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Where Do We Go From Here?:
Two Key Informants' Perspectives on How to Address Conscientious Objection
in TOP Provision in South Africa

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Abstract

This perspectives research endeavor examines the barriers to TOP access that arise from conscientious objection through the conflicting network of rights and legislation in South Africa. While previous research has evidenced the demonstrable barriers to accessing TOP care in South Africa, this project aims to push the existing literature and the field as a whole one step further to interrogate how to move forward within the realities of conscientious objection.

To do so, I conducted interviews with key informants in the field of reproductive healthcare provision, research, and activism in Cape Town on their perspectives about the practice of conscientious objection, specifically focusing on their recommendations for how to address the barriers to abortion access that arise from the right to freedom of conscience.

Through this perspectives research, I found that there is general consensus among the participants of this study and other experts in the field around the barriers to accessing TOP services in South Africa and around conscientious objection in particular. The key informants interviewed for this project, despite their diverse backgrounds and unique approaches to the field, offer parallel recommendations for addressing conscientious objection. These recommendations include creating and enforcing official guidelines for how conscientious objection is used in practice and the role of authority in particular, transforming public perceptions of TOP, establishing incentives programs to encourage increased access, and fundamentally altering the way the right to freedom of conscience is conceptualized. These recommendations require transformation on multiple fronts, but are essential to guaranteeing basic human rights in the country.

KEY WORDS: termination of pregnancy (TOP), conscientious objection, constitutional rights, healthcare, access, barriers, recommendations

Dedicated to Pop-Pop

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Glossary of Terms

Termination of Pregnancy (TOP): “the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman” (Choice on Termination of Pregnancy Act, 1996); also referred to as ‘abortion’

Choice on Termination of Pregnancy Act (CTOPA): legislation passed in 1996 and enacted in 1997 to govern termination of pregnancy services in South Africa

Conscientious objection: “to object in principle to a legally required or permitted practice” (Amnesty International, 2017, p. 8)

Introduction

Affronts to abortion access are emerging all over the world. From legislative attempts to undermine the legality of services (Singh, Remez, Sedgh, Kwok, & Onda, 2018) to anti-abortion protestors who use various tactics to intimidate and deceive individuals looking for care (Crary, 2018), there are no shortage of efforts to curtail access to this essential healthcare service. South Africa's constitution and termination of pregnancy legislation, despite being incredibly progressive, nonetheless give space for yet another method of undermining access – one that in its specifics is rather unique to the country – conscientious objection.

Conscientious objection is the practice of refusing to perform termination of pregnancy (TOP) services on personal, moral, or religious grounds, and, in its unregulated and unmonitored practice, has been proven to establish many barriers to accessing TOP services in South Africa (Harries, Cooper, Strebel, & Colvin, 2014). While some research has been done on conscientious objection to date, most previous studies are focused on illustrating the barriers to access that the practice of conscientious objection creates. While this work is essential, there also needs to be work done that fosters action-oriented thinking on this topic. As such, the objectives of this paper are twofold. Through examining existing literature and interviewing key informants in the field of TOP provision, research, and activism in Cape Town, I aim to provide a general overview of the situation regarding conscientious objection in South Africa. Secondly, through investigating the perspectives of these key informants, I aim to provide a concrete collection of policy, framework, and other recommendations for how to address the barriers to TOP access that are created from the practice of conscientious

objection. I took this specific approach to this project because of my own personal interests and work in the field of reproductive healthcare. My academic and personal life in the United States is deeply involved in the reproductive justice movement, and I saw this project as an opportunity to explore familiar topics in an entirely new context. Beyond the personal fulfillment and interest I took in this subject area, I also saw this project as an opportunity to connect the perspectives of a diverse group of people and collect a variety of responses that will be beneficial to inform the future work of the community they are coming from.

There is a wide body of knowledge in Cape Town among direct service providers, researchers, and activists who are involved in the work of TOP rights and access and acutely understand the challenges that accompany the right to freedom of conscience. This project aims to tap into that expertise to ask: how can one address the barriers to TOP access that arise from the right to conscientious objection in South Africa? In other words, how can South Africa move forward within the realities of the conflicting constitutional rights to reproductive healthcare access and to freedom of conscience (Constitution of the Republic of South Africa) within TOP provision? Because of the nature of this study, I did not begin this research with a traditional hypothesis statement per se. However, I did anticipate that there would be a general consensus among participants of the need for concrete regulation and accountability systems as well as a new framework for understanding conscientious objection that moves away from an emphasis on individual rights to focus on structural access.

In order to answer these main questions, this report is divided into four main sections. I begin by providing context of the history and current situation of

TOP services and conscientious objection in a literature review, and then after detailing the methodology and ethical considerations of this project, I present my findings and analysis. The findings and analysis section will be further broken down into four subsections, detailing the specifics of the participants in the study, participants' perspectives on what barriers to accessing formal TOP services exist, participants' perspectives on and experiences with conscientious objection, and finally participants' recommendations for addressing conscientious objection in TOP provision, the last of which forms the bulk of the findings and analysis section. Through this presentation of my research findings and analysis, I demonstrate that there is consensus among participants in regard to the existing barriers that serve to limit access to TOP services. I argue that despite some variety in responses and the diversity of participants' backgrounds and experiences, there is general agreement that transformation of the practice of conscientious objection needs to occur on multiple levels.

This study is not without its limitations. The short time frame and minimal resources of the project severely limited my ability to reach the variety of participants that I had originally hoped to. Seeing as though there are already some recommendations that have been put out by researchers in their published studies, the intention of this project was to interrogate these perspectives along with those of others, such as abortion providers and activists. While the reality of the project did not quite work out that way, as I was unable to recruit any nurses or activists, I was able to recruit two participants for the project in the short time frame that are true key informants in their fields. I still see this research as an opportunity to compare voices and perspectives that may not have been placed alongside each other before.

Ultimately, this research is a perspectives inquiry into the future of TOP access in South Africa as it relates to the practice of conscientious objection. It aims to reimagine the conflicting rights within TOP provision and define a path forward to increase access to TOP services in the country, ensuring equal and legitimate access to healthcare services and human rights more broadly in South Africa.

Literature Review

The objective of this literature review is to provide a general overview of the work that has already been done to analyze conscientious objection in the context of TOP service access in South Africa. Conscientious objection in this context is the practice of refusing to provide termination of pregnancy services on moral or religious grounds, and is an important issue to examine in order to better understand the accessibility of TOP services in the country and how to improve it. Due to the time and resource constraints on this project, including journal article paywalls, this literature review does not claim to offer a full and comprehensive review of all the work that has been completed on the subject. Rather, this literature review aims to provide context to better understand the findings and analysis that will be presented later in the report and to place this research in the field of study. This review will synthesize the findings of previous research, provide an overview of recent news related to TOP access, and offer a summary of the legal and policy analysis that has been completed in reference to TOP rights and conscientious objection. This literature review illustrates that there is broad consensus in the field regarding what conscientious objection is, how it is meant to be implemented, and how it is misused in practice. Previous

research has demonstrated the barriers to TOP access established by conscientious objection, leaving space for this project to examine key informants' perspectives on how to move forward within these realities.

Constitutional Rights and Protections for TOP Services

South Africa ushered in a new democracy in 1994, and with it a new constitution (Kende, 2003). Heralded as one of the “most admirable constitutions in the history of the world” (Kende, 2003, p. 138), the South African Constitution includes a wide variety of provisions and protections that range from the right to adequate housing to the right to a healthy environment, along with many others (Constitution of the Republic of South Africa). The South African Constitution is also the foundational document for TOP rights in the country. Haroz (1997) provides a general overview of the protections guaranteed within the Constitution and how those protections relate to the implementation of TOP services. She explains that the Bill of Rights guarantees each South African “the right to bodily and psychological integrity,” including “the right to make decisions concerning reproduction and the right to security in and control of their body” (Haroz, 1997, p. 879). Furthermore, Haroz (1997) details the constitutional guarantee that “everyone has the right to have access to health care service, including reproductive healthcare” (Haroz, 1997, p. 879). As TOP services are an essential component of reproductive healthcare, these provisions within the Bill of Rights provide the constitutional basis for ensuring access to termination of pregnancy services in South Africa.

The Choice on Termination of Pregnancy Act

Much of the existing literature highlights the significance of the Choice on Termination of Pregnancy Act (CTOPA) of 1996 on TOP service access in South Africa. The CTOPA replaced the Abortion and Sterilization Act of 1975, which in its strict conditions and coupled with the network of racist apartheid policies that restricted movement and resources along racial lines, had the effect of severely restricting TOP services in the country and essentially limited access to safe and legal TOP services to white women in South Africa (Haroz, 1997; Mhlanga, 2003). To illustrate, it is estimated that approximately 1,000 legal terminations were performed each year in South Africa during apartheid, and nearly all of them were performed for middle and upper class white women (Morrone, Myer, & Tibazarwa, 2006). During the same time period, an estimated 200,000 illegal and unsafe terminations were performed each year for black women (Morrone et al. 2006), resulting in an estimated 45,000 hospitalizations and 400 deaths each year (Morrone et al. 2006). Moreover, these numbers are likely conservative approximations that do not fully reflect the lived experiences of many black, poor, or rural individuals who lived under apartheid laws that exerted legislative control over their reproductive choices and bodies. However, the official end of apartheid policies in 1994 left room for the establishment of new reproductive healthcare policy in the country. As such, the Choice on Termination of Pregnancy Act was passed in 1996 and went into effect in South Africa in 1997 (Haroz, 1997).

The CTOPA is explicit in various provisions related to termination of pregnancy services. Most notably, the CTOPA imposes gestational conditions on levels of access to TOP services. In the first 12 weeks of gestation, the CTOPA

stipulates that TOP services must be available upon request and do not require justification (Mhlanga, 2003), and that the procedure can be performed by a medical practitioner, a nurse, or a midwife (Amnesty International, 2017). Between 13 and 20 weeks gestation, only a registered medical practitioner can perform a TOP (Amnesty International, 2017), and only under specific conditions including rape or incest, severe fetal abnormality, risk to the physical or mental health of the woman, or adverse social or economic conditions for the woman (Harries et al. 2014). South Africa is rather unique in how many second-trimester TOPs are sought in the country. Approximately 30% of TOPs are performed in the second trimester, which is nearly three times the percentage of second-trimester TOPs performed in the U.S. (Harries, Stinson, & Orner, 2009). Studies suggest that barriers to accessing healthcare services early in a pregnancy and personal circumstances contribute to this high percentage of TOPs in the second trimester (Harries et al. 2009). After 20 weeks, the conditions for legal TOP provision are much more limited, as a medical practitioner can only perform a TOP if the continuation of pregnancy poses a severe risk to the physical health of the woman or fetus (Amnesty International, 2017; Harries et al. 2014). These gestational conditions are one aspect of the CTOPA in which there is little confusion or dispute.

Additionally, the Choice on Termination of Pregnancy Act was passed with specific provisions to increase the accessibility of TOP services for historically marginalized communities in South Africa. For example, by establishing programs to train nurses and midwives to perform first-trimester terminations, the CTOPA creates opportunities for TOP services to be offered in public primary health care facilities (Varkey, 2000). This in turn makes TOP

services more accessible to those who only have access to public health care services and to those who do not have the financial resources, time, or physical access to private TOP services. Furthermore, the CTOPA explicitly allows minors to obtain TOP services without parental consent (Varkey, 2000). This provision increases access for youth who live in abusive households or are otherwise unable to obtain parental support for their decision. These two specific provisions are just some of the many in the CTOPA that aim to increase access to termination of pregnancy services after the severe restrictions that were in place under apartheid.

These provisions, among others, have played a demonstrable role in abating unsafe abortions in the country. Immediately following the passage of the CTOPA, studies found that abortion-related morbidity declined by 91% (Harries et al. 2014). However, despite the initial health benefits the CTOPA offered in South Africa, there remain some issues with the legislation. While the CTOPA is explicit and clear on the guidelines regarding access based on gestational age and other provisions to increase access to TOP services, the CTOPA is silent on regulating a major issue: conscientious objection.

Conscientious Objection

According to Amnesty International (2017, p. 8), conscientious objection is broadly the practice of “objecting in principle to a legally required or permitted practice.” The phrase ‘conscientious objection’ is often used in reference to the decision of individuals to refuse to engage in military service on religious or moral grounds (“International Covenant on Civil and Political Rights,” 1966). However, conscientious objection is also often frequently discussed in a medical setting as the practice of refusing to provide certain medical care for various

personal or religious reasons. This is particularly common in the field of termination of pregnancy. In the context of TOP provision, conscientious objection is the practice of refusing to perform TOP services on personal, moral, or religious grounds (Harries et al. 2009; Mhlanga, 2003).

The right to claim conscientious objections, including in TOP provision, is based in the South African Constitution. The South African Constitution guarantees the “right to freedom of conscience, religion, thought, belief and opinion” (Constitution of the Republic of South Africa). While the CTOPA does not explicitly mention the right to conscientious objection, there is general consensus among medical practitioners and legal scholars that the constitutional right to freedom of conscience allows for doctors and nurses to claim conscientious objection to TOP services on religious and moral grounds, as long as there are efforts made to refer the patient to another facility or provider (Dickson, Jewkes, Brown, Levin, Rees, & Mavuya, 2003; Harries et al. 2009; Harries et al. 2014; Sibuyi, 2004; VM, 2012).

While the CTOPA does not directly regulate the practice of conscientious objection, the CTOPA does offer guidelines in regard to the general expectations of medical providers (Harries et al. 2014), and through these guidelines there is consensus that the right to conscience is not absolute. Amnesty International’s (2017) report on barriers to abortion access in South Africa explains that the right to freedom of conscience applies only to the “direct provision of services” and cannot be used to deny care in emergency situations (Amnesty International, 2017, p. 8). A medical provider therefore cannot claim a conscientious objection to other, indirect elements of TOP-related care or refuse to provide TOP-related care in the case of an emergency (Amnesty International, 2017; Harries et al.

2014). This understanding of conscientious objection therefore necessarily restricts its applicability to only those providers who would be directly involved in the TOP procedure (Harries et al. 2014), not every individual who is peripherally involved in service provision. There are also ethical guidelines specifically related to conscientious objection that have been put out by the South African Nursing Council. These guidelines further stipulate that regardless of claims to conscientious objection, nurses must provide medical care outside of the immediate TOP procedure and must lodge their conscientious objection in writing (Harries et al. 2009). Despite these consensus-driven expectations and externally-produced guidelines, research demonstrates that there remains confusion about the particulars of conscientious objection.

This confusion may have been avoided by definitive regulation of conscientious objection within the CTOPA. Interestingly, a draft version of the CTOPA included an explicit clause to permit medical practitioners to claim conscientious objection in TOP service provision, however, that clause was rejected in the final version of the legislation (Haroz, 1997). Haroz (1997, p. 888-889) writes, “It remains to be seen whether this omission will allow the imposition of a criminal penalty against a practitioner who refuses to perform such abortions.” While Haroz wrote this in 1997 immediately following the passage of the CTOPA, her doubts have since proven to be valid. It may seem as though omitting such a clause would work in favor of TOP access, as perhaps without explicit acknowledgement of conscientious objection, it would be assumed that the practice would not be admissible. However, as previously explained, the practice is widely accepted as relevant in TOP provision, and the lack of explicit mention of and specific guidelines for implementing

conscientious objection in the CTOPA has merely resulted in widespread confusion and misuse of conscientious objection in TOP service provision without any form of accountability measures. While the CTOPA broadly stipulates that it is illegal to “prevent or obstruct access to legal abortion services” (Amnesty International, 2017, p. 8; Dickson, 2003), in practice there is significant confusion as to who is eligible to claim a conscientious objection and how to legally do so (Amnesty International, 2017) – confusion that ultimately obstructs access to TOP services.

Barriers to Accessing TOP Services

There is broad consensus in existing literature that the way in which conscientious objection is implemented in reality establishes many barriers to accessing TOP services. The research that has been conducted on conscientious objection highlights how haphazard the implementation of these commonly accepted and externally produced standards for conscientious objection are. Research conducted in the Western Cape in 2009 and 2010 found that “in most public sector facilities there was a general lack of understanding concerning the circumstances in which health care providers were entitled to invoke their right to refuse to provide, or even assist in abortion services” (Harries et al. 2014, p. 3), and this confusion led to the misuse of conscientious objection. Facility staff – including individuals not directly involved in procedural work – were found to deny services on the grounds of conscientious objection (Harries et al. 2014); in another study conducted in 2006, one interview revealed that “access to care had been blocked by an admissions clerk” (Harries et al. 2009). Research also found instances in which emergency care was denied through conscientious objection (Harries et al. 2014) – occurrences which are explicitly prohibited under accepted

understandings of conscientious objection. These qualitative studies reveal that there is demonstrable misuse of the right to conscientious objection in the country. Harries et al. (2014) concluded that “conscientious objection was either poorly understood, or in many cases incorrectly implemented in health care facilities” (Harries et al. 2014, p. 5) and that, “one of the main identified obstacles to women accessing abortions in South Africa is the unregulated practice of conscientious objection” (Harries et al. 2014, p. 2). It is impossible to identify the pervasiveness of the misuse of conscientious objection in South Africa from these few studies, but additional quantitative data provides consensus and indicates that the lack of understanding surrounding conscientious objection and the improper implementation that results has a direct impact on TOP service accessibility around the country.

Leading researchers in the field have concluded that the prevalence of conscientious objection in South Africa has tangible consequences for the accessibility of TOP services in the country. To illustrate, a 1996 study found that only 8% of nurses in South Africa believe in the right to full TOP access (Althaus, 2000). While it cannot be assumed that all 92% of nurses who do not believe in full TOP access would claim a conscientious objection, and this statistic has likely changed in the past 20 years as the CTOPA has become more ingrained in the medical field, this statistic, even if one is generous with the assumptions that come from it, has staggering impacts on the accessibility of TOP services in the country. Under the CTOPA, nurses were meant to be trained and provide the bulk of first-trimester TOPs (Varkey, 2000). However, with so many providers, nurses, and staff objecting to TOP rights and claiming conscientious objections, many health care facilities are left without the staff or

resources to be able to provide TOP services (Varkey, 2000). The Department of Health reported to Amnesty International in 2016 that of the 505 public health facilities that are licensed to offer TOP services in South Africa, only 264 actually do (Amnesty International, 2017), as without staff resources, facilities are forced to discontinue the service (Varkey, 2000). Furthermore, a 2013 study conducted in Cape Town found that “45% of women did not receive the abortions they sought at the clinic... 20% because the clinic did not have the staff to perform their abortions that day” (Harries, 2016). As such, the widespread use of conscientious objection – whether it be in line with the law or not – is not merely a theoretical issue, but rather has direct consequences for individuals seeking TOP services in the country.

Legal Implications of Barriers to Accessing TOP Services

Literature has also been published that analyzes the impact of conscientious objection on access to TOP services through an international legal framework. Amnesty International’s (2017) report explains that:

Both the African Commission on Human and People’s Rights (ACHPR) and the United Nations Committee on Economic, Social, and Cultural Rights (CESCR) are clear that States have an obligation to ensure that the practise of conscientious objection is not a barrier to accessing abortion services. Human rights standards also require that South Africa must ensure ‘an adequate number of health care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach.’ (Amnesty International, 2017, p. 10)

Consensus seems to be that without regulatory structures within the CTOPA (Harries et al. 2009) and no official monitoring systems (Amnesty International, 2017), there is little information on the prevalence of conscientious objection in South Africa, and therefore little to no accountability for legally ensuring that conscientious objection does not establish a barrier to ‘adequate’ TOP access. This means that the misuse of conscientious objection not only leaves many individuals in the country without access to the care they desire, but it also leaves the government of South Africa at risk of violating its human rights obligations (Amnesty International, 2017).

Recent Legislative Efforts to Curtail TOP Access

To add to these barriers that the practice of conscientious objection establishes, there have been recent legislative efforts to curtail TOP services in South Africa and limit the strength of the CTOPA. The African Christian Democratic Party (ACDP) has an official anti-abortion stance (Pilane, 2019), and in 2018 introduced a bill known as the Choice on Termination of Pregnancy Amendment Bill (Ndenze, 2018). Under the guise of ‘helping women,’ this legislation would have instead established more barriers to accessing TOP services. The bill aimed to require ultrasounds and mandatory counseling for individuals seeking terminations, as well as an obligatory social worker consultation for second-trimester terminations (Ndenze, 2018). Parliament’s Health Committee decidedly voted the proposed legislation down due to the cost-prohibitive resources it would require and its potential to establish further barriers to accessing care (Ndenze, 2018). The CTOPA has always been considered strong legislation, it was merely the implementation of the law that created barriers to care. However, with recent legislative efforts to weaken the

foundational strength of the CTOPA, providers and other individuals in the field may be forced to grapple with struggles on a different front.

Conclusion

The structure of rights within the South African Constitution and the legislation based off of it creates a web of rights and freedoms that sometime come into conflict with one another. The area of TOP rights and access is one instance in which this occurs. While the South African Constitution and the Choice on Termination of Pregnancy Act guarantee access to TOP services in South Africa – with conditions – the practice of conscientious objection serves to limit that access. With confusion among providers in regard to who can claim conscientious objection and under what circumstances, as well as the improper implementation that results from this lack of understanding, only approximately half of healthcare facilities that are licensed to offer TOP services in the country actually do so. Additionally, recent anti-abortion legislative efforts and international legal analysis are important context through which to view the current state of conscientious objection in South Africa. Ultimately, previous literature has demonstrated that the practice of conscientious objection in TOP provision creates major barriers to accessing abortion services in South Africa.

However, most of the research conducted in regard to conscientious objection is geographically specific, making it difficult to grasp a full picture of the situation in the country, and much of the research is not especially recent. It seems as though there was extensive work done and published on this topic in the years following the implementation of the CTOPA, but aside from a few major reports published in the past decade, there remains work to be done to analyze the current situation surrounding conscientious objection in South Africa.

This project aims to build off of this existing research that has demonstrated the barriers to TOP access to move towards more action-oriented work on the topic. While some researchers have already offered brief recommendations in their publications, this study aims to interrogate the perspectives of not just leading researchers in the field, but also those of others doing work in the field, including TOP providers and activists. While time constraints and minimal access limited the success of this goal, this project nonetheless hopefully provides a valuable addition to the existing field of research by taking a forward-looking approach and bringing together the voices of diverse key informants in the field.

Methodology

In order to carry out this study, I conducted interviews of key informants in the field of TOP rights, access, and provision. I decided to carry out this project through interviews in order to hear directly from those directly involved in the field, and chose interviews over focus groups for logistical reasons and to respect the individual expertise of the participants (Kvale, 1996). I conducted these interviews myself in English, and each interview took place in the location most convenient to the individual participant, whether that be their place of work, a coffee shop, or another location. One interview took place in person to better foster an interpersonal connection and read body language (Kvale, 1996), but due to geographical distance, one interview took place over Skype. The interviews were held over a three-day span between the dates of April 10, 2019, and April 12, 2019, and the interview questions can be found in Appendix A. I held a single meeting with each participant with the intention that my flexibility with location

and the low time commitment would minimize the burden to the research participants. Participants were not compensated for participating in the interviews, and I did not work with any external human resources such as translators, guides, or research assistants.

Possible diverse participants for this research were approached through multiple means, but the participants that were ultimately recruited were done so through personal connections. In my attempt to speak with a reproductive justice activist, I sent out a generic interview request over email to the Sexual and Reproductive Justice Coalition (SRJC) and followed up through their active Facebook page. I received a Facebook message response from the SRJC Facebook page with the name and email of an individual at their organization who would be best to reach out to for an interview request, but after doing so received no email response. To recruit providers and nurses, I ran a Google search of private TOP providers in Cape Town and called two offices that I found through this method. However, both requests were turned down by the individual who answered the phone. Additionally, my advisor, Emma Arogundade, sent out a request for interviews on her Facebook account to wield her own connections and sent a personal Facebook message to a nurse who had posted an interesting comment on Facebook, but both efforts were met with silence. As these methods to recruit a wide variety of participants were unsuccessful, I ultimately recruited both of the research participants through recommendations and introductions by a family friend who works in the field of reproductive rights in Cape Town.

This connection and recruitment method was certainly a great benefit to my project. I was able to recruit multiple high-level key informants that I otherwise would not have had access to, participants were likely better inclined to

respond to my interview request because of the personal connection I had to them, and the assistance I received in contacting potential participants substantially decreased the time it took for me to recruit some participants, allowing me more time to try to recruit more people. However, this recruitment method is also not without its faults. In eventually using my family friend as my singular source for recruitment, she came to serve as the gatekeeper for this project. The perspectives offered in this report are based off of her circle of connections and, as many people are friends or colleagues with like-minded individuals, there is likely an echo-chamber effect. Therefore, I likely did not achieve as much diversity in identity or opinion as I would have through a different form of recruitment. This recruitment method, while advantageous for its access, success, and time allowances, ultimately likely skewed the findings towards a singular narrative.

I specifically recruited individuals who are involved in the field of private TOP provision or reproductive healthcare policy work, research, or advocacy. I intentionally excluded individuals who work in the public sector, as that raises potentially difficult logistical questions and because much of the existing research has focused on the public sector, so I saw this project as an opportunity to interrogate the perspectives of individuals in the private sector who have previously been left out of the discussion. I selected potential participants based off of my own research about them, their work, and their qualifications, as well as based off of recommendations of advisors and trusted relations. I originally hoped to recruit at least four individuals for participation, but I was concerned that the time constraints of this project, lack of access to potential participants, and the research fatigue within the field might constrict this numerical goal. And

yet I came close to meeting this goal, as I recruited three participants for this project. However, one of the recruited participants had to cancel their interview at the last minute due to illness and was unable to reschedule before this report was due. As such, I ultimately interviewed two individuals in the field of private TOP provision and reproductive healthcare research for this project.

I made substantial efforts to ensure the privacy, anonymity, and confidentiality of participants at all time. In order to protect the privacy and personal integrity of participants, I made sure that it was clear throughout the interview that participants did not have to provide any information that they did not feel comfortable sharing and that they could ask to end the interview at any time. I also specifically asked participants how they would like to be identified in the final report and presentation, whether that be through a pseudonym to protect anonymity, full identifiable information, or a combination thereof. This question was included in the informed consent form and the preference of the participant was strictly adhered to. I decided to leave the form of identification up to the discretion of each individual participant because I wanted to allow for anonymity if desired, but I also recognize that by nature of this perspectives study, there might be some recommendations offered by participants that they want attributed to them. Especially given the fact that all of the participants are from the same field and hold rather senior positions, I realized that some participants may want themselves and their ideas to be identifiable to their peers. Unfortunately, by nature of how I recruited participants to the study, I necessarily knew the names of participants. However, for the participants that opted for anonymity, the handwritten notes I took were not traceable to the name of the individual and I used an anonymous identifier within the report. I was also intentional in not

identifying the organization or practice that the individual works for or is associated with, nor did I identify their specific position, in order to minimize unique identifiers of the participant. To maintain the confidentiality of participants, I stored the audio data that I collected on my personal phone that is only accessible with a private passcode. The raw data was only stored until the report was completed, and will not be used for any future research or be accessible online. The use of the data is consistent with the intended use stated in the informed consent form.

Due to differences in interview format and technological constraints, there were a range of ways in which participants gave their consent to be interviewed and included in the report and presentation. One participant read and signed a physical consent form, while the participant that was interviewed over Skype read the consent form in a digital format and gave verbal consent for the various provisions. The informed consent form (see a copy in Appendix B) asked for consent for multiple aspects of participation: consent for general participation, consent to use the identifiable information requested by the participant, consent to quote from the interview, and consent to be audio-recorded during the interview. As all of the participants were adults, spoke English fluently, and did not identify themselves as vulnerable or at risk in any other way, I was able to obtain full and informed consent from each individual personally.

On a broader level, I chose to conduct and present this research through this methodological approach to accumulate a thorough perspectives report that is properly situated. Interviews were the chosen field study method as perspectives research requires the direct opinions of individual participants, and the recruitment method was important to be able to access the key informants I was

looking for. I also chose to include the literature I did to provide context to the situation regarding conscientious objection and TOP in South Africa and the specific responses of the participants. Information included in the literature review reflects the general consensus in the field of existing literature and coincides with the stance that I assumed most participants would have towards the subject. Some information was purposefully added to the literature review after an interview in order to offer background information for my future analysis of the topic. I also decided to treat my analysis the way I did for specific reasons. I included multiple foundational questions on access and barriers in the interview, and later examined these responses in the analysis, for context on a topic that is relatively unknown in South Africa. I felt the need to include the background information and context offered by participants in the findings and analysis in order to create a fuller understanding of the issue for readers before diving into potential recommendations. I then collected and analyzed the various recommendations and suggestions offered to fulfill the goal of completing a perspectives report.

Ethical Reflexivity

There are multiple ethical implications within the research that I conducted, but I attempted to address these ethical issues in the design of the project to the best of my ability.

While there are inevitably power dynamics at play in any research project, I found that for the most part power dynamics in this study actually leaned in favor of the participants rather than myself as a researcher. As an international undergraduate student with some experience in the field of reproductive

healthcare rights and access in the United States but little to no background in the local South African context, I was humbled by the amount of experience and expertise that the participants had on the subject – after all, they were true key informants in the field. As such, I entered these interviews with humility and reverence to the expertise of the participants and did not pretend to be an expert on the subject in any way. However, I also recognize that as an American, the common deference to Western knowledge and research placed me in a slight position of power over the participants. Furthermore, while the participants had authority and power over myself by nature of their professional status, I also acknowledge that I hold a certain amount of power due to the fact that I designed the study, defined how the interviews would be conducted, have control over how they are represented (Kvale, 1996), and am the gatekeeper of which information gets included in the report. I have made all effort possible to represent the participants as authentically as I could and avoid common tropes associated with abortion provision and advocacy, while ensuring that I maintain the privacy, anonymity, and confidentiality of participants as previously discussed in the methodology section. Ultimately, I believe that the power dynamic based on age and expertise that overwhelmingly tilted in favor of the participants protected potential participants from feeling pressured to participate in the study, as there were likely no professional or social implications of saying no to participating in short-term, undergraduate research, despite its Western association.

That being said, while the power dynamics likely established a level of protection from pressure to participate, the method of recruitment may have exerted further pressure on potential participants. As potential participants were contacted both by myself and my family friend, there may have been personal

pressure to participate because the request was in part coming from a friend or colleague and they felt obligated to do her a favor or help her out. There are also further ethical implications of having such immediate access to key players in the field through my family friend. As I mentioned in the methodology section, because of my unsuccessful external outreach efforts, the participants in this study were ultimately dictated by the personal and professional connections of a single individual. While this is not inherently negative, it likely skews the findings towards a singular perspective. I am also conscious of how using this connection distanced myself from the project in a way and to an extent made parts of the research process easier and more straightforward for me, as I did not have to go through the same difficult recruitment process as other students may have. I very much value the access and ease that this personal connection granted to this project, while being simultaneously cognizant of the bias and potential discredit that also accompanies that connection.

Additionally, I think it is important to identify and address the biases I hold as a researcher based on my positionality and personal beliefs. I previously addressed how my identity as an international undergraduate student influenced the power dynamic between myself and potential participants, but I also hold other intersecting identities that likely played a role in how I conducted the research and analyzed the findings. I identify as a staunch feminist and advocate for reproductive justice, and my academic and personal life revolves around organizing for reproductive justice issues. As such, it is important to name the substantial bias that I entered this research with: I strongly believe that TOP services should be available to all individuals and free of financial, social, and structural barriers. Therefore, I inherently hold a negative view of the practice of

conscientious objection when it impacts systemic access to reproductive healthcare. This bias is evident throughout this research project and report, as even the angle I have chosen to approach the research from conveys a baseline assumption that conscientious objection is an issue that needs to be addressed. I acknowledge this bias, which I believe is an important first step, but I have also taken this bias into account when I recruited participants, conducted interviews, and analyzed findings. For example, I began this research with the assumption that all of the participants would be dedicated to expanding TOP access and opposed to the pervasive use of conscientious objection, if only because individuals who support conscientious objection likely are not private TOP providers or work in the field of TOP rights in general. While this expectation was ultimately accurate, I organized my field research knowing that this assumption might be flawed and I was prepared to encounter beliefs contrary to the broad assumption I was making. To respond to this and to minimize the acknowledged bias, I purposefully asked open-ended questions to allow for response diversity and to not pigeon-hole participants into specific answers based on my own beliefs. By nature of this research project and my personal interest in it, there is inevitably bias in the research and report. However, I have made explicit in the report how my own biases influenced my interpretations and analysis to begin to acknowledge how my own identity plays a role in this research.

Another major aspect of my identity that came into play in the formulation of this research project was my Americanness. I entered a South African context as an outsider and based my knowledge of and interest in this topic off of my experiences in the United States. As there is not an explicit right

to freedom of conscience in the United States, the specific framework of conscientious objection does not pose barriers to abortion access in the context in which I do most of my work. While there are certainly other barriers to access in the U.S., the practice of conscientious objection and the network of rights that it emerges from appeared novel in my American lens, as I would not be able to analyze this particular phenomenon in the United States. This othering based on my identities and positionality informed my interest in pursuing this subject, and must be acknowledged as a major factor in this research.

I would also be remiss if I did not acknowledge other identities I hold and the many privileges that accompany them. Power dynamics between identities inevitably influence interviews, and vary not only on the intersecting identities of the participants, but also on the intersectional identities of myself as a researcher (Maxwell, Abrams, Zungu, & Mosavel, 2015). Among other privileges, I am a white, financially secure, temporarily able-bodied, cis- woman. These privileges could have come into play and exerted power over participants in the study in various ways depending on their own intersecting identities. However, all of the participants that were recruited for this study were also white women, which likely minimized the racial and gendered dynamics present in the interviews. The racial makeup of the participants could potentially be attributed to the racial disparities in research and academia in general in South Africa (“Why are there so few black professors in South Africa?,” 2014), the fact that many physicians who provide second-trimester TOP services in the country are European (Participant B, personal communication, April 12, 2019), and is likely also another consequence of using my family friend, who is also white, as a gatekeeper. I also believe that my identity as a woman potentially made me more

of an ‘insider’ in the research process (Maxwell et al. 2015), as many individuals who are involved in the field of reproductive healthcare provision and advocacy identify as women and may feel more comfortable sharing their perspective with an ‘insider.’ Due to similarities in major aspects of our identities, the notable identities that came into play between the participants and I during interviews seemed to be age and professional status, as previously mentioned. In speaking with giants in the field, I certainly felt my inexperience and youth during the majority of these interviews. This led to my capitulation on some questions that the participant did not seem interested in answering, and my general discomfort during the interview process. My intersecting identities as well as those of the participants inevitably influenced research dynamics and the lens through which I viewed the results, but by naming and acknowledging them, I hope that those dynamics and biases were in some way checked.

While research is inherently somewhat exploitative, and potentially even more so in this case given the structure of this short-term research project, I purposefully designed this project in order to ensure that participants could benefit in multiple ways from being involved. On a material level I offered to treat each participant to coffee or tea during the interview, although technological barriers and choice of meeting location prevented this offer from coming to fruition. However, I also believe that participating in this study was substantially beneficial to participants. First, being asked questions about how to address a demonstrated problem may have led participants to consider ways that they can take action themselves to make those suggestions a reality. Additionally, I consider this report to be a useful tool in gaining a comprehensive idea of how to move forward in regard to conscientious objection and TOP provision. I intend to

email or deliver a hard copy of the final report to each participant who requests it, and I anticipate that the participants will benefit from receiving the final project and seeing what their colleagues and peers recommend about the topic, potentially informing participants' work in the future. Ultimately, I believe that this report will be useful for the community I conducted the research in and positively "contribute to the lives of the participants" (Glesne, 2016, p. 2). As such, the deliberate design of this research intentionally addresses issues of reciprocity and the potential exploitation of participants.

As discussed, there were many ethical implications of the research I conducted. However, I believe that my ethical considerations in planning, conducting, and analyzing the research informed a deliberate structuring of the project that mitigated serious ethical concerns.

Research Findings and Analysis

This research project asks: how can one address the barriers to TOP access that arise from the right to conscientious objection in South Africa? Or, in other words, how can South Africa move forward within the realities of conflicting rights within TOP provision? Through this perspectives research endeavor, I found that there is broad consensus among key informants in the field on the barriers to access that exist in TOP provision, especially as they relate to conscientious objection. I argue that these key informants, despite their diverse backgrounds and angles from which they approach this work, offer similar recommendations that range from the need for clarified guidelines and government and facility accountability to an implied suggestion of rethinking service provision in terms of obligation rather than individual choice. While there

is some variation in the recommendations they offered to address conscientious objection in South Africa, there is consensus around the need for change on the part of many individuals involved in medical service provision in the country.

This section will detail the research findings alongside my own analysis to make for maximum clarity. While findings and discussion are usually kept separate in traditional research reports, I have chosen to integrate the findings and analysis sections in this report because of the myriad of issues within conscientious objection that are highlighted in this section. Rather than redescribe which issue or recommendation I am analyzing, I found it easier and clearer to give my analysis immediately following the presentation of an idea.

Participants

Two individuals who are key informants in the field of TOP rights, access, and provision participated in this research. As previously explained in the methodology section, each participant chose their own form of personal identification to allow for agency in how they are represented in the report, so there is some variety in how participants are identified throughout this section.

The first participant, Marijke Alblas, is a private TOP provider who is originally from Holland. She moved to South Africa with her South African husband once he returned to the country from exile, and in 2000 received funding from Holland to train South African nurses in TOP provision. However, Marijke explains that the extreme opposition that she faced from the very beginning of her time in South Africa compelled her funding to stop, after which she started working as an independent consultant. Over the past 18 years, Marijke has performed second-trimester TOPs as an independent consultant for government hospitals, clinics, and Marie Stopes, and currently has a contract with a hospital

in the Western Cape, a few hours outside Cape Town. She describes herself as a “traveling abortion doctor,” and is frequently the only physician who is willing to perform second-trimester TOP services in her area. Alongside direct TOP provision, Marijke also teaches occasional TOP courses to medical students (M. Alblas, personal communication, April 10, 2019).

The second participant is a female senior public health researcher at a higher education institution in the Cape Town area. Her work focuses on service provision and how to increase autonomy and access to TOP services. She will henceforth be referred to as Participant B in this report.

The participants of the study certainly informed the results of the project. Seeing as this is a perspectives research endeavor, the perspectives of the participants necessarily dictated the findings. I chose to work with these specific people, first due to their connections with a family friend, as previously discussed, but also because they are truly key informants in the field in which they work and are precisely the people I was hoping to speak with for this project. The senior researcher is a leading figure in the field of TOP research, and while she cautioned me that she does not consider herself to be a true key informant on the specific issue of conscientious objection, her general experience and the numerous encounters she has had with the issue of conscientious objection in her office are enough for me to consider her a key informant on this subject. I knew this individual would provide invaluable information on the subject and have concrete recommendations from her research in the field. Marijke, too, as a private TOP provider, has direct experience with conscientious objection in practice. She has worked at clinics and hospitals where conscientious objection is a major issue and establishes barriers to accessing care, and as such I

knew she would be able to provide recommendations from an on-the-ground perspective. I originally intended to also speak with an activist and a nurse, but time constraints and difficulty in accessing these individuals hindered this objective, making my findings much less diverse than I would have hoped for. And, as previously mentioned, the findings and argument resulting from them were necessarily influenced by my family friend because she served as the gatekeeper for participant recruitment. However, this influence was not inherently negative, as the connections to true key informants that I was able to access through her ultimately makes these findings more legitimate. The participants in this project truly are experts in their field, and from their direct experience with the subject area, the findings are likely more credible.

Barriers to Accessing Formal TOP Services

Before launching into the specifics of conscientious objection and participants' recommendations for addressing it, I thought it was important to get the participants' perspectives on the overall situation of TOP access in South Africa to provide context and rationale for the recommendations they would offer. Both participants highlighted multiple barriers to accessing formal TOP services in South Africa, paralleling existing literature and providing valuable context for understanding the situation regarding conscientious objection in the country.

Marijke explained these barriers to access from a medical perspective, focusing on inadequate support for nurses, lack of resources to meet demand, and the difficult circumstances of many of the individuals she has encountered in her practice. As previously mentioned, Marijke began her career in South Africa training nurses to provide TOP services. However, Marijke found that many of

the nurses she trained soon left the facility in which they were working, leaving the facility without sufficient staff resources to provide TOP services. These nurses move to facilities that are not designated to provide TOP services or not interested in doing so (M. Alblas, personal communication, April 10, 2019).

Marijke explained, “that is why many of the designated facilities are not doing [TOP] service; there just aren’t providers” (M. Alblas, personal communication, April 10, 2019).

Alongside this high turnover rate, Marijke has observed that there is inadequate support offered to nurses who do stay. In terms of logistics, Marijke said, “If the medical superintendent in the hospital or clinic is not supporting that service and not really helping you get the material that you need... if you don’t get any support in that, it just doesn’t work. You can’t continue” (M. Alblas, personal communication, April 10, 2019). Marijke also noted that nurses burn out not only from lack of administrative support, but also from lack of support from their colleagues. She discussed the toxic work environment that many nurses face because their “colleagues look at you and they say, ‘You’re a murderer’” (M. Alblas, personal communication, April 10, 2019). While Marijke does not face this kind of treatment because she holds a higher status as a doctor and does not work full time in a single hospital or clinic (M. Alblas, personal communication, April 10, 2019), she has noticed that nurses who provide TOP services often face so much hostility in the workplace that they chose to discontinue the service, decreasing the number of facilities that can offer TOP services and therefore reducing the accessibility for individuals seeking care.

I was especially intrigued by Marijke’s discussion on the effects support for nurses, or lack thereof, has on the accessibility of TOP services in South

Africa because it added a new layer of nuance to my own understanding of conscientious objection. In the literature review I highlighted how nurses are a substantial determinant in the incidence of conscientious objection in South Africa. While previous research and my own biases led me to assume that this was the case because of moral, personal, and religious factors, Marijke's statements on this topic made me consider the impact that work environments have on TOP accessibility. Perhaps more nurses would provide first-semester TOP services if they had the resources and professional support to do so. This reality reinforces the need for nuanced conversations around conscientious objection and a fuller interrogation of the reasons individuals claim conscientious objections in the first place before one can begin to address the practice. These findings about inadequate support for nurses in particular also highlight my argument about how widespread the transformation of conscientious objection must be in South Africa. Change can not only be on the part of the government, policymakers, or medical superintendents; it requires a fundamental change in workplace culture on the part of each individual involved in the healthcare sector.

As a provider, Marijke has also noticed that there are insufficient resources to meet the demand for TOP services in the area and that stigma and a lack of knowledge create situations in which individuals do not know where to access formal TOP services. To illustrate, Marijke explained that because she is getting older, she is only scheduled to provide second-trimester TOPs one day every other week. However, due to the demand for second-trimester TOPs, she has been going in every week and performing upwards of a dozen procedures a day (M. Alblas, personal communication, April 10, 2019). When asked why there is such a high demand for second-trimester TOPs, Marijke explained that many

individuals come late because they “don’t know where to go and it’s such a stigma that they’re scared to ask anyone, they’re scared to talk about it” (M. Alblas, personal communication, April 10, 2019). Stigma and a lack of knowledge about what resources exist, which in turn leads to high demand for later-gestation TOP services that is difficult for the few TOP providers to meet, coupled with inadequate structural support for nurses who are trained and willing to provide TOP services, were the main barriers to accessing TOP services from Marijke’s perspective.

While Marijke took a provider approach in describing barriers to access, Participant B highlighted a wide variety of barriers that she has come across during the course of her research. Participant B pointed to the logistical difficulties of accessing the formal sector for TOP services, hostile staff, stigma, and overworked providers as main barriers to accessing care in the formal sector. Participant B began by explaining that clinics or hospitals within the public sector often demand multiple visits and that for advanced gestations, individuals may be required to attend three or four appointments before they are able to obtain the TOP service (Participant B, personal communication, April 12, 2019). Participant B further expressed how, despite the long journey to actually accessing care, there is still uncertainty among patients about how hospital or clinic staff will behave towards them. She said, “From the moment you step in... to the moment you leave, I think women are concerned, especially young women, that they may face hostile and uncaring attitudes, and they probably will” (Participant B, personal communication, April 12, 2019). Beyond this stigma presented by staff at the clinic or hospital, many individuals also face the added stigma of their neighbors, family, and peers. Participant B explained,

There is a very high likelihood of seeing your neighbor or auntie or somebody related to you [at the clinic] and they will, especially if you're young and well, they will make a guess as to what it is you're there for which is usually difficult for many. (Participant B, personal communication, April 12, 2019)

Additionally, Participant B noted that TOP providers often get “burned out” because demand frequently requires that they work exclusively in this concentration but many get tired of doing the same procedure day in and day out (Participant B, personal communication, April 12, 2019). She expressed that “if everybody were doing it, it would be more diluted” (Participant B, personal communication, April 12, 2019), but as the situation stands now, TOP providers are often burned out and exhausted from the demand. While the two participants approached the topic from their distinct backgrounds, they both described a similar situation on the ground. High demand, inadequate structural support, logistical challenges, lack of knowledge, and stigma all converge to establish difficulty in accessing TOP services in South Africa. While this is only the perspective of two key informants, the information they offered is consistent with the findings of previous research and work on this subject. This consensus indicates that there is likely widespread homogeneity in the barriers individuals face in accessing TOP services, specifically in the Cape Town region.

Participant B, however, did highlight another component of TOP context that Marijke did not. Participant B explained that there are constant political attacks on the Choice on Termination of Pregnancy Act, expressing that “at any stage, the law is under threat. Various little efforts by anti-abortion policymakers... come up and they try to overturn the law in some way” (Participant B, personal communication, April 12, 2019). She argued that “the service is so vulnerable” and that, particularly for second-trimester services, “at

any stage it can suddenly not be available” (Participant B, personal communication, April 12, 2019). This information about recent anti-abortion legislative attacks, although Participant B was vague about the specifics of these political efforts, is important context to understand the situation surrounding the future of TOP access in the country.

While Marijke did not explicitly note this component of TOP context in her interview, I do not think that necessarily implies that the two participants disagree on this particular element within the field of TOP access. Rather, I think it is instead a reflection on the varying backgrounds of the two participants. Marijke is focused on the day-to-day provision of TOP, and while that grants her a valuable perspective on the inner-workings and realities of facility management and service provision, it means that she may not be as focused on political attempts to curtail TOP services and therefore did not take this aspect into consideration when she was describing barriers to TOP access. Participant B, on the other hand, does research to get a comprehensive view of the situation, necessitating that she look at all angles of attacks on access, whether that be on the facility or political level. As such, it makes sense that she noted the recent legislative efforts to overturn the CTOPA while Marijke did not. There will always be future threats to access, and while it is important that there are people and activists working to fight off those threats, in the meantime it is imperative that there are also individuals who continue to focus on current provision. The two participants of this study come from the two different sides of this work, and their responses, while similar in many ways, reflect that variation.

Finally, both participants noted that these barriers to accessing TOP services in the formal sector can often lead individuals to search for TOP services

in the informal or unregulated sector. Marijke explained that because the stigma surrounding TOP means that nobody talks about it, “Women see these advertisements [for unregulated abortions] and they don’t even know their own clinic is providing this service. Never in these clinics or hospitals do you see any signs saying ‘we are performing abortion.’ You have to ask” (M. Alblas, personal communication, April 10, 2019). This lack of knowledge caused by stigma leads individuals to turn to the informal sector for TOP services. Participant B also expressed that it is “not surprising” that there is so much interest in the informal market despite the legality of TOP (Participant B, personal communication, April 12, 2019). While more expensive, Participant B explained that with the logistical difficulties and fear of hostile treatment in the formal sector, “it’s much easier and quicker... to just go and get some pills... With the fairly ready availability of misoprostol and its efficacy... I think there’s a market” (Participant B, personal communication, April 12, 2019). From their discussions on the appeal of the informal sector for TOP services, both participants highlighted the very real effects barriers to accessing TOP services can have on individuals searching for this care.

In their interviews, both participants detailed various barriers to accessing TOP services that they have encountered both directly and indirectly in their work. Marijke took a more medical, first-hand perspective to the topic while Participant B emphasized a wide range of barriers that she had come across in her research. Despite their differences in background, it seems as though only a single major element was distinct between the two responses, and even that difference was likely only a result of their perspectives and priorities, not their beliefs. In fact, there were many similarities and consensus among the two

participants. They explained how hostile environments, stigma, high demand for services, and lack of information all lead to inaccessible formal TOP services and an increased appeal of informal and unregulated services. As this understanding also aligns with the previous work that has been done in the field, I argue that there is true and broad consensus among key informants in the field on the barriers to accessing TOP services in South Africa – barriers that are exacerbated by the practice of conscientious objection.

Conscientious Objection in Practice

Many of the barriers to accessing TOP services that the participants highlighted stem from the practice of conscientious objection and the resulting lack of service providers. Participant B defined conscientious objection simply as a “provider refusing to provide on the basis of their conscience, whatever that might be” (Participant B, personal communication, April 12, 2019). In both the field and research endeavors, the two participants have observed the unregulated and widespread use of conscientious objection – use that often tangibly reduces access to TOP services.

Marijke has noticed in her years as a provider that conscientious objection is not handled properly. She explains that providers should be required to have an official conversation with the medical superintendent about why they do not want to be involved in TOP services and then sign a document that reflects that. However, Marijke notes “that is not happening at all. As far as I know, they just say ‘No, I don’t want to do it,’” explaining that “officially there are [regulations] but no one sticks to that” (M. Alblas, personal communication, April 10, 2019). This sentiment echoes previous research done on conscientious objection. As the literature review explored, there are commonly accepted guidelines and

regulations surrounding how conscientious objection should be used and by whom, but these regulations are almost never adhered to, and there is no method of accountability or enforcement. Additionally, Marijke has also noticed that there is a status quo in many hospitals in regard to providing TOP services that can be very difficult for a single person to change. She explained that often there is “an attitude of ‘no, we don’t do that here’... so everyone new coming in is immediately being told about this. You have really to stick out your neck to say ‘I don’t care what you people say, I am willing to do that’” (M. Alblas, personal communication, April 10, 2019). This situation is directly related to the toxic work environments and lack of support that Marijke highlighted in her discussion about nurses. When the norm in a facility is to claim a conscientious objection to TOP provision, not only are there no material resources present for TOP services, but there are also hostile colleagues and superiors to contend with. As Marijke explains, it takes considerable courage and strength to stand up to such formidable obstacles.

Marijke also went into detail about why she believes the situation regarding conscientious objection is so widespread. She expressed that there is “no effort really, to improve things. It gets very little attention” (M. Alblas, personal communication, April 10, 2019), and when I pushed her to expand on who exactly is not putting in the effort, she explained that there is no effort on the part of both the government and medical superintendents. For one, Marijke said that the current Minister of Health in South Africa is “not pro-abortion at all” (M. Alblas, personal communication, April 10, 2019) and is silent on the problems facing TOP accessibility. She also described how the government does not exert control over its public hospitals or clinics, explaining that “those hospitals that

are designated are not being pushed to do it” (M. Alblas, personal communication, April 10, 2019). Furthermore, Marijke highlighted the role of individual medical superintendents in determining the application of conscientious objection. She said, “There are medical superintendents that say ‘No, no, not in my hospital!’ They don’t want that service in their hospital. It’s not their bloody hospital, it’s a government hospital! They just have a job there. But no one is correcting them” (M. Alblas, personal communication, April 10, 2019). From this individual discretion on the part of medical superintendents – and the authority they exert over what takes place at ‘their’ hospital – and the inaction of government officials and offices to hold public hospitals and clinics accountable, conscientious objection goes unregulated.

This framing of the role of authority, specifically medical superintendents, in permitting and even encouraging the widespread misuse of conscientious objection is one that I did not encounter in existing literature. Most of work that has been done on conscientious objection has noted the lack of accountability on the part of the government to encourage facilities to fulfill their obligations and provide the services that they have been designated to provide, but I did not come across any information on the role that medical superintendents play while I was completing my literature review. However, Marijke highlighted the unilateral power and authority of medical superintendents and their self-imposed gatekeeping as a major factor in determining how conscientious objection is used. With so much individual discretion and little to no accountability for how that discretion is used, conscientious objection becomes practically ungovernable. The role that medical superintendents and facility managers play in this structure seems to have been overlooked in much of the existing literature, a major

oversight given the weight Marijke gave to it in her interview and the seemingly significant impact it has on how conscientious objection is used in practice.

This culture of conscientious objection and the pervasiveness of the practice has tangible effects on access to TOP services. Marijke described one situation she experienced recently that clearly illustrates these effects on TOP access. Last year, Marijke was out of the country for five weeks and the hospital she is currently contracted to refused to hire another independent contractor while she was away. Because there were not any other doctors in the hospital willing to perform TOP procedures, individuals looking for TOP services were forced to either wait for her return or find a way to get to Cape Town for the service. As the sole second-trimester TOP provider in the area in which she works, she explains, “when I am not there, no one takes over... they can refer them to Cape Town but the women don’t come there. It’s too complicated for them” (M. Alblas, personal communication, April 10, 2019). This situation illustrates how with so few doctors and nurses providing TOP services due to the allowances of conscientious objection, it becomes extremely difficult for individuals to access the care they need.

Participant B, too, asserted similar issues with conscientious objection related to a lack of regulation and difficulty in pushing against the status quo. While Participant B explicitly named that she does not consider herself to be an expert on the specific issue of conscientious objection, she cited other research that she has engaged with that details the realities of how conscientious objection is used in practice. She explained that conscientious objection is for the most part unregulated and that “workarounds are permitted by the highest authorities,” later elaborating that “workarounds result in a default position of refusing to be

involved. Not even as strongly as refusing, just turning your back” (Participant B, personal communication, April 12, 2019). Participant B also detailed how hierarchical hospitals and clinics often are, and that “if those in a higher authority or status position above you as a healthcare worker are doing that [objecting], it’s so hard to address it within the workplace” (Participant B, personal communication, April 12, 2019). This sentiment about the difficulty of changing the status quo – a status quo that so often involves conscientious objection and ‘turning your back’ – reflects Marijke’s personal experience with encountering conscientious objection in a medical setting.

Both participants offered similar claims on how conscientious objection is used, or rather misused, in practice. As an unregulated practice within rigid status quos and no effort on the part of government or healthcare officials to change the situation – and even sometimes active participation in blocking service provision and allowing workarounds – conscientious objection has tangible effects on the accessibility of TOP services. Again, I observe a clear pattern of consensus in the field around the misuse of conscientious objection. The one major distinction I see is the emphasis that the two participants placed on the role of authority in determining the prevalence of conscientious objection as opposed to the relative silence on the topic in existing literature. Beyond that small divergence, however, I argue that there is general consensus among key informants on the misuse of conscientious objection and the barriers to accessing TOP services that result – barriers that will require transformation on multiple fronts to begin to address.

Recommendations for Addressing Conscientious Objection

Both participants offered multiple substantial recommendations for how to address the barriers to accessing TOP services that emerge from the practice of

conscientious objection. These recommendations range from policy reform to fundamental changes in the way in which the public perceives TOP in general. Despite the diverse angles that the participants approach the field from, the recommendations they offered overlapped in many ways and I see general agreement among them about the need for transformation on multiple fronts.

Marijke offered a wide variety of recommendations for addressing barriers to TOP access and conscientious objection in South Africa. First, she asserted that TOP in general should be much more in the public conscience and less stigmatized. She expressed that people “should read about it in newspapers, in magazines, on television,” clarifying that it should be in a “positive way” because at the moment, almost every mention of TOP in the media is negative (M. Alblas, personal communication, April 10, 2019). She mentioned that there has already been some movement in this direction, specifically noting the public protests organized by activist organizations like the Sexual and Reproductive Justice Coalition that bring TOP to the public’s attention. However, Marijke emphasized that this movement should focus on abortion specifically and not necessarily address other related subjects (M. Alblas, personal communication, April 10, 2019). This comment stood out to me, as much of the work that I do in the United States in the field of reproductive justice is built around trying to demonstrate the connections between reproductive rights and healthcare and other important social justice issues such as racial justice, economic justice, sex workers’ rights, immigrant rights, LGBTQ+ rights, etc. My first reaction to Marijke’s comment was to immediately label Marijke as a ‘white feminist,’ or someone who does not acknowledge or do work around the intersections of feminism/reproductive rights. While I certainly disagree with Marijke in thinking

that it is beneficial, or even possible, to separate the abortion debate from other related issues, I do not think it discounts the important work that she does in the field. It is possible to hold two truths at one time – Marijke can be doing good work while also being exclusive in her conception of the work. Marijke explained her thinking, however, expressing that TOP is “such a difficult topic. There’s so much resistance. So you must really work on a strategy and focus on that and not have other things come in as well” (M. Alblas, personal communication, April 10, 2019). I also find it notable that while Marijke comes from a highly medical background and spoke from a medical perspective for most of the interview, she chose to focus on public perception as her main outlet for possible change. However, I can imagine that Marijke has seen so much harm come from the stigma associated with TOP in her practice that in her recommendations she prioritized breaking down stigma as an important first step to address barriers to TOP access.

Marijke also suggested concrete changes that would come from the government level. She explained, “I think if you have a government that is really willing to help and do something for its citizens, they really should push hospitals and the clinics that are designated to do this service... to do it, really” (M. Alblas, personal communication, April 10, 2019). Marijke is looking for accountability on the part of the government to hold the hospitals and clinics that it oversees responsible for their obligations. Marijke also suggested that the government offer incentives to nurses to perform TOP services (M. Alblas, personal communication, April 10, 2019). She explained that TOP service provision is an extra skill that nurses have to learn so they should be rewarded for it, and also that “if you give this extra attention and are willing to pay a bit for it, you can get

them [to provide TOP services]” (M. Alblas, personal communication, April 10, 2019). This recommendation is one that I have not come across in previous research and is highly intriguing to me, as it would target individuals who may not be vehemently opposed to offering TOP services, but feel indifferent and want to conform with the status quo previously noted. It seems to me that an incentive program would address providers’ fears of breaking the hierarchy and status quo by giving them an impersonal justification that they can use in the face of hostile coworkers. Such a program would also address the deficit of nurses and providers who are willing to provide TOP services, thereby making services more accessible to individuals in the area. Ultimately, this recommendation would make reality one of the major provisions of the Choice on Termination of Pregnancy Act. As I noted in the literature review, the CTOPA provided for nurses and midwives to perform first-trimester TOP services with the explicit intention of increasing the accessibility of TOP services, particularly in the public sector. The unfortunate reality has been that nurses and midwives do not feel supported in many ways to be able to actually provide TOP services. However, an incentive program like what Marijke has suggested would drastically alter that situation and work towards fulfilling this major element of the legislation.

Marijke also recommended tougher guidelines for the process of claiming conscientious objection. She said, “I think if you make it less easy for them. I don’t know exactly how to do that, but it’s not like just saying no, no, no.... There must be a form that they have to sign” (M. Alblas, personal communication, April 10, 2019). She noted that she has a hunch that some of the doctors who claim conscientious objection in government hospitals turn around and “do it in their private practice for money” (M. Alblas, personal

communication, April 10, 2019). While she does not have any concrete examples of that happening, she is confident that it does, and so aimed this recommendation at rectifying that hypocrisy. I agree that a more difficult process for claiming conscientious objection would be beneficial in multiple ways. An official form would force providers to go out of their way to conscientiously object, hopefully compelling individuals who do not have a true moral or religious objection but object out of convenience or conformity to refrain from doing so. Such a form may also dissuade the hypocrisy of not performing TOP services in government facilities but doing so for private financial gain, as it would be on record that a provider is a conscientious objector. Additionally, I would hope that if a facility has a defined list of the providers who will not provide TOP services, rather than just having individuals claim conscientious objections in the moment, they can adjust their staff and hiring practices to account for the deficit of TOP providers.

Additionally, Marijke offered two final suggestions for regulating the practice of conscientious objection. For one, Marijke expressed that providers should only be able to claim conscientious objection in certain circumstances. She argued that conscientious objection to TOP services should not be allowed in cases of rape or incest, but that in “other cases you can refuse to do it yourself but then you must organize... that someone else is doing it. You can’t just say ‘No I’m not doing it’ and just leave it... You must find a solution for the girl” (M. Alblas, personal communication, April 10, 2019). I personally think that this sort of conditional policy can get a little dodgy. My main issue with it is that it legitimizes some abortions over others. I strongly believe that every individual decision to have an abortion, no matter what the reason, is legitimate and should

be respected. Inherent in Marijke's recommendation, and the many policies around the world that make special allowances for rape or incest, is that abortions are only legitimate and moral if the cause of the pregnancy is immoral. From my background of work in the United States, I simply do not agree with this sentiment. I do agree with Marijke that providers should only be able to claim conscientious objection in certain circumstances, but I believe that those circumstances are situations in which there is a readily available, easily accessible other option for TOP services that does not involve any obstacles to care, not circumstances that aim to assert a moral judgement on the legitimacy of an abortion.

Secondly, Marijke detailed a final recommendation about regulating conscientious objection, specifically as it relates to the role of medical superintendents. She expressed that there must be a specific policy for the medical superintendents that says that they "cannot refuse at all. Not that they have to do the abortions, but they must organize that it is happening in their facility," going on to further say, "No one should be able to say, 'Not in my hospital'" (M. Alblas, personal communication, April 10, 2019). I believe that this sort of top-down approach to addressing the issue, while not the end-all-be-all of solutions, is another important step towards addressing the role of authority in conscientious objection.

I would also argue that Marijke offered another indirect recommendation. I chose not to integrate into the rest of her suggestions because I want to respect that she herself did not identify it as a recommendation, but I interpret it as such. Every year, Marijke teaches a guest lecture for local medical students on TOP provision that acts as an introduction to the specialty (M. Alblas, personal

communication, April 10, 2019). While Marijke did not explain her work with medical students in terms of a possible solution for the barriers to access caused by conscientious objection, I see that work as an immediate and direct intervention into the lack of willing TOP providers. Of course not all of the medical students that she reaches will decide to become TOP providers, but she may inspire one or two to choose not to claim a conscientious objection in their future practice. I consider this form of direct intervention vital to at least in part address conscientious objection by increasing the number of willing providers in the country. The reality is that government action and the transformation of healthcare culture is not going to happen overnight, and in the meantime South Africa needs immediate solutions to increase access to TOP services. I acknowledge that I am a Westerner and that claiming to know what South Africa ‘needs’ is a recipe for neocolonial ideologies and actions. However, in my research and throughout this interview process, almost everyone – including many South Africans, albeit mostly white South Africans – have agreed that the conscientious objection situation in the country requires substantial change. This statement is therefore a combination of my own opinion that I have formed during the course of this project and the perspectives of my participants who live and work in this context. Marijke’s work with aspiring physicians may be short-term, individual, and limited in scope, but I believe that direct intervention like this is an important component of creating substantial change in the country.

Participant B also highlighted a similar sentiment. She, like Marijke, argued, “there’s no will on all the various levels where will is required to address it,” but,

There are a number of key role players in the country, dedicated individuals at certain levels who do what they can in their own small way to try to broaden the awareness of

healthcare providers, doctors in training, registrars in training, some medical students... I think there are small efforts made, and it makes a difference. (Participant B, personal communication, April 12, 2019)

From this, I gather that while individuals and organizations are pushing for substantial change on the part of the government and facilities, many people acknowledge that there needs to be transformation on an individual level, too. After all, “even one person can change the atmosphere at a clinic” (M. Alblas, personal communication, April 10, 2019).

Participant B offered similar recommendations for addressing conscientious objection to Marijke, albeit from a more secondary position. During this part of the interview, Participant B reminded me again that she does not consider herself an expert on this particular aspect of TOP rights and access. However, she did cite recommendations offered by her colleague, Professor Jane Harries, who has done significant work on this topic and other research she has read and engaged with. On a foundational level, Participant B expressed, “Obviously what needs to be done is what Prof. Harries suggests in her paper, is that conscientious objection needs to be clarified, regulated, and particularly for OBGYNs, personally I don’t think it should be allowed,” further expanding that she recognizes that such a requirement “might lead to problems, but that’s the field you chose. If you’re choosing to specialize, this is part of the deal” (Participant B, personal communication, April 12, 2019).

There was consensus on this hardline sentiment between both participants, as they seemed to agree that TOP provision is not entirely a matter of individual choice. Participant B argued that if you have decided to be a doctor, you are obligated to perform the medical procedures that your patients are asking for, and that your individual choice is overridden by your decision to enter a

profession that performs services for other people and includes this procedure. Marijke had a slightly more complicated argument. She argued that “it should be an individual decision that you’re not willing to perform abortions in general,” but she often tells her medical students, “I know that not everyone is in favor of abortion, but you are going to be a doctor and you’re supposed to be able to do it. There are situations that you have to do it, so you have to learn it” (M. Alblas, personal communication, April 10, 2019). Marijke’s argument seems to be getting at the emergency provision component of the common understanding of conscientious objection that was addressed in the literature review. While this argument is slightly more narrow than that offered by Participant B, I gather that Marijke believes that individual choice is not the only consideration at hand – there is also a professional obligation to provide TOP services, at least in emergency situations. Both participants seemed to be working from the same baseline assumption that conscientious objection is more than a matter of individual choice, albeit in their own ways.

This general consensus about conscientious objection involving more than merely individual choice offers an interesting, although indirect, response to my hypothesis. Before conducting the research for this project, I anticipated that participants would highlight the need for a new framework to conceptualize conscientious objection and the right to freedom of conscience in a way that focuses more on structural access rather than individual rights. My question directed at this idea of a new framework was somewhat rebuffed during the interview, as I think the way I framed the question to participants was leading based on my own perception of the situation and did not reflect their own conceptions of the topic. However, I argue that through these discussions about

going beyond individual choice, participants did in fact offer ideas about what could be considered a new ‘framework.’ Both participants suggested moving the conversation away from choice to obligation. In other words, once an individual has chosen to be a doctor, there are certain obligations and responsibilities that accompany that profession, including ‘do no harm.’ If a healthcare worker denies TOP care to an individual who cannot otherwise access that care, they are doing harm and therefore going against a basic tenet of physicians’ duties. I believe that this new ‘framework’ is especially valuable in thinking about the conflicting constitutional rights to freedom of conscience and access to reproductive healthcare. If the right to freedom of conscience can be understood of as not absolute in the face of professional obligations, then the practice of conscientious objection in TOP service provision is no longer a concern. As such, this conception of obligation rather than choice that both participants suggested in their own way is a beneficial approach to addressing the widespread practice of conscientious objection. While participants did not describe this as a new framework per se, I see it as such, and I think it is a valuable way to conceptualize conscientious objection and a potential way to address the conflicting rights involved.

Furthermore, Participant B also offered some general suggestions on how to address TOP access through official guidelines and enforcement. Participant B did not approach recommendations to conscientious objection from a policy perspective because she is “not a legal person and operates and does research at facility level,” but for her “that [the facility] is where the problem lies” (Participant B, personal communication, April 12, 2019). She expressed,

I think the law is okay as it stands. I think there should be a national level with provincial guidelines – official, they should be formulated and I don’t think they are. I

think they're still kind of just hovering, all these years later. Then there needs to be facility manager at clinics and department manager at hospitals enforcement of process as per guideline. (Participant B, personal communication, April 12, 2019)

This statement hits on two major themes: the strength of the CTOPA in theory and the lack of official procedural guidelines and enforcement in practice. Participant B's assertion about the strength of the CTOPA reflects the information offered in the literature review. The power of the legislation and the constitutional rights behind it are sound; access is a matter of how those laws are implemented and carried out in practice. Participant B also echoed the recommendations of Marijke when she noted the need for official guidelines and enforcement of those guidelines from facility managers and superintendents. These guidelines, while seemingly basic, are fundamental to achieving the legitimate, principled, and unified use of conscientious objection throughout the country and are widely agreed upon as essential by these two participants as well as the majority of the field.

Clearly, there were a wide variety of recommendations offered by the two participants of this study. Transforming public perceptions, establishing incentive programs for nurses, ensuring government accountability and enforcement, creating and clarifying official regulations, standardizing the role of authority in healthcare facilities, supporting individual efforts, and emphasizing a new 'framework' of obligation rather than individual choice were all highlighted as possible ways to address the demonstrated barriers to TOP services that arise from the widespread misuse of conscientious objection. There was significant overlap between the recommendations offered by the participants, which is notable given the diverse backgrounds of the two participants, yet may not be as remarkable given the echo-chamber and possibility for a singular narrative that I

discussed in regard to how these participants were recruited. However, the participants come from entirely different domains of the field of reproductive healthcare and therefore approach the work from unique angles, but they nonetheless identified similar circumstances under which conscientious objection occurs and recommendations for addressing those realities. While this study only worked with two participants and therefore cannot claim to offer conclusive findings about the field as a whole, such a pattern remains noteworthy as it may imply that, despite small variations, there is consensus in the field around the need for comprehensive and far-reaching transformation.

Conclusion

This project aimed to provide a general overview of the situation regarding conscientious objection in South Africa and foster action-oriented thinking on the topic by compiling as much of a comprehensive collection of recommendations for how to address conscientious objection as possible, based on literature and two interviews with key informants. I believe this project was successful on both fronts. From the literature review and context-setting interview questions, I situated the need for this project into the demonstrated barriers to TOP access that arise from the practice of conscientious objection. I then investigated the perspectives of key informants to provide a slew of recommendations for how to address this situation. I set out to conduct this research because of my own interests and work on abortion rights and access in the United States, but also to connect diverse perspectives in the field, and in this aspect I think I was also successful. Despite ultimately only recruiting two participants for this project, I was able to tap into the expertise of true key

informants in the field of reproductive healthcare service provision and research in Cape Town to compile information that I believe, when compared to the existing literature and research on the subject, is representative of the opinions of the majority of the field.

Barriers to accessing abortion services can emerge in many different ways. In South Africa, the conflict between the constitutional right to freedom of conscience and the right to access reproductive healthcare, as well as unclarified guidelines within the Choice on Termination of Pregnancy Act leaves the practice of conscientious objection unregulated and abused, thereby forming many barriers to accessing care. Conscientious objection establishes hostile work environments, an antagonistic status quo, and a shortage of providers willing to offer TOP services, reducing the availability of services and driving individuals to turn to the unregulated and oftentimes dangerous informal sector for TOP services. As South Africa faces a unique dilemma based on its unparalleled network of rights and seemingly progressive laws, the situation regarding conscientious objection requires unique solutions. Fortunately, the many recommendations offered by the two participants in this study confirmed my de facto hypothesis and suggest that there are no shortage of paths forward. Ranging from changing public perception, to formulating and enforcing concrete guidelines, to establishing a new ‘framework’ that emphasizes professional obligation over individual choice, these recommendations highlight the need for fundamental transformation on multiple levels.

This transformation is not straightforward, nor will it be easy. It will require the concentrated efforts of hospital staff, facility authorities, government officials, key individual activists and providers, and the public more broadly to

fundamentally change hostile workplace cultures, stigma, and the lack of will to support providers and enforce guidelines for conscientious objection. However, this transformation is essential for fulfilling basic tenets of freedom and human rights in South Africa. Access to TOP services cannot be isolated from a broader context of rights; access to reproductive healthcare, including TOP services, is vital to realizing a wide array of economic, social, and political rights. Access to TOP services allows individuals to better control their family, their relationships, their economic situation, their health, their professional life, their safety, and their own personal fulfillment. As such, TOP and the way that conscientious objection affects the availability of services is not a situation that can be viewed in isolation. When access to TOP services are at stake, so too are the promises of human rights in South Africa. This reality has dire implications for the citizens of South Africa and the country as a whole. Conscientious objection needs to be addressed immediately and on multiple fronts in order to secure the rights so progressively guaranteed after 1994.

Recommendations for Future Study

I see an opportunity to conduct further research on the perspectives of individuals who have chosen to claim conscientious objection to interrogate how they believe conscientious objection should be used in practice and addressed, if at all. While such participants may be difficult to recruit, they could provide valuable insight into the widespread use of conscientious objection in South Africa and highlight the ways in which conscientious objection may be conceptualized in different ways. I also see immense opportunity to take the foundation of this research and expand it to widely investigate the perspectives of a more diverse group of key informants. I believe that if the original intention of

this project were to be fulfilled by recruiting a wide variety of direct service providers, nurses, researchers, and activists, the recommendations offered would be stronger and the value of the project greater.

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Appendix A

Interview Questions

- Before we begin, I want to check to see if you had a chance to read over the informed consent form and ask if you have any questions?
 - How would you like to be identified in the final report?
 - Do you consent to being audio-recorded?
 - Do you consent to be quoted in the final report or presentation?
- Can you tell me a little bit about the position you hold and the work you do?
- How did you get into doing this kind of work?
- Legally South Africa has one of the most progressive TOP legislation, and yet there is a massive market for unregulated abortions (stickers on trains). Why do you think that is?
- It also seems that there is a conflict between the right to reproductive healthcare, and the right to freedom of conscience. How do you see that play out? / What do you think about that?
- How do you define conscientious objection, specifically as it relates to TOP?
- What do you think the impact of conscientious objection is on individuals trying to access TOP services?
- How do you think the barriers to TOP access in South Africa can be addressed?
- What specific policy changes would expand access to TOP services in South Africa?
- How would you reframe the concept of conscientious objection to increase access to abortion services?
- What other suggestions or recommendations do you have for addressing the practice of conscientious objection and the barriers to access that it raises?
- Is there anything I haven't asked that you think I need to know / take into consideration?

Appendix B

Informed Consent Form

The following is a copy of the informed consent form that each participant was asked to read in full and consent to before the interview began. Due to technological influences, there was a variety of ways in which participants gave their consent to this form. One participant gave verbal consent while the other signed a physical copy of the form.

Tentative title of the Study: Where Do We Go From Here?: Key Informants' Perspectives on How to Address Conscientious Objection in TOP Provision

Researcher Name: Talia Parker

My name is Talia Parker. I am a student with the SIT South Africa: Multiculturalism and Human Rights program.

I would like to invite you to participate in a study I am conducting as part of the SIT Study Abroad program in Cape Town. Your participation is voluntary. Please read the information below, and ask questions about anything you do not understand, before deciding whether to participate. If you decide to participate, you will be asked to sign this form and you will be given a copy of this form.

PURPOSE OF THE STUDY

The purpose of this study is to compile a comprehensive collection of suggestions and recommendations for how to address conscientious objection in the provision of termination of pregnancy (TOP) services.

STUDY PROCEDURES

Your participation will consist of a single interview that will last approximately one hour of your time. I will ask you a series of questions related to the research topic. The interview will take place at a location most convenient to you, whether that be your place of work or a coffee shop. You will be audio-recorded if consent is clearly given, but participation in this study is not contingent on audio-recording consent.

POTENTIAL RISKS AND DISCOMFORTS

There are no foreseeable risks to participating in this study and no penalties should you choose not to participate; participation is voluntary. During the interview you have the right not to answer any questions or to discontinue participation at any time.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

I have purposefully designed this project in order to facilitate multiple potential benefits for participants. On a material level I will offer to treat you to coffee or tea during the interview, but I believe that participating in this study will also be substantially beneficial to you. First, being asked questions about how to address a demonstrated problem may lead you to consider ways that you can take action yourself. Additionally, this study will hopefully be a useful tool to gain a

comprehensive idea of how to move forward in regard to conscientious objection and termination of pregnancy. I intend to email or deliver a hard copy of the final report to each participant who requests it, and I anticipate that you may benefit from receiving the final report and seeing what your colleagues and peers recommend about the topic. Ultimately, I believe that the final report has the potential to inform your work in the future.

PAYMENT/COMPENSATION FOR PARTICIPATION

You will be treated to coffee or tea during the interview, but beyond that you will not receive payment or any other form of compensation.

CONFIDENTIALITY

Any identifiable information obtained in connection with this study will remain confidential. I will store the data that I collect on my personal computer that is only accessible with a private passcode. The raw data (i.e. audio-recordings and notes) will be erased after the report is completed, and will not be used for any future research or be accessible online. When the results of the research are published, I will identify you as you wish to be identified, whether that be with a pseudonym, limited identifiable information, or your full personal information.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

I have read the above and I understand its contents and I agree to participate in the study. I acknowledge that I am 18 years of age or older.

Participant's signature _____ Date _____

Researcher's signature _____ Date _____

Consent to Use Identifiable Personal Information

There are various ways you can choose to be identified in the final report. You may wish to use a pseudonym to protect your anonymity, use full identifiable information, or a combination thereof.

Initial one of the following to indicate your choice, and include any further directions for implementation:

_____ (initial) I agree to use identifiable personal information in the final report.

_____ (initial) I do not agree to use identifiable personal information in the final report.

Further instructions:

Consent to Quote from Interview

I may wish to quote from the interview either in the presentations or report resulting from this work.

Initial one of the following to indicate your choice:

_____ (initial) I agree to be quoted in the presentation or report.

_____ (initial) I do not agree to be quoted in the presentation or report.

Consent to Audio-Record Interview

I would like to audio-record the interview in order to more easily and accurately collect data.

Initial one of the following to indicate your choice:

_____ (initial) I agree to be audio-recorded during this interview.

_____ (initial) I do not agree to be audio-recorded during this interview.

RESEARCHER'S CONTACT INFORMATION

If you have any questions or want to get more information about this study, please contact me at talielizabeth@gmail.com or my advisor, Emma Arogundade, at emma.arogundade@sit.edu

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

In an endeavor to uphold the ethical standards of all SIT proposals, this study has been reviewed and approved by an SIT Study Abroad Local Review Board or SIT Institutional Review Board. If you have questions, concerns, or complaints about your rights as a research participant or the research in general and are unable to contact the researcher please contact the Institutional Review Board at:

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