unprotected sexual intercourse (Boonstra, 2002:10) by stopping ovulation or by decreasing the chances of implantation or fertilisation (Pope, 2010:67). Unlike oral or regular contraceptives, EC pills are often taken in one or two doses to prevent pregnancy as they normally contain large doses of oestrogen and levonorgestrel or a progestin congener (Wernow and Grant, 2008:1670). Although clinical trials of EC were first conducted in the 1960s, the medication first became available in 1970 in the form of the Yuzpe Regimen method which employed a combination "high-dose of oral contraceptive containing ethinyl estradiol, and levonorgestrel" (Mishra and Saxena, 2013:18).

Piaggio *et al*, have argued that EC is a safe means of preventing pregnancy following unprotected sexual intercourse or potential contraceptive failure (1999 cited in Weisberg and Fraser, 2009:160). EC has been evaluated and approved by international organisations like the WHO as safe and effective to dispense with written instructions only (WHO, 1996:31-36). This approval according to recent literature stems from the fact that ECs have minimal side effects which often resolve after 24 to 72 hours (these may include nausea, vomiting, abdominal pain, fatigue, headache, dizziness and/or breast tenderness) (Glasier, 2013:309). This has led advocates of the medication to argue in favour of unrestricted access to EC dispensed over-the-counter (OTC) on the grounds that minimal health risks are involved (Grimes, 2002:846).

In pharmacy practice, pharmacists interact directly with the final consumer of medicines (Wingfield *et al*, 2004:2384). For this reason, Sneeringer *et al*, refer to pharmacists as “first-line health-care providers” (2012:219-220). Literature in various settings (Nikajima and Steinbach, 1997; Ramos *et al*, 2004; Garcia *et al*, 2003) confirms that pharmacists successfully facilitate the rapid dispensing of medications, medical information, client counselling and maintaining client confidentiality. Sneeringer *et al*, have applauded pharmacists for delivering “care related to stigmatised health conditions, including sexually transmitted infections (STIs), family planning, and EC” (2012:219-220).

It is in this context that Heather Boonstra argues that making EC available OTC has enormous potential impact on advancing women’s reproductive rights by ensuring women’s easy access to ECs without having to obtain a doctor’s prescription (2002:10; see also Weisberg and Fraser, 2009:160). However, in reality, this has not always proved to be the case. Even in those countries which have approved OTC dispensing of MAPs and where these are meant to be easily available and provided free of charge, many women still face numerous barriers to accessing ECs.

For some pharmacists, as Wingfield *et al*, have noted, EC is a controversial drug regardless of its legality and for this reason “pharmacists may block the patient’s access to these [ECs] drugs”

(2004:2384). In many countries in which OTC dispensing of EC is legal, there is ample evidence of reluctance on the part of some pharmacists to fill prescriptions for ECs because of their personal belief that these are synonymous with abortifacients used to induce an early abortion (Cadwell, 2011). A proportion of these pharmacists take the view that the sanctity of human life begins immediately after conception, and for this reason they find the use of EC morally objectionable (Dresser, 2005:9).

Pharmacists who conscientiously object to dispensing EC on these grounds, however, have been criticised by proponents of EC who hold that “it [EC] does not affect an existing pregnancy nor will it cause an abortion (Cockerill *et al*, 2004:71). Rather, EC prevents pregnancy by stopping or delaying ovulation or by preventing fertilisation (Collins, 2006:43; Feijo, 2005). Consequently, these authors view denial of lawful EC upon request as a strong violation of women’s reproductive rights (Weisberg and Fraser, 2009:160; see also Ramkissoon *et al*, 2010:36).

Proponents of CO argue for pharmacists’ exemption from professional duties which are contrary to their consciences. They base their argument on the fact that pharmacists are individuals whose moral or personal integrity must be respected (Wicclair, 2007:21; Wicclair, 2000; Deans, 2013; Brock, 2008 cited in Magelssen, 2012:18; Childress, 1979:327; Matheny Antommara, 2011:82; Stein, 2006). Their argument is that to force pharmacists to act against their consciences is tantamount to compelling them to commit a moral wrong.

Benn submits that forcing pharmacists to act contrary to their consciences has the potential to cause distress and anger (2007:345) whereas Beauchamp and Childress argue that to do so would be a serious violation of the pharmacist’s right to autonomy and self-determination (1983:390). Autonomy is a fundamental right in liberal democratic societies and refers to “recognising the importance of a person’s freedom to choose for himself the values in terms of which to structure and measure the worth of his own life” (Keller, 2009:258). For Mark Wicclair, forcing someone to act against their conscience results in significant loss of self-respect (2007:21). Martin

Benjamin contends that violating one's conscience may not only result in loss of self-respect, but also in guilt and shame (2003:469).

Between these two poles lies a more moderate view espoused for instance by Julie Cantor and Ken Baum (2004 cited in Card, 2007:9) who advocate for imposing on the objecting pharmacist an ethical and legal duty to timeously refer a woman requesting EC to another (non-objecting) pharmacist or a different pharmacy in order to ensure that the woman's health and reproductive rights are not jeopardised (see also Lynch, 2008). Referral is seen by several commentators as an appropriate compromise which respects the autonomy of both the pharmacist and that of the patient. Kohm argues that a referral ensures that the pharmacist retains his or her autonomy by not being forced to directly participate in dispensing medication which he or she regards as objectionable but at the same time the patient's access to reproductive justice is not undermined since she is given advice on how to access EC from another non-objecting provider (2007:802). In countries where EC is legally available it is a woman's right to demand access to what the law provides. Referral is thus seen to play an important role in ensuring that the patient is not denied reproductive justice by being confronted with a conscientiously objecting pharmacist (Kelleher, 2010:295; see also Deans, 2013:57).

The contrary position is argued by Robert Card who argues that professional ethics imposes obligations upon pharmacists regardless of their personal beliefs, not only to refer clients to another pharmacist, but to actually dispense EC upon the provision of a valid legal prescription (2007 cited in Strong, 2007:32; see also Charo, 2005; Savulescu, 2006; Cantor and Baum, 2004; Deckers, 2010:5). Others criticise referral on pragmatic grounds. For them, given that EC is a time frame drug, that is to say, it is effective if taken within 72 hours of unprotected intercourse, referral might be impractical or might cause delays for economically disadvantaged patients living in rural areas or in small towns that effectively result in denial of the service to such women. As Teliska suggests, given the scarcity of pharmacists, "women who live in rural areas with only one available pharmacy should not be forced to go without contraception simply because the presiding pharmacist does not agree with the prescription" (2005:231; see also Dresser, 2005:9).

Others who oppose the right of pharmacists conscientiously to object to dispensing EC or referring patients to a willing provider base their views on the professional and ethical obligations imposed by pharmaceutical regulatory and professional bodies. As argued by Herbe, serving the best interests of patients must be the pharmacist's primary commitment and concern in conducting his or her professional duties (2002:87). Likewise, as Brodsho avers "the needs of the patient must trump the pharmacist's moral objection" (2005:331). For this reason, Lumpkin contends that "the pharmacist has a duty to the patient to provide all medications including EC" (2005:125).

Wall and Brown similarly stress that pharmacists should be obligated to fill prescriptions for EC regardless of their personal values and opinions as failure to do so destructs effective delivery of medical care (2006:1148). Moreover, for Wall and Brown the primary consideration is to challenge the view that EC is an abortifacient in the sense that it "does not interfere with an implanted pregnancy and therefore does not cause abortion" (2006:1148-1150). On this view, even if one is morally opposed to abortion, dispensing EC does not conflict with an important moral standpoint. Wall and Brown thus conclude that surveillance systems should be employed to hold liable pharmacists who fail to fill legitimate prescriptions for all lawful medications, including EC (2006:1151).

But referral is not only opposed by those who want to insist that pharmacists have a duty to dispense legally prescribed medications. Referral is also not an acceptable solution for those opposed to the provision of EC. They argue that referral would make the pharmacist morally complicit in the death of an innocent (Keller, 2009:259). Thus, pharmacists who object to personally dispensing EC on moral grounds often also object to referring their clients to other providers (Card, 2007:9; see also May and Aulisio, 2009 cited in Lewis and Sullivan, 2012:117). As Robert Card explicates, replacing a duty to dispense with a duty to refer "does not remove the pharmacist from the causal chain of events that leads to the use of EC, an act that is considered morally wrong by such objecting pharmacists" (2007:9).

Conclusion

Pharmacists play a crucial role in any country's reproductive rights regime particularly for poorer women who may not have ready access to other medical facilities. But legal approval for OTC dispensing of MAPs has not resolved the tension between the right of the CO invoking pharmacist who sees dispensing MAPs as tantamount to colluding with abortion and the right of the woman seeking a medical remedy that science has described as preventing pregnancy rather than causing abortion. The medical definition notwithstanding, many pharmacists continue to see ECs as abortifacients and therefore as morally repugnant. So much so, that a proportion of these see even referring an EC-seeking patient to another willing provider as morally unacceptable.

In the eyes of their detractors, medical practitioners who refuse to perform lawful medical procedures or to prescribe legal medication are violating not only professional but legal guidelines and are preventing women from accessing their lawful rights. Moreover, their CO does not affect all women equally but rather, differentially affects poorer women. While insisting on a duty to refer is seen by some as a moderate middle ground compromise position, some argue that professional and legal obligation outweighs any consideration of personal conscience or belief and that this extends to a duty to refer. For those who refuse even this minimal duty collusion in any form with an act regarded as immoral can never be required.

Having traced the contours of the international conversation regarding the tension between medical practitioners' right to invoke CO to the provision of termination of pregnancy and related reproductive health services such as the MAP, I turn now to examine these debates as they have played themselves out in practice in selected countries where these services are legal, before going on to describe the South African context for the debate in more detail.

Chapter three: medical practitioners and conscientious objection in selected countries where TOP and MAPs are legal

At the International Conference for Population and Development (ICPD) or Cairo Conference states made a commitment to ensure that “in circumstances where abortion is not against the law, such abortion should be safe” (Kulczycki, 1996:1663). However, in reality, recent literature suggests that this ICPD recommendation has remained a reality only on paper and not in practice. The legalisation of abortion is still failing to give women full access to abortion in many different contexts (Wheeler *et al*, 2012:154). This is partly because the evolution of sexual and reproductive rights and the reforming of abortion laws in many countries has coincided with many medical personnel conscientiously objecting to providing these services (Heinonline, 2002-2003:88). Despite it having been identified as being one of the most important Millennium Development Goals (MDGs), the promotion of the provision of safe abortion has hardly enjoyed universal support. Internationally, even in countries where abortion and related services are legal, there are many challenges with the successful implementation of abortion legislation and policies. Religious leaders, politicians, pro-life movements and organisations, the general public, the judiciary and some medical professionals have challenged the idea that abortion on demand is every woman’s right. In many different contexts, as this chapter shows, the right of medical practitioners’ to conscientiously object to taking part in the provision of legal termination of pregnancy and related services has clashed with women’s legally enshrined reproductive rights. The international context shows also that poorer women are always most severely affected by the invocation of the right to CO on the part of state-employed medical practitioners.

In countries such as Italy, the United States and Ireland, the Catholic Church has been particularly vocal and influential in supporting the right of medical practitioners to oppose the provision of legal termination of pregnancy services. The Roman Catholic Church unconditionally opposes laws which legitimise abortion because under its teachings, abortion is a crime and thus, it enjoins its followers to invoke conscientious objection (CO) if requested to participate in termination of pregnancy (TOP) procedures (Whitcomb, 2010:772).

The Catholic hierarchy through the Holy See and the Bishops in many countries want to end abortion and access to contraception by claiming that the consciences of medical professionals are routinely violated and by seeking to expand the number of services covered by these exemptions (Catholics for Choice, 2010:1).

To participate in TOP services in any way, in this view, would be to collude with murder (Whitcomb, 2010:795). Endorsing the Roman Catholic belief that human life starts at conception, in 1869 Pope Pius IX argued that abortion at any time from conception is punishable by excommunication (Collins, 2006:46). This doctrine has remained unchanged. Given that these teachings are compulsory to all Roman Catholics, the church leaders in many countries with liberal abortion laws have in recent years become very influential mobilisers of people to oppose abortion (Dickens and Cook, 2011:162). These Catholic Church leaders include cardinals, bishops, and priests who have been at the forefront of challenging women's reproductive rights including the distribution of emergency contraceptive methods, abortifacients and the provision of surgical abortion services. In some settings, the main targets are health care professionals who are then faced with the dilemma of whether or not they should provide elective abortions which their countries' abortion laws oblige them to do but their church's teachings oblige them not to participate in (Whitcomb, 2010:772).

The United States of America (USA)

In 1973 the United States Supreme Court ruling in *Roe v. Wade* legalised abortion by emphasising the concepts of privacy, liberty and a woman's autonomy over her body (Grelewicz, 2011:178). This decision subsequently saw the 1975 joint federal-state health care programme which provides the nation's low-income population with basic health and long-term care coverage known as 'Medicaid' being extended to cover abortion care without restrictions in order to ensure that abortion services could also be accessible to indigent women who could not afford to pay for the services (National Abortion Federation, 2006). This progressive programme was however short-lived. As Yanda *et al*, have argued, "in the United States, over the past three

decades, state legislation and further court cases have narrowed the range of access to abortion, especially for poor women and adolescent girls” (2003:281).

This process started almost immediately following *Roe v Wade* when, on September 30, 1973 a powerful politician in the House of Representatives, Representative Henry Hyde sponsored the Hyde-Weldon Conscience Protection Amendment, also known as the Hyde-Weldon Amendment, a legislative provision barring the use of certain federal funds to pay for abortion with the exceptions of pregnancies resulting from incest and rape (National Abortion Federation, 2006). The passage of this legislation meant that women seeking elective abortions had to pay out of their own pockets for safe, legal abortion procedures.

In the same year former Senator Frank Church proposed the Church Amendment, which would permit health care providers to conscientiously object on the grounds of religious or moral beliefs to performing or assisting with abortions or sterilisations (Gold and Sonfield, 2000). The Church Amendment also protected health care providers from being discriminated against for making such objections and by the end of 1974, more than half of the states had endorsed the Church Amendment (Gold and Sonfield, 2000).

The first challenges to the Hyde-Weldon Amendment came shortly after its implementation in the form of two cases: *Beal v. Doe*, 432 U.S. 438 (1977) and *Maher v. Roe*, 423 U.S. 464 (1977). Both cases concerned indigent women who challenged their respective state laws for denying them state-funding to cover abortions which they claimed to be eligible to under the 1975 Medicaid health programme which provides the nation’s low-income population with basic health and long-term care coverage (National Abortion Federation, 2006). In both cases the restrictive provisions of the Hyde-Weldon Amendment were upheld as constitutional with the courts ruling that states participating in the Medicaid programme do not have the obligation to pay for abortions for indigent women where the grounds are non-therapeutic or non-medical (National Abortion Federation, 2006).

In 1996 another influential American politician, Representative Dave Weldon proposed the Weldon Amendment which aimed at barring physicians and hospitals from performing abortions or sterilisations as a condition of receipt of federal funds (Dickens, 2009a:725). Shortly after the passage of the Weldon Amendment, a Californian Court challenged the provisions of the Amendment as unconstitutional on the grounds that it interfered with effective enforcement of California's law providing for criminal and civil penalties against healthcare workers in some circumstances if they do not perform or refer abortions (Dickens, 2009a:725). In the 2008 case of *State of California v. United States*, the California federal Court judge, however, rejected California's challenge to the Weldon Amendment. In that case, the Court upheld the provisions of the Weldon Amendment and ordered the state of California to refrain "from fining and criminally prosecuting health care workers and entities refusing to perform abortions" (Dickens, 2009a:725).

While the right to CO is recognised as a prerogative only for individual medical professionals and not health care institutions including religious affiliated hospitals, in practice, devout Catholics who hold top positions in Catholic-run hospitals are able to prevent women's access to safe and legal abortions at these institutions (see Cook and Dickens, 2011:164-165). In an attempt to overturn legislation restricting abortion prior to foetal viability, the United States introduced the first version of the Freedom of Choice Act (FOCA) in 2008 which aimed at providing American women with a positive, statutory right to an abortion (Whitcomb, 2010:801-802). The FOCA was subsequently challenged by Roman Catholic hospital management staff (Whitcomb, 2010:801-802). Some Catholic leaders threatened the closure of all Catholic-run hospitals if FOCA were to be passed. Among these was Bishop Thomas Paprocki of Chicago who in 2008 explained to a gathering of over 300 Church-leaders: "If Catholic hospitals were required by federal law to perform abortions, we'd have to close [them]" (Brachear, 2008). Given that a significant number of United States hospitals are owned by Roman Catholic authorities this is a serious challenge to the legal right of women seeking abortion procedures.

The CO debate in the United States was extended to pharmacy practice when, on August, 24, 2006 the Federal Drug Administration (FDA) announced the availability of EC over-the-counter,

without prescription to women of 18 years old and over. Following this approval, in many states, pharmacists began to turn away women trying to fill their EC prescriptions (Brock, 2008:187). As a result, some states enacted mandatory fill-in laws which obliged pharmacists to honour all valid and lawful prescriptions while others passed laws with ‘conscience clauses’ to protect pharmacists refusing to dispense EC on the grounds of conscience (Stein, 2012).

The FDA’s approval of OTC sales of EC was not only challenged by registered pharmacists, but also by anti-abortion and ‘pro-family’ movements including the United States Conference of Catholic Bishops, the Family Research Council and Concerned Women for America (Boonstra, 2002:12-13). These movements reject the established scientific definition of EC as acting to stop ovulation (Pope, 2010:67), and insist instead that EC is effectively an abortifacient (Boonstra, 2002:12). Opposition also came from some leading drug retailers specifically Wal-Mart which refused to carry ECs as part of their regular stock on the grounds that doing so would be tantamount to facilitating abortion (Boonstra, 2002:11).

The more extreme end of the spectrum of CO to the provision of EC was illustrated by a 2004 Texas case of three pharmacists who were subsequently fired following their refusal to fill a rape victim’s prescription for EC arguing that it violated their moral beliefs (New Practitioners Forum, 2007:139). A study which investigated the accessibility of ECs at hospital emergency departments by surveying staff at Catholic and non-Catholic hospitals in Pennsylvania, South Dakota, and Colorado found that staff at 42% of non-Catholic hospitals and 55% of Catholic hospitals admitted to objecting to dispensing EC, even in cases of sexual assault (Harrison, 2005:108).

In some cases pharmacists not only refuse to dispense EC, but also refuse to refer their patients to willing providers as required by the provisions of the American Pharmacists Association (APhA). A highly publicised case in this regard was that of a Wisconsin pharmacist who not only refused to fill a prescription for EC, but also refused to return the prescription to the patient so that she could have it filled by a non-objecting pharmacist elsewhere (New Practitioners

Forum, 2007:139). A 2006 Californian case involved a young mother who was refused EC after failure of regular birth control. Despite the fact that she had a valid prescription from a medical doctor the pharmacist on duty not only refused to fill the prescription, but also “refused to enter the prescription information into the system so that it could be transferred elsewhere” (Morrison and Borchelt, 2007:6).

The APhA recommends that conscientiously objecting pharmacists should always refer EC-seeking women to willing pharmacists (Crary, 2004). However, states like South Dakota and Arkansas explicitly offer legal protection to pharmacists who refuse to fill prescriptions for EC (Fisher, 2005) if they believe it is an abortifacient and neither of these states’ statutes provide a referral provision (Afif, 2005:257). Mississippi’s law also contains conscience clauses which permit individual pharmacists and pharmacies to refuse to provide both EC and oral contraceptive services on the grounds of conscience (Collins, 2006:49).

Idaho’s new Freedom of Conscience Act took effect on July 1, 2010. Under this law, “[n]o health care professional shall be required to provide [certain] health care service[s] that violate his or her conscience.”⁸ It defines a provider’s ‘conscience’ as incorporating “religious, moral or ethical principles sincerely held by the person.”⁹ In 2011, this conscience clause was extended to Idaho pharmacists, giving them the right to refuse to provide any health care service or dispense any drugs which violate their conscience including EC and other abortifacients (Alarcon, 2011).

US case law on pharmacists conscientiously refusing to dispense EC reveals that many judgements have been handed down in favour of objecting pharmacists even in states whose laws and professional regulatory bodies legally oblige pharmacists to provide EC services. For instance, on June 7th, 2007 the Washington State Pharmacy Board endorsed a new rule that would permit conscientiously objecting pharmacists to refuse to fill any prescription based on their personal beliefs on condition that they refer the patient to other non-objecting pharmacists.

⁸ Idaho Code § 18-611(2).

⁹ Idaho Code § 18-611(1).

In March 2012, pharmacists successfully challenged this rule in the Washington District Court. Judge Ronald B Leighton ruled that it is unconstitutional to compel pharmacists to stock and dispense EC because conscience formed by “a sincere religious belief that EC terminates a human life” should be respected (Phillips, 2012). The judge who handed down this judgement referred to EC as an abortifacient in order to give precedence to these pharmacists’ right to religious beliefs-based conscience over their obligation to refer their patients to other willing providers.

Unlike laws in Mississippi, South Dakota, Georgia and Arkansas which protect individual pharmacists’ rights to refuse to fill prescriptions (Alan Guttmacher Institute, 2005 cited in Collins, 2006:12), the 2005 Illinois bill requires a pharmacist to fill EC prescriptions against his or her conscience. Following the enactment of this bill, the then governor of Illinois, Rod Blagojevich issued an emergency rule requiring pharmacists to provide EC without delay (regardless of their religious beliefs) upon receipt of a valid prescription (Collins, 2006:58). Blagojevich based his mandate on the grounds that Illinois’s ‘right-of-conscience’ law applied only to physicians and not pharmacists (Collins, 2006:58). Blagojevich’s statement marked the beginning of the pharmacists’ CO debate in Illinois. Illinois pharmacist, Luke Vander Bleek told the lawmakers that “I will not invest, and I will not practice in an environment in which we are legally obligated to be involved in the destruction of human life” (Ertelt, 2005).

Likewise, Wendy Wright, a policy director for Concerned Women of America condemned Blagojevich’s mandate as insensitive to pharmacists’ right to follow their consciences and be exempted from performing activities that they believe are harmful to human life (Ertelt, 2005). Three pharmacists subsequently took the issue to court, suing the state to overturn the ruling (Ertelt, 2005; see also Maloney, 2005). The case lasted more than seven years until, finally on 21 September 2012 an Illinois Appellate Court ruled in favour of the pharmacists and held that “the state cannot force pharmacists and pharmacies to sell abortion-inducing drugs in violation of their religion” (Gasser, 2012). Like the above Washington case, the Judge in this case also referred to EC as an abortifacient in order to put it in the same category with other controversial medical procedures to justify the ruling.

Among other professional obligations, the APhA enjoins pharmacists to place “the well-being of the patient at the centre of their professional practice” by promoting and respecting the needs, good, autonomy and dignity of every patient.¹⁰ In the light of this, Afif argues that legal protection for pharmacists who refuse to dispense EC is effectively “protecting one class of individuals at the expense of another” (2005:257). However, there are other instances where the US courts have played an important role in advancing women’s rights to access EC regardless of their age. In New Hampshire, Washington, California, Alaska, Hawaii, New Mexico, and Maine, pharmacists can distribute EC without a prescription from a physician (Miller, 2006:247). A current New York bill seeks to ensure the availability of EC to all women of child bearing age. The bill became law on 5 April 2013 following the US District Court Judge Edward Korman’s order (through the case of *Tummino v. Hamburg*¹¹) to the FDA to make EC available to women and girls of all ages without a prescription (it was previously available OTC only to women aged 17 years and above) (Family Planning and Contraception Research, 2013). Once again the question of whether EC can be defined as an abortifacient emerged as a significant feature of the judgement. However, in this case drawing on careful examination of scientific evidence and in agreement with the conclusions of the experts at the U.S. FDA the judge was of the view that EC interrupts rather than aborts a pregnancy. Based on this the judge subsequently ordered the FDA to make levonorgestrel-based EC “available without a prescription and without point-of-sale or age restrictions within thirty days” (Ibis Reproductive Health, 2013).

The United Kingdom (UK)

The UK’s Abortion Act, 1967, includes England, Scotland and Wales, but not Northern Ireland. In 2008 the Northern Ireland Attorney General, John Larkin QC compared TOP for reasons of severe deformity as synonymous to “putting a bullet in the back of the head of the child two days

¹⁰http://www.aphanet.org/AM/Template.cfm?Section=Pharmacy_Practice&CONTENTID=2903&TEMPLATE=/CM/HTMLDisplay.cfm.

¹¹ *Tummino v. Hamburg*, 2013 WL 1348656.

after it's born" (*BBC News Northern Ireland*, 2012). Research shows that the UK as a whole is experiencing a massive shortage of younger generation obstetrician-gynaecologists willing to acquire the necessary skills to provide adequate abortion services in the future. Several studies have documented the substantially declining numbers of younger generation students wanting to study in the fields of obstetrics and gynaecology and this has negatively affected health care services' ability to cope with rising demand for abortion services. For instance, a recent survey of students revealed that nearly half of the surveyed participants "believed in the right of doctors to conscientiously object to any procedure" on moral, cultural and religious grounds (Strickland, 2012:23; see also Roe *et al*, 1999:97). Likewise, Laurance also reported the declining numbers of students opting for a career in obstetrics and gynaecology (2007). Additionally, the 2007 statistics issued by the Department of Health revealed that although there are an increasing number of abortions taking place in the UK, fewer and fewer doctors are willing to perform them (Department of Health, Abortion Statistics, England and Wales, 2007).

Pro-life organisations and movements in the UK such as the London-based Pro-Life Alliance have been highly influential in mobilising health care professionals and encouraging them to conscientiously object to providing TOP services (Zenith, 2007). In 2007 its spokeswoman Julia Millington celebrated declining abortion rates in public clinics when she noted: "We have been hearing for some time now that young doctors, in particular, do not want to work in this field. Those choosing to go into medicine presumably do so because they want to cure sickness and disease, not end the lives of innocent human beings" (Zenith, 2007).

The so-called 'Scottish Midwives case' threw into sharp relief the clash between the medical practitioner's right to CO (protected in the UK under the 1967 Abortion Act) and women's right to termination of pregnancy (protected under the same Act's provisions) in the UK. The case¹² concerned two Roman Catholic midwifery sisters Ms Mary Doogan, from Garrowhill in Glasgow, and Mrs Concepta Wood, from Clarkston in East Renfrewshire, who were employed as labour or maternal ward coordinators at the Southern General Hospital in Glasgow (*BBC News*, 2013). Upon entering into their profession, both midwives registered their conscientious

¹² Doogan and Wood v. NHS Greater Glasgow & Clyde Health Board [2013] CSIH 36.

objection to participation in pregnancy terminations under the United Kingdom's Abortion Act of 1967. For this reason, they became concerned when all medical terminations were moved to the labour ward where they were in charge of delegating supervision and administrative duties to staff involved in TOP services (*The Courier*, 2013).

In the view of their employer, the Clyde Health Board, the midwives' termination of pregnancy-related duties were indirect and, thus not recognised under the Abortion Act of 1967 which the Clyde Health Board argued applied only to staff directly involved in the actual performing of abortions (McMillan, 2013). Both midwives argued in contrast that they were being forced to participate in abortions and that this violated their right to conscientiously object to participate in abortion on religious grounds, protected under both section 4(1),¹³ of the Abortion Act, 1967 and Article 9,¹⁴ of the European Convention on Human Rights (McMillan, 2013). Based on this, they maintained that whether their participation was direct or indirect they should be entitled to CO including delegating, supervising and supporting staff involved in TOP services (*The Courier*, 2013). As a result, with financial help from the Society for the Protection of Unborn Children (SPUC), the midwives took their employer, NHS Greater Glasgow and Clyde Health Board, to the Lower Court (McMillan, 2013). In delivering her ruling, Judge Lady Smith applied an ordinary or narrow interpretation of the term 'participation in treatment' and overruled the midwives' objections as not covered by the CO clause in the 1967 Abortion Act (*BBC News*, 2013). She argued that, 'the nature of their duties' did not "require them to ...terminate pregnancies directly....nothing they have to do as part of their duties terminates a woman's pregnancy...they are sufficiently removed from direct involvement as, it seems to me, to afford appropriate respect for and accommodation of their beliefs" (*BBC News*, 2013). She went on to rely on the UK landmark case of *Regina v. Salford Area Health Authority (Respondent) ex parte Janaway*.¹⁵ This case involved a doctor's secretary who objected to signing an abortion referral letter on the grounds of conscience (Hill, 2010:2). The House of Lords overruled the secretary's

¹³ Section 4 excuses a person from 'participating in any treatment' under the Act if they express a conscientious objection to abortion.

¹⁴ Section 9 protects protection of "freedom of thought, conscience and religion" and right "to manifest" their "religion or belief in worship, teaching, practice and observance".

¹⁵ *Regina v. Salford Area Health Authority (Respondent) ex parte Janaway* [1988] 2 W. L. R. 442; HA [1988] 3 All ER 1079 249.

objection and held that typing a referral letter was not protected by the CO clause of Abortion Act 1967(McCafferty, 2010:11).

In 2013, the midwives appealed against this decision. Unlike the Lower Court, the Court of Appeal's three judges Lady Dorrian, with Lords Mackay and McEwan, applied a broader interpretation of the term 'participation in treatment'. The court ruled that the 1967 Abortion Act's 'conscience clause' protects health care personnel against any form of compulsory involvement in TOP, including any delegation, supervision or support with the exception of participating in TOP in emergency cases when the continuation of pregnancy may endanger the life of the mother (*Catholic World News*, 2013). The Court disagreed with the Lower Court's interpretation of the term 'participation' in *Regina v. Salford Area Health Authority (Respondent) ex parte Janaway* and ruled that the midwives had the right to refuse any form of involvement in abortions: "In our view the right of conscientious objection extends not only to the actual medical or surgical termination but to the whole process of treatment given for that purpose" (*BBC News*, 2013).

The most senior Catholic in Glasgow, Archbishop Philip Tartaglia, who is also president of the Bishops' Conference of Scotland celebrated the outcome of the Court's decision as "a victory for freedom of conscience and for common sense" (Carrell, 2013). He exhorted Catholic health care professionals to follow suit in the event of being forced to participate in TOP services: "I hope that many pro-life health professionals will take heart from this judgment and have the courage to express their own objections if and when they are asked to carry out tasks which are morally wrong and violate their conscience" (Carrell, 2013). For other commentators however, rather than balancing two competing rights, this judgment made freedom of religion an absolute right which does not need to be weighed against competing rights and as a result in practice leads to compromising women's access to medically indicated and lawful care in ways that may jeopardise their health and wellbeing (see for example, Dickens and Cook, 2000:72).

The Appeal Court reached its conclusion without seeking the guidance of the United Kingdom's regulatory bodies such as the British Medical Association (BMA), the Royal College of Obstetricians and Gynaecologists (RCOG), or the National Health Service (NHS), all of which adhere to ethical guidelines which oblige medical personnel holding CO to abortion to timeously refer their patients to willing providers (McCafferty, 2010:8). Henderson notes that the Appeal Court's broad interpretation of Section 4 of the Abortion Act is likely to result in these regulatory bodies having to change their ethical guidelines to incorporate also the right to refuse to refer patients to willing providers (2013).

When it comes to pharmacy practice, in the UK, the code of ethics of the Royal Pharmaceutical Society of Great Britain (CE-RPSGB) (the regulatory and professional body for pharmacists) contains a conscience clause which allows pharmacists to conscientiously object to dispense certain medications including EC.¹⁶ Despite this obligation, however, the General Pharmaceutical Council (GPhC) imposes an obligation on pharmacists conscientiously objecting either on religious or moral grounds to always refer their patients to other willing providers.¹⁷

In January 2001, the Prescription Only Medicines (Human Use) Amendment (No. 3) Order 2000 (S.I. 2000, No. 3231) approved the OTC dispensing of EC (that is, without a prescription) to women aged 16 and over (Harrison-Woolrych *et al*, 2001). In order to increase the accessibility of EC, British law provides for the availability of EC free of charge from general practitioners, family planning clinics and hospitals (Marston *et al*, 2005:1). As noted by Anna Glasier, the deregulation of EC was aimed mainly at reducing the high rates of unwanted pregnancies in Britain (1993), particularly among teenagers (Lo *et al*, 1994; Wareham and Drummond, 1994) -- said to be among the highest in Europe¹⁸ (see also Schenk, 2003:35).

¹⁶ Royal Pharmaceutical Society of Great Britain. Medicines, ethics and practice-a guide for pharmacists. London: RPSGB, 1998.

¹⁷ General Pharmaceutical Council (GPhC) *Standard of Conduct, Ethics and Performance* 2010. <http://www.pharmacyregulation.org/pdfs/other/gphcstandardsconductethicsandperflo.pdf> Accessed 7 November 2013.

A study of pharmacists and general practitioners conducted a year prior to the deregulation of EC in the UK found that providers were prone to negatively depict women using EC as sexually irresponsible, whereas others felt that the removal of restrictions on the availability of EC would increase its potential abuse and promote promiscuity, primarily among teenagers (Barrett and Harper, 2000:205). Prior to its deregulation many pharmacists expressed their concerns and tried to block deregulation. This opposition was evident for instance in letters written by pharmacists to the editor of the *Pharmaceutical Journal* indicating that they would not dispense EC if deregulation were to take place (Baker, 1995; Holmes, 1995; Jagger, 1995; McCrystal, 1996). Some pharmacists formed the organisation ‘Christians in Pharmacy’ to promote and defend their opposition to deregulation (Payne, 1995).

The deregulation of EC in Britain saw the debate shifting attention to the morality of both the use and supply of EC and to the question of whether pharmacists should have the right to refuse to dispense EC on moral or religious grounds (Deans, 2013:49). At the centre of this debate was once again the controversy concerning whether or not EC prevents an unwanted pregnancy or acts as an abortifacient (Deans, 2013:49). In this regard, in May 2001 (four months following the deregulation of EC), the Society for the Protection of the Unborn Child (SPUC) challenged the supply of EC Levonelle on the grounds that it was an abortifacient and therefore illegal under the 1861 Offences Against the Person Act, which prohibits the supply of any ‘poison or other noxious thing’ with intent to cause miscarriage (Mayor, 2002:995). The case was eventually dismissed by the High Court on the 18th of April 2002.

In resolving this matter Mr Justice James Munby relied on several medical experts in the field and also focused on current scientific meanings of the terms ‘pregnancy,’ ‘miscarriage,’ and ‘abortion’ in medical dictionaries. On this basis, he came to the conclusion that given that EC acts before implantation, this method does not constitute abortion under the terms of present legislation (Mayor, 2002:995). Judges in the British context have tended to emphasise the importance of the medical professional’s right to CO not jeopardising women’s reproductive health rights and well-being. As Dickens notes, in Britain, a fair balance has been achieved between “the rights of healthcare professionals to respect their conscience so that they are not

customarily compelled to act against their religious convictions and the rights of patients to receive the medically indicated care” (2006:515).

That is not to say however that all pharmacists support the definition of EC upheld in the courts. Some continue to object to dispensing EC on the grounds that it is an abortifacient (Barrett and Harper, 2000:201; see also Cadwell, 2011). In one prominent case, a nurse lost her job at a general practice because she refused to administer the MAP which was one of the requirements of the post (Burnell, 2001). There have also been cases of pharmacists refusing to refer patients to willing providers. An example is that of Ruth Johnson aged 33 who in October 2008 was refused the MAP by a supermarket’s duty pharmacist who argued that it was against his religious beliefs (Stokes, 2008). Pharmacy owners have, moreover, also strongly opposed the September 2011 General Pharmaceutical Council (GPhC) stance that disciplinary action would be taken against pharmacists or pharmacies refusing to stock EC or to refer their patients to willing providers. These pharmacists argued that by obliging them to refer patients and always ensuring that they have ECs in stock the GPhC mandate effectively made them morally complicit in an action they believe to be morally wrong (Cadwell, 2011).

Ireland

In July 2013, the Irish Taoiseach (Prime Minister), Enda Kenny spearheaded the passage of new abortion legislation, the Protection of Life During Pregnancy (PLDP) Bill, which partially liberalised abortion in Ireland by allowing doctors to perform abortions “only when a woman’s life is under threat if her pregnancy continues or if she is suicidal” (McDonald, 2013). Despite the fact that the PLDP Bill is still restrictive in the sense that it did not legalise abortion even in cases of rape (McDonald, 2013), the Irish Roman Catholic Church leaders condemned its passage as an attempt to “licence the direct and intentional killing of the innocent baby in the womb” (Steffan, 2012; see also McDonald, 2013). Some even threatened Enda Kenny with excommunication (Steffan, 2012; McDonald, 2013). Irish Catholic Church officials have expressed concerns over the passage of the PLDP Bill on the grounds that it imposes a duty on

faith-based hospitals to provide TOP services in violation of Catholic hospitals' entitlement to act in accordance with the dictates of conscience (Hunter, 2013). For example, Fr Doran, who sits on the board of governors and the board of directors of the Mater hospital in Dublin, told the *The Irish Times* that the "Mater cannot comply with the Protection of Life During Pregnancy Act and cannot carry out abortion.... I would be very concerned that the Minister [for Health, James Reilly] sees fit to make it impossible for hospitals to have their own ethos" (Holland, 2013).

Australia

In the Australian state of Victoria, abortion was decriminalised by the Abortion Law Reform Act 2008 (Vic) which came into force on 23 October 2008, permitting abortion upon request on the grounds of one doctor's consent to the procedure, regardless of the interests of the foetus, up to 24 weeks of gestation. The Act contains a clause which obliges a conscientiously objecting medical practitioner to refer a woman seeking an abortion to another non-objecting provider¹⁹. The Bill also imposes an obligation on all medical practitioners to assist in emergency treatment²⁰. The Bill was widely criticised by Australian Catholic Church leaders for not accommodating doctors' rights to CO. For instance, the Catholic Archbishop of Melbourne, Denis Hart stated that: "Catholic hospitals will not perform abortions and will not provide referrals for the purpose of abortion as this will be contrary to Catholic ethical codes" (Brennan, 2008).

Italy

In Italy, the rise of illegal abortions and pressure from feminists and women's groups positively resulted in the passage of Law 194, in 1978, which conditionally legalised abortion in that country (Connelly, 2013). Various Catholic groups protested for the overturning of this law, but were defeated by nearly 68% in a 1981 referendum (Connelly, 2013). In August 2009 following

¹⁹ 8(1) (b) of the *Abortion Law Reform Act 2008* (Vic).

²⁰ 8(4) of the *Abortion Law Reform Act 2008* (Vic).

the government's legalisation of the abortion drug RU-486, also known as Mifepristone, heightened opposition again resurfaced with the President of the Italian Bishops' Conference, Cardinal Angelo Bagnasco exhorting doctors to invoke their right to CO (*Catholic News Agency*, 2009a). In that same year (2009), the President of the Pontifical Academy for Life, Archbishop Rino Fisichella also expressed concern over the government's legalisation of the distribution of RU-486 arguing that the Church will never accept such an initiative on the grounds that abortion whether by surgical or medical methods is contrary to the Roman Catholic moral ethos of defending human life from conception to natural death (*Catholic News Agency*, 2009b). As a result many doctors in the public health sector have invoked their right to CO. Recent research indicates that women seeking abortion services in public health care facilities now face long waiting periods to obtain an abortion, leading to some arguing that "there is too much interference in public hospitals from the Vatican" (Connelly, 2013).

Under these unfavourable circumstances, affluent women who can afford to travel abroad to countries such as Switzerland, Spain, France, the UK and the Netherlands for safe terminations do so while poorer women are not able to exercise this option (Connelly, 2013). The denial of abortion services in the public sector sees poorer women seeking illegal abortions through underground networks which, for instance, "smuggle Misoprostol from Latin America to Italy through the port of Genoa and then sell the drug at half the price it costs on the internet" (Connelly, 2013). A May 2013 report in *La Repubblica* (one of the largest circulation Italian daily general-interest newspapers) argued that conscientiously objecting doctors were forcing many poor "women into a shadowy world of illegal abortions,... the true figure of clandestine terminations was up to 50,000 annually, far above the official figure of 15,000" (Connelly, 2013). Mirella Parachini, a practising gynaecologist and former president of FIAPAC, the International Federation of Professional Abortion and Contraception Associates confirmed this when she argued that "women suffering from the after effects of illegal abortions – through Misoprostol use – are regularly presenting themselves for help at our hospital" (Connelly, 2013).

The CO debate in Italy was extended to pharmacy practice when the distribution of EC was authorised in September 2000 with a decree from the then Minister of Health Umberto

Veronesi,²¹ which made EC a prescription drug that could be accessed only in pharmacies (Ceva and Moratti, 2013:139). Italian law does not recognise pharmacists' right to CO. Rather, it requires all registered pharmacists to fill all valid prescriptions irrespective of their religious or personal beliefs (Jones, 2007). Nevertheless, research in Italy (Ceva and Moratti, 2013:140; Cooper *et al*, 2008; Wynn *et al*, 2007) indicates that some pharmacists continue to refuse to dispense EC. The Roman Catholic Church is very influential in Italy and its leaders have taken a frontline role in persuading pharmacists to object to dispensing EC on the grounds that it is an abortifacient. In November 2007 Pope Benedict XVI called upon pharmacists to conscientiously object to dispensing EC on moral and religious grounds (*Daily Mail UK*, 2007). The Pope went on to describe conscientious objection as a "right that must be recognised for your profession so you can avoid collaborating, directly or indirectly, in the supply of products which clearly have immoral aims" (Jones, 2007).

However, the Pope's statement was challenged by pharmacists who argued in favour of dispensing EC based on their professional duties and the legality of the distribution of EC under Italian law. In response to the Pope's statement, Franco Caprino, head of pharmacists' professional group Federfarma told Reuters Report that given that Italian law does not contain a conscience clause protecting pharmacists from refusing to fill prescriptions, "We can't be conscientious objectors unless the law is changed" (Jones, 2007). In interviews conducted by the Italian Media with devout Catholic pharmacists, the majority of them prioritised their professional responsibilities over religious and personal beliefs with regard to prescribing EC. For the most part those who conscientiously objected to dispensing EC said they preferred to refer their patients to other willing providers (*MailOnline*, 2007). The Pope's statement also prompted angry reaction from politicians (*Daily Mail UK*, 2007). In the daily *Corriere della Sera* newspaper, the Italian Health Minister Livia Turco exhorted pharmacists to ignore the Pope's statement, arguing that the Pope had no right to tell pharmacists how they should conduct their professional duties: "I don't think his warning to pharmacists to be conscientious objectors to the morning after pill should be taken into consideration" (Jones, 2007).

²¹ Ministerial Decree, 26 September 2000, no. 510.

Chile

In Chile CO among pharmacists first became an issue in April 2004 when EC was included in the treatment protocol for rape victims and made available free of charge at all public health care facilities (Casas, 2009:82). The debate further intensified in March 2006 when Ms Michelle Bachelet took office as the country's first female President. Given that Bachelet's main objective was to promote adolescent reproductive rights and equality between men and women in Chile, she was quick to further liberalise the country's existing contraceptive policy and made EC available free of charge, on request at all state-run hospitals to women including girls aged 14 and older, without parental notification (Rohter, 2006). In September 2006, the Health Ministry issued new fertility treatment regulations, which recognised CO to the provision of EC on condition that the objecting pharmacist refers the patient to another willing provider (Casas, 2009:82).

President Bachelet's rationale for providing unrestricted access to EC had its roots in research which showed that high rates of unwanted pregnancies among teenagers was a public health problem which needed urgent attention. For instance, government statistics found that Chilean adolescents have 40,000 unwanted pregnancies a year (Lynch, 2007). In addition to that, a 2003 survey revealed that around 15 percent of all births in Chile were to teenage mothers 18 or younger, most without the means to afford quality care (Rohter, 2006). The survey further found that the proportion ranged from 22% in the poorest neighbourhoods of Santiago to just 1% in the richest. The reasons for this huge discrepancy ranged from underprivileged teenagers' limited use of oral or EC, absence of sex education in schools, non-existence of AIDS awareness information and absence of condom-vending machines (*The Economist*, 2006).

Chile's policy on the provision of EC free of charge to all women of child-bearing age was vehemently challenged by the pharmaceutical company, Salcobrand as the owners raised concerns over the government's initiative as a violation of their freedom of opinion about the drug which they regarded as having an abortive effect. One of the company owners was quoted

in the *Associated Press* as saying “We express conscientious objection to being forced to sell a product that can have that [abortive] effect” (Jones, 2007).

Roman Catholic Church leaders in Chile were quick to condemn the OTC provision of EC on the grounds that it violated the right to life due to its abortive effect and they also expressed their concerns over EC’s potential to promote promiscuity among young girls (Rohter, 2006). One Chilean Catholic bishop vehemently attacked Bachelet’s family planning programme by depicting it as “policies imposed by totalitarian regimes to establish state control over the intimate lives of citizens” (Gallardo, 2006).

Rape victims’ access to EC in health care facilities under their jurisdiction has been obstructed by some conservative Chilean mayors (Casas, 2009:82). In 2006 conservative mayors joined forces with conservative opposition politicians (Lynch, 2007) and the Catholic Archbishop of Santiago to challenge in court the Health Ministry’s directives for providing EC to adolescents aged 14 without parental consent (Casas, 2009:82). Conservative mayors have also challenged the distribution of EC at public clinics within their municipalities as a violation of their religious beliefs (Rohter, 2006). In 2008, conservative mayors and legislators requested the Constitutional Court to rule EC, copper and levonorgestrel based IUDs as well as adolescent contraceptive services unconstitutional. In April 2008, the Constitutional Court of Chile endorsed the conservative mayors’ request by banning the free distribution of emergency contraception through the public system as unconstitutional (Castellanos, 2009; see also Casas, 2009:82-83).

Conclusion

While the right to freedom of conscience is a universally accepted human right, globally, the invocation of conscience in relation to the provision of women’s reproductive health services has effectively meant that many women’s ability to access these services is dependent upon social position, such as race and class. Access to safe abortion is, in many contexts, a privilege for rich women who can afford to pay out-of-pocket for abortion procedures when these are difficult to

procure in the state sector, in part because health professionals invoke their right to CO which renders the existence of reproductive rights in law difficult to exercise in practice. Research has confirmed that “women most affected by lack of access to safe abortion care are those who are most vulnerable to unwanted pregnancy, in particular teenagers and poor women” (Ipas and IHCAR, 2002:8). CO on the part of health professionals is one of the many barriers that indigent women face when it comes to accessing lawful termination of pregnancy services. Health and even life-threatening unsafe, illegal ‘back street’ abortion (Dickens and Cook, 2000:72) differentially affects indigent women who are determined to terminate their pregnancies in these circumstances. Thus low-income women suffer an unequal burden of unsafe abortion because their governments’ legislative and policy mechanisms do not accord them the rights of full citizenship (Casas, 2009:79; see also Special Rapporteur Paul Hunt, 2004).

In the context of the USA for instance, Susan Yanow has argued that, “the *Roe v Wade* decision made safe abortion available but did not change the reality that more than a million women face an unwanted pregnancy every year [and] forty years after *Roe v Wade*, the procedure is not accessible to many US women” (2013:14). Among other reasons, this is because the passage of the 1973 Hyde Amendment with its restrictions to funding non-medically necessary abortions “fell disproportionately on low-income women who have limited resources with which to overcome this obstacle” (National Abortion Federation, 2006). The Hyde Amendment restrictions differentially affect low-income women who cannot afford to pay for abortion services in the private sector and therefore may either resort to unsafe, illegal abortions from untrained practitioners or self-induce an abortion (National Abortion Federation, 2006). The finding of a 2012 survey of 639 women at six geographically diverse healthcare facilities in the United States found that a significant number of low-income women “delayed or did not pay bills such as rent (14%), food (16%), or utilities and other bills (30%) to pay for abortion” (Jones *et al*, 2013:173). As noted by Yanda *et al*, in settings “where abortion is legal, safe and accessible, [it] has been impeded by political obstacles” (2003:277). In these settings, some have argued that government legislation and policies which deny women reproductive agency are tantamount to denying them their right to citizenship (Casas, 2009:83). Laws made by elected representatives through the appropriate democratic processes are thwarted because there is not

enough political will to ensure that the conditions are created for the effective implementation of the law.

Chapter four: South African women and reproductive health

Globally, high levels of unsafe abortions often occur in countries where there are restrictive abortion laws (Berer, 2004:1; see also Benson *et al*, 2011:1; Fawcus, 2008). The previous chapter argued that internationally, one of the unintended consequences of upholding the rights of medical practitioners to conscientiously object to the provision of termination of pregnancy and related services is the differential impact of CO on poorer women. In South Africa the post-apartheid dispensation specifically set about trying to instantiate reproductive rights with a focus on poorer women. In the context of apartheid South Africa, the 1975 Abortion and Sterilisation Act promoted the assumption that ‘woman’ meant ‘white woman’ and this meant that poor African women were often forced to resort to unsafe backstreet abortions (Bradford, 1994:7). Research conducted prior to the introduction of the Choice on Termination of Pregnancy ‘CTOP’ Act 92 of 1996 showed that approximately 425 women died each year in public hospitals as a result of complications associated with unsafe abortion (Rees *et al*, 1997:432-437). In Soweto alone, it was estimated that 2000 backstreet terminations took place every month in 1973 (Bertrand, 1977:266).

For this reason, “by 1994 unsafe abortions had become a long-standing and significant threat to women’s health in South Africa” (Rees *et al*, 1997; see also Jewkes *et al*, 1997). White middle-class women were less likely to resort to unsafe abortion because they could afford to pay for abortion procedures in the private sector (Ngwena, 2004:714) and some even travelled abroad to terminate their pregnancies, usually in Britain where abortion was already legal (Bradford, 1994:27).

Annually, on average 1000 legal abortions were granted during apartheid, almost exclusively to white women (Rees *et al*, 1997). African women resorted to unsafe illegal ‘back street’ abortion

procedures to terminate their unwanted pregnancies because they could not afford the prohibitively high costs for abortion services in private clinics. It was in this context that the post-apartheid African National Congress (ANC) government made the provision of reproductive rights, particularly to poorer African women, a priority (Andrews, 2001:327; Mhlanga, 2003:117) and made termination of pregnancy part of its campaigning strategy for the 1994 democratic elections. In its early policies such as the Reconstruction and Development Programme (RDP), the ANC promised that “every woman must have the right to choose whether or not to have an early termination of pregnancy according to her own beliefs” (Guttmacher *et al*, 1998:193). The Choice on Termination of Pregnancy (CTOP) Act makes safe, legal abortion the right of every South African woman of reproductive age regardless of her race or class (Whitcomb, 2010:775; Andrews, 2001).

The Act came into effect on 1 February 1997 with the aim not only of eradicating unsafe abortion-related mortalities (Jewkes *et al*, 2003:277-278), but also to enable women to exercise their sexual and reproductive rights to control over their own bodies (Potgieter and Andrews, 2004:21; see also Dickson *et al*, 2003:277). It repealed the Abortion and Sterilisation Act of 1975 with its restrictive provisions which for the most part criminalised abortion (Naylor and O’ Sullivan, 2010:8). Section 2 of the CTOP Act provides that a pregnancy may be terminated upon request of the pregnant woman during the first 12 weeks of gestation. During this period, the termination may be carried out by a medical practitioner, a registered midwife or a registered nurse who has completed the prescribed training course.²² From the thirteenth to the twentieth week of gestation the termination of the pregnancy must be approved by a medical practitioner,²³ and, after the twentieth week, two medical practitioners (or one medical practitioner and a registered midwife).²⁴ The law also stipulates that the only consent required for abortion is that of the pregnant woman herself.²⁵ With regard to minors, a medical practitioner or a registered midwife must advise a minor to “consult with her parents, guardian, family members or friends” but abortion is not denied if she does not consult with any of these people.²⁶ In order to ensure

²² Section 2(2) of the Choice on Termination of Pregnancy Act 92 of 1996.

²³ Section 2(1)(b) of the CTOP Act.

²⁴ Section 2(1)(c) of the CTOP Act.

²⁵ Section 5(1) of the CTOP Act.

²⁶ Section 5(3) of the CTOP Act.

that abortion services would reach the really poor the Act provides for the provision of abortion services free of charge at all designated facilities (Ngwena, 2004:715; see also Jewkes *et al*, 2003:278). In terms of the Act it is an offence if any person prevents a lawful termination of pregnancy or obstructs access to a facility performing termination of pregnancies.²⁷ Women's reproductive rights are also constitutionally protected in South Africa. For instance, section 12(2)(b)²⁸ of the Bill of Rights enshrines the right of every citizen to 'bodily and psychological integrity, which includes the right: to make decisions concerning reproduction; to security in and control over the body.' Section 27 1(a)²⁹ stresses every woman's access to reproductive health care as an important right as it provides that "everyone has the right to have access to health care services, including reproductive health care."

According to Ngwena, the early years of the passage of the CTOP Act specifically from 1997 to 1999 witnessed an increase in women's access to TOP services with figures increasing from 26 401 to 39 328 between those years (2003:3). Jewkes *et al*, note that abortion-related deaths decreased "by as much as 90% in the years following legalisation of abortion" (2005b). For these reasons, the CTOP Act has been hailed by many authors as one of the most progressive pieces of women's reproductive justice legislation in the world (Althaus, 2000:84; Naylor and O'Sullivan, 2010:8; Cook *et al*, 1999; Whitcomb, 2010:775; Ngwena, 2003:2; Vincent, 2012:265).

On paper this cannot be disputed if one takes into account the Act's progressive provisions which surpass those of many other countries. However, the promise of the Act has yet to be fully realised. In South Africa, in the context of the transition from apartheid, the aim of the new legal framework was specifically to cater for the needs of those who had been denied rights under the previous dispensation. The South African government decriminalised abortion to end the burden of unsafe abortion among the majority disadvantaged African women in contrast to other settings where other goals predominated. For instance, the Indian government reformed its abortion law under the Medical Termination of Pregnancy (MTP) Act, 1971 to curb population growth (Dalvie, 2008:38). Unlike the United States' legislation which justified a woman's access to

²⁷ Section 10(1)(c) of the CTOP Act.

²⁸ Section 12 (2) (b) of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996).

²⁹ Section 27 1 (a) of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996).

abortion merely on the grounds of the right to privacy, the South Africa's law takes a comprehensive, equality and autonomy driven approach to abortion which is more protective of a woman's right to choose abortion and places the burden of responsibility on the state for the realisation of women's rights through providing free elective abortion services in designated public health care facilities (Grelewicz, 2011:178).

As was the case in other parts of the world, the legalisation of abortion through the enactment of the CTOP in 1996 has also been challenged in South Africa, with religious leaders and organisations featuring prominently in the opposition to legal abortion. The Christian Lawyers Association (CLA) is an association which encourages "members of the legal profession to develop and apply a biblical Christian world view in their world and in society" (Christian Lawyers Association, 2014). In the case of *Christian Lawyers Association of South Africa v Minister of Health*,³⁰ the CLA sought a declaratory order striking down the CTOP Act in its entirety because they argued that the Act contravenes Section 11 of the South African Constitution, which guarantees the right to life, as human life starts at conception (Kruger *et al*, 2010). The Court dismissed this case by ruling against the CLA on the grounds that the Constitution does not award legal personality to the foetus (Kruger *et al*, 2010).

Opponents of legal abortion in South Africa have branded women seeking TOP services on demand as irresponsible for failing to use appropriate contraception. In 2012 the Health Minister, Aaron Motsoaledi released statistics in parliament indicating a 31% increase from 2010 to 2011 in the number of abortions carried out in public sector health facilities (amounting to some 77,771 legal abortions in 2011) (*Sowetan Live*, 2012). Joe Maila, the Health Ministry's spokesperson expressed his great concern over these figures:

We are very worried. Not only about the high statistics, but also about the fact that so many people are having unprotected sex... it's clear that people are not using contraceptives like condoms, so they are exposing themselves to serious illnesses like AIDS (*Sowetan Live*, 2012).

³⁰ 1998 (11) BCLR 1434 (T), 1998 (4) SA 1113 (T).

Similarly, African Christian Democratic Party (ACDP) MP, Cheryllyn Dudley said the figures were a matter of great concern as they were an indication that “we’re moving in a direction where human life is being increasingly disregarded and treated with contempt” (*Sowetan Live*, 2012).

These figures notwithstanding, South Africa faces severe challenges when it comes to giving full effect to women’s reproductive rights (van Bogaert, 2002:176). Currently South Africa is severely affected by a ‘brain drain’ -- the massive immigration of large numbers of health professionals, primarily doctors and nurses to the UK and other countries (Padarath *et al*, 2004; Coovadia *et al*, 2009:830). This has proved detrimental to the provision of TOP services in public health care facilities (Chopra *et al*, 2009:1027) which are used by eighty-four percent of South Africa’s population (Grobbelaar, 2013). This sector is underfunded with government allocating sixty-percent of total health financial and resources expenditure to the private sector which only serves fifteen-percent of South Africa’s population (Chopra *et al*, 2009:1027; Sanders and Chopra, 2006:75). Since the majority of abortions take place in public health care facilities (McIntyre and Klugman, 2003:112), the implementation of the CTOP Act has been hampered by the extreme disparity in resource allocation between the public and the private health sectors. In KwaZulu-Natal province, for instance, only 30.4% of all public healthcare TOP facilities are functioning (Health Systems Trust, 2009).

The provision of TOP services is further undermined by the increasing numbers of doctors, nurses and midwives who object to taking part in the provision of TOP services in designated public health facilities (Ngwena, 2003:4). In 2000 this challenge drew the attention of the South African health portfolio committee which indicated in parliament its concern about the preventable deaths of women from unsafe illegal abortions that continue to be carried out outside of designated TOP facilities (van Bogaert, 2002:137; see also Jewkes *et al*, 2005a:1240; Dickson *et al*, 2003:284; Meel *et al*, 2009). In that parliamentary session the Health Minister responded as follows: “Health care workers should place their duty before their beliefs”. Echoing this view, the Chief Director for Maternal and Child Health Services noted: “Health care workers should not use their beliefs to deny people access to service” (Bateman, 2000).

Nevertheless, the reality is that many health care providers in South Africa “refuse to undergo abortion training as they believe that once they are trained they will be forced to provide abortions” (Braam and Hessini, 2004). One recent South African survey of medical school students attending the University of Cape Town and Walter Sisulu University found that of 1,308 students who participated, one-fifth of these students believed that abortion should not be allowed for any reason (Stephanie *et al*, 2012:154).

Thus, as we have seen is the case in many other parts of the world, the legalisation of abortion alone “is not always sufficient to ensure women’s access to safe abortion services” (Fredrick, 2007). In South Africa “translating new laws into service programs that make safe abortions available to all women continues to be a daunting challenge” (Singh, 2009:15). While the allocation of more funding to public health care facilities which cater mainly for low-income abortion-seeking patients might appear on the face of it to be the obvious solution, in reality no amount of money can solve the challenge posed by a lack of medical practitioners willing to perform terminations.

One Western Cape study, found that fourteen percent of doctors opposed to abortion admitted “that they would not attend to women seeking abortion even in medical emergencies” (Ngwena, 2003:4). Nurses willing to provide abortion face hostility from peers and members of their communities (Potgieter and Andrews, 2004:22; Mokgethi *et al*, 2006; Ngwena, 2003:4). Willing TOP services providers also face hostility from their high and medium-level hospital managers (Ngwena, 2003:4) who have often been reported for overlooking willing providers for promotion (Vincent, 2012:266). It has been noted that not only are medical professionals opposed to abortion, but abortion-seeking clients face hostility also from other layers of staff at designated facilities including cleaners, admissions clerks and administrative personnel. What this means is that through informal ways of negatively treating the abortion-seeking client these personnel all play a role in gate-keeping abortion services especially when it comes to poorer and younger women seeking access (Harries *et al*, 2009:5). Hord and Xaba’s study of 20 nurses found that 75% of the nurses were against TOP and the majority of these nurses based their opposition to

TOP on their religious beliefs (2001:16). In relation to midwives, one study conducted in one of the rural hospitals in KwaZulu-Natal Province found that most of the midwives had a negative attitude towards the implementation of the CTOP Act (Harrison *et al*, 2000:429). Another 2002 study revealed that health authorities throughout South Africa had difficulty in implementing the CTOP Act primarily because of many midwives' reluctance to be trained to administer TOP services (Varkey and Fonn, 2000:6).

In apartheid South Africa, abortion was a privilege only for the upper and middle class white women who could afford to abort in the private sector or to travel abroad to terminate their pregnancies (Bradford, 1994:27). Although it was hoped that this would change following the decriminalisation of abortion in 1996, in reality, this hope has not fully materialised. An increasing number of medical professionals invoke CO to the provision of TOP services in public sector health care facilities, threatening to once again make abortion a privilege reserved for higher-income women who can afford to pay for the procedure in the private sector. Recent research in South Africa has demonstrated the discontinuing of TOP services in many designated facilities because of the unavailability of medical personnel willing to perform TOP services (Varkey, 2000:87). The private sector has and still continues to profit from this through providing safe abortions to those women who can afford them – and also receives funding from the government's annual budget for this purpose (Chopra *et al*, 2009:1027; see also Sanders and Chopra, 2006:75).

Unlike public health care facilities, private TOP facilities are fully functioning with the benefit of the services of sufficient skilled and willing TOP services providers (Chopra *et al*, 2009:1027). They provide varied, client-centred services including abortion pills like mifepristone (National Abortion Federation, 2013) and South African women have reported preferring to terminate their unwanted pregnancies in the private sector because they find services in the private sector more “accessible, helpful, private, and having no waiting period” (Jewkes *et al*, 2005a:1241).

There are also reports of unethical practices on the part of medical practitioners who shy away from being seen to be providing termination services while at the same time prescribing misoprostol to abortion-seeking patients who are then advised to seek surgical evacuation in the public sector when they start bleeding in order to complete the abortion procedure (Jewkes *et al*, 2005a:1241).

In an attempt to overcome provider resistance to the provision of these services, the South African government has promoted values clarification workshops (VCWs) targeting all health professionals involved in TOP services (Healy, 2013:2; Turner *et al*, 2008:108; Harisson *et al*, 2000:429). VCWs are aimed at promoting “tolerant attitudes among medical service providers, increased empathy and respect for women with unwanted pregnancies” (Berer, 2002:39; see also Cooper *et al*, 2004:76; Dickson-Tetteh and Rees, 1999) but there is little evidence to suggest that these workshops have successfully turned the tide of medical opinion in South Africa in favour of women’s reproductive rights in circumstances where those rights contradict the provider’s right to conscience. The tension is particularly acute in the case of second trimester abortion which is regarded by many as more morally troubling than first trimester abortion and the invocation of CO thus becomes more likely in the case of second trimester abortion. As a result, access to second trimester abortions remains poor: second trimester abortions account for only 20% of all terminations in South Africa (Turner *et al*, 2008:113).

A 2000 South African study found that “death due to pregnancy related sepsis, including septic abortion, was one of the top five causes of maternal death indicated in the first report on maternal deaths. The majority of those abortion deaths occurred in the second trimester” (Democratic Nursing Organisation of South Africa, 2000) leading Harries *et al*, to conclude that that “the high rate of death during second trimester abortion in South Africa is a public health concern” (2009:9). This is mainly because there are a limited number of doctors willing to provide these services (Bateman, 2011:304; Turner *et al*, 2008:108-113). A more recent study by Bateman found that most of women’s pregnancies developed to second trimester level because of the long

waiting lists that they encounter at public health facilities,³¹ and in the majority of cases these women are more likely to seek unsafe abortion procedures (2011:304). The fact that second trimester abortions remain unsafe was also confirmed by Jewkes and Rees who found that “all the abortion-related deaths in 2005 due to complications occurred in the second trimester” (2005:250).

Their legal right to free abortion on demand notwithstanding, South African women continue to face uncommonly high levels of mortality and morbidity associated with unsafe illegal backstreet abortions (Pearson and Sweetman, 2007:50). Alongside this fact further fuelling the urgency of South Africa’s medical conscientious objection debate is the fact that women and adolescent girls in South Africa, as is well documented, face heightened levels of sexual violence which often makes it difficult for them to be in full control of their sexual and reproductive rights (Wood and Jewkes, 2001; see also Prinsloo, 2006). Women’s choices are limited by the fact that they are often disempowered in their sexual relationships, for instance in terms of negotiating the use contraception. A study conducted by Wood and Jewkes with pregnant teenagers in an African township in Cape Town for instance revealed the extremity of sexual violence against adolescents in South Africa (1997). This study reported widespread male coercion and violence within these sexual relationships. Teenage girls had little power to negotiate sexual contact and most participants reported being forced by their partners to have sex (1997:42; see also Buga *et al*, 1996; Jewkes and Abrahams, 2002; Richter, 1996; Vundule *et al*, 2001).

A 1997 study exploring the personal experiences of African, Indian and Coloured women admitted to the six big public hospitals in four different provinces of South Africa found that disempowerment in relationships coupled with financial pressures constituted major reasons for why women terminate their pregnancies (Maforah *et al*, 1997:79). In another study, interviews with Black South African women seeking TOP services revealed disempowerment in their relationships which resulted in unwanted pregnancies (Orner *et al*, 2010). Reported forms of disempowerment included the inability to negotiate condom use with male partners especially

³¹ In this context Bateman particularly refers to a six week waiting list for services at a major Cape Town hospital.

among economically disempowered women who relied on their partners for financial support (Orner *et al*, 2010).

Equally well documented is the fact that South Africa has among the worst rape statistics in the world – reportedly the highest number of reported cases of rape per female population in the world (Cooper *et al*, 2004). An estimated 1.3 million rapes take place annually in South Africa and a significant proportion of teenage pregnancy results from coerced sexual encounters (*The Times*, 1997 cited in Wood and Jewkes, 1997:43). The high incidence of rape in the country adds further urgency to the need for comprehensive abortion and EC service provision. It is in this context that a variety of commentators have called for more concerted efforts to protect South African women’s reproductive rights (see Harrison *et al*, 2000:430).

In 2000 a further attempt to enlarge women’s access to reproductive choice was seen in the South African Medicines Control Council’s (SAMCC) re-classification and approval of the OTC dispensing of EC by pharmacists to women over 16 years old without a doctor’s prescription (Blanchard, 2005:173). Those under the age of 16 years are required to obtain a prescription from a doctor in order to purchase ECs from any pharmacy (Vitacare, 2013). Two basic EC products were approved and are currently sold in South Africa by private pharmacies: E-Gen-C which is a combination of oestrogen and progestin and NorLevo which only contains progestin (Health 24, 2007). The SAMCC also approved the availability of ECs free of charge at public health care facilities which include hospitals and clinics without any age restrictions, usually in the form of ‘cut-up’ regular combined oral contraceptives (COCs), that is prescribing to patients a higher than normal dose of birth control pills as ECs (Maharaj and Rogan, 2008:351; see also Myer *et al*, 2007:2).

The 2000 SAMCC ruling concerning the availability of EC directly from pharmacies without a prescription was first challenged by a Johannesburg-based pro-life group called Doctors for Life on the grounds that it “was just another abortion technique with the potential risk of encouraging irresponsible sexual behaviour in the country” (Harvey, 2001). As is the case in other settings,

some opponents of EC equated these measures with abortifacients (Smit, 2001; McFadyen *et al*, 2003; Moodley and Morroni, 2007; Myer *et al*, 2007). Others expressed concern that increased access to EC may encourage unprotected sexual intercourse – with the associated risk of contracting sexually transmitted diseases, including HIV -- or reduce routine contraceptive use (Blanchard *et al*, 2005:175).

The latter are serious concerns in a country noted for its high prevalence of HIV/AIDS. The 2012 Human Science Research Council Household survey estimated that 6.4 million people are living with HIV/AIDS and that the proportion of infected people increased from 10.6% in 2008 to 12.3% in 2012 (van der Linde, 2013). This survey further revealed that the HIV prevalence among unmarried persons is twice that of married persons: 19.2% compared with 9.8% (van der Linde, 2013). Given that EC does not protect against HIV/AIDS infection, these current high rates of HIV/AIDS have been said to have impacted negatively on pharmacists' and providers' attitudes toward the provision of EC as they fear that the easy availability of ECs easily can exacerbate the spread of HIV/AIDS. For instance, a study by McFadyen *et al*, found that many providers expressed concerns around women discontinuing more reliable methods of contraception in favour of using EC (2003; see also Blanchard *et al*, 2005:175; Maharaj and Rogan, 2011). Similar findings were reported in a 2005 by Blanchard and colleagues' study which explored pharmacists' knowledge and perceptions of EC in Soweto and the Johannesburg Central Business District. In that study numerous pharmacists vehemently condemned the use EC for increasing the spread of sexually transmitted diseases (STIs), including HIV/AIDS. As one participant expressed, EC “encourages people not to use precautions...[and to overlook] the spread of STIs like HIV/AIDS” (Blanchard *et al*, 2005:174).

However, research in many settings (Marston *et al*, 2005:271; Glasier and Baird, 1998; Jackson *et al*, 2003; Raine *et al*, 2000; Raine *et al*, 2005; Lovvorn *et al*, 2000) has shown that expanded access to EC does not increase the rate of unprotected sexual intercourse nor does it change sexual behaviour. While the high prevalence of HIV/AIDS pandemic within South Africa cannot be doubted, the risk of HIV/AIDS cannot be used as a basis to deny women services to which they are legally entitled. Under the South African pharmacy practice laws and regulations,

registered pharmacists and assistant pharmacists can legally dispense EC and also counsel clients on all medications including ECs (Blanchard *et al*, 2005:173). In this context, given that condom use is generally low in South Africa (Ibis Reproductive Health, 2005) pharmacists can play an important role in raising HIV/AIDS awareness among women seeking EC. Given that counselling is a key component of EC provision as Harrison *et al*, (1989) and Gold *et al*, (1997) have concluded, pharmacists have an important opportunity to counsel ECs-seeking clients on other aspects of reproductive health and to raise awareness concerning STIs and HIV/AIDS as well as to promote the use of barrier mechanisms among sexually active women seeking ECs as these are effective in preventing the transmission of HIV and STIs (Vitacare, 2013). However, this does not seem to be an opportunity that for the most part is being explored. A study conducted with pharmacists practicing in Kwa-Zulu Natal, Gauteng and the Western Cape provinces in 2003 reported that, despite their concerns that EC may discourage the use of regular contraception, pharmacists directed little attention to counselling clients about the risk of STI/HIV transmission after unprotected sexual intercourse (McFadyen *et al*, 2003).

A recent study which explored attitudes towards EC among pharmacists working in private and public health facilities in Durban found that most pharmacists admitted seldom having opportunities to counsel women about EC because of time constraints (Maharaj and Rogan, 2011). Research in other settings has reported similar findings. For instance, a study which evaluated the knowledge and EC services provided by pharmacists in Delhi, India found that most pharmacists rarely counselled their clients to use regular contraception nor advised them to use barrier methods such as condoms in order to prevent the spreading of HIV and STIs (Mishra and Saxena, 2013:19).

It has been argued that barriers associated with the accessibility to EC in many developing countries (including South Africa) often force women to resort to unsafe abortions, which contribute significantly to maternal morbidity and mortality (Cheng *et al*, 2004 cited in Byamugisha *et al*, 2006:195). For this reason, it could be argued that easy availability of EC to these women would have saved at least some of their lives. This is because EC has the potential to reduce significantly the prevalence of unintended pregnancy and the consequent need for

abortion (Trussell *et al*, 1992) and therefore, lead to a reduction in both safe and unsafe abortion rates (Smit *et al*, 2001; Dickson-Tetteh *et al*, 2000).

In South Africa, fertility is very high among adolescent black African women (Kaufman *et al*, 2001 cited in Burgard, 2004:95). The age group between 15-24 years old has been reported to have the highest unintended pregnancy rates among all age groups (Ibis Reproductive Health, 2005). It is estimated that up to 75% of pregnancies in South Africa are unintended, with the highest proportion occurring among adolescents (Department of Health, 2001; Morroni *et al*, 2006), and the incidence of sexual assault is also very high among this age group (Jewkes and Abrahams, 2002).

It is for this reason that Blanchard *et al*, stress the prioritisation of timeous access of EC to all rape or sexual-assault survivors to prevent unwanted pregnancies (2005:175) and pharmacists have a significant role to play in making this possible. Pharmacists practicing in both private and public sectors play a key role in the dispensing of EC. To date, studies conducted with pharmacists have mainly focused on exploring their knowledge and attitudes towards the dispensing of EC. The limited literature that has been produced since the legalisation of EC has emerged from studies that have mainly been provincially-based and have been conducted only in the capital cities of these provinces. For instance, in KwaZulu-Natal province, two studies focusing on pharmacists were conducted in Durban (Maharaj and Rogan, 2011; and Hariparsad, 2001). In Gauteng province, one study focusing on pharmacists was conducted in Johannesburg (Blanchard *et al*, 2005) and only one study has incorporated three provinces including KwaZulu-Natal, Gauteng and the Western Cape (McFadyen *et al*, 2003). Little has been written about South African pharmacists' rights to CO with respect to the dispensing of EC despite the fact that it is pharmacists who interact directly with women seeking EC and, as such, they are in a position to promote use of EC, and client awareness of its availability (Delbanco *et al*, 1997 cited in Maharaj and Rogan, 2008:354).

An indication of the extent to which South African women continue not to have knowledge of, or access to, their legal right to these and other services, is the emergence of an underground market for abortion drugs as was reported in a 2009 article in *The Sowetan*, under the headline “Abortion For Sale”. The article stressed the prevalence of the sale of abortion pills outside of clinical settings, particularly Cytotec, also known as Misoprostol (*The Sowetan*, 2009). Of concern is the fact that low-income women buying these abortion drugs from illegal dealers would usually have little information on correct dosage and administering of the drug which can be harmful to women’s health if used improperly.

Conclusion

Despite the high minded intentions of South Africa’s legal and constitutional protections for women’s reproductive rights, women continue to resort to unsafe abortion to terminate their unwanted pregnancies (Yanda *et al*, 2003:276-277; see also Millar, 1934 cited in David, 1992:1). While the minority high-income women have easy access to safe abortions in the private sector the majority low-income “women put their health, social standing, future fertility, and lives at risk to end unwanted pregnancies” (Bernstein and Rosenfield, 1998) as they self-induce or consult with ‘back street’ practitioners to terminate their pregnancies.

Not having the money to pay for an abortion or related service in the private sector should not disadvantage poor women from terminating their unwanted pregnancies or avoiding pregnancy through the use of the MAP. While Pearson and Sweetman suggest the need on the part of governments with liberal abortion laws to take a step further by making abortions safe, legal, accessible and affordable to all women seeking them (1994:48), this is difficult to do in circumstances where sufficient willing medical providers, whether doctors, nurses, pharmacists or other personnel working at medical facilities, support and believe in these rights. In the following chapters I discuss the ways in which the participants in my study either invoked, or rejected the right to conscientious objection – and the ways in which these approaches are influenced by how a person frames these questions. In the first instance I discuss how the idea of

‘rights’ is deployed to frame approaches to both the invocation and the rejection of CO, depending on whose rights are prioritised: the rights of the foetus, the rights of the pregnant woman or the rights of the medical practitioner.

Chapter five: qualifying ‘rights’

Every individual has a freedom of choice. Moreover, women abort because they are disrespectful of human life; lack of precaution taken...abortion is not the solution (Doctor Thirty-eight).

The WHO has defined reproductive rights as:

...the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (Report of the International Conference on Population and Development, 1994).

The ICPD, also known as the Cairo Conference, held in Cairo, Egypt in 1994 and attended by over 180 nations, agreed on basic improvements and protections of women’s ability to control their reproductive lives through providing ‘universal access’ to sexual and reproductive health (Glasier *et al*, 2006:2). Chrisler and Garrett have pointed out that the Cairo Conference was a milestone event in the international women’s movement because it marked the first formal acceptance of women’s reproductive rights as basic human rights (2010:129). Corrêa and Petchesky define reproductive rights as women’s ability “to decide whether, when, and how to have children” – rights rooted in the claim to bodily integrity and sexual self-determination (2007:299; see also Cook and Dickens, 2009b:108). Ever since the Cairo Conference, the United Nations (UN) and other international assemblies have urged governments to safeguard women’s reproductive rights (Reproductive Rights Are Human Rights, 2014).

In the language of Ronald Dworkin (1984), rights are ‘trumps’, by which is meant that for a right to make sense it has to be considered as having special normative force overriding other possible considerations and social aims such as, for example, productive efficiency. While there is relative consensus concerning this normative priority that ought to be afforded rights over non-rights considerations, left unresolved is how to settle disputes that arise from the clash of rights. While in some instances the clash is easy enough to resolve since some rights clearly outweigh others – freedom of speech for instance is thought to be legitimately abridged in cases where life is threatened – in other cases no such easy prioritisation is on offer. The right of medical professionals to refuse to provide medical services which they regard as tantamount to murder – which is the stance that some take with regard to abortion services – is a case in point. Here a serious and seemingly irresolvable tension arises between women’s reproductive rights and the right on the part of medical practitioners to conscientiously object to providing abortion services or services which they believe to be related to abortion. To complicate the matter further, a third rights-bearing subject often enters the debate in the form of the foetus whose purported claim to a right provides the grounds for the anti-abortion stance. However, what this chapter shows is that there are ways in which women’s reproductive rights can be narrowed and eroded that have nothing to do with serious and intractable clashes of this kind but have, rather, to do with imbalances of power between medical professional and patient which allow the medical professional to base their decisions and application of the law on their own particular moral point of view concerning, essentially, sexuality and what constitutes responsible and appropriate sexual behaviour.

The right to CO is most often described as resting on the clash between women’s reproductive rights and health professionals’ right to refuse to participate in TOP or services thought to be related to TOP (such as MAPs) on religious and moral grounds. While the CTOP Act allows every woman “the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs” (Republic of South Africa, 1996a:1) this right may conflict with the constitutionally protected right to freedom of belief and conscience which may be interpreted as allowing for medical professionals to conscientiously object to providing TOP services.

Several participants in the present study argued that their constitutional rights were at stake when regulatory bodies attempt to put pressure on medical practitioners to comply with laws relating to women's reproductive rights. As Doctor 53 put it:

Medical professionals are also South Africans (most of them) first and foremost so which means that they should be afforded the ability to practice what is accepted within their religious and cultural beliefs.

Similarly:

It cannot be expected of a medical professional to perform a procedure against which he/she has a moral objection. We are supposed to live in a country with freedom of choice for everyone, not just the one party.

Doctors should have the right to refuse to participate in all stages of terminations (Doctor Twenty-seven).

Doctors have a right to conscientious objection to participating in TOPs (Doctor Twenty-five).

Doctors morally opposed must have the right not to perform these procedures (Doctor Twenty-six).

It is every doctor's right to either accept or refuse a request to carry out an abortion. I do not do abortions (Doctor Seventeen).

However, opposition to abortion is only rarely stated in these terms. From the outset hierarchies of legitimacy and deservingness have pervaded the abortion debate. As James Wilce notes, discourse plays an important role in medicine, and medical discourse is "about healing, curing, or therapy..." (2009:199). "Since the 1950s, when abortion was widely legalised for the first time, the discourse of medical expertise pervaded the representation of abortion in public debate" (Dudova, 2010:946). Dudova further argues that this medicalised discourse surrounding the right to abortion served to delegitimise social conditions as grounds for termination of a pregnancy, leaving only "serious threat to health, cases of rape or incest and cases of foetal impairment as grounds for legal abortion" (2010:946). This gave rise to a hierarchy of acceptability in the exercise of women's reproductive rights rather than these rights being seen as trumps.

For instance, the following doctor argues against abortion on demand, rather he encourages women to use various prevention methods in order to avoid the risk of falling pregnant as follows:

...Any abortion due to a lifestyle choice is abhorrent-whether by clinical or chemical means...Recreational sex is a misnomer but it is 99% possible, with various methods, to not fall pregnant and have physical ‘intimacy’. Abortion must always be seen as the very last resort and never a lifestyle choice (Doctor Forty-one).

Here the idea of ‘balance’ is invoked: the need to balance two rights that are in conflict with one another – that of the foetus and that of the pregnant woman; neither is absolute and must be weighed as equally legitimate (Ferree *et al*, 2002:106-107). This doctor argues that women have the right to engage in sexual activities, but this right goes along with the responsibility to prevent pregnancy. However, if it happens that women fall pregnant, the right of the foetus should take precedence and ‘abortion should always be seen as the very last choice or resort’. This diminishes this doctor’s willingness to perform abortion on demand. For this doctor, it does not matter whether abortion is performed by surgical or medical methods; the bottom line is that abortion on demand is wrong.

Chris Kaposy has argued that the notion of ‘life choices’ is often invoked by abortion opponents or health care professionals who seek to justify their right to conscientiously object to provide TOP services by claiming that “abortion is a medically unnecessary elective procedure. Very often they make two assumptions: (1) that medically necessary care is care needed to treat disease, illness, or injury, and (2) that pregnancy is not a disease, illness, or injury” (2010:25). Likewise, as noted by Charo some health care providers have conscientiously objected to perform certain medical procedures on the grounds that they view them as life choices, not treatments of diseases and these include: “birth control, abortion, and in vitro fertilisation...” (2005:2473). In the context of Canada for example, Kaposy has pointed out that the *Canada Health Act* emphasises the notion of life style choice as it provides public funding

only for medically necessary hospital procedures and New Brunswick and Prince Edward Island provinces have strictly enforced this requirement (2010:25).

The urgency of the claim for the foetus to be regarded as rights bearing and more than this foetal rights to be seen to outweigh the rights of the pregnant woman not to be pregnant grows as the pregnancy advances, giving rise to nuances in the position taken by medical professionals to making available the conditions under which women's reproductive rights can be realised. Sarkin-Hughes argues that abortion should be limited on 'foetal viability' grounds, which is said to occur at around 22 weeks of gestation (1993:89), because at this stage a "foetus should be capable of living independently of its mother if it is born, since all of its vital organs are developed and are able to perform their functions sufficiently" (Cohen and Sayeed, 2011:235). Some associate foetal viability with 'quickening', which is "when the woman first feels the movement of the foetus which usually occurs near the end of their first trimester of gestation" (Cook and Howard, 2007:1087).

We are told that it is unethical to perform medical experiments on human embryos in the test tube, even though such experimentation could save countless lives and relieve huge sufferings. But we may physically dismember and pull apart (in late term "abortions") children who are perfectly formed and in an environment conducive to full development. This is an extreme contradiction illustrating the total lack of logic in the arbitrary timing of the definition as to when life starts in utero (the cutoff point for legal abortions) (Doctor Forty-four).

Framing the issue as one of protection of the rights of the foetus, Doctor 44 argues that late term abortions are as unethical as performing medical experiments on human embryos in a test tube. To frame the issue in this way is to arrive at the self-evident conclusion that 'second trimester abortion should be illegal'. Foetal personhood and the idea of the foetus as a rights-bearing subject are invoked in Doctor 44's language which refers to 'children' rather than fetuses. The idea of women's right to abortion becomes irrelevant when the issue is framed in this way since the right to life typically takes precedence in cases where rights find themselves in tension with one another.

Foetal viability is also for example, placed at the centre of Doctor 7's argument for the pre-eminence of foetal rights. In this view second trimester abortion seekers are seen as delaying abortion for no good reason and therefore there is no pressing requirement to consider the rights of the pregnant woman above those of a viable foetus.

I am against such late abortions, as there is no need to delay it to such a late gestational age. The exception would be maternal physical health at risk (Doctor Seven).

The construction of the second trimester abortion seeker as undeserving is shared for example by Doctor 55:

I am against them [second trimester abortion] unless there is a medical indication. Up to 16 weeks pregnancy it is still if necessary possible to perform an abortion especially if medically indicated. I would not perform an abortion over 16 weeks simply if the mother requested it. Only medical reasons for an abortion after 16 weeks would be considered. If a mother takes 4 months to decide if she wants an abortion or not, then she shouldn't be having one! (Doctor Fifty-five).

Rather than respecting the autonomous decision of a woman to exercise her legal right to a second trimester abortion, several respondents constructed this choice as ill-advised and saw themselves as having the responsibility to persuade these women to carry their pregnancies to term:

Second trimester abortion carries more risk, patients must be informed, and encouraged to continue with pregnancy (Doctor Sixteen).

Far from invoking CO as an absolute right then, these respondents take a selective approach to their disinclination to provide abortion services -- abortion is seen as acceptable in some circumstances but not others (Gustafson, 1987). Foetal viability plays a large role in their approach to the acceptability of abortion as does their conviction that women seeking second trimester abortions are guilty of tardiness and could have avoided doing so if they had only acted more responsibly. While these doctors acknowledge that women have the right to abortion, they

frame the right as limited for instance by gestational age. By failing to seek an early termination, women in this view are seen to effectively forfeit their right to reproductive choice as their right gives way to the right to life of the foetus which takes precedence from the second trimester of gestation.

If second trimester abortion is considered the most morally troubling of circumstances in which abortion is sought, one might imagine that the least morally troubling would be its polar opposite – the client seeking the MAP. However, even in the case of this service, many participants express only qualified support for the MAP as a woman's reproductive right. As Dworkin has pointed out, to qualify a right is to empty it of its force. Many participants, far from expressing unequivocal support for the right of patients to request lawful access to medication, drew a distinction between those whose need for the MAP is 'legitimate' and those whose request for the medication is constructed as 'illegitimate'. These constructions in turn shape behaviour, informing decisions concerning whom to dispense to and under what circumstances. The appeal to conscience as a reason for refusal to comply with SAMCC policy is selectively invoked depending on the health professional's own views regarding the circumstances under which a person might legitimately seek the MAP. These circumstances include: 'mistakes', 'accidents', 'rape' and 'regular contraceptive failure'.

...not all patients abuse the emergency contraception and they use it because of a mistake such as a condom bursting during coitus (Pharmacist Thirty-seven).

I see it as an emergency prevention after a mistake (Pharmacist Forty-three).

People can make a mistake (have a slip) and some sort of relief is needed (Pharmacist Fifty).

Stenvoll points out that language, categorisations and problem definitions play an important role in mobilising people to provide solutions to how certain issues should be dealt with (2007:43). For instance, in the debate in Norway in late 1990's concerning emergency contraception some groups which wanted to restrict access to IUDs did so on the grounds of equating them to abortifacients since 'life starts at conception' (Stenvoll, 2007:43). In the present study, in

contrast, many pharmacists expressed support for the 2000 SAMCC's approval OTC dispensing of various emergency contraceptive methods, including the MAP to sexually active females aged 14 year, referring to the initiative as a 'good policy'. Yet closer analysis reveals that this support is in many cases carefully qualified, not because the MAP is regarded as an abortifacient but on other grounds.

James Paul Gee argues that in analysing communication it is useful to ask why the speaker has built and designed a piece of talk in the way that they have and not in some other way – what he refers to as the 'why this way and not that way tool' (2011:54). Gee enjoins the analyst of discourse to always ask how else something could have been said and what the speaker achieves by saying something one way and not in other ways (2011:54). For example, some participants constructed the dispensing of the MAP as simply lawful medication which women have the right to request and to be provided with in accordance with the right to reproductive health enshrined in the Constitution³² which is very different in its effect to constructing the MAP as acceptable only in certain prescribed circumstances such as in the event of a mistake, accident and emergency.

Gee's 'fill in tool' helps one to think about what one needs to 'fill in' that is not explicitly said in the communication that is being analysed, based on what has been said and what one knows or can surmise about the context (2011:11-12). In constructing the MAP as an emergency remedy health professionals by implication construct repeated requests for the MAP as illegitimate. The portrayal of some patients as deserving the MAP and others as not deserving in turn results in particular treatment of the person who is doing the repeated requesting who is viewed as in need of 'counselling' or 'correction' of their behaviour which is deemed inappropriate.

I feel it has a place for reducing unwanted/unplanned pregnancies in emergency situations i.e. the condom breaks or in rape cases. It is not meant as a generalised contraception, which is apparent when we counsel the ladies (Pharmacist Forty-six).

³² Section 12 (2) (b) of the Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996).

I am willing to dispense the emergency contraception tablet for “accidents”. I do not agree with giving the tablets to males, but prefer to counsel the women to try and ascertain that they are not using it “every second weekend” (Pharmacist Forty-six).

The eminent scholar of discourse, Norman Fairclough has noted that some representations are ‘naturalised’ as ‘common sense’ and once they are seen as ‘common sense’ they are no longer seen as questionable or subjected to scrutiny (1989). The naturalised reference to the MAP as ‘emergency contraception’ is a case in point. To refer to something that is invoked only in times of ‘emergency’ immediately implies that it is by definition a rare occurrence – for many pharmacists ‘emergency’ means not just ‘rare’ but once and once only. The construction of the MAP as an ‘emergency’ remedy justifies a very qualified approach to compliance with the law and the constitutional protection for women’s reproductive rights.

It’s for emergency only. Other forms of contraception are encouraged if repeats are seen (Pharmacist Fifty-two).

I have no problem issuing the product once to a patient. I will ensure that I do proper counselling to ensure that the patient does get contraception from a clinic or prescribed by a doctor (Pharmacist Forty-eight).

As a means to an emergency I will dispense it provided it is not abused and only used once or twice in a lifetime as emergencies don’t occur frequently! Patients also need to accept responsibility for their actions. I personally don’t equate it to an abortion pill as it is within 72 hours post coitus (Pharmacist Twenty-six).

Rather than a generalised moral objection to the medication itself, for instance on grounds of it being an abortifacient, here the objection is a moral one which has to do with disapproval of the behaviour and moral probity of the patient who should be more ‘responsible’ rather than the health professional’s own conscience.

Emergency Contraception is exactly what it says, in case of an emergency, which is necessary sometimes in case of an oral antibiotic that may cancel the normal contraception...it is an Emergency Pill and should be sold as that (Pharmacist Nine).

Regular contraceptive failure constitutes legitimate grounds for requesting the MAP but not ‘irresponsible’ sexual behaviour which suggests that what constitutes ‘responsible’ sexual behaviour is sex with contraception.

The naturalisation of the MAP as having to do with ‘emergencies’ is coupled then, with the idea that it ought properly to be seen as a ‘once off’ medication and not a ‘quick fix’ or ‘regular contraceptive’ as the following participant explained:

I think it was a good idea [that is, the selling of the MAP through the OTC method], however, have found it to be a “quick fix” in many cases. And people don’t understand you can’t it with a regular contraceptive (Pharmacist Thirty-eight).

The idea that the MAP can be ‘abused’ and that it is the health professional’s role to prevent such ‘misuse’ or irresponsible behaviour relies then on a set of assumptions about ‘proper’ use – proper use is once or twice in a life time and does not replace ‘responsible’ regular use of contraception. If use is improper according to this set of assumptions, then the health professional feels justified in refusing to provide the medication. This refusal is constructed as the ‘prevention of abuse’ and the promotion of responsible sexual behaviour rather than the denial of a right. In this sense the health professional takes it upon him or herself to decide what does and does not constitute ‘responsible’ sexual behaviour and the misuse of medication which in turn justifies who does and does not in practice have the right to be provided with the MAP. The construction of the MAP as for emergencies thus acts as a powerful tool for establishing what this pharmacist referred to as the ‘legitimate circumstances’ under which someone may request the MAP:

People should be made aware that this is a form of emergency contraceptive provided if their circumstances are legitimate. It is unfortunately prone to abuse and that I do not approve of. Emergencies don’t occur 5 or 6 times or every weekend (Pharmacist Twenty-six).

More than this the law providing for access to the MAP is seen as in danger of promoting irresponsible sexual behaviours since women may have unprotected sex because they know that there is an easily available remedy in the form of the MAP. Given this, it is then seen as up to the

health professional to act as a bulwark against such irresponsible practices and to teach women who just do not seem to ‘understand’ that the MAP is not properly to be regarded as a form of contraception. The objection is not to the policy itself, but with women who are ‘taking advantage’ of this policy and seeking ‘quick fixes’ instead of behaving ‘responsibly’. Thus rather than this being an instance of the intractable clash between the fundamental right to the health professional’s freedom of conscience and women’s reproductive rights, what is really at issue here is the health professional’s personal disapproval of the sexual behaviour of some of their clients as these participants made clear:

I have no problem dispensing it to woman after I have consulted them that they should not abuse this and they should be more careful next time. And I take their details so next time they come they show up on the system indicating how many times they have come for it and there is where I can stop the abuse (Pharmacist Thirty-seven).

I see no problem in refusing emergency contraception if I know it is been frequently asked for...[this is because]...It is a problem as normal family planning stock is freely available, too lazy to go to a clinic (Pharmacist Thirty-five).

The implication is that in their interactions with their MAP-seeking patients, health professionals are acting appropriately if they take it upon themselves to explore the sexual behaviour of their patients and their reasons for requesting the MAP. Moreover, in the view of these participants, they are justified in making a distinction between behaviours that they regard as legitimate and those that they regard as illegitimate – and these in turn constitute grounds for agreeing or refusing to dispense a lawful medication. As one respondent put it, it is up to the pharmacist to ‘spot’ women who request the MAP repeatedly and deal with them accordingly:

...some may be abusing this medication and that is why it is our duty as pharmacists to spot these people coming into a pharmacy ever so often. Therefore, I support the policy provided pharmacists prevent it from being abused (Pharmacist Thirty-seven).

This is a very different position to the invocation of conscience on the part of health professionals who regard the MAP as tantamount to abortion. The moral disapproval of patients’

sexual mores and behaviours is framed as requiring the health professional's intervention in order to 'inform' the patient that they are not behaving appropriately.

Framing the MAP as an 'emergency' remedy and repeated requests for the MAP as a consequence, as illegitimate, irresponsible, lazy and uninformed has concrete effects on how health professionals behave. This framing acts to legitimise refusal to dispense the MAP even on the part of those who do not regard it as an abortifacient. Pharmacists acting according to a naturalised set of assumptions about what does and does not constitute legitimate use of the MAP may for instance refer patients repeatedly seeking the MAP to a clinic or hospital to be prescribed regular contraceptives. Others advocate the need for strict monitoring and surveillance of women's behaviour in order to ensure that only the deserving, legitimate MAP request is complied with:

The emergency contraception should be what it really says emergency contraception not a monthly or weekly routine. A system should be set up to monitor the use of the emergency contraception by each patient (Pharmacist Thirty-six).

While some participants acknowledged the role that the MAP plays in the prevention of unwanted pregnancy, they nevertheless insisted on the need for dispensing to take place under 'controlled circumstances':

Make these tablets available freely, but CONTROLLED and monitored (Pharmacist Forty-six; emphasis in the original).

I believe in dispensing in a controlled manner because not everyone abuses it and it does do some good for people who are not ready to have a child (Pharmacist Thirty-seven).

Yet clearly every woman who requests the MAP is doing so in order to prevent an unwanted pregnancy. It is important to ask then, what the circumstances of 'control' might constitute. In this instance the 'control' has to do with distinguishing those whose requests constitute 'abuse' and those for whom the medication would 'do some good'.

Another participant explained that:

I do find it troubling and therefore I stop it by explaining why and urge them to rather start using a prevention pill immediately (Pharmacist Forty-three).

Asked specifically whether they equated the MAP with an abortifacient or not, many participants rejected this definition and insisted that they had ‘no problem’ dispensing MAPs as long as they were reassured that the medication was not being ‘abused’. Whether or not patients’ rights to reproductive health services are realised then turns on highly subjective accounts of abuse which have little to do with the health of the patient and everything to do with the provider’s own moral standpoint regarding appropriate sexual behaviour:

I have no problem dispensing it to woman after I have consulted them that they should not abuse this and they should be more careful next time. And I take their details so next time they come they show up on the system indicating how many times they have come for it and there is where I can stop the abuse (Pharmacist Thirty-seven).

Similarly:

In my Pharmacy we provide State Family Planning but provide the Morning After Pill privately. All users of the Morning After Pill are counselled to get Family Planning if they are regularly active. Patients are educated that the Morning After Pill should not be a method of contraception. Statutory records are kept and monitored (Pharmacist Five).

The framing of the health professional’s role as one of legitimately monitoring and controlling women’s behaviour appears also to influence decisions concerning whether or not to dispense the MAP to male partners. A 2011 Nicaraguan study which explored pharmacists’ knowledge of, and attitudes towards, emergency contraception found that 84 per cent of pharmacists in that country were willing to provide MAPs to men requesting the medication on behalf of their partners (Ehrle and Sarker, 2011:70). This finding is in stark contrast with the views expressed

by the participants in the present study. Monitoring and surveillance is justified in order to differentiate between requests for the MAP regarded as legitimate and those regarded as abusive. Male partners seeking the MAP are interpreted as illegitimately seeking to control their female partners' bodies, choices and behaviours – a right that the health professionals reserve for themselves.

Also I prefer to dispense to the woman because some men buy it in advance to give it to their women after coitus (Pharmacist Thirty-seven).

Firstly I do not supply the morning after pill to any man requesting it for his wife or girlfriend. I insist on seeing the lady. She completes a questionnaire prior to me supplying the pill. It is her right to decide whether she wants to be pregnant or not (Pharmacist Thirty-three).

I am willing to dispense the emergency contraception tablet for “accidents”. I do not agree with giving the tablets to the males, but prefer to counsel the women to try and ascertain that they are not using it “every second weekend”... I feel it is wrong to give to the male. Some men try to force the lady to not use protection and then they get emergency contraception for the lady. This I feel is wrong. The lady is the one who needs to be in control of her body, not the man. I prefer to interact directly with the lady to find out her views, feelings and if she understands what she is doing by repeatedly using the emergency pill. Also what risk she puts her body in by not using protection (Pharmacist Forty-six).

The idea of women having the right to control their own bodies is thus selectively invoked – the right falls away when the pharmacist regards it as being exercised under illegitimate circumstances but comes strongly into focus when the pharmacist chooses to emphasise it. Closer inspection reveals that the invocation of the legitimising authority of the women's rights frame here has much in common with the moralising prescriptions invoked by health professionals seeking to distinguish legitimate from illegitimate sexual behaviour. The participants who took this view referred for instance to their fear that men might buy the MAP in advance in order to convince women to sleep with them without the protection of a condom (Pharmacist 37).

Women's rights are invoked as a means of legitimising refusal to dispense medication to male partners even when it is clear that the woman concerned would prefer to have this way.

Women do not realise the legal ramifications and often send their male partners in to buy emergency pills. They must sign the form personally (Pharmacist Forty).

Women thus do not have a 'right' to decide for themselves whether they wish to send their male partners to collect medication for them. Nor do women have the right to decide what to do with their own bodies if that includes repeatedly using the MAP, not using regular contraception, or succumbing to a male partner's pressure for sex – since these are behaviours of which the health professional disapproves. What is objected to is the control of male partners over women's bodies but not the control of medical practitioners over women's bodies and choices, suggesting that what is really at issue is sexual behaviour regarded as undesirable rather than women's right to autonomy and choice.

In some instances this construction of women as in need of educating, counselling, control and protection on the part of medical practitioners rather than as autonomous, rights-bearing citizens, takes an explicitly racialised form:

I do not condemn women looking for the morning after pill but do advise them to consider alternate forms of contraception with less side effects especially the black ladies who because of cultural reasons can't be found to be using contraception. But I get cross when they want to come in after every weekend for the morning after pill and have not gone to the clinic for permanent help (Pharmacist Twenty-nine).

While explicit references to race are rare, the construction of the female patient as ignorant and lacking 'understanding' is not. Patients' repeated requests for the MAP are regularly constructed as arising from their ignorance. As Gee points out, the use of language serves to build relationships and identities – chiefly through the ubiquitous mechanism of 'us' and 'them' (2011). In the participants' talk, the construction of the patient as ignorant is often accompanied by a language of 'them' and 'they'. In the South African context this language often acts as a

marker for race. It is thus not unreasonable to assume that what the speaker has in mind is black/poor women who are the ‘they’ and the ‘them’ who are ignorant of anatomy:

It is not meant as a generalised contraception, which is apparent when we counsel the ladies. It is sometimes difficult to get them to understand that it is not in their interest to just keep getting the emergency contraception. They don’t understand the possible impact on their hormones, cycles and female anatomy (Pharmacist Forty-six).

Very difficult to refuse but these woman need to know that this is emergency treatment and not normal contraception. Women become quite defensive if you ask any questions (Pharmacist Thirty-five).

In contrast to the robust, rights-bearing subject imagined in liberalism’s cosmology, women seeking medical services are constructed as ignorant/illiterate, particularly regarding medication and its side effects. Rather than being autonomous choice makers, the expectation arises that the patients will listen attentively and not question -- any patient who questions medical authority is constructed as being defensive.

This imbalance in power relations between the health professional and the patient is magnified in the case of younger patients. Although the law provides for patients of 14 years and older to seek the MAP, the in-practice realisation of the legal right is dependent upon the willingness of health professionals to comply with the prescriptions of the law.

As far as age is concerned a 14 year old can purchase contraception but cannot be sexually active with consent until 16 which does not make sense. I believe a 14-16 year old cannot make correct decisions regarding these matters (contraception) however they are sexually active which is very worrying (Pharmacist Nine).

Gee points out that “speakers choose subjects strategically to set up how listeners should organise information in their heads and how listeners should view whatever the speaker is talking about” (2011:18). As Norman Fairclough has pointed out, health care professionals are likely to use their power “to impose the discourse type upon patients, in the sense of putting pressure on them in various ways to occupy the subject position it lays down for patients, and so behave in

certain constrained ways” (1989:61). In South Africa, while the MAP has been switched to OTC status in order to widen its accessibility to sexually active women, in practice the availability of the MAP to teenagers is circumscribed by social mores regarding the appropriacy of being sexually active at a young age (SAQ, Pharmacist Forty-six).

Although, as Weisberg and Fraser have pointed out, it is every woman’s right to have “rapid access to an effective method of emergency contraception if she believes she needs it” (2009:160), women seeking MAPs are not infrequently subjected to ‘intrusive questioning about their sex lives’. Younger clients, their legal rights notwithstanding, are often singled out for particular surveillance and disciplining. As one pharmacist explained:

If it is a teenager I refer her to our nursing sister to sit down and discuss the dangers of unprotected sex and diseases (Pharmacist Nine).

There are too many girls wanting the morning after pill, they have no shame to come and get it with friends, and even come in their school uniforms and laugh about the whole situation among each other. They also want the pill often and if we say it is too often that they are taking the pill then they just get their friends to come get it; they are uneducated on the subject and are not interested to listening to us (Pharmacist Fifty-four).

Rather than a serious clash of the health professional’s right of conscience not to participate in an act interpreted as the equivalent of the violation of the right to life, here the denial or attenuation of women’s reproductive rights is based on a set of moral beliefs about teenage sexuality, the decision-making capacity of teenagers, and the right of teenagers to make decisions concerning their own bodies. These patients are seen as in need of referral for counselling despite the fact that the law does not require such referral for those seeking the MAP.

I am not happy with this policy, as it is against my religious beliefs and another reason also being that it encourages irresponsible behaviour. The majority of patients are teenagers and young adults (Pharmacist Twenty-three).

It encourages people to get involved in sexual activity even at a young age without worrying about some of the consequences as they can get rid of the possibility of falling pregnant quite easily (Pharmacist Thirty-six).

[The 2000 SAMCC policy] has led to greater freedom for women, [however, the MAP] should not be given to under 16s (Pharmacist Thirty).

While the principle of autonomy that lies at the heart of the liberal democratic state's individual rights regime affords any woman of reproductive age the right to exercise control over her own body (Jotkowitz and Zivotofsky, 2010:150), in these participants' formulations, the age of the patient allied with normative assumptions concerning the illicitness of youth sexuality thus becomes further ground for qualifying women's reproductive rights regardless of the law's prescriptions. The MAP is seen as enticing teenagers to engage in sexual activity because it provides an 'easy way out' in the event of irresponsible behaviour leading to unwanted pregnancies.

The principle of autonomy further dictates that parental consent is not mandatory for teenagers requesting the MAP but many participants considered it inappropriate to provide the MAP to minors without parental consent.

Don't agree with [dispensing] if under-aged, without parent's consent. Same should apply with respect to other schedule 2's...It is often used for under-aged children who are supposed not to have intercourse, and parents should be aware. It might be used inappropriately where a rape case should be opened (Pharmacist Five).

The same approach to restricting the right to reproductive health services without parental consent is taken by several doctors with regard to termination of pregnancy.

I had a patient who fell pregnant in Matric and requested an abortion. I knew the family well and convinced her to tell her mom. She was very terrified about her dad as they came from a very conservative Indian background. I told her that she needed her family support for this difficult situation. Her father was as expected extremely upset. Five years on and the little girl is now the pride and the joy of her grandfather. The mother of the baby reports the little girl and her grandfather are inseparable and the baby has brought so much joy into their home (Doctor Twenty-three).

Conclusion

The participants whose views are cited in this chapter selectively uphold women's reproductive rights – qualifying these rights in line with their own moral framework which, for instance, regards second trimester abortion, repeated requests for the MAP and teenage sexuality as morally illicit. What this results in is an effective narrowing of women's legal rights to abortion on demand and other reproductive services such as the MAP.

Rather than invoking CO to the provision of TOP and MAP services these respondents are really deciding on a case-by-case basis between those whom they regard as deserving their care as health professionals and those whom they do not regard as legitimately deserving their care. This selective recognition of rights empties the idea of a 'right' of its meaning. If rights are to mean anything as Ronald Dworkin has cogently argued, they must be trumps – violated only in the most serious of circumstances. It is this strength of the claim to a right that gives rise to intractable moral dilemmas. Where two rights clash a genuine dilemma only results when they seem to be of equal force, laying equally strong claims to our sense of the prioritisation of pressing human concerns. Where someone genuinely believes that abortion or the MAP is tantamount to murder of a human being such a dilemma arises. But such a belief clearly does not pertain in cases where a person is selectively willing to provide such services. If rights are to give way on every occasion where they clash with a fellow citizen's personal belief system then the whole point of having 'rights' falls away. Vouch are precisely meant to protect citizens of democracies in cases where they require protection for instance because their choices are unpopular or controversial. While many would argue that women's reproductive rights are hardly controversial, in South Africa they clearly are which makes it all the more important that they should be protected against being casually disregarded merely because they are not popular.

In the following chapter, the precepts of the Hippocratic Oath are discussed in more detail, with respect to the question of 'harm'. The chapter shows that appealing to the requirements of the Oath does not really solve the complex moral problems that controversial reproductive health services give rise to. While the invocation to 'do no harm' is ostensibly a clear guideline in many

instances of medical practice, in the case of termination of pregnancy and related services, this is not the case.

Chapter six: ‘do no harm’

At the time of being admitted as a Member of the Medical Profession: I solemnly pledge myself to consecrate my life to the service of humanity; . . . I will practice my profession with conscience and dignity; . . . I will maintain the utmost respect for human life, from the time of conception, even under threat, I will not use my medical knowledge contrary to the laws of humanity; I make these promises solemnly, freely and upon my honour... [T]he health of my patient will be my first consideration.³³

As noted by Dickens on graduation and admission to professional practice, many health professionals including medical personnel pledge themselves to comply with modern variants of the historical Hippocratic Oath (2009:98b). The cornerstone of this Hippocratic Oath is the bioethics principle of ‘do no harm’. According to Sweifach, this principle obliges health professionals not to inflict harm upon their patients and “it derives from the maxim *primum nil nocere* (first do no harm)” (2011:4). For the purposes of this chapter, harm refers to “significant bodily harm, such as pain, disability or death or a patient’s conception of well-being” (ACOG Committee Opinion, 2007:3). By pledging the Hippocratic Oath, health professionals accept a set of moral values and duties that are central to the medical profession (Brody and Miller, 1998). Among these are the ‘duty to treat’ through using their professional knowledge and skills to serve their patients’ interests (Sweifach, 2011:1-2), even in circumstances where the service demanded may conflict with the health professionals’ personal or self-interests (Dickens and Cook, 2000). However, as the chapter shows, while health professionals all pledge the same Hippocratic Oath, their interpretation and application of the principle of ‘do no harm’ in the context of TOP services, is however highly dependent on whom they regard as their patient: the woman seeking care or the foetus and on what they regard as constituting the most serious forms

³³ World Medical Association. Declaration of Geneva, (2006), <http://www.wma.net/e/policy/c8.htm>. Accessed 5 May 2014.

of harm – for instance, harm to society, harm to the pregnant woman, harm to the unborn foetus, harm to the child arising from an unwanted pregnancy. The ‘do no harm’ injunction does not clarify which of these harms ought to take precedence when choosing a course of action.

As the previous chapter argued, the duty to refer is seen by some as a useful compromise position which enables the practitioner who objects to the provision of controversial reproductive services to nevertheless meet his or her professional and legal obligation to respect the rights and autonomy of the patient. The obligation to refer is in line with the World Medical Association’s (WMA) provision which recognises health professionals’ right to conscientiously object to providing contested legal reproductive services such as abortion on condition that they refer their patients to willing providers.³⁴ Likewise, the WMA’s Declaration of Lisbon on the Rights of Patients reinforces the duty of appropriate referral by stating that: “The patient has the right to self-determination...[and] to the information necessary to make his or her decisions”.³⁵ However, what this formulation of the health professional’s duty is not able to clarify is who the patient should be regarded as. In some instances, health professionals regard pregnant women as their patients. For this reason, they agree to honour their obligation to refer and also enjoin other health professionals with conscience-based objections to follow suit. When the patient is constructed as the pregnant woman, the violation of conscience that might be involved in the provision of referrals does not outweigh the health professional’s first duty which is to prevent harm to the patient.

I think you should be obligated to refer to a willing provider. It is not your job as a doctor to be the moral guardian of other people. In addition, the patient may be desperate and end up having a second trimester abortion or illegal or unsafe abortion (Doctor Thirteen).

For Doctor Thirteen, denying a woman timeous referral could not only result in her resorting to unsafe abortion, but could also delay her access to an early abortion and end up with her being forced to seek a second trimester abortion or an illegal abortion. Being forced to obtain a second trimester abortion is seen as another form of harm on the part of some medical practitioners because of difficulties in obtaining TOP services at later gestation stages in South Africa as

³⁴ World Medical Association. Medical Ethics Manual. 40 (2005).

³⁵ World Medical Association, 1981. Amended version. (Paragraph 3) (1992).

research shows that these services are highly stigmatised by health professionals (Jewkes *et al*, 2005a:1241; Bateman, 2011:304). Other than constructing the denying of a referral as consequently resulting in the woman seeking an abortion procedure in the second trimester gestation as constituting harm, this doctor also emphasises the need on the part of medical practitioners to prevent “conditions that put women’s health at risk” (Ferree *et al*, 2002:106-107).

In other words, Doctor Thirteen thinks that objecting to provide safe and legal TOP services may cause harm on the part of patients because he believes that women denied access to safe abortions may be desperate to the extent of either self-inducing their pregnancies or resorting to illegal and unskilled TOP providers. This doctor’s interpretation and application of the principle of ‘do no harm’ is in line with O’Connell and Mistrot’s view that “in some cases failure to refer may result in harm on the part of the patient” (2007 cited in Matheny Antommara, 2011:96). This harm results from the association of illegal abortions with higher complications than those provided by a skilled health care provider in a legal and safe environment. For Dudová, these complications may range from immediate symptoms, such as bleeding and inflammation as well as long-term effects such as infertility and in some cases death (2010:955).

Referral as necessarily implied in the duty to prevent harm to patients as the medical practitioner’s first obligation, is taken a step further in cases of emergency care necessitated by incomplete abortion. From an ethical point of view, health professionals regardless of their religious and personal beliefs are obliged to provide care as a fulfilment of their professional duty not to abandon their patients (Berlinger, 2008:39). The WMA International Code of Medical Ethics provides that, “a physician shall give emergency care as a humanitarian duty unless he or she is assured that others are willing and able to give such care” (Dickens, 2009b:98). For some health care practitioners, this implies an ethical obligation to provide abortion services in emergency circumstances for instance where the patient is a woman presenting with complications resulting from unsafe/incomplete abortion.

This [refusing care in these circumstances] is illegal, from my understanding. Several occasions in the past, I have assisted patients,

especially after their visit to a ‘back-street’ provider, with resuscitation (Doctor Fifty-eight).

If a woman has attempted an abortion herself she should be assisted to complete the process safely (Doctor Twenty-nine).

Importantly, in this framing of the limits and extent of the obligation of the medical practitioner, a distinction is to be made between an obligation to provide abortion on demand and an obligation to provide emergency assistance to a patient even if this emergency assistance involves completing an abortion or treating a spontaneous abortion. This is a distinction clearly articulated by several participants:

An abortion for non-medical reasons is not an emergency. If the patient has an emergency I will always help. I will help if the patient had an abortion and gets complications due to the abortion (Doctor Eighteen).

Spontaneous abortion occurs naturally, and so patients must be helped when it is incomplete, or becomes a threat (Doctor Sixteen).

I would not perform termination of pregnancy on request, but I would attend to medical emergencies. I would and have performed many evacuations for incomplete abortions, being aware of the fact that probably most of those had attended backstreet abortionists or used other questionably methods (Doctor Thirty-three).

For these doctors, vulnerable women showing up at health care facilities with complications from unsafe abortion qualify to be patients whom health professionals ought not to harm. In these instances not harming the patient requires the doctor to assist with the completion of incomplete abortions even though the same doctor would not provide abortion services in non-emergency circumstances.

No patient should ever be denied attention in an emergency. I do not terminate pregnancies but would treat the aftermath (Doctor Thirty).

However, for some doctors, it is not immediately apparent that emergency circumstances ought to be framed in terms of harm to the pregnant woman alone. For these doctors, the question

remains whether the emergency is constructed from the point of view of the foetus as patient or the pregnant woman.

According to the Health Professions Council of South Africa (HPCSA) no doctor may refuse to provide emergency treatment to a patient but when involving taking a life to save a life the doctor should be allowed to say no (Doctor Thirty-five).

A study conducted in the Western Cape Province of South Africa shows that this view is not an isolated rarity. The study found that “14% of doctors who are opposed to abortion said that they would not attend to women seeking abortion even in medical emergencies” (Ngwena, 2003:4). As Fiala and Arthur have noted, “conscientious objection regulations also require objectors to provide emergency care, but some doctors will risk a woman’s death rather than perform an abortion” (2014:9-10). This is because, as Sweifach argues, in the view of these practitioners, “the principle of nonmaleficence (do no harm), can be viewed in abortion cases as doing no harm to an unborn child” (2011:4). Several participants in the present study took the view that abortion is harm to the foetus and that the ‘do no harm’ injunction therefore ought correctly to be applied from the perspective of the serious harm to human life caused by abortion which is equated with murder.

From an ethics perspective, I have a dilemma of how a medical professional will apply the first rule of medical ethics “do no harm” as she/he will be taking a life. Thus, personally, I cannot perform abortions (Doctor Twenty-one).

In fact, abortion should not be part of the health system at all in my opinion. There could be a totally separate government department dedicated to abortions apart from the health department, with abortion technicians instead of nurses and doctors having to do the dirty work. Doctors and nurses professions developed out of the drive to care for people and they are being perverted and twisted into professions that kill people instead (Doctor Three).

We study to help people and save lives, not to kill babies. The foetus is perfectly formed in a few weeks and there is a heartbeat and a life (Doctor Forty-three).

We are raised to heal and save lives, not to play God and not to end innocent lives (Doctor Five).

These participants emphasise the personhood of a foetus which is referred to as a ‘baby’ or ‘child’ (see also Scheidler, 1985:68) rather than, for example, as a foetus or ‘the product of conception’ which is more typical of those who are willing to countenance abortion on demand. This construction of the foetus as person then gives rise to the view that the foetus is the patient whom they should not harm. TOP is thus seen as ‘taking life’ from Doctor Twenty-one’s perspective, ‘kill[ing] people’ from Doctor Three’s perspective, ‘kill[ing] babies’ from Doctor Forty-three’s perspective, and ‘end[ing] innocent lives’ from Doctor Five’s perspective – because the foetus is constructed as a person/patient.

Many (see for example Doctor Five) who adopt this position do so on religious grounds – for example equating abortion even to provide life-saving emergency treatment to an adult woman with ‘playing God’ (see also Collins, 2006:45; Deckers, 2010:1-2; Hopkins *et al*, 2005). Griffith has argued that Christian doctors who invoke CO to the provision of TOP procedures fear punishment directly from God on judgment day (2000). When contrasted with the enormity of disobeying God’s commands this renders the consequences that might result from denying women safe abortion insignificant.

Constructed in this way the medical profession’s obligation to do no harm is framed as aimed at saving and not ending lives of patients – and abortion ends the life of the patient that is the foetus. From Doctor Three’s point of view, abortion is therefore seen as ‘dirty work’ that doctors and nurses should not participate in because doing so would be tantamount to intentionally harming (killing) patients rather than prolonging their lives and caring for them. Since in this view, “embryos are persons from conception” the inevitable conclusion is that “they should be granted the same *prima facie* right to life as all other human beings” (Deckers, 2010:1-2; see also Ord, 2008:12).

Dickens and Cook have referred to health professionals who conscientiously object to providing TOP services on the above doctors’ grounds as prioritising “the perceived interests of embryos and or fetuses over the rights and interests of the pregnant women who bear them” (2011:164).

Such prioritisation emanates chiefly from the characterisation of the medical profession as striving to help, heal, promote, protect and prolong human life (Whitcomb, 2010:799) combined with the characterisation of fetuses as human lives with interests that cannot be thought to be a priori outweighed by the interests of the pregnant woman. When the fetus and the pregnant woman are constructed as equal rights bearing subjects with interests that are opposing there is no easy way to resolve the moral dilemma posed even by emergency procedures aimed at saving a woman's life at the expense of aborting a fetus. In such cases there will be serious harm to one of two rights-bearing subjects, both of which are worthy of equal consideration and protection from harm. Abortion will cause serious harm to one (the fetus) while completing an abortion will prevent serious harm to another (the pregnant woman).

This has been the position taken in a number of high profile cases in which medical practitioners have taken an absolute position against the provision of any services related to termination of pregnancy including emergency intervention and referral. A case in point is that of the two Scottish midwives discussed in chapter three who refused even to indirectly participate in TOP services on religious grounds and subsequently took their employer, the NHS Greater Glasgow and Clyde Health Board to court (*BBC News*, 2013). The Court of Appeal ruled in favour of the midwives, ruling that they had the right to refuse any form of involvement in the whole process of TOP including delegating, supervising and supporting staff involved in TOP services. In celebrating their victory in this case both midwives highlighted the ethical principle of 'do no harm' as one of the important objectives of the midwifery profession:

In holding all life to be sacred from conception to natural death, as midwives we have always worked in the knowledge we have two lives to care for throughout labour: a mother and that of her unborn child (*BBC News*, 2013).

While health professionals have an ethical obligation not to abandon their patients including those seeking contested reproductive services (Berlinger, 2008:39), the interpretation of the principle of 'do no harm' from the perspective of the fetus provides a justification for also objecting to terminate pregnancies in emergency cases where such a termination could save the life of, or prevent injury to, a pregnant woman. For instance, in a Polish case, "...doctors let a

woman die out of concern that treating her for her colon disease might harm the foetus” (Center for Reproductive Rights, 2010). Another illustrative example is the October 2012 highly publicised Irish case of Savita Halappanavar who died of sepsis after doctors refused to terminate her pregnancy on the grounds that her foetus still had a heartbeat despite the fact that her life was in great danger (Berer, 2013). Both cases reveal the extreme degree to which health professionals may be willing to exercise CO when their views are based on the construction of the foetus as an equal, rights bearing subject (Fiala and Arthur, 2014:8).

This view as a basis for the right to CO has been challenged by Cook *et al*, who have argued that this amounts to health professionals imposing their beliefs upon patients and also denying them adequate and quality care, thus violating the bioethical principle of non-maleficence ‘do no harm’(2003 cited in Casas, 2009:78). In this view, medical personnel as members of the ‘helping professions’ are expected to subordinate their own interests and beliefs in order to provide comprehensive care to their patients (Dickens, 2009a:726). However this objection is somewhat disingenuous since it begs the question of who the patient is. The debate between those who argue for the right of medical practitioners to exercise this extreme form of objection – extreme in the sense that taken to its logical extremity it can and has resulted in cases where the life of the foetus is rendered more significant or deserving of care than that of the adult pregnant woman – arises then, not because these medical practitioners are impervious to the ‘do no harm’ injunction, but rather because of who they see as needing to be protected from harm.

This has given rise to the argument, in some settings, that forcing health professionals to both provide or refer patients for TOP and emergency contraception services “violates the Hippocratic Oath, which strictly opposes the harming of human life” (Stein, 2005 cited in Card, 2007:9). A case in point is that of Karen Brauer, President of Pharmacists for Life International (PFLI³⁶), who, despite losing her job as a pharmacist for refusing to fill birth control prescriptions Karen Brauer has remained committed to her interpretation and application of the principle of ‘do no harm’.

While the above debate discusses the principle of ‘do no harm’ from an individual point of view – whether that of the individual pregnant woman or the individual foetus -- a different construction of harm is the association of the aftermath of unsafe abortions with negative social consequences. As is the case in many other developing countries, studies in South Africa have shown that the total annual costs of treating complications from unsafe abortion morbidity in public health care facilities far exceed the costs of providing legal safe abortion services (Kay *et al*, 1997 cited in Grimes *et al*, 2006:1914; see also Moodley and Akinsoto, 2003:35). Unsafe abortion thus has and continues to negatively impact on the already declining and overburdened government health sector.

Taking these considerations into account, some argue that the interpretation of ‘do no harm’ as giving rise to an obligation to treat incomplete abortions is unsatisfactory and in violation of the 1994 Programme of Action of the United Nations International Conference on Population and Development’s (ICPD) recommendation that health professionals practicing in countries with liberal abortion legislations should provide safe TOP services on demand (Girard and Nowicka, 2002).

Feminist scholars have argued for an understanding of the choice to seek an abortion as an attempt to avoid “a kind of hardship that would follow from the birth of a particular child” (Stenvoll, 2007:45). As pointed out by Fiala and Arthur, “the right to CO in reproductive healthcare is widely accepted, even though refusing to provide an abortion for a woman in the difficult situation of an unwanted pregnancy has adverse consequences for her, not the objector” (2014:4). For patients who find themselves in particularly impoverished or difficult family circumstances, avoidance of the hardships that would result from the birth of a child is so pressing a need that if denied safe, legal services as Doctor 39 reasoned, the likely outcome will be an unsafe, illegal abortion. The research literature backs up this conclusion, showing that poor and vulnerable women who are denied access to TOP services often opt for unsafe abortion as a last resort (Grimes *et al*, 2006; see also Fiala and Arthur, 2014:9-10; Erdman, 2012:85). In South Africa moreover, high levels of maternal mortality has been directly attributed to health

professionals' assertion of CO. Due to CO by health professionals, the number of terminations performed decreased from 77 207 in 2009 to 68 736 in 2010 (Department of Health, 2010). The findings of a 2011 South African report states that more than half of facilities designated to provide abortion do not do so, partly because of CO, resulting in the persistence of widespread unsafe abortion, morbidity and mortality (Guttmacher Institute, 2012).

For several participants, the South African context of high levels of poverty and inequality with multiple forms of disadvantage highly concentrated among black women of lower socio-economic status gives impetus to the moral imperative to provide services to these women which the health practitioner might under other circumstances find morally repugnant. These participants take a wider view of the harm that would result from invoking CO given the particularities of the South African context. To describe these circumstances very briefly: in its assessment of poverty trends from 1996 to 2001, the Human Sciences Research Council (HSRC) found that an approximate of 57 percent % of individuals in South Africa were living below the poverty income line in 2001 and this had remained unchanged from 1996 (HSRC, 2004:1). As was the case during apartheid, the majority of the people who continue to suffer the brunt of poverty are those living in rural areas (Lund, 2008:67). This is evidenced by the fact that the greater proportion of rural households rely mainly on remittances and state social grants for income (Department of Welfare, 1997:3) with black people continuing to be the most affected (Woolard *et al*, 2010:03; Neocosmos, 2011:10). This is evidenced by research conducted in 2011 which found that "...in terms of poverty share, more than nine out of 10 (94,2%) poor people in South Africa were black Africans in 2011, a proportion that increased slightly from 2006 (92, 9%) and 2009 (93, 2%)" (Statistics South Africa, 2014:27).

This leads to the conclusion that invoking CO to the provision of TOP and MAP in this context, given an awareness that many black South African women bear the brunt of poverty and inequality, would be ethically unwarranted. Knowing these circumstances, to force these very women who are the most disempowered and vulnerable members of our society to carry their unwanted pregnancies to term would be to cause them harm by worsening this burden as well as

placing at risk of poor life outcomes the unwanted children who would result from these pregnancies.

I 100 percent agree with this policy. It helps in preventing a lot of unwanted pregnancies especially with regards to patients who are under financial constraints which is the case with many South African women...I [also] believe in dispensing emergency contraception as we are living in an impoverished society filled with crime. I believe in women's choice as to whether to have the baby or not, the number of unwanted babies can be reduced (Pharmacist Fourteen).

I believe the patient should be referred to a colleague that has no objections to dispensing the product. An unwanted pregnancy might have a very detrimental effect to their financial position in life (Pharmacist Forty-eight).

Children obviously cost a lot of money and change your life permanently, [the dispensing of] emergency contraception would help make a difference (Pharmacist Forty-five).

As a woman I would prefer to see women exercise responsible decisions regarding a future pregnancy. Teenage Mothers and Mothers who have no means of supporting their baby need to concentrate on education and work to support themselves (Pharmacist Forty-two).

For Doctor 57, social harms (as opposed to physical or psychological harms) would include, for example, in the case of a pregnant teenager remaining permanently in poverty:

[In cases where a]...15 year old daughter with exceptional grades, presents with an unwanted 21 week pregnancy. [The doctor has to consider]...an extra year of school fees and the costs of a new born baby makes the situation impossible. The opportunity for this young girl (and her potential new born baby) to get out of the poverty cycle will be lost perhaps forever. Often adoption is not an acceptable alternative to the 15 year old and her mother (Doctor Fifty-seven).

As Jessica Shaw has argued “it is critical that women are able to decide whether to have children only when they feel that they are able to meet their personal requirements of what is needed to raise a healthy and happy family” (2013:5). Wicclair adds that pharmacists who refuse to fill legal prescriptions or to refer a patient to a willing provider cause obstruction to the provision of health services to which women are lawfully entitled (2006:242). Ceva and Moratti also add that

pharmacists denying women timely access to EC risk undermining women's right to reproductive self-determination (2013:139; see also Hepler, 2005 cited in Keller, 2009:263). For Keller, restriction of access to EC perpetuates the gender injustice that is committed when men contribute to pregnancy but "often see themselves as free to ignore their role in that outcome" (2009:263). Also arguing from a gender equality perspective, Rebekah Gee points out that "limiting access to contraception sets women back, threatening their rights to achieve equally in society by robbing them of options for planning for childbearing" (2006:2). Likewise, Carolyn McLeod suggests that the disappointment that a woman suffers after being denied lawful access to EC by a pharmacist constitutes harm in the form of hindering her from exercising her reproductive rights (2010:17-18). McLeod disputes the contention of some pharmacists who refuse to dispense EC to women, particularly teenagers on the grounds that the easy availability of these drugs is likely to promote irresponsible sexual behaviour or promiscuity (2010). She argues that these beliefs serve to restrict and stigmatise women's legal access to EC by validating sexist prejudices which aim at continuing the oppression of women and disrespecting their choices by depicting them as incapable of making autonomous decisions regarding their reproduction (McLeod, 2010:18-19).

For several participants avoiding the social harms that result from the birth of unwanted children outweigh other possible moral considerations surrounding for instance the OTC dispensing of MAPs as well as TOP.

You might be morally against it [that is dispensing the MAP] but will you be prepared to bring up that unwanted child? (Pharmacist Forty-three).

I am prepared to be involved in TOP services..., if a woman really feels unable to raise a child; I have no right to force her to carry the pregnancy [to term]. That would be paternalistic, and I will not be there when the baby cries from hunger, or is abused. It is a huge responsibility to raise a child. In my view, all pregnancies should be planned so that it can be a joy to the parents as it was intended. Conscientious objectors [should refer their patients]. If a doctor refuses to refer, and the woman ends up giving birth to an unwanted child, who is going to raise that child? I see too many unwanted kids in the paediatric ward – with emotional neglect affecting their growth (Doctor Fifteen).

The claim that an unintended pregnancy in a younger teenager is more likely to result in adverse outcomes such as placing her at risk of educational underachievement and poorer long term economic outcomes is supported in literature (Boden *et al*, 2008). Doctor Fifteen willingness to provide TOP services stems from her concern about preventing future negative consequences on the part of resultant unwanted children who might run the risk of being victims of poverty and abuse. Doctor Fifteen also interprets the harm that results from health professionals' right to CO from the perspective of resultant unwanted children and for this reason, she enjoins conscientiously objecting health professionals to refer their abortion-seeking patients to willing providers. For Doctor Fifteen, health professionals' invocation of CO risks significantly harming the resultant children born to parents who were denied TOP services.

The world is overpopulated, with poverty and all the other social evils that go hand in hand with it. I support this policy (Pharmacist Fifty-seven).

I am not happy with the idea but then take the ladies into to consideration who could bring unwanted children into the world who will not be cared for and there are enough of those already (Pharmacist Twenty-nine).

Our country is overpopulated, and more people and young children are having sex before marriage and before they are able to even support themselves so it [the MAP] does help with that...(Pharmacist Thirty-seven).

As a young idealistic doctor I was anti-abortion. I then watched real life situations which were too tragic. The tragedy of many unwanted abandoned babies I have seen flushed down toilets or thrown into long drops, the destruction of lives of young girls from unwanted pregnancies is overwhelming and these and other personal experiences made me change my mind. I applaud the ANC government for bringing in this law (Doctor Twenty-six).

These views are supported by research findings which suggest that harms to children born as a result of unwanted or unintended pregnancies range from lifelong dysfunction, including child abuse or neglect, to emotional handicaps, and stunted intellectual and educational development (Arthur, 1999; see also David, 2011). Gipson *et al*, found that in low-resource countries unintended pregnancies negatively impact on prenatal care, breastfeeding behaviour, and child nutrition (2008). Foster *et al*, found that unwanted children whose mothers were denied access to

TOP services are likely to grow up in poverty or face health complications (2012). A longitudinal study in Prague, Czech Republic found that many children born to women who were refused abortion for unwanted pregnancies ran a greater risk of negative psychosocial development and mental well-being as adults (David, 2006; see also Dytrych *et al*, 1975). For these reasons, Weisberg and Fraser have pointed to the need to always take into account the right of the unborn child when considering EC because “every child has the right to be a wanted child and not enter this world because its mother was denied access to EC” (2009:162).

While many participants cited the difficulty of reconciling provision of termination services with their own religious and moral beliefs, in some cases the predicted harm to children born of unwanted pregnancies were seen to outweigh their own religious views.

I do believe in dispensing the emergency contraception because the implications of unwanted pregnancy are huge and far reaching and outweigh [the pharmacist’s] moral, religious and cultural beliefs (Pharmacist Ten).

With reference to my comments regarding the fact that many unwanted babies are often abandoned and abused etc. and no doubt many on these could be avoided if the mother had been able to prevent the pregnancy, I do not let my personal feelings or religion interfere with the patients’ feelings. If the patient wanted this baby she would not be asking me as her pharmacist for the morning after pill (Pharmacist Forty-two).

I am prepared to be involved in TOP services...I have agonised over this issue as a Christian, and came to the conclusion that my calling is to help, not to judge...because I know for many of the women choosing TOP as a last resort, if they had the means to look after a child they would have kept the pregnancy. And it is the woman who makes the decision, not me. I just facilitate it happening in a safe clinical environment, one of the main reasons for the law was the number of deaths from septic backstreet abortions (Doctor Fifteen).

Conclusion

This chapter has shown that the application of the principle ‘do no harm’ in relation to controversial reproductive health services leads to a divergence of possible practices ranging

from an injunction to provide abortion on demand to a refusal to treat even in cases of emergency when the life of the pregnant woman is in danger. Where the principle of ‘do no harm’ is interpreted from the perspective of the pregnant woman alone and the foetus is not regarded as having the status of a person deserving moral consideration, the likely outcome is to regard such treatment as required and morally permissible. But where the foetus is regarded as a person it is possible to argue that the requirement to act according to the obligations of the law is unthinkable because it is tantamount to requiring a physician to murder a patient. The latter view can be used to support even a refusal to refer a patient to a willing provider given that this can be equated to collusion with the deliberate killing of an innocent.

A different interpretation of the ‘do no harm’ injunction goes beyond the narrowly constructed individual relationship between the physician and the individual patient (whether woman or foetus). A longer term social interpretation of the harms that follow from the lack of provision of termination of pregnancy and related reproductive health services is taken by those who include in their analysis of harm such considerations as the public health burden resulting from illegal abortion, the economic burden resulting from women having to leave education in order to take care of children and the harm to future children born to parents denied access to safe and timely reproductive health services.

Chapter seven: consequentialism

Judging the morality of an act according to its consequences is a commonly employed and compelling form of moral reasoning. According to Frank Jackson, “consequentialism approaches the question of whether an action is right or wrong in terms of a comparison of the possible outcomes of the action with the possible outcomes of each available alternative to that action” (1991:462). For Dale Jamieson and Robert Elliot, “consequentialism is the family of theories that holds that acts are morally right, wrong, and indifferent by virtue of their consequence [and] right acts are those with good consequences” (2009:241). Consequentialism thus judges the ethical rightness or wrongness of an action based on the consequences that action has. While

there are many versions of consequentialism, for purposes of this chapter I confine my discussion to the earliest and most well-known consequentialist theory, which is hedonistic utilitarianism which holds that the goodness of an outcome is the total balance of happiness over suffering (Moore, 1912). Utilitarianism is an ethical doctrine that judges actions according to the number of people who are made happy by these actions with the aim of achieving the greatest happiness for the greatest number (Vincent *et al*, 2012:169). As John Stuart Mill famously expressed the doctrine, “actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness” (1863 cited in Vincent *et al*, 2012:149). According to Jamieson and Elliot, “hedonistic act utilitarianism hold that acts are right, wrong, or indifferent by virtue of the pleasure they produce; an action is right if it produces the maximum possible pleasure and wrong if it does not” (2009:242; see also Moore, 1912:19).

Some have argued that consequentialism is fruitful in solving moral conflicts as it always provides an answer to hard moral questions (Bergström, 1996:77). When solving morally controversial disputes, Charles Goodman enjoins consequentialists to always “endorse rules that would produce the best consequences if everybody followed them; or merely if everybody tried to follow them; or perhaps if enough people tried to follow them” (2013:613-614). In this chapter I discuss the ways in which participants in the study employed various forms of consequentialist reasoning to negotiate their interpretation of the moral dilemma occasioned by the tension between women’s reproductive rights and the health provider’s right to conscientious objection. As the chapter illustrates, the difficulty with consequentialist forms of moral reasoning is that they can be employed to support diametrically opposing courses of action, given the complexity of calculating social outcomes with any degree of accuracy or impartiality. The consequences that are predicted to be the result of a particular action often say more about the ideological position, interests and identity of the speaker than anything else.

Thus we see in the chapter those who allege negative long-term health consequences for women resulting from TOP and MAP citing these as justification for their right to CO. On the other hand those who cite negative and social individual consequences resulting from unwanted pregnancy see these consequences as justifying their conclusion that CO is not morally supportable.

- **Consequentialist reasoning employed to justify non provision of termination and MAP services**

The ethical principle of ‘beneficence’ imposes on health professionals a moral duty to promote the welfare, health, and wellbeing of their patients (Beauchamp and Childress, 2001; see also Schroeter, 2008). Guided by this ethical principle, some participants justified their invocation of CO to the provision of TOP and MAP services as yielding the greater health promoting outcomes for their patients. Pharmacists argued for example that the negative health consequences of unrestricted distribution of MAPs include the spread of sexually transmitted infections (STIs) and sexually transmitted diseases (STD’s) including HIV and AIDS, the promotion of promiscuity, and even cancer and stroke.

I find it troubling because the person is having unprotected sex which could be with one or many partners, and this leaves them at risk for any STDs/STIs. Pregnancy is not the only thing we worry about as health care professionals (Pharmacist Thirty-seven).

I do find it concerning. Then there can also be increased risk to HIV, AIDS and STD’s if it is not in controlled relationship (Pharmacist Nine).

The scary part is the risk of STI’s and AIDS. Very often women do not realise these dangers (Pharmacist Forty).

It was a good idea to prevent unwanted pregnancies, but I see a lot of people using it in place of the pill or other forms of contraception without ever thinking that HIV could also be contracted and it becomes a life style, have sex get morning after pill (Pharmacist Twenty-nine).

As is the case with other hormonal contraceptives, all emergency contraceptive methods provide no protection from STIs, STD’s, HIV and AIDS, rather abstinence or latex condoms provide the best protection against these diseases (Parker, 2005:4). The participants cited above construct their reluctance to comply with clients’ requests, especially repeated requests, for MAP resulting from their awareness of these consequences. However infused in these remarks are moral prescriptions and assumptions,

MAPs are suspected of enticing women to adopt a more promiscuous ‘lifestyle’; the idea of a ‘controlled’ relationship suggests a distinction between approved of and not approved of relationship types and women are constructed as ignorant of how diseases are transmitted. It becomes clear then that these participants do not feel uncomfortable with the medication as such – for example because it is regarded as an abortifacient. Rather, their discomfort stems from disapproval of their clients’ lifestyles, relationships and choices.

Similar findings have been reported in many other settings. In a 2011 cross-sectional survey conducted in Managua, Nicaragua which explored pharmacists’ knowledge of and attitudes toward emergency contraceptive pills (Ehrle and Sarker, 2011:72), the majority of study participants expressed negative attitudes toward emergency contraceptive pills. They were particularly concerned that the pills’ availability might encourage sexual risk-taking including lack of condom use which they feared would increase the transmission of HIV and other STIs (Ehrle and Sarker, 2011:72). Likewise, a study of emergency contraception providers in Jamaica and Barbados also found that many providers criticised OTC dispensing of EC as they felt this could encourage sexual risk-taking and lead to an increased incidence of STIs (Yam *et al*, 2007).

Defending his principle of harm to others as the sole basis on which the freedom of choice of a person can legitimately be restricted, John Stuart Mill specifically excluded others deciding what is in our interests as grounds for preventing us from doing something.

The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant (Mill, 1806-1873:68).

At the basis of many of these claims to be acting in the interests of their patients who are ignorant lies an infantilisation of women and a relationship of power between the health provider and the patient, particularly when that patient is poor, female and black.

If used correctly [emergency contraception], there is a place for it in society, unfortunately it has resulted in too much promiscuity leading to STDs and HIV-taken too lightly (Pharmacist Sixteen).

I believe that it will promote promiscuity and expose people to dangerous health concerns. It is a concern (Pharmacist Forty-seven).

I think that it was not a good policy because it just give women and men another reason to have unprotected sex when South Africa is already known as the country with the highest AIDS rate...I see it as an easy way out (scape goat), it is just another reason for people not to put their health first (unprotected sex) (Pharmacist Six).

Yes, I find it [dispensing repeated requests for emergency contraception] troubling because it makes you wonder how many partners they have or if it's some else's partner (Pharmacist Six).

In these participants' comments, the concern about negative health outcomes is closely intertwined with the concern than unrestricted provision of MAPs will make women more promiscuous. Gee's 'figured worlds' tool enjoins the analyst of discourse "to ask what typical stories or figured worlds the words and phrases of the communication are assuming and inviting listeners to assume" (2011:168). The figured world that Pharmacist Six is inviting listeners to assume can be understood by the distinction that he draws between what he thinks is normal and abnormal with regards to women requesting MAPs. From this, what Pharmacist Six regards as normal or good is for women to request MAPs once in their lifetimes as this shows that they are having sex with one partner and are also loyal to their partners and this is a normal and appropriate way of conducting oneself sexually. Normal and appropriate conduct in turn leads to the right to access the MAP. In contrast repeated requests for MAPs are an indication of abnormal or bad behaviour which includes either being unfaithful to one's partner or having unprotected sex with many different men. The distinction in turn justifies refusal to provide MAPs for those who do not fit into the moral norms constructed as appropriate by the speaker.

Given that there is scant evidence to suggest that availability of MAPs does actually increase the rate of STDs, HIV and AIDS, it is hard to resist the conclusion that the argument about negative health outcomes is acting as a Trojan horse. Raymond and colleagues' randomised trial study of sexually active women in Nevada and North Carolina, US between 2002 and 2005 concluded that better access to EC does not increase the acquisition of STIs (Raymond *et al*, 2006). In addition to that, other studies have also found that efforts to increase access to ECPs such as

providing women with EC in advance of need have not been shown to increase rates of unintended pregnancy or STIs (Gold *et al*, 2004; Raymond *et al*, 2006). Rather, in reality, a woman's risk of contracting an STI depends on having unprotected sexual intercourse with an infected partner (Weisberg and Fraser, 2009:161).

Nor is there evidence to suggest that claims about increased rates of cancer, stroke or loss of immunity have any basis. The fact that they are routinely cited by professionals trained in evidence-based practice suggests the need for an explanation as to why dire health consequences are invoked in the absence of evidence for such consequences.

I caution them that it is now time then for a more permanent prevention and that the morning after is just a once-off help and that it can't be used again and again, since it is dangerous and might lead to cancer if used often (Pharmacist Forty-three).

I do find it concerning. Due to simple reasons i.e. risk of DVT and stroke as result of high dosage hormone in presence of various risk factors (Pharmacist Nine).

I only prescribe the morning after pill once. It is not safe to repeat it more than twice because it messes up a woman's immune system (Pharmacist Six).

While each of these participants agrees that repeated requests for MAPs are problematic on the grounds that these result in adverse health consequences, they each have a different view regarding exactly what these health consequences might be. If there was clear evidence that these claims were based on them presumably all respondents would be making the same rather than different arguments about health consequences.

Additionally, while negative side-effects of medication are a reason to provide information to a patient, it is unusual to see these as a reason to refuse to provide a legal medication. Studies have for instance shown that "having used birth-control pills elevates the risk of developing breast cancer nearly tenfold" (McGovern, 2014) but this has never been invoked as a reason to refuse women access to birth control pills. Westleya and Glasier have argued that emergency

contraceptive methods are safe and that “it has been clearly demonstrated through countless studies and many decades of use: no new research needs to be conducted” (2010:243). Research by the WHO has shown that repeat use of all forms of emergency contraceptive methods is safe and poses no health risks and for this reason, the WHO has placed repeat EC use in Category 1 of its medical eligibility guidelines, indicating that there is no restriction for the repeat use of this contraceptive method (WHO, 2000). Moreover, the WHO guidelines on EC service delivery state that, “although frequent use of emergency contraceptive pills is not recommended, repeat use poses no health risks and [health risks] should never be cited as a reason for denying women access to treatment” (WHO, 1998a).

These widely known conclusions make it all the more troubling that nebulous ‘health risks’ are cited as a reason for refusing or for stigmatising women who choose to request this particular medication. Some respondents reported that while they would not refuse repeated requests, they felt it important to counsel women making these requests about the possible effects on their hormonal cycle. It is unclear why this is regarded as a matter of such significance that it is invoked as a serious negative consequence when weighed up against the negative consequences of unwanted pregnancy not only for the pregnant woman.

It works more like abortion before the implantation of the embryo or development, the women have to be aware how it affects their hormonal cycle and consequences such as infertility if used more often (Pharmacist Thirty-four).

The emergency contraception tablets have high doses of hormones, and fluctuations in hormonal levels in the body are not healthy for extended periods. It is at this point where patients should be made aware of the monthly regimen which has a steady administration of hormones (Pharmacist Twenty-four).

I also warn that constant and regular use of the emergency contraception could have negative effects on hormonal control (Pharmacist Forty-five).

[I find repeated requests for the MAP troubling] I always try to take time and explain the negatives when used often especially regarding characteristic of the cycle changing (Pharmacist Nineteen).

Parker maintains that providers' lack awareness and knowledge of the correct use of ECPs and often have biases and misconceptions, which pose significant barriers to potential ECPs users" (2005:6). One study of pharmacists in Jamaica and Barbados revealed that lack of specific knowledge about emergency contraceptive pills resulted in many participants overestimating their contraindications and side effects and this was then used as a justification for invoking CO (Yam *et al*, 2007).

Isaacson has argued that "language has the power to reify mental constructs as concrete realities [especially with regards to] the use of medical terminology, as part of technical language belonging to an elite profession, enables physicians to define what significant categories of meaning are" (1996:462). The association of MAPs with abortion -- which is contradicted by medical science -- serves to construct MAPs as much more controversial than they are, linking them to termination of pregnancy and thus to wider debates around the ethics of termination of pregnancy. Similarly, constant use of medical terms serves to underline the authority of the provider in contrast to the ignorance of the client.

Also noteworthy is the fact the preferred advice cited by some participants is to counsel women to use regular hormonal contraceptives instead of repeatedly requesting MAPs -- and there is no reference to the side effects and health risks associated with regular contraceptive use.

The use of MAPs may result in minimal and temporary side effects which normally last between 24 to 72 hours and these may range from nausea, vomiting, headaches, dizziness, cramping, fatigue, or breast tenderness (Glasier, 2013:309). A WHO study found that about 20 percent of women taking the combined ECP experienced vomiting and 50 percent experienced nausea, compared to only six percent with vomiting and 20 percent with nausea among those taking the progestin-only pill (WHO, 1998b). These short term side-effects aside, research has shown that repeated use of ECs does not pose any known long term health risks, apart from menstrual irregularities (WHO, 2012). Research has also demonstrated that women who used EC more than once in the same menstrual cycle have not reported serious adverse outcomes (Halpern *et al*,

2010). In this light, because of the health risks that pregnancy carries, taking EC is likely safer than carrying an unwanted pregnancy to term (FPCR, 2013).

Based on the safety of emergency contraceptive methods, some countries have begun to take an expansive approach to providing women with MAPs in advance of need. For instance, in response to growing teenage pregnancy in the UK, in May 2014, the National Institute for Health and Clinical Excellence (NICE) “renewed its 2010 call for young people to be given emergency contraception to keep at home in advance of sexual intercourse in case they need it” (Donnelly, 2014). Thus, under new guidance from the NICE teenagers under 16 years are now able to pre-order emergency contraception including the MAPs and the IUD (intrauterine device, or coil) (Donnelly, 2014). Not only that, but the new guidance also imposes an obligation on public and high school pharmacists to provide EC to sexually active pupils in advance on request without requiring the authorisation or notification of their parents (Donnelly, 2014). Professor Mike Kelly, director of the Centre for Public Health at NICE, said the reason why NICE took this extraordinary initiative was primarily because: “evidence clearly shows that the availability of contraception reduces the rate of unwanted pregnancies” (Donnelly, 2014).

Having discussed the deployment of consequentialist reasoning by pharmacists who are opposed to the unrestricted availability of MAPs to their clients, I turn now to the doctors in the study who employed consequentialist arguments to explain their opposition to termination of pregnancy. Many of these doctors referred to their belief that negative health consequences resulting from abortion including long-term psychological effects especially on the part of women who obtain second trimester abortions.

The State must fund and promote adoption agencies for those unwanted babies. We need to get to the root of the problem and not provide a quick fix solution. Research has shown there are severe psychological consequences to both women who have abortions and their partners at some stage in their life i.e. post-traumatic stress disorder and depression... In my experience as a doctor I have always guided my patient to the preservation of life (Doctor Twenty-three).

[For] many [women] abortions are requested for the wrong reasons – as admitted by the receivers thereafter. I have seen many patients become

severely depressed post-abortion. I have never done one, but have worked with a colleague, who became extremely depressed while doing them. I have counselled quite a few potential “pro-choice” mothers, whom I have referred to appropriate centres – of those many have decided to not go through with the abortion. Knowledge of alternative choices to abortion is lacking in South Africa. I know of very few studies that have been done on the effects of abortion on the woman (Doctor Eight).

I have been involved in the management of patients after they have aborted at home and those patients are so self-judgmental! So sad and unhappy that they don't need anyone else talking to them about how bad they are (Doctor Thirteen).

For Doctor 23, abortion may seem like a ‘quick fix’ but in reality it results in negative long-term psychological consequences in the form of post-traumatic stress disorder and depression. Doctor 8 sees women as often requesting TOP procedures for ‘wrong’ reasons and believes that this will lead to negative health consequences in the form of post-abortion depression, not only on the part of the patient but also on the part of the physician. Although this doctor has never actually performed an abortion procedure, he however bases his belief on the experience of a colleague experience whom he believes subsequently suffered severe depression as a result of performing abortions. Avoiding harm to self is, to say the least, a controversial justification for failure to fulfil a professional duty on the part of a medical practitioner. The remedy proposed by this doctor, moreover, reveals that his aim is to direct his patients to his preferred outcome rather than to whatever outcome is chosen by the patient herself. He refers his abortion-seeking patients to pro-life centres where they will be ‘counselled’ to carry their pregnancies to term rather than opting for abortion. Doctor 13 makes the oft-heard claim that women who undergo abortions suffer post-traumatic stress, depression and loss of self-esteem. It is worth noting however, that the empirical evidence in support of this claim is inconclusive.

The ACOG Committee Opinion has forcefully argued that “refusals to provide abortion should not be justified on the basis of unsubstantiated health risks to women” (2007:4). Yet many of the doctors in the present study cited concerns about the future psychological effects on women as the reason why they are not willing to perform terminations or to refer patients to willing

providers. Several studies have however dismissed claims that women who have elective abortions will inevitably experience psychological distress of any kind as a result of the termination. For instance, Adler and colleagues found that there is no scientific “evidence that abortion is likely to be followed by severe psychological responses and that psychological aspects can best be understood within a framework of normal stress and coping rather than a model of psychopathology” (Adler *et al*, 1992:1194; see also Adler *et al*, 1990; Bradshaw and Slade, 2003; Dagg, 1991; Lewis, 1997; Romans-Clarkson, 1989; Turell *et al*, 1990; Zolese and Blacker, 1992; Vignetta *et al*, 2008).

Yet participants routinely treated emotional trauma as an inevitable consequence of abortion, particularly in the case of second trimester abortion which, as we have seen, is a procedure that is more likely to be requested by the most disadvantaged and disempowered.

Few doctors will do second trimester abortions. I strongly believe these procedures produce far more complications than what we think. It is very difficult to treat a patient that had an abortion done when she was 20 years old and now presents with emotional issues when she is 40 years old (Doctor Fifty-one).

This [that is, second trimester abortion] is even a more serious medical and emotional situation to cope with for patient and doctor. I see too many patients that had a TOP as a young lady and end up with problems of reproduction later and have serious emotional scarring!! (Doctor Twelve).

If a second trimester abortion is done on clear medical/psychological grounds I have no problem. It is that abortion done on request which causes psychological problems later. It is patients’ psychological problems which helped me make up my mind to specialise in Anaesthesia (Doctor Thirty-seven).

Doctor 51 justifies his non-involvement in performing second trimester abortions on the grounds of the resultant untreatable long-term emotional consequences for patients. Doctor 12 associates all abortions with subsequent negative psychological consequences both for the TOP service provider and the patient, but feels that these consequences are more severe in the case of second trimester abortions and particularly for teenagers.

Contrary to these claims, while abortions at later gestational ages including second trimester abortions are associated with greater risks of complications (Bartlett *et al*, 2004) as compared to first trimester abortions (Cook and Dickens, 1981:73), this does not however, mean that second trimester abortions are not safe. Dalvie argues that second trimester abortions can be carried out safely given appropriate operating facilities and facilities for blood transfusion, transportation, etc. (2008:39-40). A hospital-based South African study by Basu and Basu has also confirmed the safety and effectiveness of second trimester TOP using misoprostol drugs (2009:173).

- **Consequentialist reasoning employed to contest non provision of termination and MAP services**

While the legalisation of abortion in South Africa increased the number of abortions performed notable is the fact that this did not reduce abortion-related mortalities (Johnston, 2010), as many women continue to resort to unsafe termination practices outside designated facilities (Jewkes *et al*, 2005a:1240; Dickson *et al*, 2003:284; Meel *et al*, 2009). For instance, the 2005-2007 'Saving Mothers Report' for the first time noted an increase in the number of avoidable deaths from abortion from 4.7% to 4.9% (Bateman, 2011:302). During 1997 alone, the Department of Health inquiry into maternal deaths revealed that 575 deaths resulted from pregnancy related unsafe abortions (Department of Health, 1997). The 1998 inquiry showed that 60.5% of early pregnancy deaths and 38.8% of deaths from pregnancy-related sepsis were due to unsafe abortions (Department of Health, 1998).

Research further reveals that an increase of number of deaths by 20.1% in the triennium (2005-2007) as compared with the previous triennium (2002-2004) was caused by complications resulting from unsafe abortions (NCCEMD, 2007:3). By the 2005-2007 period, annual abortion-related deaths accounted for only 3.3% of all maternal deaths (van Bogaert, 2002). In 2006, the South African triennium report found that, maternal death attributed 3.5% of the total maternal deaths directly to unsafe abortion (Department of Health, 2006). According to the 2012 Saving Mothers report, 23% of MM resulted directly from complications from unsafe abortion (NCCEMD, 2012).

The reason for high levels of morbidity and mortality rates from complications of unsafe abortion emanates from the lack of awareness about the legality of abortion particularly among the majority poor women. Following the decriminalisation of abortion, Varkey points out that, “at the community level, little has been done by health services to inform people of the [CTOP] Act” (2000:88), and this has resulted in almost a third of South African women believing that abortion is still banned, thus resorting to illegal abortions (van Bogaert, 2002). Likewise, one 1997 study conducted in the Cape Metropolitan Region, for example, found that many women were poorly informed about their reproductive rights. Of 183 participants, more than 90% had no knowledge of the conditions under which abortion was legal (de Pinho and McIntyre, 1997). A 2006 study found that an approximate 30% of the study participants believed that abortion was still illegal (Morroni *et al*, 2006:7). Additionally, a cross-sectional study among 831 sexually-active women attending 26 public health clinics in one urban and one rural health region of the Western Cape Province conducted by Chelsea and colleagues also found that most women did not know about the legality of abortion in South Africa (Chelsea *et al*, 2006:3).

As has been illustrated by the above figures, unsafe abortions are responsible for a significant proportion of maternal deaths in South Africa. This context was referred to by those participants in the present study who described non-involvement in the provision of TOP and MAP services as having the consequence of many women resorting to unsafe abortion practices. Employing consequentialist moral reasoning, these participants argued that reducing maternal and morbidity rates required medical practitioners to either provide reproductive health services themselves or refer TOP and MAP services-seeking patients to willing providers. Objecting to the provision of these services or to referral was rejected on the grounds of the disastrous consequences that this would have, putting patients’ lives and health at risk as a result of their opting for unsafe abortion.

Yes they [the conscientiously objecting doctors] do [have an obligation to refer their patients to willing providers], otherwise their unwillingness to help the patient might lead to the patient choosing an unsafe alternative, thus making them [doctors] liable for any resulting mortality or morbidity on the side of the patient (Doctor Thirty-eight).

The doctor has an obligation to refer if he/she does not support the Act. She will probably find a back yard person to perform it as well. Therefore, I think referring to a willing colleague provides for better care and less complications (Doctor Fifty-two).

Yes, the patient must be referred. She might make use of unsafe procedures if not referred (Doctor Fifty-one).

Of course, they must refer the patient. To deny referral is to endanger the requesting woman's life and well-being (Doctor Fifty).

I personally do not think abortion is right; but feel that every woman should have the right to decide according to her circumstances. It is better for women to have abortion in controlled and aseptic circumstances than being desperate and having it done by someone not qualified or doing it too late (Doctor Forty-nine).

These participants agree that the adverse consequences of unsafe abortion can practically be prevented if all health professionals who assert their right to CO timeously refer their patients to non-objecting providers. In this view, an efficient referral system would have the positive consequence of saving lives. The negative consequences of unsafe abortion are seen to far outweigh any possible negative consequences of choosing to provide women with these services. Doctors who refuse to refer their abortion-seeking patients to willing providers are seen to directly contribute to these negative consequences.

The insistence on the duty to refer is in line with the prescriptions of the CTOP Act which “allows for conscientious objection on the part of health care providers, [but] ... also clearly states that if a woman requests a termination of pregnancy, she also has rights under the Act. If the health care provider cannot, or will not, provide an abortion, he/she is obliged to refer the woman to a health professional who is prepared to provide the service” (Dickson-Tetteh and Rees, 1999:191-192). Their reasoning is also confirmed by research which shows that women denied lawful access to TOP services are often exposed to negative consequences in the form of the serious health risks of unsafe abortion (Erdman, 2012:85; see also Fiala and Arthur, 2014:7) with an estimated 47, 000 women dying annually due to unsafe abortion-related complications (Shah and Ahman, 2010) and 8, 5 million are injured (Guttmacher Institute, 2010 cited in Fiala and Arthur, 2014:16).

Yes I believe they have to have information on proper and safe services. The patient will seek an abortion irrespective of what the doctor feels and she might end up with an illegal service provider (Doctor Thirty-nine).

I am aware that patients will seek backstreet abortionists or alternative ways if legal ways are not available. A practitioner should not fail to treat a patient in need, whatever the cause of the need (Doctor Thirty-three).

Dickson-Tetteh and Rees have argued that in South Africa, maternal deaths from complications of unsafe abortion “are almost all entirely preventable” (1999:190), and the same also holds true for other countries where abortion is legal (Grimes *et al*, 2006:1908) through improvement of family planning services and expansion of access to safe abortion services (Kulczycki *et al*, 1996:1667). The importance of the need for health professionals to refer their abortion-seeking patients has been acknowledged by participants in the international medical CO debate. Mark Wicclair, for instance, has stressed the necessity of referral on the part of conscientiously objecting health professional primarily on the grounds that to withdraw care “without facilitating a transfer would constitute abandonment” (2000:226), which is unethical both in medicine and pharmacy practice (Berlinger, 2008:39). As such, in Savulescu’s terms, this abandonment on the grounds of CO ought not to be accommodated because it compromises the delivery of quality, efficient, safe and legal TOP services for women (2006:296).

Conclusion

Consequentialism has been associated with several weaknesses by its several prominent critics. For instance, Germain Grisez, finds consequentialism rationally and morally unacceptable because it “implies that there are no intrinsically evil acts” (1978:24-25). The philosopher Bernard Williams for instance argues that the killing of innocent human beings is intrinsically wrong, and for this reason, he criticises the utilitarianism version of consequentialism for seeming “to imply that, under certain conditions, you ought to kill an innocent person in order to save several others” (1973:98 cited in Bergström, 1996:78).

Similarly, in his book, *The Rejection of Consequentialism*, Samuel Scheffler dismissed consequentialism as morally inferior as it permits an agent sometimes to behave partly in the light of what he or she naturally wants to do, even if this does not maximise utility (1982) – in other words, consequentialist moral arguments lend themselves to a selective appropriation of evidence to suit one’s existing convictions. This problem is exemplified in the present chapter which sees health professionals, particularly those who object to repeated requests for MAPs and those who object to later gestation abortions, referring to long-term negative health outcomes that are not confirmed by research. The exaggeration of negative health consequences appears to act to justify a pre-existing unwillingness to provide these services rather than being based on an impartial calculation of consequences. This is confirmed by Fiala and Arthur when they argue that “the misconceptions around abortion and the MAP turn CO into an attractive solution for individual healthcare providers (ironically reinforcing those negative attitudes and beliefs)” (2014:6).

For Mill, “the principle of utility involves an assessment of only an action’s consequences, and not the motives or character traits of the agent performing the action” (1863 cited in Vincent *et al*, 2012:169-170). But as we have seen, those invoking consequentialist reasons for their unwillingness to provide women with reproductive health services are seldom able to make this distinction very sharply in practice.

Consequentialist reasoning allows for the selection of which negative outcomes to emphasise and which to ignore. In this case negative health outcomes are emphasised but other consequences for patients denied care do not make an appearance in the moral calculation of the likely outcomes of refusing services to women or making access to such services more difficult.

The chapter shows that diametrically opposed courses of action can be supported using consequentialist reason. Some participants argued that they are justified in refusing to provide TOP and MAP services because they believe that the easily availability of these services result in long-term negative health and psychological consequences on the part of requesting patients. On

the other hand participants in favour of these services referred to current high levels of maternal morbidity levels resulting from unsafe abortions in South Africa justifying their decision to provide these even when their own religious or moral framework is not in favour of them. Consequentialist forms of moral reasoning appear to be readily cut to suit the coat of the speaker thus rendering women's reproductive rights vulnerable to the personal views of some health providers who may draw selectively and partially on the available evidence and in foregrounding their own moral views neglect to consider a wider set of consequences for their patients and for society.

Chapter eight: moral absolutism

In many ways the reverse of consequentialist forms of moral reasoning, moral absolutism is a philosophical ethical concept which is usually traced to the moral absolutist philosopher Immanuel Kant (1724-1804) and it holds that “certain actions are morally impermissible simply by virtue of being members of certain identifiable kinds of action, such as lies, acts of adultery, and deliberate killings of the innocent” (Anscombe, 1958:10; see also Geach, 1969:124-125; Nagel, 1979; Kant, 1797). This stems from the fact that such acts are categorically prohibited by divine law (Anscombe, 1958:10; Geach, 1969:124-125). Moral absolutists define murder, as the deliberate killing of the innocent (Anscombe, 1961), as such, they view murder as one of the acts that one must never do to secure any good or avoid any evil (Geach, 1969:120). Other than the wrongfulness of the deliberate killing of an innocent person, Elizabeth Anscombe has also applied the moral absolutist position in the judicial system and argues from a justice point of view that it is always wrong to knowingly punish the innocent person even if that will bring about greater good (1981:39-40). From this, it is evident that moral absolutism is the opposite of consequentialism which judges the rightness or wrongness of an action based on the consequences that action has especially its utilitarianism version which “judges actions according to the number of people who are made happy by these actions” (Vincent *et al*, 2012:169).

Those conscientiously objecting health professionals who adopt a moral absolutist position to the provision of TOP and MAP services thus think that their right to CO should always take precedence over any other consideration including the requirements of law. As we saw in the previous chapter, some conscientiously objecting health professionals object even to referring patients to willing providers as they associate such referral as tantamount to the actual provision of such services which result in serious harm to innocent human life. In this chapter I discuss the views of those who argue that their religious-based CO should always take precedence because the provision of TOP and MAP services is against the commands of their deity.

One's conscience or beliefs would depend on religious laws/commandments. World laws are developed from religious laws so I do not think we should be forced to override beliefs or conscience (Pharmacist Forty-six).

No they are not obliged to do so [that, is referring patients]. I would very gently explain my objection to the patient and explain also to her that I cannot refer her – asking her to understand that this is how I manage to live with who I am as a Roman Catholic, just as she has to manage her life and circumstances. If she indicates that she would like to discuss alternatives to abortion (I would not force this on her) I would be able to refer her to for example the Catholic Life Centre (Doctor Forty).

If it is due his/her religious beliefs then he/she should advise the patient according to his beliefs (Pharmacist Twenty-eight).

This policy is not right because by the right of my religion it is wrong for a female to use emergency contraception before marriage. By using emergency contraception it can also be harmful to your body. Due to my religion rights which is Islam and by rights of the Islamic law women should not harm their bodies (Pharmacist Six).

I don't think abortion should be legal and refuse to provide...Pretty anti-abortion and always will be on Christian moral grounds. I did a presentation in parliament before legalisation went through but it was a mockery of the process! (Doctor Eleven).

We are pharmacists 'yes', but we are also normal human beings with values and virtues and we practice with these personal values as a guide. Hence, I believe we should do as we think is right to us as long as we live with it (Pharmacist Twenty-one).

I do not support ‘abortion on demand’ – for personal reasons and religious...Of greater concern is the need to be more active in prevention of unwanted pregnancies (Doctor Thirty-one).

Yes, they should have the right to refuse due to religious reasons (Pharmacist Twenty-eight).

Some participants whose conscientious objection is religiously based are only willing to provide TOP procedures in exceptional circumstances where the life of the pregnant woman is in serious danger while others absolutely invoke CO to the treating of women with incomplete abortions including in cases of emergency. Some object only to the provision of second trimester abortions as they equate these with murder.

Advocates of health professionals’ right to CO such as the philosopher and theologian James Franklin Childress has defined conscience as “personal and subjective; it is a person’s consciousness of and reflection on his own acts in relation to his standards of judgment” (1979:318). Childress goes further to explain that “in appealing to conscience I indicate that I am trying to preserve a sense of myself, my wholeness and integrity, my good conscience, and that I cannot preserve these qualities if I submit to certain requirements of the state or society” (1979:327). Because, in this view, conscience is so central to personhood it is not morally permissible to expect someone to compromise their conscience even if to achieve some other pressing social good such as a patient’s welfare.

Pharmacist’s right to practice according to her conscience [should take precedence]...It must stay the choice of the pharmacist; you cannot force somebody to dispense anything if they are not comfortable with it (Pharmacist Twelve).

They should not be forced; they can do so if it is their choice and if they are comfortable with doing it (Doctor Forty-nine).

For these participants, the health professional should only have to participate in procedures that they are ‘comfortable’ with. Failure to respect their choices is equated with being forced. Here being comfortable with providing TOP or MAP services is constructed as the yardstick by which to determine the health professional’s obligations. Echoing this stance, Beauchamp and Childress equate forcing conscientiously objecting health professionals to provide contested reproductive

services against their consciences with a serious violation of their right to autonomy and self-determination (1983:390). Lawrence and Curlin argue that this will result in the health professionals experiencing “considerable distress for having acted contrary to who[m] they perceive themselves to be” (2007:12).

As Doctor three argued,

I do feel that doctors should have the freedom not to get involved in abortion in any way at all if they feel that it is against their conscience. There should be freedom of conscience as a right to protect health providers if there is going to be freedom of choice for abortion for clients (Doctor Three).

Doctor Three constructs the health professional’s non-involvement in TOP services as a way of achieving a reasonable balance between the doctor’s right to not provide TOP services on the grounds of CO (which he associates with the doctor’s absolute freedom of choice as emphasised by the terms “in any way at all”) and the patient’s right to access a TOP procedure.

I do not do abortions without medical indication. I believe there will always be doctors that are willing to do abortions, maybe the Government can find out which doctors and pay them for non-medical abortions. On the other hand, it is legal to build a big ship, but it is your own problem to pay for it and to find someone that has the know-how and that wants to do it, you do not have the right to force me to neither build a ship (even if I could) nor to do non-medical abortions (Doctor Eighteen).

Doctor Eighteen upholds a moral absolutist stance towards performing elective TOP procedures and in so doing he challenges the CTOP Act framework which provides for publicly funded TOP services free of cost in designated public health care facilities. It is important here to elaborate on Doctor Eighteen’s parable of what he refers to as a ‘big ship’ in order to justify his invocation of CO to the provision of elective abortions. It follows from this parable that while this doctor agrees with the legality of the government’s initiative of taking an expansive approach of

legalising abortion with the objective of making such services to be accessible to the majority of women, this doctor however blames the government for failing to come up with a feasible way of ensuring a comprehensive access to elective abortions. To achieve this, this doctor suggests that the government should employ specific non-conscientiously objecting health professionals who specialise in performing elective TOP procedures in return of monetary incentive. In light of this, Doctor Eighteen therefore justify his right to CO by arguing that the government should neither expect nor force him to provide elective abortions against his conscience.

The health professionals whose views are cited below take a moral absolutist stance towards referring for TOP services and they frame and justify their invocation of CO as consistent with the current South African law. In other words they argue that they should not be held legally liable for not referring their abortion-seeking patients to non-objecting health professionals.

No, constitutionally they are not obligated [to refer]. Also a patient does not need a referral. They can simply ask another health provider themselves. A doctor or nurse should not be a portal of entry for an abortion system. It is not a doctor or nurse's job to help take life (Doctor Three).

Doctor Three cites the South African constitution to reinforce his view that conscientiously objecting health professionals do not have an obligation to refer their patients to willing providers and to also argue that patients are less likely to be inconvenienced by this because they can on themselves easily find another non-objecting health professional elsewhere without even having a formal referral letter. The philosopher Toby Ord claims that like adult human beings, embryos,³⁷ have full moral status from the moment of conception (2008:12). Likewise, drawing upon this foetal life frame, Doctor Three sees himself as having legitimate grounds for refusal to perform abortions. For him, TOP procedures are not part and parcel of doctors and nurses' professional duties as providing these services is tantamount to intentionally killing foetuses which is clearly immoral.

³⁷ Ord uses "the term *embryo* to refer indiscriminately to the *zygote*, *morula*, *blastocyst*, *embryo* and *foetus*" (2008:12).

The law allows health professionals (including doctors) not to take part in any way in abortions. For me, this includes not referring patients to health professionals who will do an abortion. I (and other doctors who believe as I do) have to take a stand on this 'exception clause' in the law (Doctor Forty).

Doctor Forty invokes CO to both the provision of TOP services and referring abortion-seeking patients on the grounds that the law allows him to do so as he constructs the law as not imposing any obligation on health professionals to provide these services. For him, there is therefore, 'no dilemma'.

No dilemma, whilst the law says that every woman has the right to TOP, an objecting doctor also has the right to refuse to perform a TOP procedure and let those doctors who agree, let them terminate pregnancies. I agree with TOP, I would not terminate a pregnancy (Doctor Thirty).

For Doctor Thirty while South African law recognises a woman's right to access a legal and safe abortion procedure at the same time the law also recognises the health professional's constitutional right to refuse to provide these services on the grounds of conscience. For this reason, Doctor Thirty frames his invocation of CO to perform abortions as something that is legitimately grounded in the current South African constitutional order.

No person should be forced by law to either perform this procedure or be forced to refer a patient for this procedure. The Department of Health should identify persons willing to do the procedure, make venues available, and make these available to potential users through media, hospital information desks, etc. as the departments deems fit, if they think that such a choice (TOP) should be made available [to every woman] (Doctor Twenty-two).

For Doctor Twenty-two, legally conscientiously objecting health professionals have no obligation to either perform or refer for TOP services. For this reason, Doctor Twenty-two argues that there is a possibility that some health professionals will not provide TOP services on the grounds of conscience. As such, the government ought to open separate private health care facilities and employ non-objecting health professionals dedicated to provide these services as this is a more feasible way of realising a comprehensive or universal provision of these services than forcing conscientiously objecting health professionals to perform or refer for these services.

If the law forces me to refer the patient to someone willing to perform the procedure ([that is] killing the baby), then the law strips me of my human right to live according to my conscience. That violates and criminalises my human rights (Doctor Forty-four).

Drawing on the foetal life frame, Doctor Forty-four associates performing an abortion procedure with intentional killing of a foetus and this acts as legitimate grounds for invoking CO. Central to this doctor's grounds for invoking CO is the personal cost she fears would incur should she be forced to violate her conscience by providing a TOP service. Doctor Forty-four frames the performing of an abortion procedure as tantamount to committing a crime – to do so would be to do wrong and it can never be morally required of a person that they do wrong.

Every doctor should be allowed to choose whether he/she wants to participate irrespective of the “law of the land” (Doctor Thirty-five).

While Doctor Thirty-five acknowledges the legality of abortion in South Africa, he however believes that it should always remain in the doctor's discretion to either provide or not provide a TOP service.

Many University lecturers, Professors, senior doctors, hospital managers spread the myth that the Constitution of South Africa requires that a doctor refer a patient to another doctor, even if they do not want to be involved in the abortion. This is a lie. The only thing stated in the CTOP Act is that no-one should “obstruct access” to an abortion facility to prevent people from entering. This was put in place to stop people from holding marches that physically prevented access to facilities. It is a very different thing from a doctor wanting to hold to his conscience by not getting involved in abortions, and so also not wanting to refer for abortions. Many doctors would feel that referring patients for this is also getting involved and being part of a murder. Patients do not even need a referral from anyone to access care anyway. This constitutionality has not been tested in court up to now, but it is clear that the meaning of the phrasing does not refer to doctors referring. But the fact that many senior professionals try to force the idea that it does, dishonestly, is enough to threaten many junior doctors to get more involved than they would like to out of fear. So their freedom of conscience is not upheld (Doctor Two).

“I do not agree morally with abortion and so will not assist you in this matter. Please find yourself another doctor”. This is what these [conscientiously] doctors should tell the patients. They normally feel so

strong regarding this that they would struggle to refer the patient. The patient must then go elsewhere to seek assistance (Doctor Twenty-six).

You may refuse to give it because you think it is wrong. If you do, then you should not recommend the lady to a pharmacist who is willing. She may on her own accord choose to look elsewhere for assistance (Pharmacist Forty-six).

The pharmacist should not have to refer, but the patient should decide where to go (Pharmacist Three).

We are not allowed to judge people on their choices, but just do not want to be accomplices [by referring] (Doctor Eight).

The pharmacist in this case cannot refer, as they will be in effect allowing the morning after pill still to be used, when they don't believe it to be correct (Pharmacist Thirty-two).

I agree referring makes one feel complicit (Doctor Eleven).

In their discussion on ethics of referral from a medical ethical principle of beneficence³⁸ point of view, Frank Chervenak and Laurence McCullough have argued that every conscientiously objecting health professional has a beneficence-based ethical obligation to make a direct or formal referral to another non-objecting health care provider in order to ensure that the patient receives a TOP procedure at the end of the day (2009:46). Not only that, but both scholars further argue that “direct referral is ethically required, because simply providing patients with referral information (which is the definition of indirect referral) does not ensure that the referral will be accomplished and the patient’s clinical needs will be met in a timely and effective fashion” (2009:46). For this reason, some proponents of the efficient referral system such as Charo have criticised health professionals who object to make formal referral to willing providers as abusing their right to CO and this makes them fail to fulfil their profession’s covenant with society (2005).

The conscientiously objecting health professionals whose views are cited above however challenge this form of formal referral requirement chiefly on the grounds that they “see any

³⁸ Chervenak and McCullough define beneficence as “the medical ethical principle that takes an evidence-based, clinical perspective on the patient’s health-related and other interests” (2009:46).

assistance in securing the service as complicity in immoral behaviour” (Dresser, 2005:9; see also Curlin *et al*, 2007 cited Frader and Bosk, 2009:66). Complicity is a principle often invoked by Catholic devotees as the grounds for conscientiously objecting to refer their TOP and MAP-seeking patients under the belief that doing so would be equivalent to doing the actual procedures themselves (Fiala and Arthur, 2014:3). Proponents of health professionals’ right to CO like Edmund Pellegrino (2008:297) and John Peppin (1997:40) approve the notion of complicity as they believe that to participate in abortion in any way, including referring a patient seeking abortion is as good as directly providing the procedure.

Those who take this view therefore dispute the provision of the CTOP Act which, while recognising a health care provider’s right to conscientiously object to perform an abortion, nevertheless obliges an objecting healthcare provider to refer his or her patient to another healthcare provider or facility (Harries *et al*, 2009:2). Doctor Two disagrees with this CTOP Act provision and argues that senior doctors take advantage of it to force conscientiously objecting junior doctors to refer their abortion-seeking patients against the dictates of their consciences, which is particularly damaging to those junior doctors who endorse the notion of complicity and might regard referral as tantamount to committing a murder.

This is a position that has been taken in a variety of other contexts. For example the pharmacist and president of the US-based PFLI Karen Brauer has argued that “physicians are not required to refer for abortion, nor should pharmacists be required to participate in this activity by giving a referral” (Stein, 2005) [because] “a patient who’s ambulatory can locate a willing provider of these services without the help of a pharmacist” (Dakks, 2005). Similarly, the Canadian anti-choice pharmacist Durad who objects to making referrals for emergency contraception prescriptions is quoted as arguing that “I will not direct people to a source of life-taking medicine. I cannot collaborate in the modern Holocaust...a pharmacist cannot dispense medication for the purpose of terminating a pregnancy” (Grady, 2006). While several participants in the present study similarly justified their invoking of CO including their non-compliance with the CTOP Act’s obligation to refer on the grounds that it is easy for patients

denied care to independently locate non-objecting providers, as will be seen in the following chapter, some have refuted this claim given social circumstances in South Africa.

The justification of non-involvement in contested reproductive services as part of exercising the individual right to act as autonomous moral agents according to their deeply held religious beliefs (Wicclair, 2000; Chervenak and McCullough, 2002; Curlin *et al*, 2007) was thus cited by several participants as the reason for their refusal to comply with what others have argued are their legal and professional obligations. Their argument is grounded in the claim that “freedom to practice one’s religion trumps one’s obligation as a professional to provide services to the patients who come to them” (Frader and Bosk, 2009:63).

In some cases the prescriptions of the health provider’s religious convictions extend to the prohibition of all forms of birth control including MAPs. Roman Catholic Church teachings for example promote the belief that “the act of sex between married partners has a two-fold purpose that cannot be separated: it brings the couple together in an act of love symbolising their depth of feelings for one another (unitive purpose) and it provides an opportunity to bear children (procreative purpose)” (Fox, 1995:75-76 cited in Spota, 2003). According to this view, not only is abortion murder, but “actions to oppose it are imperative” (Fiala and Arthur, 2014:2). The late Pope John Paul II was quoted in 1995 as saying “abortion and euthanasia are thus crimes which no human law can claim to legitimise, there is no obligation in conscience to obey such laws; instead there is a grave and clear obligation to oppose them by conscientious objection” (cited in Fiala and Arthur, 2014:2).

Seen from this light, Doctor Forty as a Catholic devotee confirms these teachings as he argues that he cannot provide or refer for TOP services and he simply expects his patients to understand this when he explains the importance of upholding his religious beliefs even in his professional practice. He refers his patients to the Catholic Life Center where they will be counselled not to terminate their pregnancies, but to carry them to term.

Operating from a different religious stand point, Pharmacist Six reaches a similar conclusion. A devout Muslim, she finds the provision of MAPs morally objectionable. She sees herself as guided not by legal prescriptions but by Islamic law which requires her not to dispense MAPs to unmarried women.

Adrienne Asch has argued that in order to preserve their moral agency, health professionals must act conscientiously, rather than slavishly follow patients' dictates (2006 cited in Frader and Bosk, 2009:64). As argued by Cannold, this is because given that "autonomy and choice are one of the partially defining features of a profession," for this reason, everyone, including abortion-seeking patients have a moral obligation to also respect the health professional's autonomy (1994:82). Both Asch and Cannold views are in line with that of Beauchamp and Childress who similarly stress the importance of respecting conscientiously objecting health professionals' autonomy and right of self-determination on the grounds that "health care providers are individuals and as such, have the same moral claim as other individuals to having their autonomy respected [thus] conscientious action is a person's legitimate exercise of his or her autonomy" (1983:390).

According to Thomas Cavanaugh, the philosophical Doctrine of Double Effect (DDE), also known as the Thomist DDE or the principle of double effect "plays a role in anti-consequentialist ethics (such as deontology), in hard cases in which one cannot realise a good without also causing a foreseen, but not intended bad effect (for example, killing non-combatants when bombing a military target)" (2006:97). Likewise, for Elizabeth Anscombe, "this principle is meant to explain such things as why it is wrong to intentionally target civilians in war, even when doing so is expected to produce a much greater good; yet it is not wrong in the same way to attack military targets, even when doing so can be expected to cause some civilian casualties as a side effect" (1981:66; see also Quinn, 1989:336). This principle holds that "it is always wrong to intentionally harm the innocent, regardless of the benefits that could be produced by doing so, but [however] it is not always wrong to harm the innocent as a foreseen but not intended side effect of an action aimed at some desirable end" (Nagel, 1986:179-185; see also Aquinas, 1920; Anscombe, 2001; Quinn, 1989; Boyle, 1991; Davis, 2001; Marquis, 2001).

St Thomas Aquinas (1225-1274) is credited for first formulating the original theory of DDE when he applied it in his discussion of the morality or permissibility of killing in self-defence by arguing that “killing an assailant is permissible as long as one does not intend to do so, but only to defend oneself” (*Summa Theologiae*, 2a-2ae, Question 64, article 7 cited in Quinn, 1989:334; see also Aquinas, 1920). Catholic moral theology teachings draw heavily upon the DDE in order to allow for “procedures that achieve abortion indirectly [but] are primarily geared to save the life of the [pregnant] woman concerned” (Naylor and O’Sullivan, 2010:19; see also Boyle, 1980; Cataldo and Moraczewski, 2002).

Often the justificatory grounds for performing a TOP procedure by conscientiously objecting health professional in such circumstances stem from the fact that the procedure is constructed or “regarded as an indirect termination” on the grounds that in this case the death of the foetus is not directly intended. Rather, the intention is to save the life of the woman whose life would be endangered by the continuation of the pregnancy (Glackin and Mills, 2013:80-81). This alone distinguishes the procedure from any primary intention to terminate foetal life (Foot, 1985). A noteworthy example which often provides for the permissibility for life-preserving interventions under the DDE is the termination of an ectopic pregnancy (Boyle, 1980 cited in Cook and Dickens, 1999:85). As defined by Glackin and Mills, an ectopic pregnancy arises “when a fertilised embryo implants somewhere other than the uterus, typically (but not always) in the fallopian tube. There is no possibility of the embryo’s survival in such a scenario; but if the pregnancy is allowed to continue it presents a severe risk to the mother’s life via the likely rupture of the fallopian tube and consequent internal bleeding” (2013:80-81). In simpler terms, an ectopic pregnancy is a misplaced pregnancy which occurs outside the uterus or womb. Several participants invoked this form of reasoning to explain why the only circumstances under which they would participate in abortion would be ‘imminent danger’ or ‘true emergency’.

Personally and professionally: [I am] totally against abortion on request. Only possible exception: life of the mother is in true imminent danger in the opinion of more than one expert. Every individual has freedom of choice...I will never participate in the act of abortion (Doctor Thirty-eight).

The doctor has the right to refuse, but if it is truly an emergency (e.g. mother's life is in danger) the doctor must make suitable arrangements for urgent referral to someone qualified to do a termination (Doctor Twenty-seven).

I don't do terminations on demand. I think every person (not only doctor) has a right to decide if they want to be involved with it. I will do terminations for medical reasons (Doctor Nine).

They are obligated to care for the patient, especially under emergency circumstances, and if they are not able or prepared to provide the necessary assistance directly, they should give the patient sufficient information about the alternatives, including other agencies that do TOPs, for her to decide (Doctor Twenty-five).

I understand the need for terminations in exceptional circumstances - such as when the mother's life is in danger or perhaps when a child has a very severe congenital abnormality-although I personally would not perform it. However in South Africa terminations have become a form of contraception, raising serious ethical issues for the staff who have either to carry out the procedure or assist with it. Fortunately as a Neurosurgeon these are not issues which affect my daily practice (Doctor Twenty-seven).

These doctors agree that it is ethically wrong to provide elective abortions, however they appeal to the principle of double effect to allow for some exceptions, particularly in emergency cases where the pregnancy may endanger the health or life of the pregnant woman. Central to these doctors' willingness to provide TOP services in cases of emergency is the emphasis they place on the need for apparent compelling evidence proven beyond reasonable doubt that such a pregnancy may pose a great danger to the health or life of the woman and as such require these health professionals to compromise their right to CO.

Personally I would not even consider this unless it is absolutely the last resort to preserve the life of the mother (Doctor Forty-one).

While Doctor Twenty-seven expresses concerns about many South African women using abortions as a form of standard contraception, he however feels that health professionals should provide TOP services regardless of their consciences especially in emergency cases where the pregnant woman's life is at risk or where there is a serious foetal malformation, although this

doctor admits that he personally would still not perform abortions in such cases. Other participants shared the view that ‘serious foetal malformation’ provides adequate ‘medical’ grounds for the moral permissibility of abortion.

This is murder and I will never do it, except if there is a very good medical indication (Doctor Forty-three).

This should not be done in normal fetuses, except in abnormal ones (Doctor Thirty-two).

To do abortions after 16 weeks pregnancy without a very definite indication is totally wrong (Doctor Fifty-one).

I am against it in other ways. That child has a right to live and there are many other parents hoping to adopt (Doctor Five).

The South African legal system rejects the recognition of fetuses and embryos as persons as was dealt with at length in the case of *Christian Lawyers Association of South Africa v Minister of Health*,³⁹ where the High Court held that the South African Constitution does not award legal personality to the foetus (Kruger *et al*, 2010). This position was contested by some participants, especially in relation to fetuses that are in the second trimester of gestation. Doctor Five, for instance paints a picture of a foetus in the second trimester of pregnancy as equal to an infant or child ready for adoption. In this view, the personhood of the pregnant woman in whose body the foetus exists should not be prioritised as a justification for obtaining an abortion (Cherry, 1999:247-248).

While some participants rejected the possibility of participating in second trimester abortions altogether, others said they would be willing to provide such abortions in exceptional cases especially for purposes of saving the pregnant woman’s life. However, they were concerned to draw a distinction between ‘genuine’ emergencies and those which they perceived to be manufactured.

There is a situation that often arises where a private General Practitioner would give a patient tablets of Misoprostol to insert in their vagina to initiate an abortion. Then they tell the patients to report themselves to the

³⁹ 1998 (11) BCLR 1434 (T), 1998 (4) SA 1113 (T).

hospital when they start bleeding. When they do report themselves, they will often keep quiet about the fact that a General Practitioner has initiated an abortion. So the doctors who receive them at the hospital would end up scraping the womb and finishing the process without even knowing it was an abortion they were completing. This also violates their choice to not get involved in abortions. To protect the rights of doctors' consciences and their right not to get involved in this manner would mean going after General Practitioners who practice in this way and putting them in jail in order to deter this practice (Doctor Three).

Doctor three thus cautions against the abuse of the emergency injunction which could lead to the violation of doctors' right to conscience.

Conclusion

This chapter has shown that health professionals who hold the moral absolutist position invoke CO to the actual and referring for TOP and MAP services and some of them also conscientiously object to treat emergency abortions. This is because they have framed the provision of these services as morally impermissible because they facilitate the intentional killing of the innocent.

While these participants equate abortion with murder, they however feel that abortion is permissible under limited exceptional circumstances. Their argument is based on refuting women's reproductive rights as overriding the right to life of the foetus. It is only when two rights regarded as equivalent clash, and the women's life is itself in danger, that a true dilemma arises which must be resolved by sacrificing either one or the other life. Similarly, the foetal malformation argument has to do with the anticipated quality of life of the unborn rather than weighing maternal rights as a serious consideration in the moral equation.

Chapter nine: legal and professional obligation

According to John Simmons political obligations are “general moral requirements to obey the law and support the political institutions of our own states and governments” (2002:17 cited in Vincent *et al*, 2012:171). For example, while a citizen may disagree with a particular law in a democracy, the general legitimacy of the system as such, is thought to give rise to an obligation to obey the law even in those cases where one disagrees with particular laws. To do otherwise would be to undermine the legitimacy of the system itself. In Kurt Baier’s terms, “obligations are tasks which one has come to have as a result of one’s entering into certain sorts of relations to others, of which the prime examples are someone’s doing something for one, or one’s doing something to someone” (1970:128). Building on John Simmons (2002), this chapter discusses health professionals who frame their willingness to provide contested reproductive services in terms of fulfilling their legal and professional obligations and they exhort other health professionals to also follow suit. Health professionals who agree to provide TOP and MAP services on grounds of obligation argue that their legal and professional obligations to do so merely emanate from the lawfulness of these services under the South African legal system. Health professionals who agree to provide TOP and MAP services on professional grounds typically cite the Hippocratic Oath as the source of their professional obligations. For these participants, legal and professional obligations override health professionals’ right to CO. Or, in other cases, legal and professional obligations imply the minimum requirement of referral.

In his prominent (1961) book, *The Concept of Law*, the influential British legal philosopher Herbert Lionel Adolphus Hart argued that everyone has a *prima facie* legal obligation to obey the government of the territory in which he or she resides because the state has political authority in its entire jurisdiction (1961:88). This reasoning has been applied to the debate concerning health professionals’ legal obligations to provide lawful (albeit contested) reproductive services. In contributing to this debate, Fiala and Arthur have for instance argued that “...doctors who exercise CO within the law are arguably unsuited for their position because they are demonstrating an inability to perform their job -- that is, they are allowing religious beliefs or

some other personal issue to interfere with their job performance to the extent of negating their professional duty to patients” (2014:8).

It has been on this basis that courts in some contexts have taken disciplinary actions against health professionals who invoke CO on religious grounds and refuse to provide legally permitted controversial reproductive services. A noteworthy example is the European Court of Human Rights’s (ECOHR) judgment in the 1999 case of *Pichon and Sajous v. France*.⁴⁰ In that case, two French pharmacists claimed that their right to CO on religious grounds was violated by French authorities who convicted them for refusing to dispense oral contraception to three female customers (Catholics for Choice, 2010:4). In ruling against these pharmacists’ grounds for invoking CO, the ECOHR emphasised that “as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they can manifest those beliefs in many ways outside the professional sphere” (Catholics for Choice, 2010:4).

The participants whose views are cited below take a similar stance to the legal approach adopted by the judge in resolving the *Pichon and Sajous v. France* case. By framing the right to CO as secondary to their professional obligations – with the latter overriding the former -- these participants rule out the possibility of CO to the provision of TOP and MAP services because they view themselves as having *prima facie* legal obligations to provide these services which cannot be ignored.

I do not feel it needs negotiation. We are obliged, 1) to follow the law and; 2) to respect the rights of patients to make informed decisions (Doctor Forty-two).

Everyone is bound by the law of the land, including doctors, so moral, religious or cultural reasons against abortion is secondary (Doctor Sixteen).

⁴⁰ *Pichon and Sajous v. France*, App. No. 49853/99, Decision of 02 October 2001, ECHR 2001-X, available at www.echr.coe.int, p. 4.

If the patient consents to the obtaining the pill then pharmacists must carry out their legal obligation and provide the pill regardless of their religious, ethical, personal and moral beliefs (Pharmacist Two).

Due to the fact that you are not breaking any laws, I don't think it's right for any pharmacists to refuse giving it because of religious beliefs... (Pharmacist Twenty).

I dispense as per legal requirements and where required... I act without moral judging as long as law is abided (Pharmacist Four).

It is law, so dispensing should take place... (Pharmacist Six).

For most of these participants, CO on the grounds of religious belief is inconsistent with the requirements of South African law. This is because, TOP and MAP services are legal under the South African legal system, in contrast to some Latin American countries such as Chile and El Salvador, where abortion is legally prohibited altogether and as such health professionals who illegally perform these procedures are charged with legal misconduct and may be incarcerated (Center for Reproductive Law and Policy, 1998). The argument from political obligation is that all health professionals have a general (content-independent) legal obligation to obey the law. Therefore where these services are legal, their professional and political obligation is to render these services accordingly.

Contrariwise, health professionals who refuse to provide these services are seen as violating their legal and professional obligations to act within the framework of the law and the requirements of their profession(s). As one doctor put it (Doctor 42), the law must be obeyed 'because it is the law'. And as another pointed out, like all other South African citizens, health professionals have a *prima facie* legal obligation to obey the laws of the state regardless of their conscience (Doctor 16). South Africa's CTOP Act confirms these legal obligations by attaching legal consequences to them in the event of any attempts to prevent a lawful termination of pregnancy or obstructing access to a facility performing termination of pregnancies.⁴¹

⁴¹ Section 10(1)(c) of the CTOP Act of the Choice on Termination of Pregnancy Act 92 of 1996.

Pharmacist Two argues that pharmacists' legal obligations to honour their patients' requests for MAPs stem from the South African legal system which. Given the controversial nature of these services in the South African context it is possible to interpret these participants' insistence on a rigid interpretation of the law as providing a legitimising narrative to explain why they are prepared, public and peer disapproval notwithstanding, to provide these services. These participants are thus able to shift the responsibility for choosing to provide these services away from themselves and to construct their actions as arising not from their own agency but from the requirements of law.

Well, pharmacists practice according to the Law and we are in no position to deny patients' rights to access to medication despite whatever my beliefs are (Pharmacist Twenty-seven).

The pharmacist still has the legal obligation to provide the morning-after-pill on request from the patient, regardless of how many times the patients makes the request ...I believe in dispensing it for the simple reason that it effectively reduces the number of unplanned pregnancies and as custodians of medicines, pharmacists have a legal obligation to dispense the morning after pill in a lawful manner (Pharmacist Two).

Pharmaceutical care is a concept which involves providing the best known pharmaceutical advice to patient within a pharmacist's scope of practice. This involves taking each patient as unique and addressing issues in an appropriate manner. The pharmacist's discretion should always be in favour of the patient's health within the legal framework (Pharmacist Twenty-four).

At the heart of the idea of political obligation lies the idea, expressed by these participants, that in circumstances where the legitimacy of the law-making body is not in dispute, a content independent obligation to obey the law arises which cannot give way merely because of individual belief or conviction. Were the latter to be regarded as morally permissible the entire edifice of the law would crumble.

Globally, most countries with liberal abortion laws have stressed health professionals' legal obligation to refer as a viable solution to the problem of the provision of contested reproductive services such as abortion and the MAP on the part of health professionals who object to such

services on grounds of personal conscience or deeply held moral conviction. Cook and Dickens argue that conscientiously objecting health professionals have a legal duty to refer patients to providers who do not object to delivering the services to which the patients are legally entitled (2009:108). In South Africa, while the CTOP Act recognises a health care provider's right to CO to performing an abortion, it however, imposes an obligation upon that provider to refer his or her patient to another non-objecting healthcare provider or facility (Harries *et al*, 2009:2). The legal obligation to refer patients was pointed to by several participants as part of the professional obligation of health care providers. For these participants, the idea of CO extending to the right not to refer does not have legitimacy.

Induced Abortion requests come from many various reasons, the law has it that any female above age 12 can request for, therefore the doctor practicing in South Africa is legally bound, if unable to perform the procedure for any reason, the doctor is obliged or must refer appropriately (Doctor Sixteen).

Legally abortion can be demanded and if one cannot provide the service a doctor should be obliged to refer (Doctor Nineteen).

To give effect to the law, it is mandatory for conscientious objectors to refer in order to allow the woman's right to access care to be realised (Doctor Fifteen).

Yes to refer to a willing provider, it is legally available and the patient has a right to get it provided it has been within the 72 hour time frame (Pharmacist Fifty-four).

In some cases, participants pointed to the obligation to refer as an obligation which they themselves felt obliged to meet, despite their own unwillingness to perform abortion.

I myself do not do any abortions. I refer all patients to other centres. Because it is a law the doctor cannot refuse to refer the patient (Doctor Forty-seven).

For these participants, CO does not pardon doctors from their legal obligations to their abortion-seeking patients, including minors. In cases where a doctor's own conscience does not permit provision of the service, legal and professional obligations are met through referral which results in the realisation of women's rights to access desired care within the legal framework of the land.

While for some, CO extends to the right not to refer, Marge Berer argues that, “a health care professional could be said to be exercising true conscientious objection if he or she makes a timely referral of abortion-seeking patient to non-objecting providers” (2002:32). Pharmacist Fifty-four’s grounds of providing the MAP as her legal obligation is in line with Berer’s aforementioned view. This pharmacist equates true CO with referring the MAP-seeking patient within the 72 hours’ time frame within which following unprotected sexual intercourse, emergency contraceptive methods including the MAP can reduce the risk of pregnancy by at least 75% (Boonstra, 2002:10). It is this limited time frame which make a timeous formal referral in order to prevent the possibility of the woman falling pregnant so pressing – and failure to refer of such significance.

In the philosophy of political obligation, the most prominent theory of an individual’s political obligation to the state is offered by the contract theorist John Locke in the form of consent theory (1689). According to Locke’s consent theory, political obligation arises from what he refers to as an individual’s ‘direct consent’ to be bound by particular obligations (1689). By this he means that special obligations in a political society come about only when one voluntarily undertakes them chiefly in the form of a social contract. In Locke’s terms, it follows that the obligation to keep a promise or fulfil a contract, for example, arises only when one has done something that generates the obligation-made in the form of a promise or signed a contract (1689; see also Simmons, 2002:33 cited in Vincent *et al*, 2012:171).

Although Locke’s consent theory focused specifically on direct individual consent on the part of individuals to the authorities of their political societies, Locke’s line of reasoning could also be applied to how health professionals are formally admitted into the health care community. In South Africa and elsewhere, on their graduation ceremony, all health professionals graduating from schools of medicine, pharmacy and nursing are formally required to swear to a professional oath known as the Hippocratic Oath. This Hippocratic Oath is taken to mean the solemn pronouncement by which these graduates promise to obey their professional and ethical obligations towards their patients when they start practicing. As argued by Ogunbanjo and van Bogaert, the Hippocratic Oath “consists of components of good practice of medicine physician-

patient relationships” (2009:30). The participants whose views are cited below draw on the Hippocratic Oath to justify their reasons for their involvement in the provision of controversial reproductive health services. In their view, health professionals’ voluntary consent to the Hippocratic Oath automatically gives rise to professional obligations towards their patients:

As a medical professional you took an Oath and I do not think you should judge people. You should help them to the best of your ability (Pharmacist Thirty-eight).

The day you became a pharmacist, you waived your right to let religious beliefs rule your business. It is not against your beliefs to cheat the medical aid out of money or to overcharge a patient, or to sell stolen or state stock. But you have a problem supplying the emergency contraceptive! What morals, ethics and religion are we talking about???? (Pharmacist Thirty-three).

Given that health professionals voluntarily enter the health care profession, it follows that they should also provide contested reproductive services in contexts where those services are legal, particularly TOP, and regardless of their consciences. Their obligation arises from their direct, freely-given consent to participate in profession of which these services and procedures are a part (Brody and Miller, 1998; Meyers and Woods, 1996; Brock, 2008:198; Anderson, 2005 cited in McLeod, 2008:35). As Cannold asserts, health care professionals should honour their professional obligations to patients as part of “the set of obligations that rightfully flow out of the professional-client relationship” (1994:80).

Conscious of the possible stigma associated with services such as emergency contraception, Pharmacist 38 invokes the Hippocratic Oath in order to justify provision of a potentially controversial service as arising out of professional obligation rather than implying his own particular moral approach. In this way, participants who wish to provide these services are able to shift agency from their own moral decision-making to describing themselves as professionally bound to prioritise their patients (rather than their own conscience). Thus these health care providers are able to frame their willingness to provide a controversial and potentially stigmatised service to their patients as merely arising as a logical extension of their consent to the requirements of their profession as well as their legal obligations.

[In the pharmacy practice the pharmacist's professional role in patient care (through the lawful distribution of emergency contraception) should take precedence because]...the patient's health and well-being is the first priority (Pharmacist Eleven).

Refusal is in turn framed as unprofessionalism rather than a legitimate invocation of conscience. In the same way as Locke's direct consent theory is the basis on which political obligation is typically justified in its purest form, here the participants argue that by taking the Hippocratic Oath, health professionals are giving their direct consent to the dictates of their profession and are thus professionally bound not to invoke CO to the provision of TOP and MAP services.

While for some the actual provision of these services is every practitioner's obligation, regardless of personal views, for others the obligation is the more minimal one of referral.

I have no objection to this policy...I think ethically the woman should be referred to another provider...[because] we have an obligation to our profession, for patients' well-being [and] patient's care should not be compromised because of conscience (Pharmacist Eight).

I believe the patient should be referred to a colleague that has no objections to dispensing the product. In the end, the patient and their well-being should still be the deciding factor (Pharmacist Forty-eight).

Yes, I believe that the patient is your ethical responsibility and that you should formally, after counselling, refer the patient (Doctor Two).

Some advocates for referral have argued that "accepting a collective obligation does not mean that all members of the profession are forced to violate their own consciences. It does, however, necessitate ensuring that a genuine system for counselling and referring patients is in place..." (Charo, 2005:2473). Referral is thus seen as consistent with the provisions of the Hippocratic Oath which require health professionals to act so as to benefit the sick and keep them from harm primarily through protecting their patients' well-being and placing the latter above their personal interests (Mappes and Degrazia, 2006:59).

Some participants included respect for patient autonomy as a further value embedded in the legal and professional obligations of health professionals.

Women must have a right to choose whether they want a child or not and the South African law allow abortion to be provided by trained individuals and [doctors] should therefore be obliged to assist either by performing or referring for the service (Doctor Nineteen).

The pharmacist professional role in patient care [takes precedence]...because as pharmacists we are here to provide a service and we are not allowed to judge or put our personal feelings into our work as we are professionals expected to act professionally. And it is the patient's decision to take it or not (Pharmacist Thirty-seven).

Doctor Nineteen confirms the principle of respecting the patient's autonomy as one of the important health professionals' legal obligations that medical personnel should honour regardless of their conscience. From a legal obligation point of view, respecting the patient's autonomy in this doctor's opinion is respecting the patient's final decision regarding how she wants to deal with the fate of her pregnancy. Using terms as "women must" this participant underlines the view that under the South African legal system, women have an absolute right to access TOP procedures. Given the lawfulness of abortion and the significance of rights in the post-democratic legal system, doctors' legal obligation to provide the service arises. And in Pharmacist Thirty-seven's view, the principle of respect for patient's autonomy is the cornerstone of pharmacists' professional obligations towards their patients. This participant associates genuine respect for the patient's autonomy with readily dispensing the MAP upon request, as failure to do so on the grounds of conscience amounts to being unfairly judgmental, thus violating pharmacists' professional obligations.

While respect for patient autonomy is one of the guiding principles in the practice of medicine, in sexual and reproductive health services where moralising discourses concerning sexual and lifestyle choices are prone to influence how patients are treated, this is a particularly important norm. The principle of 'patient's autonomy' holds that persons should be free to choose and act without controlling constraints from others (Faden and Beauchamp, 1986). Respecting the 'patient's autonomy', in Faden and Beauchamp's terms is respecting the patient's capacities and

perspectives including her right to hold certain views, make certain choices, and take certain actions based on certain values and beliefs which may well differ from those of the health care provider (1986). Respecting the ‘patient’s autonomy’ also involves respecting decision-making rights and acting in a way that enables patients to make choices for themselves rather than acting in such a way as to oppose those choices on the patient (ACOG Committee Opinion, 2007:3; see also Frader and Bosk, 2009:66). Doyal argues that while respect for ‘patient’s autonomy’ may not imply an obligation to actually provide legal services, however, conscientiously objecting health professionals have an ethical and legal obligation to refer their patients if they themselves are unwilling to provide a service, and that this obligation emanates from the principle of respect for patients’ right to self-determination and autonomy (1994).

Conclusion

Health professionals discussed in this chapter frame the provision of TOP and MAP services as a matter of discharging their legal and professional obligations. As such, they advocate for an approach which elevates abiding by one’s legal and professional obligations in medicine and pharmacy practice above any invocation of the right to CO to the provision of controversial reproductive health services. South African abortion law and the professional obligations outlined in the Hippocratic Oath are here invoked as overriding conscience. It may be argued, however, that the invocation of legal and professional reasons for overriding conscience may be as a result of these particular practitioners not having particularly strong views against the law in the first place. For those who find themselves at one with the law it then becomes possible to insist on its precedence as a way of acting in accordance with their own conscience while framing these actions as merely being law abiding or professionally diligent and thus avoiding possible social sanction or stigmatisation.

Chapter ten: social justice

The preceding chapters have outlined the varying ways in which prominent ways of framing termination of pregnancy and related services in contemporary South African medical practitioners' discourse have in practice for the most part been unable to resolve the tension between the claimed right to conscientious objection on the part of providers and the reproductive rights particularly of poorer women. In this chapter I outline an alternative way of casting this debate – as one not of 'rights', 'choice', 'consequences' or 'obligation' but one of justice. Although the participant who chose to frame the issue as one of social justice was the rare exception, I argue that a social justice framing offers fresh insights into ways of reframing the debate with the potential for successfully traversing the current impasse.

Jost and Kay view an unjust society as that which has a social system “that fosters arbitrary or unnecessary suffering, exploitation, abuse, tyranny, oppression, prejudice, and discrimination” (2010:1222). On the contrary, John Rawls points out that a society could validly be described as just if “all social values -- liberty and opportunity, income and wealth...are distributed equally except where an unequal distribution of any, or all, of these values works to everyone's advantage” (1971:62).

The concept of 'social justice' originates in the philosophical discourse. While there are many theorists of social justice, I draw heavily on one of the most influential political philosophers of social justice, John Rawls. I will place particular emphasis on Rawls's application of social justice principles which emphasises the distribution of material and non-material goods among members of the society (1971). A distributive paradigm defines “social justice as the morally proper distribution of social benefits and burdens among society's members” (Young, 1990:15). In his theory of social justice, Rawls discusses two important principles of social justice. The first one involves 'the priority of liberty' and the second principle involves process of fairness through demanding that 'positions and offices be open to all' (1971). It is important here to explain Rawls's notion of prioritarianism - that is to say, which principle gets priority and in this

regard Rawls argues that social inequalities are to be tolerated only to the extent that they benefit the least well off in society (1971:303).

It should be further argued that Rawls also conceptualises ‘justice as fairness’ in the context of equitable distribution of material and non-material goods by prioritising the less advantaged members of society (1971). Rawls conceptualises justice as “providing in the first instance a standard whereby the distributive aspects of the basic structure of society are to be assessed” (1971:9). The main objective of this assessment is to achieve the reforming or abolishment of unjust state laws and social institutions regardless of how efficient and well-organised these may be (Jost and Kay, 2010). Rawls was critical of the utilitarianism account of justice as being able to be used to justify the concentration of goods in the hands of the few, benefiting the privileged classes of a society on the basis that this state of affairs is ultimately for the greater good (1971).

Among Rawls’s followers, Runciman points out that justice could be achieved in a society if there is an ethical criterion which constantly assesses the distribution of social goods for purposes of ensuring that these goods also reach the disadvantaged groups of people (1978:37). Likewise, William Galston’s work also builds upon Rawls’s theory of distributive justice with regards to both material and non-material goods (1980). Galston notes that “issues of justice not only involve the distribution of property and wealth, but also such non-material goods as productive tasks, opportunities for development, citizenship, authority and honour” (1980:6).

Plantenga and Hansen have also built on one of Rawls’s concept of access to ‘equal opportunities’ with regards to fundamental goods in a society in order to ensure equal starting points for all members of the society (1999). Plantenga and Hansen have applied this concept in their work on the labour market to call for the prioritisation of women employees in the equal distribution of opportunities in the form of “material equality, e.g. an equal distribution of work, care tasks and income” (1999:352-353). Likewise, Rubery has also applied the concept of equal opportunities in the work environment context (1999). However unlike Plantenga and Hansen who confined its application only to women employees, Rubery broadened Rawls’s concept of

access to ‘equal opportunities’ with regards to paid and unpaid work to both women and men employees (1999:7). This is because he believes that the ultimate goal of this concept is to bring about change in all employees’ lives regardless of their sex (Rubery, 1999:7).

Some scholars have sought to assess education systems through applying Rawls’s principles of social justice (Jencks, 1988:518). In the context of South Africa, Mafumo’s work has looked at the concept of equitable distribution of opportunities with specific focus on institutions of higher learning (2011). He argues that “social justice implies the participation of all groups in an education system that is mutually shaped to meet the needs of all students irrespective of their culture, race, language, sex, financial background and political affiliation” (Mafumo, 2011:1554).

Most of Lee Anne Bell’s work on social justice in education has also drawn heavily on Rawls’s conceptualisation of ‘justice as fairness’. For instance, in Bell’s terms, social justice constitutes the right to fairness and equity in the distribution of available resources in order to avoid the concentration of these in the hands of a privileged few members of a society at the cost of the majority of disadvantaged people who might be in great need of these resources for the betterment of their lives (2007).

David Miller has argued that unfavourable social conditions which produce inequalities in a society can effectively be redressed by an inclusive and “fair distribution of benefits or resources amongst members of various associations, that is, members from different racial, cultural, linguistic, sexual, and financial backgrounds or who may be disabled” (1999:2; see also Miller, 2001). Like Miller, King Davis’s definition of social justice takes an inclusive approach which challenges any form of unfair discrimination on the grounds of one’s status and he also views social justice as the ultimate goal a democratic society:

A basic value and desired goal in democratic societies and includes equitable and fair access to societal institutions, laws, resources [and] opportunities, without arbitrary limitations based on observed, or interpretation of, differences in age, colour, culture, physical or mental

disability, education, gender, income, language, national origin, race, religion or sexual orientation (1996:1).

In combining all the aforementioned scholars' application of Rawls's principles of social justice, it could be argued that social justice is based on compassion for people and it aims to ensure that all persons have full and equitable access to opportunities and services in a society (Long *et al*, 2006; Mullaly, 2010). A social justice approach to any public policy arena is thus alert to conditions which make it likely that legal or institutional benefits and opportunities are distributed unfairly such that for instance, those with means, status or resources can access the benefits that the democratic state provides to a greater extent than those who do not.

In the field of health, one of the most prominent applications of Rawls comes from influential American philosopher, ethicist, and bioethicist Norman Daniels, and particularly his (1985) book *Just Health Care*, in which he addresses the unfair allocation of medical resources. Daniels is credited with formulating a 'theory of just health care'. Drawing on Rawls's theory of distributive justice, Daniels has argued that a theory of justice in health care requires the state to implement health policies which provides patients with fair equality of opportunity to access health care services in order to reduce health inequities and social harms among members of society (1985). Daniels's application of social justice theory in health care largely stems from his belief that "health care is of special moral importance, because it helps to preserve [people's] status as fully functioning citizens" (2001:4). For this reason, he views health as an important "special social good" (Daniels, 1985:56) because of its crucial role in maintaining human being's normal functioning. By 'primary goods' I mean "things that every rational person would want because they are needed to carry out a personal life plan" (Macklin, 2001:375).

Daniels is of the opinion that health and opportunity are directly related in the sense that meeting people's health needs promotes their equality of opportunity (1981; see also Daniels, 1985). Daniels's fair equality of opportunity argument for justice in health care derives from his belief that people have "rights and entitlements [to health care that are] defined within a set of basic institutions governed by the fair equality of opportunity principle" (1985:54). Daniels also

suggests that justice in health care could also be achieved through equitable distribution of the social determinants of health, such as education and income, using Rawls's principles of social justice (2008). Daniels further points out that justice requires guaranteeing fair equality of opportunity to members of a society and could feasibly be achieved if health care institutions are to be governed by Rawls's principle of fair equality of opportunity as this principle give citizens their rights and entitlements to health care in practice (1985:41).

In most of his work Daniels has advocated for an equality of opportunities approach in health care which gives complete prioritisation “to treating the worst off patients in terms of those who are the most sick or disabled” (2001:9), chiefly HIV/AIDS infected and elderly patients (Daniels, 2003). He also emphasises that in order to protect and achieve fair equality of opportunity for poor people, health care should not be distributed according to one's ability to pay, and the burden of payment should also not fall disproportionately on the ill (Daniels, 1985; Daniels, 1995; Daniels *et al*, 1996).

While termination of pregnancy and related medical services are often framed in terms of women's rights for instance to bodily integrity and freedom of choice, more recently scholars have turned to theories of justice to reframe the abortion debate in ways that recognise that a discourse of rights and choice does not necessarily address the context of social inequality in which such rights and choices must inevitably be exercised. As Chrisler and Garrett put it:

If women are not able to exercise their rights, it does them little good to know that the government guarantees their right to make their own 'choices.' Rights + resources + accessibility = justice (2010:130).

Joan Chrisler defines 'reproductive justice' as a framework which “addresses aspects of women's social status that promote or interfere with their power in relationships, bodily integrity, and ability to engage in family planning and reproductive decision-making” (2013:4). The origins of the term date back to the 1990s when it was first introduced by a group of American Women of colour, particularly delegates who had attended the 1994 Cairo Conference (Silliman *et al*, 2004). Loretta Ross who is the co-founder and coordinator of a social movement

called SisterSong is credited with coining the term ‘reproductive justice’. Ross defines reproductive justice as an “intersectional theory emerging from the experiences of women of colour in the United States whose multiple communities experience a complex set of reproductive oppressions” (2006). Reproductive oppression is “the controlling and exploiting of women, girls, and individuals through [their] bodies, sexuality, labour, and reproduction (both biological and social) by families, communities, institutions and society” (Asian Communities for Reproductive Justice, 2005; see also Ross, 2006). The reason why members of SisterSong particularly advocate for the reproductive justice framework in their activism stems primarily from the fact that “[o]ur ability to control what happens to our bodies is constantly challenged by poverty, racism, environmental degradation, sexism, homophobia, and injustice....” (Ross, 2006 cited in Silliman *et al*, 2004:4).

As pointed out by Ferree *et al*, the ‘women’s rights frame’ puts emphasis on the woman’s right to control her own body which affects other rights such as participation in the labour force and in political life (2002:106-107), as such, it takes “a pro-choice perspective which holds that women have the right to dispose of their bodies as they choose” (van Bogaert, 2002:139). Some have argued that despite the progressive recommendations proposed at the Cairo Conference, the ‘women’s rights frame’ has failed to feasibly provide for poor women’s access to TOP services. This is because, in reality, a woman with an unwanted pregnancy living in a country with liberal abortion legislation cannot necessarily practically exercise her right to readily access a TOP service “if she lacks the financial resources to pay for reproductive health services or the transport to reach them...” (Petchesky, 2000:13; see also Chrisler, 2012).

In many countries with liberal abortion legislation which affords women the right to TOP services, research has shown that despite this many poor women, particularly those living in rural areas face challenges in accessing TOP services for a variety of reasons including for instance transportation, lack of medical facilities and personnel. This lack of access to abortion services, especially for marginalised women, entrenches abortion as a social justice issue (Shaw, 2013:3).

The social justice framework is of particular relevance to our consideration of conscientious objection because research has shown that where health professionals are unwilling to provide TOP services the negative effects are differentially felt by poorer women living in rural areas, particularly those with inadequate financial means to travel to access these procedures in urban areas or in neighbouring countries (McCafferty, 2010). Poverty also affects women's ability to practically exercise their reproductive rights in other ways (Silliman *et al*, 2004:4). In the context of the United States, for example, women's rights activist, Loretta Ross, has argued that many poor women of colour's abilities to control what happens to their bodies is constantly challenged by poverty (Silliman *et al*, 2004:4).

One of the most important goals of the reproductive justice framework is to highlight the ways in which poverty and lack of social status for instance due to racism or other forms of discrimination often disables many women from practically exercising their individual rights to abortion. This is done by understanding women's access to abortion in the social context in which the right is being exercised and stressing that in many cases social factors particularly those resulting from social inequalities often play an important role in determining women's access to safe abortion care, regardless of the legality of the procedure (Cook, 2006:6). In other words, the reproductive justice approach confirms the fact that women make their reproductive decisions within a social context rather than merely as socially disembodied, rationally choosing free agents. As such, it is important to take seriously individuals' context or social positions in trying to understand their welfare (Di Chiro, 2008:284).

Seen in this light, reproductive justice then takes a holistic approach which seeks to address social root causes or iniquities which heavily affect disadvantaged poor women by preventing them from fully exercising their rights to access TOP services. This holistic approach critiques the framing of termination of pregnancy as a matter of 'rights' and individual 'choice'. The language of 'choice' it is argued, disregards the differential pressures that individuals face and the many constraints on the freedom to make a genuine choice (British Medical Association Views, 2007:4). As Silliman *et al*, have argued, the dominant 'choice' framework ignores "the

fact that for women of colour, economic and institutional constraints often restrict their choices” (2004:5; see also Ross, 2006).

For some, the unequal context in which individual rights are exercised implies a special burden on the state to ensure the realisation of these rights in practice. Callahan and Robert thus propose “a feminist social justice approach [which] calls for state assistance of women’s right to an abortion because the abortion right is essential to eliminating women’s social subordination and to ensuring that a woman’s choice not to be a parent can always be realised” (1996:1234). For others see (Hartung and Blustein, 2002; McWhirter, 1998), the emphasis is on the special responsibility of health professionals that is implied when termination of pregnancy is understood as having social justice ramifications. Drawing on Miller’s work on social justice (1999), Jessica Shaw has for instance exhorted social workers to work towards achieving social justice for abortion-seeking patients in Canada who are facing challenges from inequitable access to TOP services because some health professionals invoke CO to the provision of TOP services (2013:2-3).

The social justice framing which emphasises the importance of equal access to opportunities with regards to accessing TOP services was recognised by the American College of Obstetricians and Gynaecologists, (ACOG) Committee Opinion in 2007 as part of its recommendations to solve women’s inequitable access to TOP services. On this occasion it was acknowledged that health professionals’ right to CO may negatively impede women from exercising their rights to abortion, particularly in cases where CO is invoked both to the provision of the procedure and to the referral of the patient to willing providers. ACOG advocates the incorporation of social justice principles in evaluating conscientious refusals in order to prevent subsequent social harms resulting from unregulated exercise of health professional’s right to CO which often compromises the health and well-being of abortion-seeking patients (ACOG Committee Opinion, 2007:5). The committee argued that given that physicians are responsible for ministering to patients’ needs, they have a responsibility to redress social inequities and “not to create or reinforce racial or socioeconomic inequalities in society” through invoking CO (ACOG Committee Opinion, 2007:4). It was argued further that social justice requires medical

professionals and policy makers not only to treat individuals fairly, but also to provide medical services in a non-discriminatory manner (ACOG Committee Opinion, 2007:4). The ACOG Committee Opinion further suggests that equitable access to TOP services could effectively be achieved by regulating CO through the distributive paradigm approach which stresses fair allocation of society's benefits and burdens in reproductive medicine (2007:4). Drawing on this concept of distributive justice, ACOG concluded that health professionals who invoke CO to the provision of TOP procedures to the most vulnerable women in the society "violate the core commitment to justice in the distribution of health resources" (2007:4).

In contrast to those who frame abortion and conscientious objection to the provision of abortion-related medical services as questions of individual rights, choices and harms, the social justice frame asks whether the costs and burdens of existing policies fall unequally on the poor and whether the ability to choose an abortion is unfairly dependent upon social location (Ferree *et al*, 2002:106-107). Given the prominence of the challenge of inequality and a history of racism and discrimination in South Africa it is perhaps unsurprising that many participants in the present study wishing to explain why they do not invoke their right to CO to the provision of termination of pregnancy and MAP services, even although they may not personally feel comfortable with these procedures, drew heavily on ideas of social justice to frame their arguments..

In the context of widespread stigmatisation of abortion and related services, the social circumstances of indigent women is invoked as a powerful legitimising narrative for why these participants believe in providing TOP services to these women whom they see not having the financial means to care properly for children. The social justice frame is invoked to emphasise the social costs and burdens of unwanted children born to poor women who are not in a position to care for them. Unusually, South Africa's legislative framework specifically provides for social circumstances to be taken into account in the provision of abortion services. Moreover, the inequalities and injustices of the past which unequally distributed access to scarce abortion services and therefore unequally placed the burden of unsafe abortion with poor black women were specifically cited when the legislation was first passed as Dickson-Tetteh and Billings describe:

When the parliament passed the law in October 1996, it intended to ensure accessible and available abortion services for all women, particularly those who are poor or who were disadvantaged during apartheid, who are the most likely to suffer complications or die from an unsafe abortion (2002:144).

Thus, rather than framing abortion solely in relation to individual rights or choice as is the case in some other contexts, notably the United States, the CTOP Act from the outset took the unusual approach of acknowledging social and economic circumstances as part of the framework within which abortion is to be understood in relation to the law in South Africa. As Cook and Dickens put it, the CTOP Act “addresses abortion as a matter of social equity and justice, rather than on health grounds alone” (1999:84).

David Miller describes the idea of social justice as having to do with “how the good and bad things in life should be distributed among members of a human society” (2001:1). Miller illustrates one of the principles of social justice as follows: “we attack some policy or some state of affairs as socially unjust, we are claiming that a person, or more usually a category of persons, enjoys fewer advantages than that person or group of persons ought to enjoy” (2001:1). In sum, social justice takes a social approach to distribution rather than an individual rights-based, historical or contractual approach in seeking to decide what is just (Gamarnikov and Green, 2003:210).

Applied to reproductive health, a social justice framing seeks to address the inequitable social distribution of poor reproductive health outcomes. In South Africa, the historical context of apartheid has meant that in patterned ways, previously disadvantaged poor African women face the most disadvantageous health outcomes for instance with regard to maternal mortality, child mortality, access to appropriate contraception, the capacity to make informed decisions, coercive social relations, and access to termination of pregnancy services. To frame abortion as a matter of social justice then, is to take the interests of this most disadvantaged group as the starting point for social policy and health services provision. Abortion services are free of charge at all designated public health care facilities (Ngwena, 2004:715) and the government also earmarked

funds to train midwives to perform first trimester abortions so that services can also be provided in primary health care facilities (Varkey, 2000:87). However, in seeking just reproductive health provision outcomes for this most excluded of groups – that is, poor African women and rural women in particular – the legal framework has to be implemented by willing TOP providers. As Shaw points out:

Physicians who offer abortion care are, by the very nature of the work that they do, key figures in promoting social justice for women. By participating in the highly controversial service of abortion care, providers become advocates for women's rights and act as the tool through which social justice is enacted in the form of abortion care (2013:13).

While the CTOP Act aims to provide every woman with “the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs” (Republic of South Africa, 1996b:1) the point about understanding this right from a social justice point of view is to realise that access to the right is unevenly distributed across the society in patterned ways. While the law treats everyone equally, the social reality is that the burdens of inequalities of access fall unevenly on women who are poor, black and especially rural. Similarly, while on the one hand the individual right to CO on the part of health care providers can be accepted the reality is that the outcome of the exercise of this right results in once again a greater burden of unequal access for poorer, black rural women.

For the middle class urban woman who seeks a termination, the exercising of the right to CO on the part of one or more health care providers will be of little consequence to her being able to exercise her right to the provisions of the CTOP Act. She will have access to ready alternatives, to information about how and where to access them and to transport and other means that will make it possible for her to exercise her rights under the Act regardless of individual health providers objecting to provision of the service. In particular, wealthier women in urban centres have access to private provision of termination services rather than having to rely on a designated public health facility where in some cases no willing providers exist at all.

Both abortion and emergency contraceptive methods, specifically the MAP are controversial reproductive services which health professionals may conscientiously object to providing on religious, personal, ethical grounds even in countries where these services are legal. Dickens and Cook contrast this stance with what they refer to as ‘conscientious commitment’: “the reverse of conscientious objection, [conscientious commitment] inspires healthcare providers to overcome barriers to delivery of reproductive services to protect and advance women’s health” (2011:163-164). For many providers who take this approach of ‘conscientious commitment’ the social injustice of unequal access to legal reproductive health services is what inspires their commitment rather than personally being particularly comfortable with, or in favour of, abortion.

The challenge of second trimester abortion is particularly significant from a social justice point of view as it is often the most disadvantaged women who for reasons of lack of proximity to a medical facility or for social and economic or personal reasons only seek abortion relatively late into pregnancy (Harries *et al*, 2007). Health professionals who are willing to provide these especially controversial services frequently frame their willingness to provide highly stigmatised services which many other South African doctors refuse to provide on grounds of conscience as a question of social justice. Rather than framing their willingness to provide these services as having to do with the rights of the individual woman as patient alone their responses frame the question as one of social injustice occasioned by the unequal access of poorer women to reproductive health services.

South African health professionals’ resistance especially to performing second trimester abortions has been confirmed in literature (van der Westhuizen, 2001; Bateman, 2011:304). In many provinces this has resulted in some public health care facility managers discontinuing second trimester TOP services altogether (Varkey, 2000:87). Thus, doctors who are willing to perform second trimester abortions are somewhat the exception, especially in the public health sector. In explaining why he takes the approach he does, the following participant focuses on the disadvantaged circumstances of patients which justify why they are seeking second trimester abortions in the first instance:

I feel that there is no difference as some patients are not aware that they are pregnant until the 2nd or even the 3rd trimester. I feel they should not be punished by their lack of knowledge as they will ultimately resort to backstreet abortion with dire consequences (Doctor Thirty-six).

For this doctor denying women in these circumstances access to second trimester abortions is tantamount to punishing them for being poor which he is unwilling to do.

The reproductive justice frame challenges the assumption that because abortion is legal it follows that every woman has equal access to the realisation of the right in practice. This approach was explicitly taken in a recent speech by South Africa's Social Development Minister Bathabile Dlamini at the Ipas conference in June 2014) where she spoke at length about the need for South African politicians to stand up for South African women's rights to abortion. Rather than employing the language of women's 'right to choose', Dlamini argued that "what we call 'choice' may just become an elitist individualised response to reproductive rights which would still be mainly for the middle classes and the rich" (Davis, 2014).

Conclusion

Shannon and Winikoff have noted that "one woman dies every eight minutes from an unsafe abortion somewhere in the world, most likely south of the equator" (2010:149). Unsafe abortion has consequently been dubbed a preventable public health plague (Grimes *et al*, 2006:1908-1916; see also Lisa *et al*, 2009:122; Shannon and Winikoff, 2010:149; Cates, 1982). For some commentators the centrality of the right to bodily integrity and autonomy implies that with the failure of health care systems to meet women's reproductive needs amounts to denying these women full citizenship rights (Casas, 2009:83; Special Rapporteur Paul Hunt, 2004). Shannon and Winikoff argue that these governments reduce women to "second-class citizens – either by law or in reality" and it is this diminished status which contributes directly to low levels of contraceptive use and high levels of unwanted pregnancy and unsafe abortion among these women (2010:155).

Some authors argue that governments' failure to address the pressing issue of unsafe abortion and its devastating effects on women's health and lives stems from gender inequities in access to health services (Ipas and IHCAR, 2002:3). This has resulted in women's reproductive rights not being fully prioritised, thus jeopardising their health and lives. The former president of the International Federation of Gynaecology and Obstetrics (FIGO), Dr Mahmoud Fathalla has argued that, "Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving" (1997:3). Dr Fathalla further adds that: "pregnancy related deaths...are often the outcome of cumulative denial of women's human rights. Simply put, they die because they do not count" (1997:11). David Grimes feels the international community is not taking decisive measures to address the issue of high mortality and morbidity rates from complications of unsafe abortion "perhaps in part because the victims are all women, they are mostly of colour, and they live in developing countries" (2003:100).

In South Africa, the apartheid government did not take any initiatives to implement any comprehensive reproductive health policies aimed at addressing maternal mortality among the marginalised African population group (Cooper *et al*, 2004:70). For this reason, public maternal health care facilities designated for black women were characterised by overcrowding, understaffing, and lack of privacy (Rees, 1994). The demise of apartheid saw the ANC government implementing progressive health legislation targeted in particular at addressing the needs of previously disadvantaged women. A notable example was the 1994 introduction of free health care for pregnant women with the aim of improving women's access to reproductive health services (Cooper *et al*, 2004:74). Another notable achievement took place in 1997 with the setting up of a National Ministerial Committee on Confidential Enquiries into Maternal Deaths (NCCEMD) by the Department of Health. The NCCEMD was set up to improve the care of pregnant women and reduce maternal deaths through auditing maternal deaths in 200 hospitals across the country, providing information on the major causes of maternal deaths and the factors related to the deaths and finding feasible ways of addressing these problems through recommendations to the Department of Health (Benson *et al*, 2011:6).

While South Africa has a range of progressive sexual and reproductive health and rights policies these are not always practically implemented in the way envisioned by legislation (Stevens *et al*, 2008). An indicator of policy failure is the fact that the MMR was as high as 369 per 100, 000 live births in 2001 (Blaauw and Penn-Kekana, 2010). The 2007 Community Survey found that the level of MM in South Africa was 625 per 100 000 live births (Minnesota Citizens Concerned for Life Global Outreach, 2011:1). This level of maternal mortality is far higher than the Millennium Development Goal (MDG) target of 38 per 100 000 live births by 2015 (Stevens *et al*, 2008).

In this context the ANC government made it an explicit policy goal to introduce women's reproductive health legislation that would specifically impact positively on the life and well-being of the poorest and most marginalised women in the country. However the continued treatment of women's reproductive health in a framework of individual rights has failed to acknowledge the social, historical and economic context in which the right is exercised. In patterned ways poor women, black women and rural women continue to have diminished access to their rights. A social justice framework enables the acknowledgement of the social conditions that make for the realisation or non-realisation of rights on the part of certain citizens as an alternative to framing abortion as a question of individual choice and rights – whether the choice and rights of the pregnant women or the choice and rights of the objecting medical professional.

Chapter eleven: conclusion and recommendations

The present study has been interested in the role that the right to conscientious objection on the part of medical practitioners in South Africa plays in attenuating women's reproductive rights in South Africa. Given that the absence of willing providers has been identified as one of the key reasons why women in South Africa continue to be denied reproductive rights afforded them in law, self-administered questionnaires completed by a sample of doctors and pharmacists from across the country were analysed in order to provide an insight into how health professionals in South Africa frame their willingness or unwillingness to provide TOP and MAP services.

The thesis describes three broad categories among the participants. The first category consists of those who expressed willingness to provide TOP and MAP services or to refer patients to a willing provider, irrespective of their right to CO which they rendered as immaterial compared to their patients' well-being or right to access these services. These included health professionals who prioritised women's/patients' rights and equated providing these services with respecting their patient's choices, autonomy and right to self-determination. For these participants' the patient's health care needs and right to full control over their own bodies and choices, should always take precedence over a health professional's right to CO. For pharmacists drawing on this frame, women (including teenagers) can practically take full control of their bodies only if pharmacists dispense the MAP (including repeated requests) upon request. Likewise, for doctors drawing upon this frame, women (including teenagers) can practically take full control of their bodies only if they have access to both first and second trimester safe and legal abortion services upon request.

For some, in this first category of non-objecting participants, what is paramount are their legal and professional obligations. Their willingness to provide these services is described as merely arising from the requirements of South African law or, in other cases, as part and parcel of their professional obligations which emanate from swearing to the Hippocratic Oath upon admission into medicine and pharmacy practice. While some of these participants object to the actual provision of TOP and MAP services, they are willing to refer their patients to non-objecting providers as they equate doing so with fulfilling both their legal and professional obligations.

Others in the first, non-objecting category, relying on consequentialist moral reasoning, they regard the provision of TOP and MAP services as ethically right because to do so results in best or good consequences for the pregnant women and/or the unborn child. Many of these participants described their willingness to provide these services as stemming primarily from their awareness of high levels of unsafe abortion-related maternal morbidity rates in South Africa. As a result, they frame their willingness to provide TOP and MAP services as achieving the favourable consequence of protecting and saving the lives of women. Denial of these services

is in contrast said to contribute directly to many women resorting to unsafe abortion practices. While some who recognise these consequences as having considerable moral weight are willing themselves to provide TOP and MAP services, others are willing only to refer their patients to non-objecting providers. Referral is seen as preventing bad consequences while not violating the dictates of their own consciences.

Then there are those in the first, non-objecting category who draw on the ‘do no harm frame’ to explain why they do not object to the provision of these services, or if they do, are willing to refer their patients to willing providers. They regard the pregnant woman rather than the foetus as their patient. They fall into two groups: the first group invokes CO to the actual provision of TOP services, but are willing to refer their abortion-seeking patients to willing providers as they believe that this will avoid harm to their patients in the form forcing them to consult with ‘back street’ abortionists. The second group interpret and apply the principle of ‘do no harm’ to mean not invoking CO in cases of emergency where the pregnancy can endanger the health or life of the pregnant woman. These participants are willing to assist such women by completing their incomplete abortions as failure to do so will result in imminent harm in the form of death and will also constitute abandoning of their patients.

Finally, participants who draw on the ‘social justice frame’ also fall in the first, non-objecting category. They are willing to provide second trimester abortions regardless of their consciences because they believe that there are many unavoidable social circumstances which push women of low income to acquire abortions during second trimester gestations. Their willingness to provide these abortions stems primarily from their belief that, unlike wealthy women, the majority of poor African rural women’s rights to access TOP services can practically be realised only if health professionals who work in the public sector are willing to provide second trimester abortions.

The second of the three categories of participants consists of those who believe their right to CO is absolute and should always take precedence over other goals. TOP and MAP services are seen

as facilitating murder and pharmacists in this category equate the MAP with abortifacients. Health professionals who draw on the ‘foetal life frame’ have based their objections to the provision of these services on the respect and value which they attach to the sacredness of human life. For this reason, they feel justified to invoke CO to the provision of TOP and MAP services as they regard the end result of both services as violating the rights of fetuses by intentionally killing them. Health professionals who draw on the ‘moral absolutism frame’ typically invoke religious beliefs-based CO to the provision of TOP and MAP services.

Some restrict their objection to performing second trimester abortions. Many who draw on the ‘moral absolutism frame’ believe they have an absolute right to invoke CO even when it comes to treating incomplete abortions in emergency cases as they equate doing so with the performing of abortion itself which is viewed as the deliberate killing of the innocent. For these participants, life begins at conception and referral is morally impermissible because it amounts to complicity: the facilitation of the killing of innocent fetuses. For these participants ‘doing no harm’ is interpreted from the perspective of the foetus, not the pregnant woman. In some cases this extends even to cases of emergency where the health or life of the pregnant woman would be endangered by the continuance of the pregnancy. While these participants accept the dictates of the Hippocratic Oath, they regard fetuses as the patients that they ought not to harm. Their obligation is therefore to always unconditionally protect the foetus’s right to life at all gestational stages of the pregnancy as well as in whatever circumstances, including rape or incest.

Some participants in this second category who invoke CO to the provision of TOP and MAP services do not necessarily believe that human life begins at conception nor do they equate the MAP with abortifacients. Rather, their grounds for CO stems from their desire to prevent future negative consequences which they see as likely to ensue if these services were to be easily available for women and for this reason, they suggest the need to limit the provision of these services in certain circumstances. For instance pharmacists argue that invoking CO to the provision of repeated requests for MAPs will result in the preservation of patients’ health. Likewise, doctors who draw on the ‘consequences frame’ invoke CO to the provision of second trimester abortions in particular because they associate these abortions with negative health

consequences in the form of long-term psychological effects for the women who obtain them – and in some cases negative psychological impacts on the providing doctor.

A third category of respondents consists of health professionals who take a moderated approach, evincing mixed feelings towards invoking or not invoking CO. They see themselves as endorsing women's rights but violate Ronald Dworkin's notion of rights as 'trumps' (1984). They do acknowledge women's right to access TOP services, but impose restrictions on the exercise of the right. Some confine the applicability of this right to abortion in the first trimester of gestation. As a pregnancy advances to the second trimester of gestation, they believe that this right ought to come to be shared with the rights of the foetus. CO to the provision of second trimester abortion is justified on grounds of 'foetal viability'.

While both the CTOP Act and the 2000 SAMCC policy take an expansive and progressive approach with respect to women's reproductive justice, many of the participants in the present study do not fully endorse this approach. Several participants are influenced by their own particular moral point of view concerning, essentially, sexuality and what constitutes responsible and appropriate sexual behaviour. For instance, while both the CTOP Act and the 2000 SAMCC policy do not discriminate on the grounds of age with regards to the right to access TOP and MAP services, some participants are loathe to provide these services to teenagers without parental authorisation even though the law does not impose this requirement. Legal prescriptions notwithstanding, these participants construct teenagers as lacking the capacity to make informed decisions. Some refuse to dispense the MAP to teenagers, preferring to refer them to clinics where they will be counselled to abstain from engaging in sexual intercourse despite the fact that the law does not require such referral for those seeking the MAP.

Some participants who at first glance seemed to draw on the 'women's rights frame' because they support the passage of the 2000 SAMCC policy as a good policy, on closer inspection were seen to be invoking 'hierarchies of legitimacy and deservingness', taking it upon themselves to distinguish between legitimate and illegitimate circumstances for the provision of TOP and MAP

services. Pharmacists who view the MAP as an ‘emergency’ remedy for circumstances such as rape, condom failure and rare human error are willing to provide this medication only once or twice in a lifetime to their clients thus emptying the idea of a ‘right’ of its meaning and force. Repeated requests for MAPs are associated with ‘irresponsible’ sexual behaviour and the misuse of medication in the form of using the MAP as a form of regular contraception. Some proposed the need for strict monitoring and surveillance of women’s behaviour in order to ensure that only the deserving, legitimate MAP request (that is requesting the MAP once in one’s life time) is complied with.

‘Hierarchies of legitimacy and deservingness’ were also invoked by some doctors who, although drawing on the ‘women’s rights frame’ drew a distinction between patients whom they regard as fully deserving to be provided with an abortion and others whom they regard as undeserving. Those repeatedly seeking abortion are constructed as illegitimately using abortion as a form of contraception. On the contrary, women who seek TOP services for medical reasons (where the life or health of the mother can be endangered by the continuation of pregnancy or where there is foetal malformation) are seen as having legitimate reasons for seeking a termination of pregnancy procedure. The decision to provide the service then rests not on a deeply-held moral conviction that all abortion is murder but rather on a subjective evaluation of the reasons why someone wishes to have an abortion.

Recommendations

These research findings have shown that despite the legalisation of both TOP and MAP services, many South African women continue to face barriers in accessing these services because of health professionals’ right to CO. Previous research has demonstrated that the high rate of second trimester abortions in South Africa is of particular concern (Harries *et al*, 2009:9). The findings of the present study confirm this and link this challenge to the reluctance of some medical practitioners to comply with their legal and professional obligations. Given this, the recruitment of South African doctors who are willing to provide second trimester abortions could viably reduce unsafe abortion-related morbidity and mortality rates (Mbele *et al*, 2006:1197).

Such recruitment could feasibly be implemented if the South African government were to follow the example of other countries which have effectively dealt with the issue of CO.

Most notable in this regard is Sweden which deals with the issue of CO in a way which prioritises women by granting them the right to abortion upon their own request and provides services to implement that choice (Berer, 2002:34). Medical personnel's right to conscientious objection to abortion is not recognised under Swedish abortion law (O'Rourke *et al*, 2012:91). Rather, under the Swedish legal system, all medical personnel are contractually bound to assist in the termination of pregnancy services (van Bogaert, 2002:136; see also Berer, 2002:34; Heino *et al*, 2013). Berer argues that Sweden's approach "reflects the country's high level of commitment to equitably providing abortion through preventing medical professionals from becoming 'gatekeepers' to women's sexual and reproductive rights through invoking conscience clauses" (2002:34). In Bulgaria, the Czech Republic, Finland, and Iceland medical practitioners are also not legally permitted to conscientiously object to providing abortion services, whereas in Norway, employers can refuse to hire objectors and employment advertisements may require performance of abortion as a condition for employment (Heino *et al*, 2013).

The present study shows that South African teenagers face particular barriers to accessing TOP and MAP services as a result of health provider attitudes towards youth sexuality. Respondents expressed concerns about the easy availability of these services as encouraging irresponsible sexual behaviour or promiscuity and also causing long term negative health and psychological outcomes for teenagers. Some participants selectively invoked CO in relation to teenagers based on their expectation that teenagers should be asexual and should require parental notification to access these services.

According to Boonstra, approximately "25% of sexually active teens do not use any method of contraception at first intercourse, and many find it difficult to take oral contraceptives every day or to consistently use intercourse-related methods, such as the condom or diaphragm" (2002:13). Thus, making TOP and MAP services more readily available to teenagers could make a positive

impact of reducing levels of unwanted pregnancies “for sexually active teens, who may have sex only sporadically, and also are more likely than older, married women to experience contraceptive failure” (Boonstra, 2002:13). The South African government could draw on practices in such countries as France which have “taken extraordinary steps to ensure that adolescents in particular have access to emergency contraceptive methods” (Boonstra, 2002:12). This has been the case in France since December 2000 following the passage of a law allowing public and parochial high school nurses to provide emergency contraception at no charge and without requiring authorisation from a parent (Boonstra, 2002:12). Not only that, but the French law also provides no right to CO on the part of pharmacists; rather they “are required to counsel young women and provide them with information about other forms of birth control” (Boonstra, 2002:12). Commenting on the positive impact of this approach on the part of the French government, the president of the French Association for Contraception, Elizabeth Aubeny argues that it has resulted in “more open discussion—among pharmacists, nurses in school, across all society—about what to do to prevent pregnancy and sexually transmitted diseases... and the more you talk about contraception, the more women use it and the fewer abortions there are” (Boonstra, 2002:12).

The South African government can also draw on some European countries with a reliable induced abortion surveillance system such as Estonia, Latvia, Lithuania, the Netherlands and the Nordic countries (Lazdane, 2005:5). Norway has established a comprehensive regulatory and oversight framework on conscientious objection to abortion, which includes ensuring the availability of providers.⁴² Given that the South African Constitution recognises health professionals’ right to CO to the provision of contested reproductive services, it would be fruitful if the South African government were to put in place an oversight mechanism which ensures that conscientiously objecting health professionals do refer their TOP and MAP-seeking patients to willing providers as mandated by the CTOP Act. This oversight mechanism should be aimed at holding accountable health professionals who conscientiously object to referring their TOP and MAP-seeking patients to willing providers. In this regard, South Africa could draw on the approach taken by other countries in solving the issue of CO with regards to health

⁴² Health Services Act, Art. 56, Official Gazette of the Republic of Slovenia (Slovenia).

professionals' obligation to refer their TOP-seeking patients that they cannot treat on the grounds of conscience. A notable example to draw upon in this regard would be the Australian state of Victoria's *Abortion Law Reform Act 2008* (Vic) which contains a clause which obliges a conscientiously objecting medical practitioner to refer a woman seeking an abortion procedure to another non-objecting provider.⁴³ In order to ensure that conscientiously objecting medical practitioners honour their obligation to refer, the country subsequently took the law a step further by creating an oversight and monitoring mechanism known as the Australian Health Practitioner Regulation Agency (AHPRA) (Smith, 2013). The AHPRA follows up and investigates cases reported by patients who have been denied referrals by conscientiously objecting doctors in order to take judicial disciplinary action against such doctors (Smith, 2013). Commenting on the disciplinary measures taken by the AHPRA against medical practitioners who refuse to refer, Andrew Smith argues that "penalties for failing to follow the law in Victoria can include the loss of their medical registration [which] "would prevent a doctor from practicing anywhere in Australia" (2013). In October 2013, a Melbourne city-based, Victoria doctor, Mark Hobart was faced with losing his medical registration for refusing to refer a couple for a sex-selective abortion who subsequently reported the case to the AHPRA (Smith, 2013).

A further recommendation relates to the present study's inclusion of pharmacists among the participants. The latter are often overlooked in the debate concerning women's reproductive rights. However pharmacists have an enormous contribution to make to the realisation of women's reproductive justice as they directly interact with patients. Research in other settings has demonstrated that the effective provision of emergency contraceptive methods by pharmacists may help lessen the burden of high levels of women seeking TOP services. In Spain, for instance, the switching of emergency contraceptive methods to being dispensed OTC reduced abortion rates. This is evidenced by the fact that "in 2008, there were 115,000 abortions according to the Ministry of Health but since the morning after pill became available without prescription on January 2010, there has been a decrease of 9% in the abortion rate" (Lalanda, 2010). Likewise, data from the Alan Guttmacher Institute indicates that the use of emergency contraceptive methods has played a significant role in reducing abortion rates in the United

⁴³ 8(1) (b) of the *Abortion Law Reform Act 2008* (Vic).

States. For instance, according to the 2000 to 2001 national surveys conducted by the Alan Guttmacher Institute, “an estimated 51,000 abortions were averted by women’s use of emergency contraceptives in 2000; moreover, emergency contraceptives accounted for up to 43% of the decrease in total abortions between 1994 and 2000” (Boonstra, 2002:13; see also Jones *et al*, 2002).

While it is evident that easy access to emergency contraceptive methods plays an important role in the reduction of abortion rates, however, it should be pointed out that many women are most likely to face barriers to access the MAP within the required 72 hours’ time frame. Thus, the second option for such women would be to terminate the established pregnancy and the availability of non-objecting doctors is and will always be important in this regard. Not only that, but the recruitment of non-objecting doctors has a positive impact not only for the lives of women who may risk their health and lives through seeking unsafe abortion procedures, but may also positively impact the public health budget which is often drained by the management of incomplete abortions. This is evidenced by a 1997 South African study which estimated that “the total yearly cost of treating unsafe abortion morbidity in public hospitals was ZAR 9.74 million (about US\$1.4 million)” (Kay *et al*, 1997 cited in Grimes *et al*, 2006:1914; see also Moodley and Akinsooto, 2003:35).

A final recommendation relates to the question of mid-level providers (MLPs). Conscientious objection and women’s reproductive rights are thus an exemplar of rights in tension with one another such that to exercise the one might be to negate the other. The question then becomes one of what to do in a case of conflicting rights. ‘Clear and present danger’ was a term used by Justice Oliver Wendell Holmes, Jr. concerning the right of the government to regulate speech. ‘Clear and present danger’ has become a common standard for judging cases in which normal rights and freedoms might justifiably be abridged. While in the normal course of things the right to conscience of medical personnel is upheld as a justifiable right, within this view that right could legitimately be suspended when it conflicts with the right to life of the pregnant woman. So if, for instance, by not providing referral to an abortion clinic or not admitting a woman to a hospital bed or not providing information, on grounds of conscientious objection to abortion, that

woman's life is placed in danger then the health professional would be falling foul of the clear and present danger moral test. Likewise those health professionals, consulting their conscience, this argument suggests, would necessarily weigh the clear and present danger to the patient's life more heavily than their own right to freedom of conscience. For this reason, in cases of emergency, usually when continuation of pregnancy poses a serious danger to the life or health of the woman, it is argued that healthcare professionals have an unconditional obligation to terminate a pregnancy regardless of their personal beliefs (Dickens and Cook, 2000:72; see also Naylor and O'Sullivan, 2010:15; McCafferty, 2010:6). This standard, however, does not solve the problem of the more routine cases of requests for abortion. Nor does it offer a solution in those circumstances in which the life of the foetus is regarded, in the moral view of the physician, as bearing equal weight to the life of the pregnant woman.

Given the intractability of this debate and the resultant paucity of medical practitioners particularly in the public health sector and particularly in developing nations, who are willing to provide legal termination of pregnancy services, since the beginning 1990s, emphasis has been placed on the important role that mid-level health care providers (MLPs) could play in reducing morbidity and mortality related to unsafe abortion:

.... a [1990] recommendation made jointly by the International Confederation of Midwives (ICM), the World Health Organisation (WHO), and United Nations Children's Fund (UNICEF) encouraged midwives' participation in abortion care as a solution to address limited access to services" (Miller *et al*, 2002:247).

According to Warriner *et al*, MLPs may include "health-care providers who are not doctors, such as registered nurses, midwives, and doctor-assistants trained to undertake first-trimester induced abortions" (2006:1965). In the wake of this recommendation, research emerged showing the potential significance of the role of MLPs in abortion care (Fullerton *et al*, 2011:146-147; Grimes, 1992; Darney, 1993; Taylor *et al*, 2009 cited in Goldberg *et al*, 2013:454; McKee and Adams, 1994; Lieberman and Lalwani, 1994 cited in Goldman *et al*, 2004:1352; Ipas and IHCAR, 2002:3; Dickson-Tetteh and Billings, 2002:149), particularly with respect to first trimester abortions (Goldberg *et al*, 2013:458; Jones and Kooistra, 2011).

MLPs are potentially significant also in the context of the new emphasis on medical abortion (Yanda *et al*, 2003:279; Cooper *et al*, 2005:36; Creinin, 2000; Willmott *et al*, 2008; Goyal, 2009; Baggaley *et al*, 2010; Pollack and Pine, 2000; Coyaji, 2000; Winikoff *et al*, 1997) which proponents see as a safe and effective method of abortion particularly for women with early pregnancies (Creinin, 2000; see also Abuabara and Blum, 2004). MLPs can play an important role in distributing drugs for inducing abortion chiefly in resource-poor areas with scarce or no doctors and this may positively result in making abortion safe, effective and accessible to many more woman (Yanda *et al*, 2003:279; see also Cooper *et al*, 2005:36). Medical abortion requires minimal medical attention as the pregnant woman can self-induce abortion at home using drugs: either misoprostol or mifepristone (Bateman, 2011:304). MLPs without a professional background in surgical abortion can be trained to provide early medical abortion services (ICMA, 2004).

The key challenge is that few women present for TOP before eight weeks, which is the preferred time for medical termination (Fawcus, 2008:541). In 2001 the Medicines Control Council (MCC) of South Africa approved mifepristone as a safe and effective agent when used in conjunction with misoprostol for the termination of early pregnancy (National Abortion Federation, 2013). However, unlike in countries like Brazil (De Zordo and Mishtal, 2011:34; Yanda *et al*, 2003:279) where medical abortion through the use of misoprostol has reduced the rate of serious complications from unsafe abortion, in South Africa medical abortion has not yielded positive benefits for the majority of poor African women in need of abortion services. This is because while many abortions occur in public hospitals (Varkey, 2000:87), there is no formal national policy which permits the provision of medical abortion in these facilities (National Abortion Federation, 2009) As such, medical abortion is only available in private health care facilities which charges fees for TOP services that are unaffordable for most women. In South Africa, moreover, MLPs are no less likely than other health practitioners to invoke CO to the provision of abortion services.

MLPs and new generation abortion drugs do not solve the problem of second trimester abortions which require the intervention of willing, skilled physicians and a reasonable level of infrastructure. MLPs also cannot treat women experiencing complications from unsafe abortion (Miller *et al*, 2002:247). In South Africa research points to many reasons why women present for abortion only in the second trimester of pregnancy. In some cases this is itself a result of the absence of local facilities or health care professionals' refusals to provide abortion services. Other factors include poor knowledge about the legality of abortion among many women (Chelsea *et al*, 2006:3; Engelbrecht *et al*, 2000; Morroni *et al*, 2006:7), long waiting periods in some locations (Harries *et al*, 2007:7; Henshaw and Finer, 2003:22), initial delays or problems in suspecting a pregnancy primarily among young women with little awareness of pregnancy symptoms (Berer, 2008:3; Harries *et al*, 2007:7; Drey *et al*, 2006; Finer *et al*, 2006; Cooper *et al*, 2005; Varkey, 2000:87; Gallo *et al*, 2007). Not only do these factors force women to seek abortion services when the pregnancy has advanced to the second trimester (Turner *et al*, 2008:108-113; Naylor, 2004), but also force many women to resort to unsafe services outside designated health care facilities, which may result in death or severe medical complications (Turner *et al*, 2008:113; Mbele *et al*, 2003:1198; Walker *et al*, 2004; Skuster, 2012:1).

Globally, the continuing unsafe abortion-related mortality and morbidity rates in countries which have liberalised abortion has resulted in the emergence of recent scholarship stressing the need to train and equip willing medical personnel in order to achieve comprehensive provision of abortion services by health care systems (Healy, 2013:1; Erdman, 2012:85; Ngwenya, 2004:716; Gasman *et al*, 2006:311). Gasman and colleagues enjoin obstetricians and gynaecologists to use their elitist and privileged positions for the benefit of women (Gasman *et al*, 2006:311). The former President of the International Federation of Gynaecology and Obstetrics (FIGO), Dr Mahmoud Fathalla is on record saying that, given that women in many societies are voiceless in issues pertaining to their reproductive rights because of gender inequalities, rather than being neutral, medical personnel ought to “stand beside women and behind women” (Fathalla, 1994) rather than regarding their own privileged, empowered access to ‘choice’ and ‘freedom of conscience’ as paramount. Dr Fathalla goes on to argue that medical personnel need “to speak for women’s rights, because we know more than others that the powerlessness of women is a

serious health hazard” (Fathalla, 1994). As the former President of FIGO (2006-2009), Dr Dorothy Shaw has argued:

As professionals, our privileged position in society obliges us to advocate for improvement of health services for women and to reflect on how best to collaborate with others to bring about the necessary changes so that women will be valued equally to men and will be able to exercise their sexual and reproductive rights as enshrined in human rights laws... (2004:198)

The ideals cited in the above quote cannot be realised until we see this as a matter of social justice and find ways of serving the poorest and most marginalised with policy rather than pretending that good policies impact equally on everyone regardless of their class, race or age.

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Appendix one: Doctors self-administered questionnaire

A. Please could you start by saying a bit about yourself - I am asking for this information because I want to make sure that I get views from as diverse a group of doctors as possible.

1. What is your age? [Click here to enter text.](#)
2. What is your language? [Click here to enter text.](#)
3. What is your gender? [Click here to enter text.](#)
4. Where did you study? [Click here to enter text.](#)
5. How long have you been practicing? [Click here to enter text.](#)
6. Which town do you practice in? [Click here to enter text.](#)
7. What are the different contexts in which you have practiced? [Click here to enter text.](#)

B. The South African Choice on Termination of Pregnancy Act since 1997 provides for every woman's right to safe and legal abortion on request. Because abortion is controversial in every society, medical professionals might have moral, religious or cultural reasons for not wanting to perform abortions. On the other hand it is the law of the land.

1. Can you provide your professional and personal insight into how you think we should negotiate this dilemma in South Africa and your personal approach as a doctor within that?
[Click here to enter text.](#)
2. Do you think that there is a relevant moral distinction to be made between clinical abortion and abortion provision through the distribution of drugs such as mifepristone or misoprostol or the prescription of the "morning after pill"?
[Click here to enter text.](#)
3. Some doctors who object to being involved with the provision of abortion services also would refuse to attend to a patient seeking an abortion in cases of emergency? What is your view on this?
[Click here to enter text.](#)
4. Do you feel that doctors who have a serious moral objection to abortion are obligated to refer a patient to another willing provider or not? Could you discuss your approach to this issue?
[Click here to enter text.](#)

5. Unlike registered midwives and nurses, doctors (perhaps including you) are qualified to provide second trimester abortions. I understand that rates of second trimester abortions in South Africa are quite high. Could you tell me your view on doctors performing second trimester abortions?

[Click here to enter text.](#)

6. Is there anything more you would like to say or comment about this subject that would help me to deepen my understanding of the issue seen through the eyes of a medical professional? Please feel free to share your experiences and insights in as much detail as possible.

[Click here to enter text.](#)

C. Additional information

1. If you would like to speak to me in person about the issues of my study please indicate here.

[Click here to enter text.](#)

2. I would love to include as many doctors as possible in my study. If you have emails of other doctors whom you think wouldn't mind hearing from me could you please add them here.

[Click here to enter text.](#)

Appendix two: Doctors consent form

**Department of Political and
International Studies**
CONSENT TO PARTICIPATE IN AN EMAIL
INTERVIEW

A study in conscientious objection to lawful termination of pregnancy services in South Africa

You have been asked to participate in a research study conducted by Desire Chiwandire g09c5390@campus.ru.ac.za from the Department of Political and International Relations at Rhodes University. The purpose of the study is to investigate South Africa's doctors' opinions on abortion and the provisions of the Choice on Termination of Pregnancy Act 92 of 1996. The results of this study will be included in my thesis research for Master's Degree which will be completed in December 2014. In keeping with the ethical procedures, please read the information below, and ask questions about anything you do not understand before deciding whether or not to participate.

- This email interview is voluntary. You have the right not to answer any question and you are also free to withdraw from the study at any stage if you so desire.
- Upon receiving your email, for purposes of analysing data, I assure you that I will delete all self-identifying information that you would have provided as well as your email address.
- You will not receive monetary compensation for this interview.

I assure you of confidentiality as this interview response will be printed, transcribed and then deleted from my email inbox account. The printed version of this interview will then be stored in a secure work space for 6 months. The printed emails will then be destroyed.

Please note that by replying this email you consent to the following:

That you understand the procedures described above:

- All questions have been clarified you have responded to your satisfaction.
- You have agreed to participate in this study and you have been given a copy of this form.
- You have given permission for this interview to be printed and then used in my thesis research project.
- You have given permission for the following information to be included in publications

resulting from this study, for instance, your direct quotes from this interview.

Please contact Desire Chiwandire (Cell: 0737543556) with any questions or concerns.

My Supervisor: Prof Louise Vincent, louise.dorothy.vincent@ru.ac.za (27 (0) 46 603 8353).
Department of Political & International Studies, Rhodes University.

Appendix three: Pharmacists self-administered questionnaire

A. Please could you start by saying a bit about yourself - I am asking for this information because I want to make sure that I get views from as diverse a group of pharmacists as possible.

1. What is your age? [Click here to enter text.](#)
2. What is your language? [Click here to enter text.](#)
3. What is your gender? [Click here to enter text.](#)
4. Where did you study? [Click here to enter text.](#)
5. How long have you been practicing? [Click here to enter text.](#)
6. Which town do you practice in? [Click here to enter text.](#)
7. What are the different context in which you have practiced? [Click here to enter text.](#)

B. The South African Choice on Termination of Pregnancy Act since 1997 provides for every woman's right to safe and legal abortion on request. Because abortion is controversial in every society, health professionals might have moral, religious or cultural reasons for not wanting to perform abortions. On the other hand it is the law of the land.

1. In 2000, the South Africa Medicines Control Council approved the dispensing of emergency contraception by pharmacists to women of any age without a doctor's prescription. What are your personal views regarding this policy?

[Click here to enter text.](#)

2. In the international debate on pharmacists' rights to conscientious objection to the dispensing of emergency contraception, some prefer to see the pill as delaying or inhibiting ovulation whereas others equate it to an abortion pill which does the same work as other 'abortifacients' like mifepristone and misoprostol. What is your personal approach as a pharmacist to this question and how do you interact with women requesting the morning after pill?

[Click here to enter text.](#)

3. Given that emergency contraception is legally available in South African pharmacies through over-the-counter distribution, should pharmacists have a right to refuse to dispense emergency contraception if this is against their religious, ethical, personal and moral beliefs?

[Click here to enter text.](#)

4. Some pharmacists find repeated requests for the morning-after-pill on the part of a single patient troubling for various reasons while other pharmacists do not. Please describe your own response.

[Click here to enter text.](#)

5. Do you think those pharmacists who refuse to dispense emergency contraception on grounds of conscience should refer the woman to another willing provider or non- objecting pharmacist – or does this constitute collusion in a practice that the pharmacist may find morally reprehensible?

[Click here to enter text.](#)

6. In the pharmacy practice, what do you think should take precedence: the pharmacist's professional role in patient care (through the lawful distribution of emergency contraception) or the pharmacist's right to practice according to his or her conscience?

[Click here to enter text.](#)

7. If you do/do not believe in dispensing emergency contraception, please explain the reasons for your approach.

[Click here to enter text.](#)

C. Additional Information

1. If you would like to speak to me about issues concerning my study please indicate here.

[Click here to enter text.](#)

2. I would like to include as many pharmacists as possible in my study. If you have other emails of pharmacists whom you think would whom you think wouldn't hearing from me could you please forward them both attachments or add the emails here.

[Click here to enter text.](#)

Appendix four: Pharmacists consent form

Department of Political and International Studies

CONSENT TO PARTICIPATE IN AN EMAIL INTERVIEW

A study in conscientious objection to lawful provision of Emergency Contraception/the morning-after- pill in South Africa

You have been asked to participate in a research study conducted by Desire Chiwandire g09c5390@campus.ru.ac.za from the Department of Political and International Relations at Rhodes University. The purpose of the study is to investigate South Africa's pharmacists' knowledge, perceptions and opinions on the morning-after-pill and the provisions of the South African Medicines Control Council which approved the dispensing of emergency contraception by pharmacists to women of any age without a doctor's prescription in 2000. In keeping with the ethical procedures, please read the information below, and ask questions about anything you do not understand before deciding whether or not to participate.

- This email interview is voluntary. You have the right not to answer any question and you are also free to withdraw from the study at any stage if you so desire.
- Upon receiving your email, for purposes of analysing data, I assure you that I will delete all self-identifying information that you would have provided as well as your email address.
- You will not receive monetary compensation for this interview.

I assure you of confidentiality as this interview response will be printed, transcribed and then deleted from my email inbox account. The printed version of this interview will then be stored in a secure work space for 6 months. The printed emails will then be destroyed.

Please note that by replying this email you consent to the following: That you understand the procedures described above:

- All questions have been clarified you have responded to your satisfaction.
- You have agreed to participate in this study and you have been given a copy of this form.
- You have given permission for this interview to be printed and then used in my thesis research project.
- You have given permission for the following information to be included in publications resulting from this study, for instance, your direct quotes from this interview.

Please contact Desire Chiwandire (Cell: 0737543556) with any questions or concerns or my Supervisor: Prof Louise Vincent, louise.dorothy.vincent@ru.ac.za (27 (0) 46 603 8353).

Department of Political & International Studies, Rhodes University.