BRIEFING

Barriers to Safe and Legal Abortion in South Africa

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The South African Government's Human Rights Obligation to Ensure Access to Safe and Legal Abortion Services

ACCESS TO SAFE AND LEGAL ABORTION SAVES LIVES

The World Health Organisation (WHO) is clear that access to safe abortion is a key step for avoiding maternal deaths and injuries.[1] In contrast, restrictive access to abortion services violates numerous human rights, including the right to life, health, privacy, and to be free from discrimination, torture and ill-treatment.

Abortion has been legal in South Africa for almost twenty years. The Choice on Termination of Pregnancy Act (CTOPA) (1996), gives women and girls the right to have an abortion on request up until the 12th week of pregnancy and with certain conditions before the 20th week. This legislation has been credited for advancing women's health and rights.[2] Abortion related deaths and injuries are estimated to have reduced by over 90% since the CTOPA came into force.[3]

Despite the progressive legal framework, many women and girls - especially those in the poorest and most marginalised communities - are still struggling to access safe abortion services. A recent expert review of maternal deaths has indicated growing concern that the lives of pregnant women and girls are put at unnecessary risk due to barriers to abortion services, which are legal and available.[4]

1. World Health Organization (WHO), Safe Abortion: Technical and Policy Guidance for Health Systems, 2012, pp. 23, 47-49. The WHO defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both (Hereafter WHO 2012).
2. R Jewkes, H Rees *SAMJ* Vol 95, No 4 (2005) Dramatic decline in abortion mortality due to the Choice on Termination of Pregnancy Act.
3. Ibid. The CTOPA 92 of 1996 was amended by Choice on Termination of Pregnancy Amendment Act 1 of 2008 from 18 Feb 2008: Section 1, 3, 7-10; the Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007 from 16 Dec 2007: Section 1; the Choice on Termination of Pregnancy Amendment Act 38 of 2004 from 11 Feb 2005: Section 1, 3, 7-10 see further http://www.gov.za/documents/choice-termination-pregnancy-act accessed 1 December 2016.
4. National Committee for Confidential Enquiry into Maternal Deaths, Saving Mothers 2011-2013: Sixth report on confidential enquiries into maternal deaths in South Africa Short report (2014)

This briefing focuses on South Africa's human rights commitments, which place clear obligations on the government to safeguard women and girls' access to safe abortion care.[5] It discusses three key barriers, in policies and practice, to safe abortion services:

- **The failure to regulate conscientious objection;**
- **Inequalities in access to services for women and girls from poor and marginalised communities;**
- **Lack of access to information on sexual and reproductive rights, including how and where to access legal abortion services.**

Women and girls who are unable to access safe and legal abortion care, because or in part of these barriers, may be compelled to seek unsafe alternatives.

METHODOLOGY

This briefing is based on desktop and qualitative research from Amnesty International and The Women's Health Research Unit, School of Public Health and Family Medicine at the University of Cape Town.[6]

On 29 September 2016 Amnesty International wrote to the South African Minister of Health and the National Department of Health requesting further information in relation to the barriers to safe abortion and the related government programmes and policies in place to implement the CTOPA. Information received in reply on 3 November is reflected in this briefing. The National Department of Health emphasized that the provision of termination of pregnancy services in South Africa is part of the provision of comprehensive sexual and reproductive health and rights.

This briefing draws on guidance from human rights bodies, including the Technical Guidance on Reducing Preventable Maternal Mortality and Morbidity developed by the Office of the United Nations High Commissioner for Human Rights (OHCHR), which has urged States parties (where abortion is legal) to include authoritative public health guidelines on access to safe abortion to which universal access should be effectively ensured in the national plan – as essential for improving maternal health. This briefing makes a number of recommendations in relation to addressing the identified barriers to safe abortion, to support South Africa's full compliance with its human rights obligations.

5. The World Health Organisation advises governments that they have an obligation to 'ensure that every woman who is legally eligible has ready access to safe abortion care.' WHO 2012, pages 9, 87 and 98.
6. The Women's Health Research Unit would like to acknowledge the funding they received from the South African Medical Research Council for some of the research on which their input to this Briefing is based.

THE NEED FOR SAFE AND LEGAL ABORTION SERVICES

The untimely death of a 19 year old student in Johannesburg in 2016, following complications due to an unsafe abortion, highlights the urgent need for action to address barriers to abortion services. Speaking at the United Nations in April 2016, the Representative for South Africa cited health systems deficiencies, stigma and discrimination as impacting the student's access to safe abortion services.

> **"[She] was a poor student, who could not access private health care. There was insufficient information available of the [abortion] services that she could access at public health care facilities and there is also some speculation that she may have been afraid of the attitudes of the public health care workers based on the experiences of some of her friends."[7]**

Choosing to have an abortion is a personal decision based on women and girls' individual social or economic life circumstances. High rates of sexual violence in South Africa, as well as unpredictable health and life risks in pregnancy and the possibility of severe foetal abnormalities, mean that no matter how well fertility management services and information are implemented, there will always be a need to ensure access to abortion services.

7. Special Advisor to the Minister of Social Development of South Africa, Speech to United Nations, April 2016.

The CTOPA gives women and girls the right to an abortion in the following circumstances:

TERMINATION OF PREGNANCY (TOP) AND GESTATIONAL LIMITS ON ABORTION UNDER THE SOUTH AFRICAN CTOPA

TIMELINE FOR PREGNANCY	CONDITIONS	ABORTION PERFORMED BY:
First 12 weeks of gestation	Termination of pregnancy available on request	Registered medical practioner (Dr), registered nurse or midwife (who has completed the training)
13-20 weeks of gestation	Termination of pregnancy available under following conditions: • Rape or incest • Danger to woman's physical or mental health • Foetus not viable • Affect woman's socio-economic status	Registered medical practitioner (Dr)
Above 20 weeks of gestation	Termination of pregnancy only available under very limited circumstances: • Severe threat to life of woman or foetus • Severe foetal congenital problems	Registered medical practitioner (Dr)

Abortion is a safe procedure when performed by skilled health care providers in sanitary conditions. However, illegal abortions are generally unsafe and lead to high rates of complications and to maternal deaths and injuries.[8] Under the CTOPA, abortion is a time restricted service in South Africa (see table above). As the pregnancy progresses there is a higher risk of complications.

Women and girls should not have to risk their lives and health to end a pregnancy.

8. WHO 2012 pages 23, 46-47.

HUMAN RIGHTS FRAMEWORK

Access to sexual and reproductive health care is a constitutional right in South Africa[9] and part of the universal right to health. South Africa has ratified international human rights treaties and agreements which place South Africa under a duty to ensure that abortion services and information are available, accessible, and acceptable and of good quality.[10]

South Africa has ratified the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, the Convention on the Elimination of All forms of Discrimination Against Women, the African Charter on Human and Peoples' Rights, the Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) and the African Charter on the Rights and Welfare of the Child.

The international and regional human rights treaties provides for the establishment of monitoring mechanisms including different committees of independent experts who are mandated to oversee State parties' compliance with their respective treaty obligations. The committees issue concluding observations on State parties' progress and also issue general comments and recommendations, which clarify the content and scope of States parties' obligations under the specific treaty provisions. Taken together, these rulings provide guidance to governments and advocates in further advancing and promoting human rights. They are also a crucial tool for holding governments accountable under international human rights law.[11]

See further: *ANNEX 1: Table of South Africa's Human Rights Obligations*

9. Constitution of the Republic of South Africa (Act Number 108 of 1996) Section 27. 1. A: "Everyone has the right to have access to health care, *including reproductive health care*", emphasis added.
10. E/C.12/GC/22, United Nations Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (Hereafter CESCR General Comment 22), paras 1-21; CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) paras 12 (a)-(d).
11. For further information related to the International Framework for Human Rights and Abortion, see the Center for Reproductive Rights, "Bringing Rights to Bear. Abortion and Human Rights Government Duties to Ease Restrictions and Ensure Access to Safe Services", Briefing Paper, 2008, available at: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_abortion_hr_revised_3.09_WEB.PDF, on which Annex 1 relies, in addition to updates from Amnesty International research and reports. Annex 1 also draws from Ipas Africa Alliance: Human Rights and African Abortion Laws: A Handbook for Judges. Nairobi, Kenya, Ipas Africa Alliance 2014, available at: http://www.ipas.org/en/Resources/Ipas%20Publications/Human-Rights-and-African-Abortion-Laws-A-Handbook-for-Judges.aspx in relation to the Maputo Protocol.

THE FAILURE TO REGULATE CONSCIENTIOUS OBJECTION

The Department of Health's response to the request for information from Amnesty International confirms that 505 facilities are designed to provide termination of pregnancy services and of these, only 264 health facilities are providing first and second trimester termination of pregnancy services.[12]

The unregulated refusal by health care professionals to provide abortion services is a major contributor to the shortage of health facilities providing abortion services.[13] Such refusal is often referred to as 'conscientious objection', which means: 'to object in principle to a legally required or permitted practice'.[14]

The CTOPA does not refer to conscientious objection, but under the right to freedom of conscience in the South African Constitution,[15] health care professionals are understood to have the right to refuse to perform an abortion in certain cases. This right applies only in relation to the direct provision of services and not to pre- and post- abortion care.[16] In addition, the right to conscientious objection would not apply in cases where there is a risk to the woman's life or an immediate risk to her health. For example, conscientious objection is always limited by the clear professional and ethical duty on health care providers that they must provide the necessary care in emergency situations.[17]

The CTOPA stipulates that any person who prevents or obstructs access to legal abortion services is guilty of an offence, punishable by a fine or imprisonment.[18] Therefore, in terms of the law, health care providers who are not directly involved with the abortion procedure cannot use their beliefs as a reason for not assisting a woman seeking abortion services with information and appropriate referrals. Despite the clarity of the law, there is an apparent lack of understanding among many health care providers and individuals working in health care facilities of the obligations the CTOPA imposes.[19] The WHO warns that "allowing conscientious objection without referrals on the part of health-care providers and facilities" is one of the major barriers to access of safe abortion services in contexts where abortion is legal.[20]

The lack of clear policy guidelines for all involved in health care provision creates a vacuum for conscientious objection to be applied in an "ad hoc, unregulated and at times incorrect" manner.[21] Despite the development of a National Strategic Plan for the Implementation of the CTOPA by the National Department of Health[22] and a Draft National Policy for Conscientious Objection in the Implementation of the CTOPA (2007),[23] Amnesty International and the Women's Health Research Unit (WHRU) have documented failures in the referral process.[24] Left unchecked, conscientious objection has been found to lead to fragmented care,[25] and risks being invoked opportunistically;[26] restricting women and girls' access to lawful procedures.

A 2013 study of women in Cape Town found that "45% of women did not receive the abortions they sought at the clinic".[27] The related 2016 study highlighted that of those denied care, 20% were turned away for advanced gestational age, 20% because the clinic did not have the staff to perform their abortions that day, and 5% because of an inability to pay for their abortions.[28]

An expert review of all maternal deaths in South Africa from 2011-2013 has recommended that: "Facility managers must ensure that all doctors and nurses are aware of their professional and ethical responsibilities when on-duty, and must hold them accountable when these responsibilities are neglected."[29]

12. Information received by Amnesty International from the National Department of Health 3 November 2016. These figures correspond to estimates that only half of the facilities that should be offering abortion services currently do so, see further Karen A. Trueman and Makgoale Magwentshu. Abortion in a Progressive Legal Environment: The Need for Vigilance in Protecting and Promoting Access to Safe Abortion Services in South Africa. *American Journal of Public Health:* March 2013, Vol. 103, No. 3, pp. 397-399.
13. Harries J, Cooper D, Strebel A, Colvin CJ. Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. *BMC Reproductive Health.* 2014, Feb 26;11(1):16.
14. New Dictionary of Medical Ethics, quoted in N. Naylor and M. O'Sullivan, Conscientious Objection and the Implementation of the Choice on Termination of Pregnancy Act 92 of 1996 in South Africa, 2005.
15. Section 15 (1) which reads; "Everyone has the right to freedom of conscience, religion, thought, belief and opinion." http://www.justice.gov.za/legislation/constitution/SAConstitution-web-eng-02.pdf Accessed 16 August 2016.
16. N Naylor and M O'Sullivan Conscientious Objection and the Implementation of the Choice on Termination of Pregnancy Act 92 of 1996 in South Africa, 2005, Women's Legal Centre
17. In terms of the constitutional right of all people in South Africa to emergency health care, Section 27 (3) of the Constitution, a conscientious objector is ethically and legally obliged to care for patients with complications arising from an abortion.
18. Section 10 (1) (c).
19. Condoms yes! Sex No! Conflicting responsibilities for Health Care Professionals under South Africa's framework on reproductive Rights, Hoffman-Wanderer et al 2013;http://www.ghjru.uct.ac.za/ghjru/publications/recent-research-reports#sthash.uEddbZA9.dpuf.
20. WHO 2012 page 87, noting further at page 96, that the right to conscientious objection is not unlimited; "While the right to freedom of thought, conscience, and religion is protected by international human rights law, international human rights law also stipulates that freedom to manifest one's religion or beliefs might be subject to limitations necessary to protect the fundamental human rights of others. Therefore laws and regulations should not entitle providers and institutions to impede women's access to lawful health services."
21. Harries J, Cooper D, Strebel A, Colvin CJ. Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. *BMC Reproductive Health.* 2014, Feb 26;11(1):16.
22. Information received by Amnesty International from the National Department of Health 3 November 2016.
23. National Department of Health, Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and beyond Final Draft, accessed http://www.agenda.org.za/wpcontent/uploads/2012/09/SRHR-Fulfilling-our-Commitments.pdf 28 November 2016
24. Amnesty International interviews with health care providers conducted in KwaZulu-Natal and Mpumalanga in 2014; Harries J, Orner P, Gabriel M, Mitchell E. Delays in seeking an abortion in the second trimester: a qualitative study in South Africa *BMC: Reproductive Health*; 2007, 4:7.
25. Harries J, What health-care providers say on providing abortion care in Cape Town, South Africa: findings from a qualitative study Social Science Policy Brief Department of Reproductive Health and Research World Health Organization 2010.
26. In a recent study, health care providers were found to have "only provided certain aspects of care which were linked to various interpretations of what they were prepared to provide underscored by negative attitudes towards abortion provision and care" see further, Harries J, Cooper D, Strebel A, Colvin CJ. Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. *BMC Reproductive Health.* 2014, Feb 26;11(1):16. doi: 10.1186/1742-4755-11-16.
27. J Harries, Denial of Legal Abortion in South Africa, Reproductive Health Research Policy Brief, March 2016. See further Harries J, Momberg M, Gerdts C, Greene Foster D. An exploratory study of what happens to women who are denied abortions in a legal setting in South Africa. BMC Reproductive Health 2015 12:21
28. J Harries, Denial of Legal Abortion in South Africa, Reproductive Health Research Policy Brief, March 2016.
29. National Committee for Confidential Enquiry into Maternal Deaths, Saving Mothers 2011-2013: Sixth report on confidential enquiries into maternal deaths in South Africa Short report (2014) at page 63.

> **"It is always a problem to get somebody to assist as we don't have a fully functioning clinic with permanent staff. I need a doctor who can prescribe misoprostol, and a doctor to help me, but then they say, "No, it's against my religion and I'm not doing it". But it's not my position to say to them 'where is your written excuse'? It is not part of my responsibility, so then I have to look around for somebody who will be able to assist me."**
>
> *Nurse involved in abortion provision, Western Cape*

Under regional and international human rights standards, South Africa has a duty to ensure that conscientious objection does not impact on access to services and that a functioning referral process is in place to ensure that the person seeking care can be guaranteed timely and appropriate quality care.[30] Both the African Commission on Human and People's Rights (ACHPR)[31] 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.[32] 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."[33]

The UN Special Rapporteur on the right to health has warned of the dangers of inadequate regulation of conscientious objection as a barrier that contributes to making legal abortions inaccessible.[34] The Special Rapporteur has recommended that States "ensure that conscientious objection exemptions are well-defined

30. CESCR General Comment 22, citing CESCR, Concluding Observations: Poland, para. 28, UN Doc. E/C.12/POL/CO/5 (2009); Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, para. 24 & 65(m), UN Doc. A/66/254 (2011); CEDAW, General Recommendation No. 24: Women and health, (1999), para. 11.; ACHPR General Comment 2 (para 48 and at para 29:"State parties must ensure that the necessary infrastructure is set up to enable women to be knowledgeable and referred to other health care providers on time"; See also The European Court of Human Rights in the case of RR v Poland, para 206 (2011); P and S v Poland (2012, para 106) "…States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation."
31. ACHPR Gen Comment 2 on A14 para 48.
32. ACHPR Gen Comment 2 on A14.
33. CESCR General Comment 22.
34. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/66/254, (2011) para.24.

in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider."[35] Evidence indicates that conscientious objection risks becoming a way of 'gate-keeping' access to services in South Africa.[36]

> **"Individual health-care providers have a right to conscientious objection to providing abortion, that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women, putting their health and life at risk"[37]**
>
> *WHO*

The ACHPR further requires that States ensure accountability mechanisms are in place, along with the 'development of implementation standards and guidelines; a monitoring and evaluation framework, and availing accessible, timely and efficient redress mechanisms for women whose sexual and reproductive rights have been violated.'[38]

A woman's right to life, health and dignity must always take precedence over the right of a health care professional to exercise conscientious objection to participation in an abortion procedure. This is not the reality in South Africa. The government's failure to sufficiently regulate and monitor conscientious objection means that South Africa risks breaching its human rights obligations. Regulation and clear policy guidelines are urgently required to both respect the right of health care professionals and ensure that women and girls' right to reproductive health care is uniformly fulfilled within the health system.[39]

35. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. Doc. A/66/254, (2011) para.65.
36. Orner and Cooper, Investigation of health care worker's responses to HIV/AIDS care and treatment in South Africa, December 2011, noting healthcare providers in the public sector frequently act as "gate keepers" to abortion services, 'refusing to provide any information about the procedure or misinforming women about the legal conditions for abortion', at page 3 of 9; Hoffman-Wanderer et al 2013, the report notes the failure of some healthcare professionals to even inform pregnant girls who do not wish to continue with their pregnancies of their right to seek an abortion.
37. WHO 2012 Page 69.
38. ACHPR, General Comment No. 2 Africa at para 50.
39. Harries et al., Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study *Reproductive Health* 201411:16, DOI: 10.1186/1742-4755-11-16, available at: http://reproductive-health-journal.biomedcentral.com/articles/10.1186/1742-4755-11-16; Editorial *SAMJ* December 2014, Vol. 104, No. 12, page 857, noting the need for "comprehensive engagement and appropriate response at the broader policy and institutional levels as well as at community and individual levels."

INEQUALITY OF ACCESS TO SERVICES

Delivery of public health services remains hampered by the legacy of South Africa's colonial and apartheid past.[40] Despite efforts to invest in the public health care system since 1994, inequalities remain deeply entrenched,[41] many women and girls - especially those in the poorest and most marginalised communities - are still struggling to access safe abortion services.

Profound inequalities persist between the private and public health systems in terms of infrastructure and resources. Nearly 83% of the population relies on the public health system[42], yet the private health care sector employs the majority of health care professionals and spends nearly 6 times more per patient.[43]

Access barriers to abortion are greatly exacerbated by the failure to ensure abortion services are available at the primary health care level. A National Department of Health audit reported in 2013, recorded 3880 public health facilities in South Africa, including over 318 hospitals.[44] In contrast, as noted above, the National Department of Health have confirmed only 264 health facilities are providing termination of pregnancy services.[45]

While the National Department of Health note that 'all General Practitioners can provide medical terminations [of pregnancy] as part of the general medication services that they provide,'[46] the 2013 audit found nearly half of the 3 074 clinics (47%) and 20% of the 238 Community Health Centres reported no access to Doctors.[47]

Only 76% of primary health care facilities offered termination of pregnancy counselling.[48] As an urgent step to implement increased access, South Africa's Expert Committee on Maternal Deaths has advised that "All hospitals must be able to provide medical termination of pregnancy to ensure that all women have access to safe [termination of pregnancy]. Medical [termination of pregnancy] must be available at, but not restricted to, dedicated [termination of pregnancy] clinics."[49]

40. The health and health system of South Africa: historical roots of current public health challenges Coovadia, Hoosen et al. *The Lance*t, Volume 374, Issue 9692 , 817 – 834.
41. HST District Health Barometer 2012; Negotiated Service Delivery Agreement 2013 http://www.hst.org.za/sites/default/files/NSDA_booklet.pdf, page 6; South Africa National Development Plan 2030 Executive Summary http://www.gov.za/sites/www.gov.za/files/Executive%20SummaryNDP%202030%20-%20Our%20future%20-%20make%20it%20work.pdf, page 41.
42. National Health Care Facilities Baseline Audit National Summary Report, February 2013 http://www.hst.org.za/sites/default/files/NHFA_webready_0.pdf Accessed 28 November 2016
43. Department of Health, Human Resources for Health South Africa, (2011) 2012/13 - 2016/17, page 28; RSA Negotiated Service Delivery Agreement For Outcome Two: "A Long and Healthy Life for All South Africans" 2010 notes the disparity in per capita spending: "in 2009 nominal terms, the per capita spend in the public sector is estimated at R1,900 whilst in the private sector it is R11,300." And that "in the public sector there are about 4,200 patients to a general doctor compared to 243 patients to a general doctor in the private sector," page 6.
44. National Health Care Facilities Baseline Audit National Summary Report, February 2013, at page 11.
45. Information received by Amnesty International from the National Department of Health 3 November 2016.
46. Information received by Amnesty International from the National Department of Health 3 November 2016.
47. National Health Care Facilities Baseline Audit National Summary Report, February 2013, at page 24.
48. National Health Care Facilities Baseline Audit National Summary Report, February 2013, Table 4: PHC Clinical Services Audited, at page 28 and at page 11, Table 1: Number of audited facilities, by facility classification, which lists 253 District Hospitals, 55 Regional Hospitals and 10 Tertiary Hospitals

Those living in rural areas (43.6% of the population) often experience the greatest adversities accessing quality health care.[51] For example, they are served by only 12% of the country's doctors and 19% of nurses.[52] Across the country, especially in rural areas, access to safe abortion (both medical and surgical) is severely hampered due to large distances to facilities and the high costs of transport to reach them.[53]

Additional disparities occur between and within South Africa's nine provinces and 52 health districts. These are associated with divergent rates of spending on health care provision and health systems management,[54] which often have a discriminatory effect on women and girls' health, by virtue of significant differences in sexual and reproductive health services and outcomes, including varying rates of unplanned pregnancies,[55] teenage pregnancies,[56] and prevalence of HIV.[57] This system has exacerbated inequalities and access barriers to safe abortion due to the lack of national guidelines and standards.

The National Department of Health refer only to the Western Cape Province as having developed specific guidelines for the management of conscientious objection.[58] However, Amnesty International and the Women's Health Research Unit remain concerned that these guidelines are not formalised or operational across all facilities. In addition, there are reports of disparities in access to the medicines necessary for medical termination of pregnancy in some provinces.

49. National Health Care Facilities Baseline Audit National Summary Report, February 2013, Table 4: PHC Clinical Services Audited, at page 28 and at page 11, Table 1: Number of audited facilities, by facility classification, which lists 253 District Hospitals, 55 Regional Hospitals and 10 Tertiary Hospitals
50. Saving Mothers 2011-2013: Sixth report on the Confidential Enquiries into Maternal Deaths in South Africa Short Report Compiled by the National Committee for Confidential Enquiry into Maternal Deaths, page 63.
51. Department of Health, Human Resources for Health South Africa, (2011) 2012/13 - 2016/17, page 30.
52. Department of Health, Human Resources for Health South Africa, (2011) HRH STRATEGY FOR THE HEALTH SECTOR 2012/13 - 2016/17, page 30.
53. Amnesty International interviews with community representatives in conducted in KwaZulu-Natal and Mpumalanga from 2014 to 2016.
54. HST, District Health Barometer 2012/13.
55. HST District Health Barometer 2012 noting: "Districts in socio-economic quintile 5 (highest) appear to have the best access to contraception and quintile 1 (poorest), the worst," page 97; Wabiri N, Chersich M, Zuma K, Blaauw D, Goudge J, et al. (2013) Equity in Maternal Health in South Africa: Analysis of Health Service Access and Health Status in a National Household Survey. PLoS ONE 8(9): e73864. doi:10.1371/journal.pone.0073864, found nationally only 44.4% of pregnancies were planned, with the lowest rates in KwaZulu-Natal (25.5%). Further, almost 90% of pregnancies of those aged under 20 were unplanned. "Among women with HIV, only 31.7% of pregnancies were planned, compared with 42.1% of those non-infected (P = 0.07)," page 12.
56. Indicated by the birth rate for girls aged under 18 who gave birth at a health facility, the national average is 8%, "the highest proportion of 2012/13 under-18 deliveries was in the Eastern Cape (10.3%) and the lowest in Gauteng Province (4.8%)." HST, District Health Barometer 2012/13, page 60.
57. Wabiri HSRC (2014) Page XXV.
58. Information received by Amnesty International from the National Department of Health 3 November 2016.

The WHO urges governments to ensure that "The availability of facilities and trained providers within reach of the entire population is essential to ensuring access to safe abortion services."[59] Human rights standards place an obligation on states to ensure that marginalised communities are provided with communication and transport to care.[60] The ACHPR has recently emphasised that State parties should take all appropriate measures to remove obstacles to safe abortion, including economic and geographic barriers faced by marginalised women and girls, such as those living in rural areas.[61]

THE RIGHT TO ACCESS INFORMATION

Research from South Africa has highlighted the lack of knowledge among women and girls in relation to the legality of abortion as a major driver of unsafe abortions.[62] Lack of information can lead to unnecessary delays in women and girls accessing abortion services. Delays can result in women and girls being denied abortion services due to gestational limits under the CTOPA. South Africa has high rates of second trimester abortions, which account for over 25% of abortions performed,[63] and been linked to long delays between the date of first clinic appointment and the date of admission for an abortion and complex referral processes.[64]

Higher rates of injury are associated with abortions later in pregnancy.[65] In this context, a plethora of online illegal abortion providers portraying themselves as legal providers is worrying, especially as women accessing legal services have reported accessing these online illegal providers.[66]

Health care workers are often the main source of health related information.[67] The CTOPA requires health care providers to inform anyone requesting an abortion of their rights under the Act.[68]

59. WHO 2012 page 65.
60. CESCR General Comment 22 at Para 16; CESCR General Comment 14, paras 12 (b), 37 (ii), 40, 43 (a) and (f), and 52.
61. ACHPR General Comment 2 para 61.
62. Jewkes R et al. Why are women still aborting outside designated facilities in metropolitan South Africa? *British Journal of Obstetrics and Gynaecology,* 2005, 112:1236–1242 which found "Lack of information on abortion rights under the Act and perceived poor quality of designated facilities were the most important barriers to access and should be addressed by policymakers and health service management."; Morroni C, Myer L, Tibazarwa K. Knowledge of the abortion legislation among South African women: a cross-sectional study. *Reproductive Health,* 2006, 3:7; Harries et al. Delays in seeking an abortion until the second trimester: a qualitative study in South Africa, *Reproductive Health* 2007, 4:7.
63. J Harries et al. *J. Biosoc. Sci* (2012) 44 197-208 at page 198, noting comparable figures with the USA and UK where 12% or less of abortions take place in the second trimester; D Constant et al. Clinical out comes and women's experiences before and after the introduction of mifepristone into second-trimester medical abortion services in South Africa, *Published: September 1, 2016http://dx.doi.org/10.1371/journal.pone.0161843,* noting that in the Western Cape Province of South Africa, 28% of all abortions are performed in the second trimester, which is higher than reported for the United States, United Kingdom, Nepal and the Russian Federation.
64. Grossman et al. Surgical and medical second trimester abortion in South Africa: A cross-sectional study, BMC Health Services Research201111:224, DOI: 10.1186/1472-6963-11-224.
65. WHO 2012, p. 97 notes: "Abortion is a very safe procedure but the risk of complications increases with increasing gestational age".
66. Harries J, Momberg M, Gerdts C, Greene Foster D. An exploratory study of what happens to women who are denied abortions in a legal setting in South Africa. *BMC Reproductive Health* 2015 12:21
67. Amnesty International October 2014, Index: AFR 53/006/2014.
68. Section 6 amended by Section 7 of Act 38 of 2004.

However, negative attitudes of health care workers in relation to sexual and reproductive health services – including abortion – are a well-documented barrier to services, especially among adolescents.[69]

> **"They make it difficult for you. They spread the word in the community... and also isolate you in the hospital where you're supposed to work hand in hand, and you can become extremely unhappy. And you'd often find mid-wives who would often not be practicing doing abortions because they fear the victim-ization, being stigmatized, being isolated from their peers."**
>
> *A hospital manager describes feelings of isolation experienced by some nurse providers*[70]

Amnesty International has previously highlighted the importance of human rights training for health care workers who provide sexual and reproductive services and information.[71] The WHO recommends that health care workers should ensure respect for women and girls' autonomy, confidentiality and privacy and be trained to support women's informed and voluntary decision-making.[72] At the primary health care level, the WHO recommend that "all health-care workers providing reproductive health services [are] trained to provide counselling on contraception, unintended pregnancy and abortion"[73] and to "provide information on, and referral to, pregnancy-detection and safe, legal abortion services."[74] This duty is emphasised by the ACHPR as a human rights obligation.[75]

69. Amnesty International October 2014, Index: AFR 53/006/2014; Myers, L. (2014). A rapid assessment of the need for teenage pregnancy communication in O.R. Tambo district, EC and uMgungundlovu district, KZN. Cape Town: CADRE; Wood, K. & Jewkes R. (2006) Blood Blockages and Scolding Nurses: Barriers to Adolescent Contraceptive Use in South Africa. *Reproductive Health Matters*, 14(7):109-118; Ehlers, V. (2003) Adolescent mothers' utilization of contraceptive services in South Africa. *International Nursing Review,* 50(4).
70. Harries J, What health-care providers say on providing abortion care in Cape Town, South Africa: findings from a qualitative study Social Science Policy Brief Department of Reproductive Health and Research World Health Organization 2010.
71. Amnesty International 2014, Struggle for Maternal Health; Barriers to Antenatal Care in South Africa Index: AFR 53/007/2014.
72. WHO 2012 page 68.
73. WHO 2012 Page 68.
74. WHO 2012 Page 68.
75. ACHPR General Comment 2 at para 29.

> "State parties must ensure that the necessary infrastructure is set up to enable women to be knowledgeable and referred to other health care providers on time"
>
> *African Commission on Human and People's Rights, 2015*[76]

Training on sexual and reproductive rights has potential to reduce the professional stigma experienced by abortion providers. The National Department of Health has acknowledged that some health care providers work in contexts of physical and psychological stress, which are often exacerbated when they are offering stigmatised services - for example, termination of pregnancy.[76]

Research has also highlighted the difficult working conditions of abortion providers and feelings of isolation or being stigmatized by colleagues in the work place.[77] This has led to "burn-out" with professionals leaving the services, as "they could not endure the comments or the attitudes of their colleagues."[78] In turn, such contexts exacerbate the challenges in ensuring South Africa fulfils its human rights obligations to ensure accessible services.

Ensuring access to information on how and where to access lawful abortion services is a critical part of protecting access to sexual and reproductive rights and ensuring that women and girls are empowered to make decisions regarding their own health and lives. In the context of the country's very high rates of maternal deaths, medical experts have called for the government to ensure that women and girls are aware of their right to abortion and where to access services, recommending that: "Communities must be educated about... how to access safe [termination of pregnancy]".[79] As an essential first step, information on which public health facilities provide abortion services and at which gestational ages, should be available on the Department of Health website and at health facilities.

The provision of education and access to information about the main health problems in the community is a core obligation under the right to health.[80] The Maputo Protocol requires States to "provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas".[81] Human rights bodies are clear that such information should be

76. ACHPR General Comment 2 at para 29.
77. National Department of Health, Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and beyond Final Draft 2011.
78. Harries J, Stinson K, Orner P. Health care providers' attitudes towards termination of pregnancy: A qualitative study in South Africa. BMC Public Health 2009, 9: 296. Page 7.
79. Saving Mothers 2011-2013: Sixth report on confidential enquiries into maternal deaths in South Africa.
80. CESCR General Comment 14, para 43.
81. Article 14 (2) (a) Maputo Protocol.
82. ACHPR General Comment 2 para 28; CESCR General Comment 14, paras 11, 12 (b), 14, 21-23, 34, 35, 44 and 50.

'complete and accurate'.[82] Information on abortion services is especially important for girls and should be included in comprehensive sexuality education and available to girls both in and out of school.[83] Furthermore, human rights standards require that provision of information and services must be free of discrimination and judgment.[84]

CONCLUSION

The government of South Africa has taken noteworthy steps towards respecting, protecting and fulfilling women's and girls' sexual and reproductive rights. The CTOPA is among the most progressive legislative frameworks worldwide, in providing women and girls the right to abortion. However, as the research presented in this briefing highlights, implementation of the CTOPA remains inadequate, risking violations of the government's obligations under international human rights law.

In failing to regulate the practice of conscientious objection, and to ensure access to safe abortion information and services, South Africa has failed to fulfil obligations under the Maputo Protocol and other human rights treaties, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, and the Convention on the Elimination of All forms of Discrimination Against Women.

83. All sexuality education programmes, both in and out of school should not censor or withhold information or disseminate biased or factually incorrect information, such as inaccurate information on contraceptives or abortion. See, Committee on the Rights of the Child, General Comment 3 HIV and the rights of the Child, para 16 (2003); Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health, para. 23 & 34 (2000); Report of the UN Special Rapporteur on the Right to Education, para. 39, Doc. /A/65/162 (2010).
84. ACHPR General Comment 2 at para 51; CESCR General Comment No. 14, para. 34 (2000); Report of the UN Special Rapporteur on the Right to Education, paras. 21-23, 63, 87 (d), Doc. /A/65/162 (2010).

RECOMMENDATIONS TO THE SOUTH AFRICAN GOVERNMENT

- **Collate and publish disaggregated data on maternal deaths resulting from abortion, including unsafe and illegal abortions, as part of the Confidential Enquiry into Maternal Deaths in South Africa.**

In relation to:

CONSCIENTIOUS OBJECTION

- **Issue clear guidelines and protocols, to all health care professionals and health facility management, including:**
  - **What constitutes conscientious objection;**
  - **The conditions in which conscientious objection can be applied;**
  - **The measure which must be undertaken in order to lodge one's right to conscientious objection;**
  - **The limits of conscientious objection including the ethical duties of health care professionals who exercise their right to conscientious objection to provide accurate information and referrals;**
  - **The accountability mechanisms for health professionals who fail to comply with their ethical duties; and**
  - **Ensure careful record keeping and mapping of health care professionals who have registered their conscientious objection and ensuring an adequate number of health care providers willing and able to provide such services are available in both public and private facilities and within reasonable geographical reach. Including such concerns within the next Human Resources for Health Strategy for the Health Sector.[85]**
- **Continued value clarifications training of health care workers especially around conscientious objection.**

In relation to:

INEQUALITY OF ACCESS TO SERVICES AND INFORMATION

- **Provide information of where women can access abortion, including easy identification of hospitals designated as termination of pregnancy sites, which is publically available and easy to access, including on the National Department of Health website, Department of Health mobile apps including MomConnect and B-Wize, and via telephone call centres.**
- **Ensure accurate information and referrals are provided by all health care personnel, regardless of their personal views.**
- **Ensure planned patient transport is available for all women and girls needing to access health facilities offering abortion services.**
- **Prioritize the prevention of unwanted pregnancy through access to comprehensive sexuality education and modern contraception, including emergency contraceptives, which must be available without any barriers to all women, especially women and girls who have been raped.**
- **Implement stigma reduction strategies, including through educating health care providers and communities on what the right to health requires of service provision and ensuring the delivery of health care that is free from stigma, coercion, discrimination, violence and respects human rights, including the rights to confidentiality, privacy and informed consent.**

85. Noting the gap that the Human Resources for Health Strategy for the Health Sector 2012/13 – 2016/17 does not reference termination of pregnancy services.

ANNEX 1:

South Africa's Human Rights Obligations in relation to Access to Abortion[1]

INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS

Ratified by South Africa: 10 December 1998
Treaty Monitoring Committee: Human Rights Committee (HRC)

Human rights obligation related to abortion

Article 6 recognizes every person's right to life.

Article 7 establishes the right to be free from torture and from cruel, inhuman, or degrading treatment or punishment.

Article 17 protects the right to privacy.

General Comments/General Recommendations

International and regional human rights treaty provisions protecting the right to life, and the official bodies that interpret articles protecting life and other human rights guarantees, do not extend such protections prenatally. No international human rights body has ever recognized a fetus as a subject of protection under the right to life under Article 6 (1) of the ICCPR or other provisions of international human rights treaties, including the Convention on the Rights of the Child.

CPPR General Comment 6: The Right to Life[2] emphasizes that the inherent right to life should not be understood in a restrictive manner and that States should take positive measures to increase life expectancy (Para. 5).

CPPR General Comment 28: Equality of Rights Between Men and Women[3] calls upon States, when reporting on women's enjoyment of Article 6 on the right to life, to "give information on any measures taken by the State to help women prevent unwanted pregnancies, and to ensure that they do not have to undergo life-threatening clandestine abortions" (Para.10).

The Office of the United Nations High Commissioner for Human Rights (OHCHR) has urged States parties where abortion is legal) to include authoritative public health guidelines on access to safe abortion to which universal access should be effectively ensured in the national plan – as essential for improving maternal health.[4]

In its General Comment 28, the Committee also asks States parties to report on laws and public or private actions that interfere with women's equal enjoyment of the right to privacy, and to take measures to eliminate such interference (Para. 20).

Concluding Observations

The HRC has discussed illegal and unsafe abortion as a violation of Article 6 of the Civil and Political Rights Covenant, the right to life,[5] and has made the link between illegal and unsafe abortions and high rates of maternal mortality.[6] The UN Human Rights Committee has criticized a State party's Constitution which grants the right to life of the "unborn" on an equal footing with a pregnant woman's right to life. Human rights bodies have refrained from stating that right to life protections apply prenatally as these would inevitably lead to conflicts between a pregnant woman or girl and her fetus. A position such as this would not only undermine the rights of the woman in the context of access to abortion, but also in other maternal health and general health care services required.[7] The Committee has urged States parties to revise laws to help women prevent unwanted pregnancies and to prevent women from resorting to clandestine abortions, which put their lives at risk.[8]

INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Ratified by South Africa: 10 December 1998
Treaty Monitoring Committee: Committee on Economic, Social and Cultural Rights (CESCR)

Human rights obligation related to abortion

Article 12 protects the right to the highest attainable standard of physical and mental health.

General Comments/General Recommendations

CESCR General Comment 14: The Right to the Highest Attainable Standard of Health[9] clarifies that States are required to implement measures to "improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information" (Para. 14).

The Committee underlines the need for States parties to provide a full range of high-quality and affordable health care, including sexual and reproductive services; reduce women's health risks and lower maternal mortality rates; remove all barriers to women's access to health services, education, and information, including in the area of sexual and reproductive health (Para. 21). While abortion is not explicitly mentioned, the OHCHR has outlined the categories of good practices to address maternal mortality and morbidity in compliance with human rights obligations, which include: enhancing the status of women, ensuring sexual and reproductive health rights, strengthening health systems, addressing unsafe abortion, and improving monitoring and evaluation.

The general comment also elaborates on the application of principles of non-discrimination on the basis of gender and equal treatment with respect to the right to health (Paras. 18-19) and recommends that States parties integrate a gender perspective into their health-related policies, planning, programs, and research (Para 20).

CESCR General Comment 22 on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)[10] recommends that "preventing unintended pregnancies and unsafe abortions requires States to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents, liberalize restrictive abortion laws, guarantee women and girls access to safe abortion services and quality post-abortion care including by training health care providers, and respect women's right to make autonomous decisions about their sexual and reproductive health" (Para. 28).

Concluding Observations

Unsafe Abortions and Maternal Mortality: The CESCR has expressed concern over the relationship between high rates of maternal mortality and illegal, unsafe, and clandestine abortions.[11] The Committee has recommended that States parties expand educational programs regarding reproductive and sexual health[12] as well as implement programs to increase access to family planning services and contraception.[13]

THE CONVENTION AGAINST TORTURE AND OTHER CRUEL INHUMAN AND DEGRADING TREATMENT OR PUNISHMENT

Ratified by South Africa: 10 December 1998
Treaty Monitoring Committee: Committee against Torture (CAT)

Human rights obligation related to abortion

Article 1 defines torture as any intentional act, inflicted for reasons based on discrimination of any kind, which causes severe physical or mental suffering, and is committed with the consent or acquiescence of a public official.

General Comments/General Recommendations

The UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment has stated that: "International and regional human rights bodies have begun to recognize that abuse and mistreatment of women seeking reproductive health services can cause tremendous and lasting physical and emotional suffering, inflicted on the basis of gender." Examples of such violations include denial of legally available health services such as abortion and post-abortion care.[14]

Concluding Observations

The CAT expressed concern to one State party that "medical personnel employed by the State den[y] the medical treatment required to ensure that pregnant women do not resort to illegal abortions that put their lives at risk."[15] The Committee recommended that the State party "take whatever legal and other measures are necessary to effectively prevent acts that put women's health at risk, including by providing the required medical treatment, by strengthening family planning programmes and by offering better access to information and reproductive health services, including for adolescents."[16]

THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF RACIAL DISCRIMINATION

Ratified by South Africa: 10 December 1998
Treaty Monitoring Committee: Committee on the Elimination of Racial Discrimination (CERD)

Human rights obligation related to abortion

Article 5(b) links the right to be free from racial discrimination to the enjoyment of the right to security of person and the right to protection from violence and bodily harm.

Article 5(e) links the right to be free from racial discrimination to the enjoyment of a number of economic, social, and cultural rights, including the right to health.

General Comments/General Recommendations

General Recommendation 25: Gender Related Dimensions of Racial Discrimination[17] specifically recognizes that some forms of racial discrimination may be experienced only by women and may be directed at women because of their gender (Para. 2). The Committee states that it will take gender into account when evaluating and monitoring racial discrimination against women and how such discrimination affects the exercise of all other rights (Para. 3). This would include the rights to health and to life, which are implicated in the case of women and abortion.

Concluding Observations

The CERD has expressed concern and regret that certain groups are disproportionately affected by maternal mortality as a result of lack of access to reproductive health-care and family planning services.[18] It has recommended that one State party address persistent racial disparities in reproductive health by improving access to health care and family planning and expressed regret over the high incidence of unintended pregnancies and greater abortion rates among women belonging to a minority group.[19] In a subsequent review the Committee recommended that State party effectively identify and address the causes of disparities, and to improve monitoring and accountability mechanisms for preventable maternal mortality.[20]

THE CONVENTION ON THE RIGHTS OF THE CHILD

Ratified by South Africa: 16 June 1995
Treaty Monitoring Committee: Committee on the Rights of the Child (CRC)

Human rights obligation related to abortion

Article 2 prohibits discrimination on several grounds, including sex or "other status."

Article 6 ensures children's right to life and survival.

Article 13 establishes children's right to impart and receive information of all kinds.

Article 24 guarantees children's right to the highest attainable standard of health and places responsibility on States parties to ensure proper health care for mothers, children, and families.

Article 37 ensures children's right to liberty and security of person.

General Comments/General Recommendations

CRC General comment No. 20 (2016) on the implementation of the rights of the child during adolescence recognizes unsafe abortion as a particular health risk during adolescence (Para 13), and urges States to decriminalize abortion to ensure that girls have access to safe abortion and post-abortion services, review legislation with a view to guaranteeing the best interests of pregnant adolescents and ensure that their views are always heard and respected in abortion-related decisions (Para. 60).

CRC General Comment No. 4: Adolescent Health and Development[21] recommends that "States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents." (Para. 37)

Concluding Observations

Unsafe Abortions and Maternal Mortality: On several occasions, the CRC has made the link between maternal mortality and high rates of clandestine[22] and unsafe abortions.[23] The Committee has called upon at least one State party to undertake a study on the negative impact of early pregnancy and illegal abortion.[24] The Committee has called upon a State party to ensure that abortions "could be conducted with all due attention to minimum standards of health safety,"[25] and recommended that States parties provide greater access to youth-sensitive and confidential counseling and reproductive health education.[26]

The Committee has recommended a State party "take urgent measures to reduce maternal deaths relating to teenage abortions and ensure children's access to safe abortion and post-abortion care services, in law and in practice."[27]

The Committee has asked States to provide adolescents with youth-friendly counseling services.[28] The Committee has also advocated for adolescents' access, without parental consent, to youth-sensitive and confidential counseling, care, and rehabilitation facilities,[29] and to reproductive health and family planning information.[30]

The Committee has called on States to guarantee the best interests of pregnant adolescent girls, and ensure, in law and in practice, that the views of the child are always heard and respected in abortion decisions.[31]

THE CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

Ratified by South Africa: 15 December 1995
Treaty Monitoring Committee: Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Human rights obligation related to abortion

Article 12 protects women's right to health and requires States parties to eliminate discrimination against women in the area of health care, including reproductive health care such as family planning services.

Article 16 protects women's right to decide on the number and spacing of their children and to have access to the information and means to do so.

General Comments/General Recommendations

CEDAW General Recommendation 24: Women and Health[32] states that it is the duty of States parties to "respect, protect and fulfill women's rights to health care" (Para. 13). The Committee recognizes the importance of women's right to health during pregnancy and childbirth as it is closely linked to their right to life (Para. 2). The Committee has explicitly stated that "[i]t is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women" (Para. 11).

Concluding Observations

Unsafe Abortions and Maternal Mortality: The CEDAW Committee has given considerable attention to the issue of maternal mortality due to unsafe abortion in numerous sets of Concluding Observations.[33] The Committee has explicitly framed the issue as a violation of women's right to life.[34] The Committee has emphasized that access to sexual and reproductive health services is essential to reducing maternal mortality and protecting women from resorting to unsafe abortion,[35] and it has called upon States parties to study behavioral patterns of women to determine why they do not use available health services.[36]

The Committee has expressed concern regarding high rates of maternal mortality due to high numbers of abortions among adolescents,[37] and unsafe,[38] clandestine,[39] and illegal abortions.[40] It has noted that women's need to resort to unsafe abortion is linked to their lack of access to family planning services[41] and has recommended that States parties increase access to family planning[42] as well as to sexual and reproductive health information.[43]

The Committee has raised general concerns about the lack of accessibility of safe abortion,[44] particularly in cases of rape.[45] The Committee has also urged States parties to ensure access to post-abortion care to reduce maternal mortality.[46]

The Committee has also recommended that States parties provide comprehensive, youth-friendly,[47] and gender-sensitive[48] reproductive health services. In one instance, it recommended that the State party provide social security coverage for abortions.[49]

The Committee has called upon States parties to provide detailed information in their next periodic reports regarding incidence of abortion,[50] including rates and causes of maternal mortality, contraception use, and access to family planning services.[51] The Committee also recommended that at least one State party conduct a survey regarding high rates of maternal mortality due to abortions, and adopt legislative and policy measures to reduce and eliminate abortion-related deaths.[52]

The Committee has expressed concern regarding situations where women do not have access to safe abortion despite legalization of the procedure. It has recommended that States parties provide safe abortion services or ensure access where they are permitted by law,[53] and review restrictive interpretations of abortion legislation.[54]

Conscientious Objection: The CEDAW Committee has expressed concern over the lack of access to abortion services due to laws permitting conscientious objection by hospital personnel.[55] The Committee has made it clear that, in these circumstances, it considers a government's failure to ensure access to another provider willing to perform the procedure an infringement of women's reproductive rights.[56] The Committee has recommended that States parties ensure access to abortion in public health services.[57] The Committee has praised the provision of South Africa's CTOPA that health workers may not obstruct access to services for termination of pregnancy.[58]

The Committee has called on a State party to "[c]ease all negative interference with women's sexual and reproductive rights including by ending campaigns that stigmatize abortion and seek to negatively influence the public view on abortion and contraception," and "establish an adequate regulatory framework and a mechanism for monitoring of the practice of conscientious objection by health professionals and ensure that conscientious objection is accompanied by information to women about existing alternatives and that it remains a personal decision rather than an institutionalized practice."[59]

THE MAPUTO PROTOCOL TO THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS ON THE RIGHTS OF WOMEN IN AFRICA (MAPUTO PROTOCOL)

Ratified by South Africa: 17 December 2004

Treaty Monitoring Committee: African Commission of Human and People's Rights (ACHPR)

Human rights obligation related to abortion

Article 2 commits States to combat all forms of discrimination against women and modify social and cultural patterns of conduct of women and men in order to eliminate all practices based on the idea of the inferiority or the superiority of either of the sexes, or on stereotyped roles for women and men.

Article 3 protects every woman's right to respect for her dignity, free development of her personality, and recognition and protection of her human and legal rights including protection from all forms of violence, particularly sexual and verbal violence.

Article 4 protects every woman's right to life, integrity and security of the person and prohibits all forms of cruel, inhuman or degrading punishment and treatment and exploitation.

Article 8 enshrines every woman's right of equal protection before the law including obligating States to reform of existing discriminatory laws and practices in order to promote and protect the rights of women.

Article 14.1 protects the right to health of women, including sexual and reproductive health, including the right to control their fertility; the right to decide whether, when and how many children to have; the right to choose any method of contraception; the right to self-protection and to be protected against STIs and HIV/AIDS; the right to be informed on one's health status and on the health status of one's partner; the right to have family planning education.

Article 14.2 obligates States to: a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas; b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding; and c) protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

Article 25 (a) obligates States to provide for appropriate remedies when rights or freedoms under the Charter have been violated.

Article 26.2 obligates States to adopt all necessary measures and in particular shall provide budgetary and other resources for the full and effective implementation of the rights herein recognised.

General Comments/General Recommendations

General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa: The General Comment clarifies that in order for States to meet their international human rights obligations, they must remove the legal and administrative barriers that impede women's access to safe abortion services (Para. 20); reform socio-cultural structures and norms that promote and perpetuate gender inequality, and remove all barriers stemming from intersectional forms of discrimination in laws, policies, plans, administrative procedures and the provision of resources, information and services concerning contraception and safe abortion in the specific cases listed in the Protocol (Paras. 22, 60 and 61).

The General Comment also emphasizes that women must have access to sexual and reproductive health information, services and commodities needed only by them (including related to contraception and safe abortion) in order to enjoy their rights in a non-discriminatory manner and achieve gender equality (Para. 31).

Women must not be criminalized and should not incur any legal sanctions for having benefited from health services needed only by them such as abortion and post-abortion care. Furthermore, the health personnel should not fear neither prosecution, nor disciplinary reprisal or others for providing these services in the specific cases provided for in the Protocol (Para. 32).

In order to ensure that women equally benefit from scientific progress (as per ICESCR Article 15.1.b), they must not be denied the means to interrupt an unwanted pregnancy safely, using effective modern services (Para. 33).

The General Comment recognizes that women's rights to privacy and confidentiality are violated when women seeking therapeutic abortion services are interrogated why they want to interrupt a pregnancy by health care providers, police and/or judicial authorities or when they are charged or detained for suspicion of illegal abortion when seeking post-abortion care (Para. 34).

States are required to ensure, immediately and unconditionally the treatment required for anyone seeking emergency medical care including women seeking post-abortion care regardless of legality of abortion (Para. 35).

States must ensure that women are not treated in an inhumane, cruel or degrading manner when they seek reproductive health services such as contraception or safe abortion, where provided for by national law and the Protocol (Para. 36).

States must create legal, economic and social conditions that enable women to exercise their sexual and reproductive rights. To this end, States must address stigmatization and discrimination related to reproductive health by supporting women's empowerment, sensitizing and educating communities, religious leaders, traditional chiefs and political leaders on women's sexual and reproductive rights as well as training health-care workers (Para. 44).

State parties must provide comprehensive information and education on human sexuality, reproduction and sexual and reproductive rights, especially to adolescent girls and young people. The content must be evidence-based, rights-based, non-judgmental and according with evolving capacity of children and adolescents (Para. 51). Educational programmes should reach out to women and girls out of and in school (both public and private) (Para. 52).

States must ensure available, accessible, acceptable and good quality services that are comprehensive, integrated, rights-based, and sensitive to the reality of women in all contexts, and adapted to women living with disabilities and the youth, free from any coercion, discrimination and violence (Para 53 and 61). This includes ensuring specific budget allocations and tracking health expenditures on these budget lines for the purposes of monitoring, control and accountability (Para 63).

Regional Policy Initiatives

The Maputo Plan of Action: The African Union has also adopted several policy initiatives to address unsafe abortion[60] and is most recently guided by the Maputo Plan of Action 2016-2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights.[61] The Maputo Plan of Action includes the goal of reducing levels of unsafe abortion,[62] and calls for health legislation and policies to ensure access to safe abortions to the full extent of national laws and policies.[63] Strategies for implementation include the need for ensuring gender equality, women and girls' empowerment and respect of human rights;[64] improving sexual and reproductive health and rights information, education and communication;[65] and investing in sexual and reproductive health and rights needs of adolescents, youth and other vulnerable and marginalized populations.[66] Member States are tasked to domesticate and implement the Plan, including by establishing advocacy, resource mobilization and budgetary provision.[67] The AU Commission has an oversight role, including through ensuring 'policies and strategies among member states are harmonized with continental and global instruments' and by establishing 'a monitoring, reporting and accountability mechanism for the plan under which a biennial, five-year, ten-year and end of term evaluations of progress of implementation of plan would be ensured.'[68]

In January 2016 the ACHPR launched a continental Campaign for the Decriminalization of Abortion in Africa, with the aim to bring attention to the serious threat to women's and girl's rights to sexual and reproductive health posed by unsafe abortion.[69]

Notes

1. This table draws on information compiled by the Center for Reproductive Rights, "Bringing Rights to Bear. Abortion and Human Rights, Government Duties to Ease Restrictions and Ensure Access to Safe Services", Briefing Paper, 2008, available at: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/BRB_abortion_hr_revised_3.09_WEB.PDF, on which Annex 1 relies, in addition to updates from Amnesty International research and reports. Annex 1 also draws from Ipas Africa Alliance: Human Rights and African Abortion Laws: A Handbook for Judges. Nairobi, Kenya, Ipas Africa Alliance 2014, available at: http://www.ipas.org/en/Resources/Ipas%20Publications/Human-Rights-and-African-Abortion-Laws-A-Handbook-for-Judges.aspx in relation to the Maputo Protocol.
2. CCPR General Comment No. 6: Article 6 (Right to Life), Adopted at the Sixteenth Session of the Human Rights Committee, on 30 April 1982
3. CCPR General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women). Adopted at the Sixty-eighth session of the Human Rights Committee, on 29 March 2000
4. Report of the Office of the United Nations High Commissioner for Human Rights, Technical guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (Hereafter; OHCHR Technical Guidance 2012) A/HRC/21/22, 2 July 2012, at para 33.
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63. MAPUTO PLAN OF ACTION 2016-2030 At para 17 ii.
64. MAPUTO PLAN OF ACTION 2016-2030 At para 17 iv.
65. MAPUTO PLAN OF ACTION 2016-2030 At para 17 v.
66. MAPUTO PLAN OF ACTION 2016-2030 At para 17 vi.
67. MAPUTO PLAN OF ACTION 2016-2030 At para 30.
68. MAPUTO PLAN OF ACTION 2016-2030 At para 28.
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