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CONSCIENTIOUS OBJECTION AND WOMEN'S SEXUAL AND REPRODUCTIVE HEALTH: A COMPARATIVE ANALYSIS OF NIGERIA AND SOUTH AFRICA

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Abstract

Conscientious objection in healthcare, often justified on the grounds of moral integrity, autonomy, and religious belief, presents a significant challenge to the realisation of women's sexual and reproductive health rights. This article examines the tension between the rights of healthcare providers to refuse participation in certain medical procedures and the rights of women to access lawful reproductive healthcare services. Focusing on a comparative analysis of Nigeria and South Africa, the article highlights how differing legal frameworks produce distinct, yet convergent, barriers to access. In Nigeria, restrictive abortion laws and the absence of a formal regulatory framework for conscientious objection result in a system where access to reproductive healthcare service is already severely limited, rendering objection both structurally redundant and practically harmful. In contrast, South Africa's rights-based legal regime, particularly under the Choice on Termination of Pregnancy Act, formally guarantees access to abortion services, yet fails to provide clear and enforceable limits on the exercise of conscientious objection. This regulatory gap enables the overextension of refusal by healthcare providers, thereby undermining the effective realisation of women's rights in practice. The article argues that while conscientious objection remains a legitimate expression of individual autonomy and religious freedom, its exercise within public healthcare systems must be strictly limited to prevent obstruction of access to essential

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medical services. It proposes a rights-prioritising regulatory model that accommodates individual conscience only to the extent that it does not compromise timely, equitable, and non-discriminatory access to care. Ultimately, the article contends that access to sexual and reproductive healthcare must not be contingent upon the moral or religious disposition of individual providers.

Keywords: Conscientious objection, sexual and reproductive health, women's rights, autonomy, religion, healthcare access.

1.0 INTRODUCTION: THE COLLISION OF RIGHTS

The relationship between conscience and care sits at one of the most contested intersections in contemporary healthcare law and policy. When a healthcare provider refuses to participate in a lawful medical procedure on grounds of moral conviction or religious belief, two foundational claims of human rights law are brought into direct and uncomfortable confrontation. On the one hand stands the provider, invoking the dignity of conscience, the inviolability of personal belief, and the constitutional and international protection afforded to freedom of religion and thought. On the other hand, is the patient, a woman seeking access to sexual and reproductive health (SRH) care invoking her equally foundational rights to health, bodily autonomy, dignity, and non-discrimination. Both claims are legally acceptable; both are morally serious. But, in the structure of public healthcare, they cannot always be simultaneously honoured.

Conscientious objection in SRH care is a growing global concern, intensified by the U.S. Supreme Court's Dobbs[1] decision, which overturned decades of constitutional backed protection for abortion access

[1] *Dobbs v Jackson Women's Health Organization* 597 US 215 (2022).

and emboldened restrictive reproductive health agendas worldwide.[2] In Africa, this global shift collides with entrenched religious, cultural, and political orientations that have long shaped the legal regulation and frequent non-regulation of reproductive healthcare, thus widening the gap between the formal recognition of women's SRH rights and their practical access to the services.[3]

This article examines the tension between conscientious objection and women's SRH rights through a comparative analysis of two African jurisdictions that represent structurally distinct approaches to the problem: Nigeria and South Africa. Nigeria operates one of the most restrictive abortion legal regimes on the continent, criminalising the procedure in all but the narrowest circumstances under both the *Criminal Code Act*[4] and the *Penal Code*.[5] In this context, the country's highly restrictive abortion laws effectively embed conscientious objection into a system already designed to limit access. In contrast, South Africa, despite having Africa's most progressive SRH framework, with constitutional protections of the rights to dignity, bodily integrity and equality[6] on one hand, and legal abortion access under the Choice on Termination of Pregnancy Act (CTOPA)[7] on the other, sees these gains undermined in practice by widespread, unregulated conscientious objection among healthcare

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2 R J Cook, 'Human Rights and Reproductive Self-Determination' (1995) 44 *American University Law Review* 975, 978.

3 C Ngwena, *What is Africanness? Contesting Nativism in Race, Culture and Sexualities* (PULP 2018) 134–137.

4 Secs 228–230 Criminal Code Act, Cap C38, LFN 2004.

5 Sec 232 Penal Code Act, Cap P3, LFN 2004.

6 Secs 10, 12 and 27 South African Constitution 1996.

7 Choice on Termination of Pregnancy Act 1996.

providers and institutions. [8] The comparison is deliberate, highlighting how both restriction and progression can equally fail women's access to SRH care.

Although Nigeria and South Africa sit at opposite ends of the SRH regulatory spectrum, both systems produce similarly harmful outcomes for women. Nigeria's legal framework itself blocks access, making any conscientious objection mechanism both redundant and dangerous. South Africa formally guarantees access but fails to define the limits of conscientious objection, allowing provider refusals to hollow out the guarantee at the point of care. [9] In both jurisdictions, the heaviest burden and consequences falls on women; especially the poor, rural and marginalised ones.[10]

Conscientious objection, while rooted in legitimate claims of moral integrity and religious freedom, becomes legally and normatively indefensible when it blocks women's access to SRH care. The right to conscience does not extend to denying others access to essential medical care. This is not merely a policy preference; it is a conclusion compelled not merely by policy preference; but also, international human rights law, the structural demands of public healthcare systems and the fundamental principle that rights must be practically effective to be meaningful.[11]

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[8] J Harries *et al,* 'Conscientious Objection and Its Impact on Abortion Service Provision in South Africa: A Qualitative Study' (2014) 11(16) *Reproductive Health* <https://pubmed.ncbi.nlm.nih.gov> accessed 14 April 2026.

[9] O A Savage-Oyekunle & A Nienaber, 'Adolescents' access to emergency contraception in Africa: An empty promise?' (2017) 17 *African Human Rights Law Journal* 490.

[10] WHO*, Safe Abortion: Technical and Policy Guidance for Health Systems* (2nd edn, WHO 2012) 94-96.

[11] Para 11, CEDAW General Recommendation No 24: Article 12 (Women and Health)- UN Doc A/54/38/Rev.1 (1999).

To develop this argument, the article proceeds as follows: section 2 establishes the conceptual foundations, examining the philosophical basis of conscientious objection and how conflicting provider-patient rights should be resolved. Section 3 analyses Nigeria's legal and institutional framework governing SRH care framework and its regulatory failures. Section 4 examines South Africa's rights-based legal order and the operational gaps that undermine it. Section 5 draws a comparative analysis between the situation in the two jurisdictions, identifying the central paradox that legal progress does not automatically guarantee practical access, while legal restriction can obscure deeper rights conflicts. Section 6 deepens the analysis by engaging with critical theoretical tensions, including the limits of conscience in public professions, the question of institutional objection, the risk of abuse, and disproportionate impact on vulnerable women. Section 7 concludes the article by proposing an original rights-prioritising regulatory model consistent with international human rights standards and the practical demands of accessible healthcare delivery.

2.0 CONCEPTUAL FOUNDATIONS

a. Conscientious Objection: Nature, Justification, and the Problem of Public Role

Conscientious objection is the refusal to perform an act that one's moral, religious, or ethical convictions deem wrong.[12] Rooted in moral and political philosophy and notably theorised by Thoreau and Rawls, who distinguished it from civil disobedience, as a private, integrity-preserving act,[13] Conscientious objection in healthcare refers to a provider's refusal to participate in lawful medical procedures like abortion, contraception, sterilisation, or assisted reproduction, on moral or religious grounds.[14]

The case for accommodating conscientious objection in healthcare rests on three propositions. First, moral integrity is central to human dignity,[15] thus, compelling people to act against their conscience violates them as; moral agents. Second, freedom of conscience and religion is a foundational right recognised in major international treaties like the International Covenant on Civil and Political Rights (ICCPR),[16] African Charter,[17] and the constitutions of both Nigeria[18] and South Africa.[19]

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[12] M Wicclair, *Conscientious Objection in Health Care: An Ethical Analysis* (Cambridge University Press 2011) 1-3.

[13] J Rawls, *A Theory of Justice* (revised edn, Harvard University Press 1999) 319-323; H D. Thoreau, 'Resistance to Civil Government' in *Walden and Civil Disobedience* (Penguin 1983) 385-387.

[14] B Dickens & R Cook, 'The Scope and Limits of Conscientious Objection' (2000) 71 *International Journal of Gynaecology and Obstetrics* 71–72.

[15] R Dworkin, *Life's Dominion: An Argument about Abortion, Euthanasia, and Individual Freedom* (Alfred A Knopf 1993) 166–168.

[16] Art 18, International Covenant on Civil and Political Rights 1966.

[17] Art 8, African Charter on Human and Peoples' Rights 1986.

These instruments do not protect conscience as a subset, but as a core right like other individual rights. Third, as Dickens and Cook argue, forcing providers to perform procedures they find morally impermissible may compromise care quality, as coerced participation may result in the creation of a detached or hostile clinical environment that can be harmful to patients.[20]

While the philosophical case for conscientious objection deserves serious consideration, it does not justify unregulated or unlimited use of conscientious objection in public healthcare. The conscience argument is premised on private moral agency, but a healthcare provider working in a publicly funded hospital occupies a public professional role, voluntarily assumed under a framework that imposes duties of care that exist independently of their personal beliefs.[21] While the shift from private moral agent to public professional does not eliminate the provider's conscience, it limits how far that conscience can be exercised at the expense of the patient's access. The power a provider exercises in this context is neither morally nor legally neutral; it exists solely because the State trained, licensed, and positioned him within a system women depend on. In this context, the provider's conscience claim must be weighed not against the State, but against the competing rights of the patients, the provider is professionally obligated to serve.[22]

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[18] Sec 38 Nigerian Constitution 1999.
[19] Sec 15 South African Constitution 1996.
[20] B Dickens & R Cook, 'Conscientious Commitment to Women's Health' (2011) 113 *International Journal of Gynaecology and Obstetrics* 163.
[21] C Ngwena, 'Conscientious Objection to Abortion and Accommodation of Providers' Moral Claims in Pluralist Societies: Lessons from South Africa' (2014) 58 *Journal of African Law* 1, 6–8.
[22] Wicclair (n 12) 45–47

Flowing from the above, it does not mean that conscientious objection has no place in healthcare. Instead, it means that its place must be clearly defined and made conditional on continuity of patient care. As the WHO affirms; it's use must not obstruct access to services to which a patient is entitled to access. The right to refuse must be inseparable from the duty to refer; both operating within a system that guarantees timely access to a willing provider within a timeframe that does not in itself constitute harm.[23]

b. The Dual Autonomy Conflict: Provider Integrity and Patients' Self Determination

The conscientious objection debate in SRH care pits two legally and morally serious but unequal forms of autonomy against each other. Provider autonomy is the healthcare professional's claim to act in accordance with their moral or religious convictions by refusing procedures they deem ethically impermissible. [24] This form of autonomy is rooted in the broader concept of personal self-determination, postulations derived from Kant through Mill to contemporary liberal theory.[25]

Patient autonomy, specifically women's reproductive autonomy, is the right to make free, informed decisions about one's body, pregnancy, health, and future, without interference by the State or third parties,

[23] WHO, *Safe Abortion* (n 10) 96.
[24] Dickens & Cook (n 14) 72
[25] I Kant, *Groundwork of the Metaphysics of Morals* (Mary Gregor tr, Cambridge University Press 1997); J S Mill, *On Liberty* (Penguin 1974).

including healthcare providers.[26] It encompasses access to accurate information, and legally entitled SRH care services, guaranteed under binding human rights instruments such as the CEDAW,[27] ICESCR,[28] Maputo Protocol,[29] and evolving jurisprudence of the United Nations (UN) treaty monitoring bodies.[30]

While the two autonomy claims are real, they are not symmetrical in consequence. When provider autonomy overrides patient autonomy, the harm to women is concrete and severe, ranging from unwanted pregnancy, unsafe abortion, maternal mortality, to delayed care, psychological distress, and even socioeconomic harm. In contexts of structural disadvantage, the consequences further compound existing inequalities of class, geography, and social power.[31] These are not speculative harms, they are documented, statistically verified, and disproportionately suffered by society's most vulnerable women.[32]

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[26] R Cook & S Cusack, *Gender Stereotyping: Transnational Legal Perspectives* (University of Pennsylvania Press 2010) 103-106.

[27] Art12 & 16, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 1979.

[28] Art 12, International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted by Resolution 2200A (XXI) of 16 December 1966.

[29] Art 14, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) 2005.

[30] Paras 11 &14 CEDAW *General Recommendation No 24: Article 12 of the Convention (Women and Health)*, UN Doc A/54/38/Rev.1 (1999).

[31] O A Savage-Oyekunle, *Female adolescents' reproductive health rights: access to contraceptive information and services in Nigeria and South Africa (LLD thesis of the Faculty of Law University of Pretoria 2014)* 333-357.

[32] Human Rights Watch, *Stop Making Excuses: Accountability for Maternal Health Care in South Africa* < https://www.hrw.org/report/2011/08/08/stop-making-excuses/accountability-maternal-health-care-south-africa> accessed 14 April 2026.

The asymmetry is stark and morally significant. A framework of rights that treats these two autonomies claims as equivalent; as if the inconvenience of referral and the harm of denial are morally comparable, is not a neutral framework. It is one that privileges the provider's moral comfort over the patient's physical and psychological integrity. The law, this article argues, cannot endorse that equivalence. It must instead recognise what this article terms *effective autonomy*: the principle that *'autonomy is only meaningfully protected where the right holder has the practical capacity to exercise it, not only the formal entitlement to do so'*.[33]

c. Religion, Conscience, and the Limits of Manifestation in Professional Life

Conscientious objection in SRH care is, in the majority of documented cases, religiously motivated.[34] Providers who refuse to perform or participate in abortion services commonly cite religious convictions, particularly those rooted in Christian and, in the Nigerian context, Islamic doctrine, as the basis for their refusal.[35] Thus, the conscientious objection debate is significantly a religious one; which is addressed in this article.

International human rights law protects religious freedom with exceptional force. Article 18 of the ICCPR guarantees the right to freedom of thought, conscience, and religion, including the freedom to manifest

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[33] M Nussbaum, *Creating Capabilities: The Human Development Approach* (Harvard University Press 2011) 17–19.

[34] Dickens & Cook (n 14) 72; I Tyler, 'Conscientious Objection and the Healthcare Professional' (2017) 43 *Journal of Medical Ethics* 89, 90.

[35] Ngwena (n 21) 4–5; S Nabaneh & A Muula, 'Abortion in Africa: An Overview of Legislation, Measures, Incidence and Consequences' (2019) 19 *African Journal of Reproductive Health* 152, 155.

one's religion or belief in worship, practice, and teaching.[36] The African Charter provides equivalent protection for the African region.[37] The Nigerian and South African constitutions[38] entrench freedom of religion as a fundamental right. These protections reflect a principled post-war human rights commitment that the State cannot force belief or punish religious expression and instead, affirm the governments' duty to uphold freedom of thought, conscience, and religion as non-derogable rights, essential to human dignity.

However, this distinction is jurisprudentially foundational. International human rights law has consistently distinguished between the freedom to hold a belief, which is absolute and non derogable; and the freedom to manifest that belief through conduct, which may be subject to limitation.[39] In line with the above, the Human Rights Committee confirms that while the freedom to hold religious beliefs cannot be restricted, the manifestation of those beliefs through conduct may be limited to protect the fundamental rights of others.[40]

The distinction above applies in the conscientious objection context. A healthcare provider's religious conviction that abortion is morally impermissible, is his belief and therefore protected by law. However, when he expresses his belief by refusing to perform or refer a woman for a lawful medical procedure, within a public healthcare system, to the extent

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36 Art 18(3) ICCPR (n 16 above).
37 Art 8 African Charter (n 17).
38 Sec 38(1) Nigerian Constitution 1999 & Sec 15(1) South African Constitution 1996.
39 Para 3 General Comment No 22: Art 18 (Freedom of Thought, Conscience or Religion), UN Human Rights Committee, UN Doc CCPR/C/21/Rev.1/Add.4 (1993).
40 Para 8 (above).

that his refusal results in denial of essential care to a patient(s), then, his right to conscience can be limited.[41]

It is necessary to point out that this reasoning is neither a novel nor radical claim, but an established viewpoint of human rights bodies which have been applied in different contexts, especially where religious objections rights clash with anti-discrimination duties. Courts across jurisdictions have consistently maintained that freedom of belief does not confer a right to discriminate when performing a public or professional duty.[42] The same logic holds in healthcare; requiring a provider to refer a patient to a willing colleague does not violate his conscience rights, as he would merely be inconvenienced. In contrast, an unregulated refusal, will outrightly violate the patient's right to access care.

d. The Hierarchy of Rights: Resolving the Collision

The preceding analysis establishes that conscientious objection and women's SRH rights are not in a hierarchy; both are genuine rights claims grounded in international and domestic law. The real question, which Nigeria and South Africa have both failed to adequately answer, is how the collision is resolved.

International human rights law resolves rights conflicts through established principles. Proportionality requires that limits on rights must serve a legitimate aim, with minimal impairment, and produce proportionate effects.[43] Every right has an irreducible that cannot be

41 Ngwena (n 21) 9 -10.
42 *Eweida & Others v United Kingdom* (2013) ECHR 37 paras 80-95.
43 *S v Makwanyane* 1995 (3) SA 391 (cc) para 104.

removed, regardless of competing claims. [44] Equally, restrictions, if necessary, must not fall heavily on those already vulnerable. [45] Applying these principles, the conclusion is clear. Requiring referral, prohibiting institutional objection, and imposing state obligations to guarantee access; all pursue the legitimate aim of ensuring effective access to lawful healthcare.[46] These measures minimally affect providers' religious freedom, since they demand only facilitation, not performance. They are proportionate too, as the harm avoided by denial of essential SRH care, outweighs the lesser burden of referral.[47]

3.0 LEGAL AND INSTITUTIONAL FRAMEWORKS IN NIGERIA

a. The Legal Position on Abortion: An Architecture of Restriction

In Nigeria, the law largely ignores conscientious objection, but its effects on healthcare are deeply harmful. Nigeria maintains one of the most restrictive abortion regimes on the African continent, a framework rooted not in contemporary rights reasoning but in colonial era criminal legislation that has survived independence. It remains mostly unchanged, protected from reform by religious conservatism, political inaction, and a legal system that has not fully embraced its international commitments on SRH rights.

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[44] Para 47 Committee on Economic, Social and Cultural Rights, General Comment No 14: The Right to the Highest Attainable Standard of Health (2000) UN Doc E/C.12/2000/4.

[45] Art 1, CEDAW (n 30); Cook and Cusack (n 27) 108.

[46] P J Grace *et al*, 'Professional Responsibility, Nurses, and Conscientious Objection: A Framework For Ethical Evaluation' (2024) 31(2-3) *Nursing Ethics* 243-255.

[47] Ngwena (n 21) 16 -17.

Nigeria's abortion law is governed by the Criminal[48] and Penal[49] Codes. Both legislations criminalise abortion, imposing up to fourteen years imprisonment on providers and seven years on the woman herself.[50] The sole exception; to preserve the mother's life, is narrowly framed and rarely used, that it functions more as a theoretical safeguard than a practical one. States in northern Nigeria further complicate the situation. Since 1999, twelve states have adopted Sharia criminal law alongside the Penal Code, creating interpretive tension as the prevailing Islamic jurisprudence permit abortion only in cases of absolute necessity, further compounding an already severe federal restriction. Women in these states therefore navigate two overlapping systems of prohibition, neither designed with their rights, health, or dignity in mind.

Nigeria has ratified several treaties like the ICESCR,[51] CEDAW,[52] African Charter[53] and Maputo Protocol which its current restrictive framework contradicts. The provision of Article 14(2)(c) of the Maputo Protocol is unambiguous: States must permit abortion in cases of rape, sexual assault, incest, and where pregnancy endangers the mother's health or life. Yet, despite ratifying these instruments over two decades ago, Nigeria has taken no legislative steps to domesticate them.[54]

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48 Sec 228 & 229, Criminal Code Act Cap C38, LFN 2004.
49 Sec 232, Penal Code Act Cap P3 LFN 2004.
50 *Dorothy Bebe v Federal Republic of Nigeria* (Suit No ECW/CCJ/APP/48/23; ECW/CCJ/JUD/16/25).
51 ICESCR (n 28).
52 CEDAW (n 27).
53 African Charter (n 17).
54 Sec 12 Nigerian Constitution 1999.

Nigeria's Criminal and Penal Codes remain unchanged, while CEDAW and the Maputo Protocol, though ratified, remain undomesticated. Meaning that the treaties are merely aspirational documents rather than enforceable rights, leaving women they were designed to protect with no domestic mechanism to invoke them.[55] The gap between Nigeria's international commitments and reality is no accident; but a choice sustained by politics, religion, and institutional neglect, with its consequences borne entirely by women. This article argues that the gap is not just legislative failure, but an ongoing violation of rights perpetuated daily by the Nigerian state's inaction.

b. Religion, Law, and the Moral Foundation of Restriction

Nigeria's restrictive abortion regime reflects more than outdated laws; it is sustained by religious moral frameworks that dominates public life and supresses rights-based debates on SRH care. With Christianity and Islam commanding nearly universal allegiance, both institutions condemn abortion more harshly than domestic law.[56] The result is a moral climate where any attempt at reform is politically toxic, professionally risky, and socially stigmatised. Religious influence on Nigerian law operates at three levels. Legislatively, efforts to reform the colonial criminal framework have repeatedly failed under strong religious opposition.[57] Judicially, the courts have consistently refused to read the therapeutic exception broadly, reflecting the same moral conservatism that shaped the

[55] *Abacha v Fawehinmi* (2000) 6 NWLR (Pt 660) 228 (SC).

[56] Pew Research Centre, *Tolerance and Tension: Islam and Christianity in Sub-Saharan Africa* (Pew Forum on Religion and Public Life 2010).

[57] O Nnamuchi, 'Kleptocracy and its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria' (2008) 52 *Journal of African Law* 1, 12.

laws.[58] At the level of healthcare delivery, the impact is direct and most harmful; faith-based organisations constitute a major part of the country's healthcare providers that serve rural communities where secular alternatives are non-existent.[59]

Finally, where a faith-based hospital is the only accessible facility for rural women, its policies on SRH care delivery determines whether women can access important SRH care services or not. In this context, institutional objection is outrightly an exercise of monopoly power over women's access to essential services. This article argues that conscientious objection in this type of environment is an abuse of power that the law has a duty to prevent.[60]

c. Practical Implications: The Human Cost of Regulatory Absence

The effect of Nigeria's outdated legal framework, compounded by the absence of monitoring mechanisms to regulate provider refusal, is real. They are empirically documented, statistically significant, and morally intolerable. Nigeria bears one of the world's highest burdens of unsafe abortion with Bankole *et al* revealing that approximately 1.25 million unsafe abortions occur in Nigeria yearly, thus contributing to a maternal mortality ratio of 993 deaths per 100,000 live births; which is among the world's highest.[61] These figures represent women denied access to SRH

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[58] C Onyemelukwe, 'Between Legality and Morality: Abortion Law and Practice in Nigeria' (2015) 15 *African Human Rights Law Journal* 414, 418.

[59] C Obinna *et al,* 'Assessment of Maternal Health Services in Faith Based Health Facilities in Southeast Nigeria' (2009) 11 *African Journal of Reproductive Health* 67, 71.

[60] Ngwena, (n 21) 1, 18.

[61] WHO, *Trends in maternal mortality 2000 to 2023: Estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division* 2025; A Bankole *et al* 'The Incidence of Abortion in Nigeria' (2015)

care by restrictive laws and other systemic barriers. The link between legal restriction, provider refusal, and maternal death is one of the most robustly documented causal chains in global public health.[62]

In Nigeria, the harm caused by restrictive abortion laws is unevenly distributed. While financially empowered women can access safe abortion services from private healthcare providers or in jurisdictions with permissive laws; poor women unfortunately cannot. This inequality is not incidental, it is a structural logic of Nigeria's approach, which the law silently permits. Thus, this article advances three arguments from the evidence gathered from Nigeria. First, the lack of regulation on conscientious objection deepens the harm inflicted by an already rights-denying framework. Second, provider refusal compounds the problem as it makes even lawful abortion inaccessible. Third, the continued survival of this framework, despite binding international obligations and overwhelming public health evidence, is not passive governance failure but a deliberate ongoing violation of women's rights. Therefore, it is imperative to examine South Africa's legal framework, which in Narismulu & Botes[63] words, fails in service delivery despite being progressive.

4.0 LEGAL AND INSTITUTIONAL FRAMEWORK IN SOUTH AFRICA

<https://pmc.ncbi.nlm.nih.gov/articles/PMC4970740/pdf/nihms797096.pdf> accessed 24 April 2026..

62 WHO, *Safe Abortion* (n 10) 1.

63 D Narismulu & M Botes, 'Emergency abortion in South Africa: Legal access, implementation, and the role of sexual violence' (2025) 121(9/10) *South African Journal of Science https://scielo.org.za/pdf/sajs/v121n9-10/16.pdf accessed 25 April 2026.*

a. A Rights-Based Legal Order: The Constitutional Foundation

South Africa's constitutional framework, drafted as a conscious repudiation of apartheid's violations on dignity, bodily integrity, and equality, provides an enabling environment for the realisation of SRH rights, a stark contrast to Nigeria's restrictive colonial-era prohibitions.

South Africa's Constitution, as the country's supreme law,[64] embeds strong protections for SRH rights. Its Bill of Rights guarantees the rights to: dignity,[65] life,[66] equality[67] and bodily and psychological integrity, which includes the right to make reproductive choices.[68] Alongside guaranteeing the rights above, section 27 guarantees the right to access healthcare including those relating to SRH. Additionally, the Constitution obliges the government to take reasonable steps to progressively realise the right.[69] Together, these provisions establish a clear constitutional mandate for the protection of women's SRH rights.

It is essential to emphasise that Section 12(2) elevates reproductive decision-making to a justiciable right rather than a mere principle. Thus, any restriction on SRH care services is prima facie unconstitutional unless justified under section 36; automatically shifting the burden on those who restrict access and not the woman seeking care. This inversion of Nigeria's starting point has direct consequences for how conscientious

64 Sec 2 South African Constitution 1996.
65 Ibid. Sec 10.
66 Sec 11 (as above).
67 Sec 9 (as above).
68 Sec 12(2) (as above).
69 Section 27(1)(a), (2) (as above).

objection must be approached.[70] The Constitutional Court's jurisprudence, from *Treatment Action Campaign*[71] to the *Jordan's case*,[72] confirms two things: the state's commitment to achieving substantive gender equality, and affirmation that section 27 imposes enforceable obligations on the South African state, that access to healthcare is a right, and the state is accountable for access failures which disproportionately burdens women.

b. The Choice on Termination of Pregnancy Act: Progressive Law and its Limits

The Choice on Termination of Pregnancy Act (CTOPA)[73] is the legislative embodiment of South Africa's constitutional commitment to SRH rights. A deliberate repudiation of the apartheid-era Abortion and Sterilisation Act which, like Nigeria's framework, permitted termination only in narrow, approval-dependent circumstances; the CTOPA decriminalised abortion on request up to twelve weeks, expanded access on socioeconomic and clinical grounds up to twenty weeks, and allowed termination beyond that where the woman's life or foetal viability is at stake.[74] It remains Africa's most liberal abortion statute and a landmark of the post-apartheid democratic order.

A central weakness of the CTOPA however relates to its silence on conscientious objection, forcing reliance on Section 15 of the Constitution which protects freedom of conscience and indirectly enables providers to refuse abortion or other SRH services. Yet this right is not absolute, as Section 36(1)[75] allows limitation in medical emergencies where a

[70] Section 36 (as above)
[71] *Minister of Health v Treatment Action Campaign* 2002 (5) SA 721 (CC).
[72] *S v Jordan 2002 (6) SA 642 (CC).*
[73] Choice on Termination of Pregnancy Act 92 of 1996.
[74] Ibid s 2(1)(a)–(c).
[75] Section 36(1) South African Constitution 1996.

woman's life or health is at risk.[76] On its face, section 15 appears to strike a reasonable balance by acknowledging the reality of conscientious objection among providers while carving out an emergency exception for life-threatening situations. But the central argument this article advances in relation to South Africa, is that section 15 is profoundly inadequate as the sole regulatory basis for conscientious objection in healthcare settings. It is inadequate in at least four distinct respects, each with real consequences for women seeking access to SRH services.

First, section 15 contains no referral obligation. It permits a provider to refuse to perform a termination on grounds of conscience without imposing any corresponding duty to refer the patient to a willing provider. The provider may simply refuse, and the patient is left to find alternative care on her own, without assistance/information, and frequently without the practical means to do so. This omission is a regulatory gap that prioritises the provider's convenience over the patient's access, and it stands in direct tension with the constitutional guarantee of access to healthcare under section 27(1)(a).[77]

Second, section 15 defines conscientious objection solely by reference to the individual provider's subjective conscience or religious beliefs, without establishing any objective criteria for what constitutes a legitimate objection in a professional healthcare context. This open-ended formulation has enabled overbroad refusal, where conscience is claimed not on the basis of genuine moral conviction but as a routine mechanism

[76] C Ngwena, 'Conscientious objection and legal abortion in South Africa: Delineating the parameters' (2003) 28(1) *Journal for Juridical Science* 4 -5.
[77] Ngwena, (n 21) 1, 10.

for avoiding the clinical and professional demands of abortion care.[78] Research across South African public health facilities documents a pattern in which objection is claimed by providers who never formally registered their objection, who refuse the full range of reproductive healthcare rather than specific procedures, and who invoke conscience interchangeably with personal discomfort, professional risk aversion, and social stigma.[79]

Third, section 15's life-threatening exception is too narrow. Reproductive healthcare is uniquely time critical as a termination, safe at eight weeks progressively becomes complex, risky, and inaccessible as gestation advances. A two-week delay caused by refusal is not a minor inconvenience; it may shift a simple procedure into a complex one, exhaust primary facility options, or push the pregnancy beyond the CTOPA's gestational limits entirely.[80]

The fourth and most fundamental weakness is what section 15 omits. Addressing only individual providers, it leaves institutional refusal entirely unregulated and it is institutional refusal that causes the gravest harm. Public facilities with direct constitutional obligations have quietly withdrawn abortion services, not through law or policy, but through inactions; untrained staff, neglected infrastructure, and designated-facility status that is nominal at best. Section 15's silence on this pattern has not merely failed to prevent it, it has created the conditions in which it flourishes.

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[78] Human Rights Watch, (n 32).

[79] D Cooper *et al*, 'Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status' (2004) 12 Reproductive Health Matters 70, 74.

[80] WHO, *Safe Abortion* (n 10) 96.

c. Religion in Practice: The Re-entry of Moral Conservatism

South Africa's framework represents a decisive commitment to SRH rights. However, commitment on paper and delivery in practice are different things. Implementation occurs not in the clean air of constitutional theory but in a society whose providers, administrators, and institutional leaders carry their moral and religious convictions into professional life. The gap between a rights-based legal order and a religiously conservative professional culture is narrower in practice than the text suggests. The re-entry of religious conservatism into South Africa's rights-based framework deepens the gap between constitutional ideals and lived reality. The tension is particularly sharp given that the Constitutional Court has consistently affirmed the Constitution's transformative mandate to reshape society towards respect for dignity, freedom and equality of persons.[81]

Research across South African public facilities reveals a consistent pattern where providers refuse referrals on personal religious grounds; unregistered conscientious objection by nurses and midwives in designated facilities; and facility managers citing institutional policy as cover for staff moral preferences. Collectively, these practices systematically hollow out the CTOPA's guarantee of access at the very point where it should be delivered.[82]

5.0 COMPARATIVE ANALYSIS: DIVERGENCE AND CONVERGENCE

[81] Klare, 'Legal Culture and Transformative Constitutionalism' (1998) 14(1) *South African Journal on Human Rights* 146, 150.

[82] Human Rights Watch (n 32).

a. Two Systems, One Failure: The Analytical Frame

It is not sufficient, for the purpose of the argument this article advances, to simply observe that Nigeria and South Africa have different legal frameworks and thereafter draw a conclusion. The analytical value of the comparison lies in what it reveals about the relationship between legal form and lived reality in the governance of SRH rights. Without doubt, an in-depth comparison should reveal the barriers which undermine women's access to SRH care services; irrespective of whether the denial is accomplished through outright legal prohibition or the quiet erosion of legally recognised guarantees at the point of care.

The two jurisdictions represent apparent opposites. Nigeria's criminalisation against South Africa's constitutional protection and decriminalisation regime. The predictable argument would be that legal form determines outcomes. The evidence argues otherwise. What determines access is not the text of the law but the regulatory infrastructure surrounding it, the enforcement mechanisms animating it, and the political will to hold the system accountable. On each count, Nigeria and South Africa converge and that convergence is this article's central insight.

b. Structural Position of Religion: Where the Divergence Begins

The most fundamental structural difference between the two jurisdictions lies in the point at which religious influence enters the legal and institutional framework governing access to SRH care.

In Nigeria, religion does not merely influence how SRH law is implemented; it shapes the law itself. Colonial-era prohibitions persist largely because organised religious opposition have successfully ensured

that the legal framework mirrors institutional religious morality rather than Nigeria's international human rights obligations. The result is that the conflict this article examines does not arise in Nigeria as a tension between provider conscience and patient entitlement. The legal system has already resolved that tension in favour of religion before any individual provider is called upon to choose.[83]

In South Africa, the constitutional framework is insulated from religious influence, with the CTOPA enacted to repudiate apartheid-era moral conservatism; constitutional guarantees of autonomy, dignity, and equality ground SRH rights in law, independent of religious sentiments for its validity.[84] Unfortunately, religion re-enters the South African framework at the implementation level *viz* the attitude and conduct of individual providers, institutional cultures of healthcare facilities and the practical denial of SRH care services in ways the law never envisaged. Thus, the religious conservatism of South Africa's healthcare workforce negatively affects the successful implementation of the CTOPA, a legislation widely acclaimed as progressive and forward looking in its guarantee of women's right.[85]

Identifying the divergence between both jurisdictions highlights where reform must begin. In Nigeria, reform must start at the legislative core, revising relevant statutes to align with ratified human rights obligations

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[83] A Gaestel & A Shelley, *The Road Through Redemption Camp: Religion, Fertility and Abortion in Nigeria* (Pulitzer Centre, 2013) <https://pulitzercenter.org/stories/road-through-redemption-camp-religion-fertility-and-abortion-nigeria> accessed 15 April 2026.

[84] Cook *et al Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (Oxford University Press 2003) 248.

[85] Onyemelukwe (n 58) 416.

and developing implementation guidelines on conscientious objection to safeguard women's SRH access. In South Africa, the deficiency is primarily operational; the legal framework is formally adequate but undermined in practice, requiring a clearly defined and strictly enforced conscientious objection framework to ensure compliance at the point of care

So, though the challenges in the two jurisdictions are structurally distinct, necessitating adoption of responses tailored to address them, they share a common foundation of the State's failure to clearly and decisively affirm that access to SRH care is a right that must be guaranteed, irrespective of the moral or religious beliefs of individual healthcare providers.

c. Regulation of Conscientious Objection: Absence and Ambiguity

The second axis of comparison concerns the regulation of conscientious objection itself, and here the divergence between the two jurisdictions, while real, is less significant than it might initially appear.

Nigeria has no regulatory framework for conscientious objection whatsoever. As Section 3 demonstrates, the concept exists neither in statute nor in professional regulation, and its absence is logical within a system that has already resolved the abortion question through criminalisation. However, the absence of regulation does not mean the absence of the phenomenon. Provider refusal operates in Nigeria as an invisible and entirely unaccountable practice, its consequences absorbed by women who have no legal framework within which to challenge it and no remedy when harm occurs.[86]

[86] Onyemelukwe (n 58) 420.

While Section 15 of the South African Constitution legitimately recognises conscientious objection, this recognition is exploited by healthcare providers to undermine the CTOPA and deny women access to SRH care. A framework that permits refusal without defining its boundaries by requiring referral, addressing institutional objection, or establishing enforcement mechanisms does not truly regulate conscientious objection, it merely legitimises it, granting provider refusal legal recognition without the constraints that such recognition demand.[87] In this sense, South Africa's partial regulation of conscientious objection may even be more dangerous in its effects than Nigeria's complete absence of regulation, because it creates the appearance of a managed framework while leaving the most harmful manifestations of provider refusal entirely unchecked.

This observation leads to the conclusion that the bare existence of a legal provision addressing conscientious objection is not sufficient to protect women's access to SRH care. What matters is the content and enforceability of that provision. A provision that grants the right to refuse without calibrating it against the right of access, without imposing corresponding obligations, and without establishing accountability for its abuse, is not a solution to the conscientious objection problem but a restatement of it in legal language.

6.0 CRITICAL ISSUES AND THEORETICAL TENSIONS

The conscience argument assumes providers entered their profession free of pre-existing obligations, but they did not. Entry into a regulated

[87] Ngwena (n 21) 13.

healthcare profession is voluntary and undertaken with full knowledge of its governing framework, which imposes duties of care independent of personal belief. Moral integrity deserves respect, but it cannot override obligations knowingly assumed upon entering the profession.[88] The provider's conscience claim does not arise in a vacuum; it arises within a professional relationship the provider chose to enter, and that choice is part of the moral calculus when the legitimacy of the claim is assessed. The calculus shifts considerably when the objection is institutional rather than individual. Institutions do not have personal histories of moral formation. They do not hold religious beliefs in any sense the philosophical traditions of conscience protection were designed to address.[89] What institutions have are policies and governance structures, and in the case of faith-based institutions, mandates that reflect the commitments of their founding bodies. These are organisational choices, not conscience, and should therefore attract considerably less protective legal analysis.

A serious regulatory framework must also draw the line between legitimate conscientious objection and its systemic abuse. Genuine objection is grounded in a deeply held and consistently maintained conviction that is specific in its object, disclosed proactively rather than invoked at the point of patient contact, and accompanied by a genuine commitment to referral.[90] Systemic abuse looks entirely different, it is invoked as a routine mechanism for avoiding clinical demands, extends to services the provider has no principled basis for refusing, is deployed

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88 J Savulescu, 'Conscientious Objection in Medicine' (2006) 332 *British Medical Journal* <https://www.bmj.com/content/332/7536/294.full > accessed 20 April 2026.

89 Wicclair (n 12) 52.

90 Dickens & Cook (n 14) 74; Wicclair (n 12) 68.

without referral, concentrates itself precisely where its consequences are greatest and its likelihood of challenge is lowest; among providers serving the poorest and most vulnerable patients.[91] The absence of any objective definition, registration requirement, monitoring mechanism, or disciplinary framework in either Nigeria or South Africa is not a minor oversight. It is the structural condition that makes this abuse possible and invisible simultaneously.

Finally, this analysis must ask: who bears the cost of regulatory failure? The women most harmed by unregulated provider refusal are not simply women; they are women whose vulnerability is compounded by poverty, geographic isolation, age and educational disadvantage.[92] The harm of unregulated conscientious objection falls hardest on women at the intersection of gender and structural disadvantage; those least able to seek alternatives when the system fails. This is not incidental but a matter of substantive discrimination, recognised under CEDAW, the Maputo Protocol, and constitutional frameworks of both jurisdictions. In Nigeria, legal prohibition compounds geographic inaccessibility for rural women lacking both legal protection and infrastructure. In South Africa, the CTOPA's formal guarantees are most effectively realised by those already most advantaged, while the vulnerable remain exposed to harm. The failure to regulate conscientious objection may appear neutral, but its impact is anything but neutral.[93]

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[91] J Harries *et al* 'Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study' (2014) 11 *Reproductive Health* 16.

[92] K Crenshaw, 'Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics' (1989) *University of Chicago Legal Forum* 139, 140.

[93] A Bankole *et al* (n 61) 3.

7.0 CONCLUSION

The article concludes that Nigeria and South Africa have failed in structurally different but equally consequential ways to regulate the tension between conscientious objection and women's SRH rights, underscoring the need for a rights-prioritising enforceable regulatory response.

The proposed model rests on five integrated elements. First, an explicit statutory definition of conscientious objection, establishing objective criteria for its legitimate exercise, confining it to individual providers, specifying applicable procedures, and distinguishing it from professional inconvenience or risk aversion. Without this, any framework risks the same overbroad invocation that has undermined both jurisdictions. Second, a mandatory and time-sensitive referral obligation, legally requiring objecting providers to refer patients immediately to a willing provider within a timeframe that does not itself constitute harm, recognising that SRH care is uniquely time-critical. A refusal that results in a two-week delay is not a minor procedural inconvenience; it may mean the difference between a straightforward procedure and a significantly more complex one, or between a procedure that is legally available and one that falls outside the applicable gestational limits entirely.[94] The referral obligation does not compromise the provider's conscience; it is the minimum condition under which the accommodation of conscience in a public healthcare system can be justified.

[94] WHO, *Safe Abortion* (n 10) 96.

The third element is a categorical prohibition on institutional conscientious objection. As this article argues, most institutions do not possess conscience in the individual moral sense that grounds legal protection, and extending such protection to healthcare facilities, whether through explicit provision or regulatory silence, constitutes a category error with serious rights consequences.[95] No institutional policy, founding mandate, or religious affiliation can displace a public healthcare facility's constitutional duty to deliver legally guaranteed services. Faith-based facilities within the public health system must meet the same access standards as secular ones. In that, where conflict arises, the obligation prevails.

The fourth element is an enforceable state obligation to guarantee geographic and structural access. Formal facility designations and nominally willing providers are insufficient if women cannot practically reach them. States must ensure adequate distribution of willing providers across geographic areas, particularly in rural and underserved communities as well as monitor concentrations of conscientious objectors to prevent systemic refusal in facilities serving the most vulnerable. Failure to ensure practical access must be treated as a justiciable breach of constitutional and international obligations.[96]

The fifth element is an independent monitoring and accountability mechanism empowered to receive complaints, investigate refusal patterns, sanction abusive objectors, and publicly report on SRH access. Without it,

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[95] Para 38, Committee on the Elimination of Discrimination against Women, *Concluding Observations on the Combined Seventh and Eighth Periodic Reports of Nigeria* - UN Doc CEDAW/C/NGA/CO/7-8 (2017).

[96] Human Rights Watch (n 32).

the preceding elements remain aspirational rather than enforceable. As both Nigeria and South Africa demonstrate, rights without remedies are not rights at all; merely promises declined to be kept. Women pay the price for this failure with their health, autonomy, and, in the most serious cases, their lives.[97]

In a nutshell, the ceiling of this model is stated plainly: conscientious objection may be accommodated only to the extent that it does not obstruct timely, lawful, and equitable access to SRH services. Where it obstructs access, it loses its claim to legal protection, and the State's obligation to ensure access must assert itself without qualification.

[97] Onyemelukwe (n 58) 422; Ngwena (n 21) 13.