THE CONTINUED DISCRIMINATION OF BLACK WOMEN IN ACCESSING SEXUAL REPRODUCTIVE HEALTH INCLUDING ABORTION ACCESS IN SOUTH AFRICA

A report to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

2 June 2022

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Please provide your contact details in case we need to contact you in connection with this survey. Note that this is optional.

Type of Stakeholder (please select one)	☐ Member State ☐ Observer State ☒ Other (please specify) - NGO
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Can we attribute responses to this questionnaire to your Institution publicly*? *On OHCHR website, under the section of SR health	Yes Comments (if any):

1. INTRODUCTION

1.1 The Women's Legal Centre is honoured to submit this report to the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Special Rapporteur) in preparing for the thematic report on "Racism and the right to health", which will be presented to the General Assembly in October 2022.

2. INTRODUCTION TO THE WOMEN'S LEGAL CENTRE

2.1 The Women's Legal Centre ("The Centre") is an African feminist legal centre that advances women's rights and equality through strategic litigation, advocacy, education and training. We aim to develop feminist jurisprudence that recognises and advances women's rights. The Centre drives a feminist agenda that appreciates the impact that discrimination has on women within their different classes, races, ethnicity, sexual orientation, gender identity and disability. The Centre does its work across five programmatic areas including the right to be free from violence, women's rights in relationships, women's rights to land, housing property and tenure security, women's sexual and reproductive health rights and women's rights to work and at conditions of work.

3. THE INFORMING CONTEXT

3.1 As this call for submissions focuses on questions of race and underlines racism as a key social determinant of health and driver of health inequalities, we focus our submission on access to abortion services and broadly the right to sexual and reproductive health through the prism of race and related grounds of discrimination within our context in South Africa. The Centre applies an intersectional feminist analysis in respect of the content of this submission as we recognise that women do not have single issue struggles and often face intersecting forms of discrimination. Specifically we focus on the right to access safe and legal abortions, highlight the barriers to accessing abortion services in South Africa and seek to answer the following questions in accordance with the questionnaire set out by the Special Rapporteur;

a) *What are the historical and ongoing legacies and impacts of colonialism and slavery on the right to health in your country? And how has the lack of reparations for slavery, colonialism, apartheid and racial discrimination impacted the right to health in your country?*

b) *Who are the most affected people and why? Please describe existing disparities in the provision of and access to health services that affect people of different racial and ethnic*

origin, descent as well as other groups, such as migrants. The lack of data, analysis or health indicators in this regard may also be reflected.

c) *What examples are there of good legal and policy frameworks that address past or ongoing racism and racial and related forms of discrimination, specifically in relation to access to underlying determinants as well as quality health care, goods, services and facilities, including sexual and reproductive health.*

d) *Under the right to health, States have a special obligation to refrain from denying or limiting equal access for all persons, comprising minorities, asylum seekers and migrants including undocumented migrants, to preventive, curative and palliative health services; abstain from enforcing discriminatory practices as a State policy as well as to ensure equal access to health care and health-related services provided by third parties. Please explain how the above point is implemented in your country, what works well and not so well and illustrate with disaggregated data if possible.*

e) *What are the main ongoing manifestations of racism, and related forms of discrimination enabled by racism that may be prevalent in your country in the area of the right to health broadly including in underlying determinants of health, health outcomes and access to health care?*

3.2. *The historical context of women's rights to safe and legal abortions in South Africa*

3.2.1 Due to South Africa's historical racial turbulence in the form of the Apartheid Regime, our country still battles with the residual effects of what was once a country that exclusively prioritised the needs of its minority white population.

3.2.2 More than 27 years later our state still grapples with accommodating the entirety of South Africa's population into a system of service delivery that was designed to only cater to the white minority. Our Public health care system and even more so our access to abortion service system is an excellent example of the ongoing challenge that black women experience when seeking to access health rights that were not previously recognised.

3.2.3 Historically during the apartheid era, most of our sexual and reproductive health rights were privatised and more easily accessible to the more affluent and racially acceptable minority of white women. The Abortion and Sterilization Act No 2 of 1975 provided access to abortion services under certain limited circumstances which in most cases had the effect of granting only women who were well-resourced and located in urban

areas access to abortion services. This Act left black women living in segregated townships and those in even less resourced rural areas of South Africa without access.

3.2.4 Without access to the apartheid regime's services, black women established a long and strong tradition of resorting to clandestine abortions that have themselves resulted in higher rates of mortality and morbidity. A tradition that still has a strong grip on today's post-apartheid era where despite the end of apartheid and state-mandated racial oppression, black women still face insurmountable challenges to accessing abortion services. Many continue to rely on clandestine and illegal methods of obtaining abortion access.

3.2.5 In a post-democratic South Africa, studies such as a poverty trends report released by Statistics South Africa in 2017 have reflected a demographic where poor black women are the predominant users of public health care services. This paints a picture where even though apartheid has come to an end the segregated and lack of quality health care access continue on racial and ethnic lines across South Africa's health services.[1] The disparities in reproductive health are of a particularly stark nature with Black South African women having higher rates of maternal death, infant mortality, and unintended pregnancy than white women.[2]

3.2.6 In 2002, infant mortality rates varied between 7 per 1000 in the white population and 67 per 1000 in the black population, and life expectancy for white adult women was 50% longer than it was for black women. There are also substantial inequities in health care between and within provinces depending on which areas are considered predominately white and which are predominately Black/rural areas.

3.2.7 The above disparities and lower rates of access to black women can be attributed to the fact that the lower resourced and underfunded public health care system largely caters to this poorer Black female majority of South Africa, while the lower minority of White women are catered to by the better-funded and well-resourced private health care system. It also an indicator of the financial resources and unequal distribution of wealth in the country having a direct impact on access to health, quality of life and life expectancy.

[1] South Africa Demographic and Health Survey 2016
[2] Borrero et al Race and Sterilization

3.2.8 There are substantial differences in resource availability between the public and private sectors. While less than 16% of the population are members of the optional private sector medical schemes, more than 50% of the Governments' health-care expenditure is set aside to subsidise private sector schemes.[3]

3.2.9 In summation, although the South African government is no longer run on the basis of racial segregation, the racial hierarchy established by the apartheid system continues to have a very real impact on the lived reality of poor black women who are very much situated at the bottom of the financial and social hierarchy of our unequal society.

3.3. *Intersectional identities of post-democracy black women in South Africa*

3.3.1 The intersectional burdens faced by black women on the basis of race, gender, age, class, social origin and pregnancy in today's society have a devastating impact on them accessing abortion services and generally positive sexual and reproductive health outcomes in South Africa.

3.3.2 The majority of South Africans from lower-income and poor households access health care services through the state healthcare system and despite a clear agenda for quality health care and significant annual expenditure, the South African healthcare system, which approximately 73% of the population rely on is under increasing strain and often unable to adequately meet the needs of South African residents.

3.3.3 According to the *South African Health Review, 2018,* the state of our healthcare system has resulted in a loss of confidence among users, escalated medico-legal claims and an overburden on both healthcare services and healthcare professionals. This state of affairs is of particular concern to the abortion sector which due to these multiple challenges has been relegated to the bottom of the list of state priorities.

3.3.4 In its report Amnesty International *'Briefing: barriers to safe and legal abortion*'[4], Amnesty International found that of the 3880 public health facilities operating in South Africa, less than 7% provided access to abortion services. Only 505 medical facilities had been designated to provide the service and of these 505 health facilities, only 197 have been recorded to actually provide access to abortion services..

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[3] Maphumulo, W.T. & Bhengu, B.R., 2019, 'Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review', *Curationis* 42(1), a1901. https://doi.org/ 10.4102/curationis. v42i1.1901

[4] Amnesty International *Briefing: Barriers to Safe and Legal Abortion in South Africa* (2017) 8-9

3.3.5 In a case study of the Western Cape specifically, it was found that 45% of women did not receive the abortions they sought at clinics and 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. Of serious concern is that these are statistics are for one of South Africa's more developed urban metropolitan areas where service delivery is considered to be some of the best in the country. It is unclear what further detrimental impact the COVID-19 pandemic has had on abortion facilities as the above statistics predates the epidemic.

3.3.6 Under the COVID-19 pandemic the *South African Health Review, 2021* recorded that there was an overall increase in South Africa's mortality and morbidity rates and that due to limited access to services, terminations of pregnancies had decreased by 17%. It is important to point out that this is based on official and recorded information and not on the clandestine abortion procedures that are taking place.

3.4. *Black women living in rural areas*

3.4.1 In general, rural black women in South Africa face intersecting structural barriers that limit their ability to fully exercise their rights. These barriers arise from inequities and discrimination based on gender, economic status, and geography. Rural black women also face extreme poverty, lack of access to economic opportunities, lack of education, and little to no access to rights based education and information. Their vulnerability is compounded in areas governed by traditional leaders and customary laws which are steeped in patriarchy and discriminatory stereotypes about women and their agency to make decisions about their sexual reproductive health and rights.

3.4.2 For rural black women wishing to access abortion services, these structural barriers have an exponentially adverse impact on their ability to exercise the right to choose and by extension their overall health and well-being. Based on their geography, rural black women have poor access to quality education, particularly comprehensive sex education and education on where and how to access abortion services, which results in them having a hollow right to choice. Accordingly, based on their geography, economic status and race, black women have poor access to abortion facilities.

3.4.3 The discrimination experienced by black women is thus complex and diverse as it is inextricably linked to the various identities and contexts women operate in and given that these intersecting factors only serve to further victimise an already vulnerable group

it becomes important to analyse the hardships these women face in accessing abortion services through an intersectional lens.

4. THE LEGAL FRAMEWORK REGULATING ABORTIONS IN SOUTH AFRICA

4.1 South Africa's revolution into a democratic dispensation has placed equality, non-discrimination, and reproductive rights squarely in South Africa's Constitution. The 1996 Constitution encompasses bodily autonomy and agency as essential elements in the empowerment of women.

4.2 South African women, in their diversity, accordingly, have constitutionally recognised rights to bodily autonomy, and to make decisions about their sexual and reproductive health.

4.3 Freedom of choice and the ability to make decisions based on one's own circumstances is a golden thread that runs through our constitution and is guaranteed in Section 12 of the Constitution. Section 12 provides for the right to freedom and security of the person, and section 12(2) specifically provides for the right to bodily and psychological integrity, which includes the right to make decisions concerning reproduction; and the right to security in and control over one's body. These rights contained in sections 12(2)(a) and (b) expressly recognise and protect the right for one to make decisions in relation to reproduction, including the right to termination of pregnancy.

4.4 These rights are also strengthened by the protections of the rights to reproductive health care (section 27(1)(a)), the right to equality (section 9); the right to dignity (section 10); and the right to privacy (section 14).

4.5 To support the realisation of the above rights the *Choice on Termination of Pregnancy Act* 92 of 1996 ("CTOPA") was adopted. The Act was enacted to give effect to the state's international and constitutional obligations in relation to sexual and reproductive rights and promotes these rights by affording every woman the right to choose whether to have an early, safe and legal termination of pregnancy according to her individual beliefs.

4.6 The preamble of CTOPA recognises the State's duty to provide reproductive health to all and to provide safe conditions under which the right of choice can be exercised without fear or harm.

5. KEY AREAS OF CONCERN

5.1 In 2004 and 2008, amendments to the CTOP Act were introduced with the aim of expanding access to abortion services. However, even with these additions, the National Department of Health ('NDOH') has found that improved access and equity are still required to enhance quality service provision. The NDOH is an executive department enacted in line with the National Health Care Act 61 of 2003 and was created to centralise the provision of public health care across the country.

5.2 Women continue to seek unsafe abortions and risky adverse health outcomes or death, with an estimated minimum of 50% of terminations being provided by informal, illegal and unsafe providers in South Africa.

5.3 Generally, the World Health Organisation considers the following to be barriers to accessing safe abortions:

a) Restrictive laws;

b) Poor availability of services;

c) High cost;

d) Stigma;

e) The conscientious objections of healthcare providers; and

f) Unnecessary requirements, such as mandatory waiting periods, mandatory counselling, provision of misleading information, third-party authorization, and medically unnecessary tests that delay care.

5.4 In the South African context, the identified barriers barring women from accessing safe public services include provider bias and opposition, stigma, lack of infrastructure, equipment and/or trained providers at the facility, general limited knowledge of legislation, and unmet contraceptive needs.

5.5 As alluded to previously in this submission, South Africa has one of the most progressive laws on abortion in the world, as the legality of abortion in the state affords women reproductive autonomy and the right to access safe abortions upon request. However, the 2016 country fact sheet on unsafe abortion in South Africa showed that an estimated 50% of abortions occurred outside of designated health facilities.

5.6 That this state itself is frustrating women's access based on the number of structural barriers put in place cannot be dismissed our of hand. The lack of political will backed

by financial investment to ensure the realisation of the right is absent, and has effectively led to designated facilities operated by the state becoming few and far between and inaccessible to women.

5.7 ***Lack of access to information on CTOPA and abortion services***

5.7.1 Women lack basic access to information about abortion facilities and their right to access these facilities. The information available to the South African public regarding public health facilities which provide TOP and related services is largely provided by individual healthcare practitioners and non-governmental organisations.

5.7.2 In its 2017 report, Amnesty International identified a lack of access to information as one of three key barriers to women's access to safe and legal abortion. Another study sought to investigate women's knowledge of abortion legislation eight years after the introduction of legal abortion services and found the following:

a) Overall, thirty-two per cent of the total 831 women interviewed in the study did not know that the law in South Africa allows for legal abortion. The proportion of this percentage is substantially higher in the rural region compared to the urban region;
b) Among the 567 respondents who were aware of legal abortion, almost half did not know there was a time restriction for legal termination of pregnancy on request (without restriction); and
c) Of those who were aware of legal abortion, only 9% had ever discussed abortion with a healthcare worker.[5]

5.7.3 Although this study was conducted some years back, the shift to the digital age has not seen greater access to information on abortion services for black women in South Africa. A quick internet search for safe and legal abortion service providers in the country does not yield satisfactory results. Much of the first few pages of such a search are dominated by advertisements for unsafe, unregistered and illegal abortion service providers while the NDOHs website does not readily provide information that can link women to facilities in their area. Access to information is particularly important because of the stigma that abortion still carries in a country where religious morality was used as the backbone to justifying racial discriminatory laws and policies.

[5] C Morroni, L Myer, & K Tibazarwa "Knowledge of the abortion legislation among South African women: a cross-sectional study" (2006) 3 *Reproductive Health* 2.

5.7.4 To further frustrate, the above studies have also shown that of the facilities that offer abortion services, 95% of these facilities could not be reached by phone and most required women to attend on the facilities on a particular day to obtain information on the services they can or cannot access. Requiring that women travel to and from a facility merely to obtain information can have a frustrating effect in a country where the public transport system in many communities and especially in rural areas simply do not exist.

5.7.5 It is our submission that formal equality fails women and that it is not enough that the law declares abortion legal when women and girls are not empowered with this knowledge and with information on where and how to safely access these services.

5.8 ***Limited facilities and health care providers***

5.8.1 In its report published in 2017, Amnesty International[6] found that of the 3880 public health facilities operating in South Africa, less than 7% provided access to abortion services. Only 505 medical facilities have been designated to provide the service and of these 505 health facilities, only 197 have been recorded to actually provide access to abortion services. These numbers are across all provinces and were recorded prior to the pandemic where access to these services was decreased by 17%.

5.8.2 A look at the #SizaMap[7] patently shows the ever-pervasive rural/ urban divide, with most facilities being concentrated in more developed provinces as well as metropolitan cities such as west of the Western Cape Province, Johannesburg central in Gauteng and Durban, KwaZulu Natal. The more rural Northern Cape and Free State provinces recorded an alarmingly low number of facilities.

5.8.3 Access to abortion services is also wholly dependent on the availability of medical service providers. The current available designated abortion facilities are too understaffed, overburdened and under-resourced to properly function and attract willing service providers. In a 2016 National Health Care Facilities Baseline Audit it was found that nearly half of the clinics and about 20% of the 238 Community Health centres had reported having no access to doctors who are authorised to provide abortion services. Rendering these designated facilities as effectively of no use to women in need of their services.

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[6] Amnesty International *Briefing: Barriers to Safe and Legal Abortion* 8-9
[7] Bhekisisa Team "#SizaMap" (20-11-2017) *Bhekisisa Centre for Health Journalism.*

5.8.4 Now not only are free and accessible abortion facilities limited, but safe and legal abortions are also further limited by a shortage of authorised medical practitioners and willing service providers. Access therefore only appears to be available on paper, but not in reality.

5.8.5 With so few abortion facilities operating as they should across the country and most importantly in rural areas where the most vulnerable women reside, it is accordingly of great concern that the access to abortion services is not a priority for the South African Government.

5.9 ***Designations of facilities***

5.9.1 The ability of a woman to access termination services in part also depends on there being, geographically, well-distributed legal and free designated abortion facilities in both urban and rural areas. In the absence of this, it becomes essential for there to be proactive strategies and policies in place to maintain existing facilities as well as expand services to women wherever they may be.

5.9.2 Section 3 of CTOPA provides for where legal abortions may be accessed and sets out the requirements that such access points. It also sets out what facilities need to comply with before being designated to offering services. These requirements apply to both public and privately run abortion facilities wishing to operate in SA.

5.9.3 In furtherance of this section, the regulations to CTOPA provide for the Minister of health to oversee the designation of these facilities as abortion services providers but unfortunately does not provide for the designation process to be followed.

5.9.4 Without a prescribed process, this designation process has been left to each provincial department of health to develop and implement as they see fit. The lack of clear directive from the Minister of Health on the process for designation had led to a fragmented and inconsistent application of the law from province to province.

5.9.5 The fragmentation and inconsistent application of the law in these processes have led to a lack of access to information to individuals and organisations which seek to provide abortion services. Service provision is frustrated when those who are able to provide access to rights do not know what the process entails for them to do so. So where women struggle to access information about facilities those who wish to offer services have the exact same issue in the designation process.

5.9.6 The challenge of designation largely impacts on private non-profit clinics and facilities funded through philanthropic investment. The lack of readily accessible and consistent information has meant that underfunded NGOs and health care providers without the resources and capacity to persistently embark on these processes are effectively excluded from the abortion provision sector. In turn contributing to the shortages of personnel and facilities in the sector as a whole and this limits the access of black women to services as they would have been the group which stood to benefit the most from an effective designation process. Women are therefore caught in a vicious cycle over which they have no control.

5.10 *Conscientious Objectors / Religious Refusals*

5.10.1 Of all the barriers discussed here, the most concerning to rights based feminist organisations such as ours is that of refusal to provide access to rights and the increasing active dissuasion of women from accessing abortion services. Both of these barriers are heavily being promoted by anti-rights, pro religious and conservative morality actors.

5.10.2 Refusals to offer abortion services on the basis of one's religious views is commonly referred to as "conscientious objections" which originated from Western cultures with roots in Christianity and a form of pacifism (the belief that taking human life under any circumstances is evil) during active war times and conscription of soldiers. Even in South Africa many young men opted not to do military service (instead serving prison terms) during apartheid because of conscientious objection to the apartheid system of discrimination. The phrase has now been co-opted by anti-rights actors and poses a grave risk to women's rights to their bodily autonomy in a country where 94% of South Africans have been noted to have some religious affiliation.

5.10.3 The practice of refusing women access to services is usually exercised by medical staff, as well as general clinical and/or hospital staff. This means that general staff as well as direct service providers turn women away when they seek abortion services, and often without a referral as required. Medical staff rely especially on the notion of conscientious objection as their basis to deny women access to services.

5.10.4 The centre has also received reports from women that security guards at state facilities would deny women access to designated facilities or deny them access to information when they make enquiry about whether the facility is designated to provide abortions. Because of the lack of information available to women they rely on security to provide

them entry into buildings, but also seek to access information from them. It is unclear whether security staff are advised to deny women entry who seek abortions or whether they are doing so based on their own stereotypical believes about women's bodies and decision making.

5.10.5 While these refusals are practised informally in the health care sector, they have of as a result of recently released *National Clinical Guideline for Implementation of the Choice on Termination of Pregnancy Act* ("The Guidelines") adopted in November 2020 by the National Department of Health been viewed as being normalised and acceptable procedure.

5.10.6 While the CTOPA does not include a clause that allows a medical practitioner to religiously refuse to provide abortion (conscientious objection clause) nor establish a clear right of refusal based on religion/ religious belief, medical practitioners have historically objected to offering abortions and related services on the basis of section 15 of the Constitution which provides for the right to freedom of religion, belief and opinion, and includes the right to freedom of conscience.

5.10.7 A study conducted in 2014 by Colvin et al exploring how providers in South Africa make sense of or understand conscientious objection in terms of refusing to provide abortion care services and the consequent impact on abortion access found the following:

a) In most public sector facilities, there was a general lack of understanding concerning the circumstances in which health care providers were entitled to refuse to provide, or even assist in abortion services;
b) At the same time in other contexts, despite being aware of the circumstances and limitations placed on conscientious objection, providers refused to provide abortion services, and the policies and procedures for managing conscientious objection were undocumented;
c) Providers seemed to have poor understandings of how conscientious objections were to be implemented; and
d) Providers incorrectly invoked their right to conscientious objection as it related to the CTOPA in that although conscientious objection serves to allow a health worker to choose not to participate in abortion procedures, it does not allow for a refusal to participate in other aspects of abortion provision.

5.10.8 *The National Clinical Guideline for Implementation of the Choice of Termination of Pregnancy Act*

5.10.8.1 These Guidelines were published by the National Department of Health in 2020 as a crucial part of the broader effort to take a comprehensive approach to reproductive health in South Africa and are primarily intended for registered medical practitioners, nurses, and midwives.

5.10.8.2 The Guidelines among other things, instruct health care providers on how to fulfil their functions and makes specific provision for the refusal of services and for the effective referral of patients to other willing service providers in such an instance.

5.10.8.3 In relation to conscientious objections specifically, the Guidelines recognize that in accordance with Section 15 (1) of the Constitution *"everyone has the right to freedom of conscience, religion, thought, belief, and opinion".* They provide that Section 15 of the Constitution implicitly accommodates a provider's refusal to provide services and acknowledge that this refusal creates harm and serves as an additional barrier for patients who are entitled to receive comprehensive reproductive care. The Guidelines thereafter go on to detail the process to be followed should a conscientious objection be exercised and detail the ethical obligations that still apply in emergency situations.

5.10.8.4 In contravention of the spirit and purpose of the CTOPA, these Guidelines have now legitimised a harmful practice in the abortion services sector and have failed to prioritise the rights of women in a South African context where access is already grotesquely frustrated or in some cases entirely curtailed.

5.10.8.5 The CTOPA act itself in relation to this issue has also failed to protect women from the direct reliance on the freedom of religion to limit access to abortion services and should have provided express reference to this practice and provided its position on the matter given that its mandate was to give effect to the constitutional rights of women to choice.

5.10.8.6 The Guidelines provide an interpretation of the related competing constitutional rights to reproductive health care and freedom of religion by exclusively focusing on the freedom of religion of providers to the detriment of the rights of women to reproductive health care. This new allowance does not give proper weight to the challenge this poses to the rights of women and does not implement an adequate process whereby the right to choice is protected. It does not detail how both the national and provincial Departments of Health will monitor the refusals to ensure that abortion services do not become even

more restricted nor establish a way to ensure that there are efforts to specifically recruit practitioners who are able to provide abortion services to bridge the gaps created by those objecting.

5.10.8.7 These new Guidelines are accordingly of great concern to women as they inappropriately legitimise a harmful practice that is having a compounded discriminatory impact on already disadvantaged to poor black women. The Guidelines through this legitimisation further obstructs access to abortion services by reducing the number of medical personnel and facilities that effectively provide these services within a context where access is all but disappearing.

5.10.8.8 The legitimisation of conscientious objection may in effect result in the complete denial of access to abortion services and may result in preventing patients from receiving accurate, scientific, and unbiased information about their options where this practice is even further abused.

5.11 ***Stigma and prejudice around the termination of pregnancy in South Africa***

5.11.1 On a regional level, South Africa has ratified the Protocol to the African Charter on Human and Peoples' Rights of Women in Africa (commonly known as the Maputo Protocol) and the Protocol defined harmful practices to mean all behaviour, attitudes and/or practices which affect the fundamental rights of women and girls, such as their right to life, health, dignity, education and physical integrity.

5.11.2 Of significance in this context is Article 5 of the Protocol which unequivocally obligates the state to prohibit and condemn harmful practices which negatively affect women. This obligation includes creating awareness through information and educating society, which in the context of South African perceptions of abortions means implementing measures geared towards eradicating stigmas and prejudices that stem/ from social, cultural and religious narratives against abortion.

5.11.3 The voluntary termination of pregnancy has historically and continues to be perceived as immoral by several sectors of society. These social perceptions and attitudes contribute to the stigma attached to the termination of pregnancies and act as a barrier to accessing safe and legal abortions. It has been obstructive in cases where medical practitioners, registered nurses or midwives, or healthcare officials who come into contact with women seeking to access terminations have denied them such access.

5.11.4 Although the CTOPA seeks to minimise the opportunity for the social, cultural or religious views of nurses, midwives or other medical practitioners to influence the treatment of women seeking termination of pregnancy and does so by mainly protecting a woman's autonomous right to choose; the 2020 National Clinical Guidelines introduced by the National Department of Health and existing medical ethics guidelines have had the effect of undermining the CTOPAs efforts to protect women from such stigmas by making allowances for conscientious objections and thereby legitimising the stigmas that threaten the right to choice.[8]

5.11.5 Accordingly, in a context where South African healthcare professionals are not adequately trained on professional objectivity, where there are still stigmas attached to accessing abortions, and limited abortion facilities available, the need for measures to address provider bias and broadly societal prejudices become pertinent to ensuring abortion services are truly accessible to women. The state as an obligation as set out above to address the stigma and stereotypes and not to entrench them in policy.

5. 12 *Pregnancy Crisis Centres*

5.12.1 The insurgence of what can generally be referred to as Pregnancy Crisis Centres (hereinafter PCC) has increasingly become a great concern in the protection of the right to choice for South African women.

5.12.2 Pregnancy Crisis Centres have based on our experience been observed as anti-choice agencies that present themselves as unbiased medical clinics or counselling centres. They are mostly run by Christian faith-based organisations and use religious persuasion to counsel women out of accessing abortion services. They generally refuse to refer clients to abortion facilities and the use of contraceptives alongside promoting misinformation about medical procedures and the impact thereof. They create false narratives around crucial information related to obtaining abortions.[9]

5.12.3 These centres are often not licenced as medical facilities with no qualified medical personnel on staff. Rather they are Non-profit Organisations designed to dissuade pregnant women from having an abortion. These organisations target lower income pregnant black women under the guise of free services such as ultrasounds and

[8] *The National Clinical Guideline for the implementation of the Choice on Termination of Pregnancy Ac*t; Health Professions Council of South Africa *Guidelines for good practice in the healthcare professions: General ethical guidelines for reproductive health* (2016) Booklet 8; South African Nursing Council *Ethical standard* (2018);
[9] Abortion Rights Coalition "*Review Of 'Crisis Pregnancy Centre' Websites in Canada"* (2016).

counselling. They are well resourced and designed to look like actual health care facilities with waiting area partitions, check-in desks and ultrasound machines. They instead provide false medical information to visitors such as myths that abortions increase the risk of breast cancer, negatively impact future fertility or will cause long-term mental health problems.

5.12.4 Bhekisisa, a centre for journalism has found that in South Africa, pregnancy Crisis Centres appoint unregistered peer counsellors on a volunteer basis with the belief that abortions are damaging to women. They task these volunteers with imposing upon women directive counselling in contravention of CTOPA and task them with dissuading women against abortions by using terms such as "murder" and "post-abortion syndrome". This seeks to convince women that they will suffer from varying psychological conditions if they proceed with abortions and would be acting against various religious beliefs.[10]

5.12.5 Akin to where the origins of PCCs can be traced to, the USA, many PPCs and similar organisations in South Africa operate from within or alongside public healthcare facilities or are intentionally located near actual abortion clinics and healthcare providers. They particularly target young low-income communities of black women by offering free pregnancy tests and by being in close proximity to colleges and universities, advertising their services on school campuses. They therefore become more accessible in many ways than designated facilities in the public health care system.

5.12.6 Due to their independence and under regulation, it's difficult to say how many operate in South Africa currently. PCCs are often not registered as non-profit organisations which ensures that they fall outside the jurisdiction of the Department of Social Development ('DSD'). The DSD is an executive department enacted in line with the Non-profit Organisations Act 71 of 1997 and several other legislative mandates and was created to centralise the regulation of non-profit organisations. PCCs are also not often registered as accredited health care facilities and have unregistered peer counsellors on a volunteer basis carrying out their daily functions. This places them outside the jurisdiction of the NDOH and institutions responsible for regulating health care professionals.[11]

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[10][For more information see: "Pregnant? Need an abortion? Here's where not to go" Bhekisisa Centre for Health Journalism https://bhekisisa.org/article/2018-09-21-00-the-gospel-of-shame-how-christian-groups-thwart-the-right-to-abortion-south-africa/ referred to as Bhekisisa in this letter].

[11] The Health professionals council and SA nursing council.

5.12.7 Instead, most PCCs, like religious structures, operate in a legal vacuum and exploit the absence of regulations specifically geared towards addressing such entities. Information on the funding models for such centres in South Africa is also scarce but researchers, nonetheless, believe that like centres established in the United States, these centres are mainly funded by right-wing Christian organisations.[12]

5.12.8 Pregnancy Crisis Centres operate in contravention of sections 4, 6 and 10 of the Choice of Termination of Pregnancy Act. In accordance with section 10 of the Choice of Termination of Pregnancy Act, a person preventing the lawful termination of a pregnancy or obstructing access to a facility is liable for an offence.

5.12.9 Pregnancy Crisis Centres obstruct access to abortion facilities in contravention of CTOPA in that they:

a) Use false advertising to imply that they are abortion clinics or reproductive health care providers. Many such centres pay for online advertising so that search results for abortions direct people to their "fake clinics". Many are also intentionally located right next to actual abortion clinics and health care providers to confuse people.

b) Have peer counsellors that make use of directive counselling and misinformation to at best dissuade women from pursuing abortions and at worst to frustrate their access to willing facilities by refusing to provide information to credible facilities or misdirecting women entirely.

c) In some instances, use graphic models and sonograms in an effort to persuade women against abortions and in some centres, personnel lie about how far along a pregnancy is to mislead people about their options and to stall abortion appointments until it's too late for people to seek abortions at real centres. All these actions create barriers that hinder women from accessing safe abortions.

5.12.10 In summation, PCCs have clear anti-abortion agendas and due to under regulation have been left unchecked in their work to obstruct access to abortion services. They've become a serious threat to the right to choice and in era where more and more underhanded challenges seek to undermine the constitutional right of women, should be of great concern to the state tasked with ensuring the rights of women are protected.

[12] [For more on this see K Kelly "The spread of 'Post Abortion Syndrome' as social diagnosis" (2017) 102 Social Science & Medicine 18 25; exposefakeclinics.com and Rosen (2012) 44 Viewpoint 201 205]

ENDS**