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Emergency abortion in South Africa: Legal access, implementation, and the role of sexual violence

Rape has historically been used as a weapon of war, inflicting profound physical, psychological and social harm on survivors while destabilising communities. The intersection of conflict-related sexual violence and restricted access to abortion care exacerbates the suffering of survivors, particularly in addressing unwanted pregnancies, stigma and long-term health consequences. Despite international legal frameworks such as the Geneva Conventions and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) recognising the importance of comprehensive reproductive health care, including abortion, significant gaps in implementation persist, leaving survivors without the necessary care. This article concludes that abortion as emergency health care is critical for addressing the needs of survivors, ensuring their rights to dignity, autonomy and health. In South Africa, constitutional provisions, supported by the *Choice on Termination of Pregnancy Act* (CTOP Act) and the *National Health Act* (NHA), provide a robust legal framework that mandates access to emergency abortion care, even in cases of conscientious objection. Placing these findings in a broader context, this article underscores the importance of integrating legal, ethical and medical guidelines to operationalise emergency abortion care effectively. Strengthening healthcare systems through practitioner training, advocacy, and the removal of systemic barriers is essential to upholding survivors' rights. These insights have broader implications for global efforts to provide equitable and rights-based reproductive health care in humanitarian and conflict settings.

Significance:

A common weapon of war, rape inflicts profound physical, psychological and social harm on survivors and their communities. Often occurring in settings with restricted access to abortion care, acts of rape bypass the protections offered by international legal frameworks, thereby exacerbating the suffering of the survivor. By reviewing these frameworks alongside the robust South African legal framework for abortion care, we underscore the importance of integrating legal, ethical and medical guidelines to operationalise emergency abortion care effectively.

Introduction

Sexual violence has long been used as a weapon of war and domination, devastating lives and communities with its far-reaching physical, psychological and social consequences.[1] From the colonisation of the Americas, where European powers frequently used rape and sexual violence to terrorise and control Indigenous populations[2], the Rape of Nanking[3], and the Partition of India[4] to modern conflicts such as the Rwandan Genocide[5] and the wars in Bosnia[6], Syria[7], Myanmar[8], Ukraine[9], and the Democratic Republic of Congo[10], the strategic use of sexual violence has served to humiliate, exert power and disrupt social structures. In colonial contexts, particularly during the conquest of Native American peoples, sexual violence was a tool of conquest, used to assert racial and cultural superiority and to enforce submission. This historical legacy underscores the continuity of gender-based violence as a means of domination in both colonial and contemporary conflict settings to destabilise populations and assert control over women's bodies. Beyond the immediate trauma, survivors often face ongoing challenges, including unwanted pregnancies, stigma and limited access to reproductive health care.

Access to abortion, as an essential component of emergency health care, is critical for addressing the needs of survivors of conflict-related sexual violence. International legal frameworks – including the Geneva Conventions[11], Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[12], and UN Security Council resolutions[13] – recognise this need and underscore the importance of comprehensive reproductive health care for survivors. However, the implementation of these protections remains inconsistent, and is often hindered by restrictive laws, stigma and resource constraints, leaving many women and girls without the care they urgently require.

In South Africa, the legal framework enshrines the right to emergency health care, including abortion, through constitutional provisions and legislation such as the *Choice on Termination of Pregnancy Act* (CTOP Act)[14] and the *National Health Act* (NHA)[15]. These laws provide a robust foundation for addressing abortion as emergency health care, balancing the rights of patients and healthcare providers. Furthermore, the integration of mental health care and protections for minors ensures a comprehensive approach to reproductive health care, particularly in crisis situations.

Despite South Africa's progressive legal framework that explicitly recognises the right to reproductive health care, including abortion in emergency contexts, significant barriers to access persist. While instruments such as the Constitution[16], the CTOP Act and the NHA provide strong textual guarantees, their implementation remains uneven, particularly for women facing structural vulnerability, such as survivors of sexual violence. In practice, access to abortion services is often constrained by provider reluctance, vague interpretations of legal thresholds for emergency, and the absence of accountability mechanisms.[17] This article addresses a key research problem: the disconnect between the legal recognition of abortion as emergency health care and its realisation in clinical settings. This article provides a narrative legal review which explores the historical and contemporary use of rape

as a weapon of war, the international legal and humanitarian responses to abortion as emergency health care, and South Africa's national legal framework. It also provides practical guidelines for healthcare practitioners to navigate these complex medical and ethical situations. By examining these intersecting issues, we highlight the critical need for accessible, rights-based abortion care in emergencies and the broader implications for global and national healthcare systems.

Sexual violence as a driver of emergency abortions

Rape has long been used as a weapon of war to terrorise and destabilise populations, humiliate enemies, and exert control over women's bodies.[1] Notable historical examples include the Japanese military's use of "comfort women" during World War II and the mass rapes by occupying forces, including during the Rape of Nanking (1937–1938).[18] During the partition of India (1947), widespread sexual violence occurred that targeted women across religious divides, with an estimated 75 000–100 000 women being abducted and raped.[19] Pakistani forces raped an estimated 200 000–400 000 women during the Bangladesh Liberation War (1971) using sexual violence as a strategy to undermine the nationalistic aspirations of Bengalis.[20] Modern examples include the systematic mass rape of Bosniak women by Serbian forces during the Bosnian War (1992–1995), often in 'rape camps', to ethnically cleanse territories.[21] Survivors of rape during the Bosnian War often had no access to abortion services due to stigma and restrictive laws. Some organisations provided clandestine abortions, while others advocated for broader access to emergency reproductive care. Between 100 000 and 250 000 women were raped during the Rwandan Genocide (1994), often with the intention of impregnating Tutsi women to create a 'Hutu' generation.[22] In this regard, the International Criminal Tribunal for Rwanda recognised rape as a crime of genocide and a crime against humanity in the case of *Prosecutor v. Jean-Paul Akayesu.*[23] Whilst the judgment does not directly address abortion, it highlights the systematic nature of sexual violence in conflict. In *Prosecutor v. Dragoljub Kunarac*, the International Criminal Tribunal for the Former Yugoslavia classified rape as torture and a war crime, emphasising its devastating impact on survivors, including forced pregnancies.[24] Conflict in the Democratic Republic of the Congo (1998–present) also resulted in widespread sexual violence, crowning it the "rape capital of the world"[25]. Similarly, reports of rape as a weapon of war have emerged from conflicts in Syria, Myanmar (targeting Rohingya women), the Ukraine (targeting Ukrainian civilians by Russian forces), and Ethiopia (Tigray region).[26] Rohingya women in Myanmar who survived these instances of systematic rape fled to Bangladesh, where humanitarian organisations provided post-rape care, including abortions. However, the lack of consistent access to safe abortion care compounded the survivors' trauma. It is thus clear that the impact of such violence extends beyond physical trauma, including unwanted pregnancies, stigma and long-term mental health consequences.

The historical and contemporary use of rape as a weapon of war underscores the need for comprehensive health care, including access to abortion. International legal frameworks and humanitarian guidelines (discussed below) recognise abortion as part of emergency medical care for survivors of conflict-related sexual violence. However, case studies highlight significant gaps in implementation due to stigma, restrictive laws and resource challenges. Strengthening legal and policy frameworks globally is essential to ensure that survivors receive the care they need.

While the South African legal framework offers robust protection for access to emergency health care, including abortion, it is essential to examine how these rights are interpreted and implemented in practice by healthcare providers. Legal instruments such as the Constitution[16], the NHA[15], and the CTOP Act[14] provide clear mandates, but the realisation of these rights is often shaped by the attitudes, discretion and constraints faced by healthcare workers. Empirical studies have shown that, despite the legal obligation to provide emergency abortion care, many providers experience uncertainty or invoke conscientious objection, even in cases where the patient's life or health is at risk.[27] These patterns reveal a gap between the law and lived experiences, which warrants closer scrutiny in both historical and contemporary contexts.

Historically, South Africa's transition from the restrictive abortion regime under the apartheid-era *Abortion and Sterilisation Act* to the more progressive CTOP Act in 1996 marked a radical legal shift but not an immediate transformation in provider behaviour. Early implementation studies found widespread provider hesitancy due to moral, religious or professional discomfort.[28] More recent research continues to reveal regional disparities and systemic delays in accessing emergency abortion, particularly in under-resourced rural clinics.[29] Factors such as limited provider training, insufficient awareness of legal obligations, bureaucratic inefficiencies, and pervasive stigma continue to inhibit full realisation of reproductive rights. These constraints are compounded by the lack of formal accountability mechanisms to monitor and enforce legal obligations under the CTOP Act and NHA.[30] Understanding these socio-political and institutional dynamics is critical for evaluating both the strengths and the shortcomings of South Africa's current emergency abortion framework.

Abortion and international reproductive health law

International regulatory frameworks recognise abortion as a critical aspect of emergency health care in conflict situations, particularly for addressing the consequences of sexual violence and conflict-related pregnancies. Under international humanitarian law, the Geneva Conventions, more specifically Convention (IV) relative to the Protection of Civilian Persons in Time of War (Fourth Geneva Convention), addresses the protection of civilians during armed conflicts, including provisions related to sexual violence and medical care.[31] Article 27 explicitly prohibits acts of sexual violence against civilians and states: "Women shall be especially protected against any attack on their honour, in particular against rape, enforced prostitution, or any form of indecent assault."[31] This provision underscores the obligation of parties to a conflict to protect women from sexual violence, recognising such acts as serious violations of international humanitarian law. However, while the Fourth Geneva Convention mandates the provision of medical care to civilians affected by conflict, it does not specifically address abortion services. The Convention emphasises the general duty to ensure medical attention and care for the wounded and sick without adverse distinction but does not explicitly mention abortion as a component of emergency health care. In this regard, Gaggioli emphasises the legal and humanitarian challenges faced by women and girls who become pregnant as a result of rape in armed conflicts, including the potential pursuit of unsafe abortion practices that may endanger their lives and health.[32] For these purposes, it is important to address these issues from both humanitarian and legal perspectives, advocating for the provision of comprehensive medical care, including access to safe abortion services, to uphold the rights and well-being of survivors.

Further, in the realm of international human rights law, CEDAW further strengthens the protection of women in conflicts.[33] Although CEDAW does not explicitly address rape as a weapon of war or abortion as emergency health care in its original text, its enshrined principles and subsequent interpretations by the CEDAW Committee provide a framework for addressing these critical issues. CEDAW defines discrimination against women broadly, including acts that impair or nullify women's enjoyment of human rights and fundamental freedoms. Article 1 of the Convention sets this foundational definition, while Article 12 specifically mandates state parties to eliminate discrimination in health care and ensure equal access to health services, including family planning. Additionally, Article 16 calls for the elimination of discrimination in matters relating to marriage and family relations, which may extend to protecting women from forced pregnancies resulting from sexual violence in conflict settings. The CEDAW Committee has expanded upon the Convention's provisions through General Recommendations. General Recommendation 19 (1992) explicitly recognises gender-based violence, including rape, as a form of discrimination against women.[34] It also emphasises that sexual violence during armed conflict disproportionately affects women and constitutes a violation of their fundamental rights. Similarly, General Recommendation 30 (2013) on women in conflict situations acknowledges the use of rape as a weapon of war and urges States to take concrete steps to prevent such violence, prosecute perpetrators, and provide comprehensive healthcare services to survivors, including sexual and reproductive health

services.[35] Further, General Recommendation 24 (1999) on women and health highlights the need for States to ensure women's access to reproductive health care, including safe abortion where permitted by law and emphasises that restrictive laws on abortion and inadequate access to health care violate women's rights.[36] The CEDAW Committee has consistently interpreted the Convention to require States to provide safe abortion services, particularly for survivors of rape, incest, and in cases where the mother's life or health is at risk. Recommendation 35 (2017) explicitly addresses sexual violence during conflict and highlights the necessity of reparative justice measures, including access to essential healthcare services such as abortion.[34] Although not conflict related, the case of *LC v. Peru* underscores the denial of abortion as a violation of human rights under CEDAW and sets a precedent for recognising abortion as necessary medical care in emergencies.[37]

Similarly, UN Security Council Resolution 1325 (2000) acknowledges the disproportionate impact of armed conflict on women and girls and emphasises the importance of addressing sexual violence as part of post-conflict recovery and ensuring that women have access to the health care they need.[38] The World Health Organization (WHO) also provides a critical perspective on abortion in conflict settings. According to its Guidelines on Safe Abortion (2022), women who experience rape during conflict are entitled to comprehensive medical care, which includes access to safe abortion services.[39] The WHO recognises abortion as essential for addressing both the physical and psychological consequences of conflict-related pregnancies, framing it as an integral component of emergency health care. International policy initiatives reflect these principles in practice, with humanitarian organisations advocating for and providing abortion care in conflict zones. Organisations such as Médecins Sans Frontières (MSF) and the International Rescue Committee (IRC) emphasise the inclusion of safe abortion services as part of emergency medical care in humanitarian settings.[40] These initiatives demonstrate a commitment to ensuring that women affected by conflict receive the medical care they need, including access to abortion, as a matter of dignity, justice and essential health rights.

What constitutes emergency health care in South Africa?

While South Africa is not a country experiencing armed conflict, the international legal and humanitarian frameworks discussed above provide an important normative foundation for understanding abortion as a component of emergency medical care. These global standards, developed in response to sexual violence in times of war, establish principles of bodily autonomy, reproductive justice and non-discriminatory access to health care that are equally relevant in non-conflict settings. Survivors of rape and sexual violence in South Africa may face severe psychological and physical harm, stigma and barriers to care that render abortion a time-sensitive and medically necessary intervention. Thus, although the nature and scale of emergencies may differ, the underlying ethical imperative, to provide immediate, dignified and comprehensive care, remains the same. The following section examines how these imperatives are legally codified and operationalised within South Africa's constitutional and statutory framework, with particular attention to how emergency abortion care is defined and implemented in a peacetime but unequal health system.

A fundamental socio-economic right provided for in the Constitution of the Republic of South Africa is Section 27, which provides access to health care, food, water and sanitation.[16] Being a progressively realisable right, the attainment of these rights is dependent on reasonable legislative and other measures, as well as available resources. Whilst access to general health care is thereby qualified and not immediately realisable, section 27(3) does, however, provide that no person in the country may be denied emergency medical treatment. The South African Constitution thus guarantees the right to access healthcare services, including reproductive health care, under Section 27(1). In cases involving abortion, this provision ensures that life-threatening pregnancies must be treated as emergencies. Furthermore, Section 12(2) upholds the rights to bodily and psychological integrity, empowering individuals to make decisions about reproduction. These rights are supported by Section 11, which enshrines the right to life. It must, however, be noted that these rights must also be balanced in terms of the so-called limitations clause (Section 36) which allows for balancing competing rights, such as a healthcare provider's conscientious objection, with patients' rights.

Section 5 of the NHA supports or reinforces this constitutional mandate by providing that no one may be refused emergency medical treatment by a healthcare worker, provider or establishments.[15] This means that an obligation is borne by all health establishments, public and private, to render emergency treatment, irrespective of the patient's ability to pay for such services. Practically, it would require all health establishments to render sufficient medical assistance to stabilise a patient, after which they would be entitled to transfer the patient to an appropriate facility. In abortion-related emergencies, the NHA ensures stabilisation of the patient before transfer to an appropriate facility if necessary. In addition, through its preamble, the NHA also acknowledges that health care in South Africa is to be rendered with due consideration being given to Section 27(3) of the Constitution.

Key to enforcing Section 27(3) of the Constitution is a clear understanding of what a medical emergency constitutes. Whilst the right to health care is provided for in international conventions, no formal definition of a medical emergency is found in these laws. In South Africa, this concept was defined by the Constitutional Court in *Soobramoney v Minister of Health (Kwazulu Natal).*[41] The court found that a medical emergency constituted a "dramatic, sudden situation or event which is of a passing nature in terms of time. There is the same suddenness and at times even an element of unexpectedness in the concept of emergency medical treatment." Based on this definition, it may be understood therefore that any patient who presents with a medical condition which constitutes a rapid change or threat to their health and life should be deemed to be a medical emergency. Accordingly, they should be treated expeditiously and rendered the appropriate treatment so as to uphold Sections 27(1) and (3) of the Constitution, including Section 11 – the right to life. No further criteria are set out for what may constitute an emergency, other than that it must be of a nature that could threaten the person's health status and life.

Abortion as emergency health care in South Africa

Abortions were legalised in South Africa in 1996 through the promulgation of the CTOP Act.[14] This Act was brought about as a result of the implementation of the South African National Health Plan, which sought to restructure public health care and consequently redress gender inequality and the reproductive rights of women, in democratic South Africa.[42]

The CTOP Act operationalises constitutional rights by allowing terminations of pregnancy under specific conditions. It specifies three scenarios for legal abortions, ranging from elective terminations within the first 12 weeks to cases of severe risk to the mother or foetus beyond 20 weeks. The CTOP Act limits conscientious objection by healthcare providers, particularly in emergencies in which the patient's life or health is at risk. Violations of the CTOP Act's provisions carry significant legal penalties, ensuring accountability for denying care.

In the case of *Christian Lawyers Association v Minister of Health*, the court addressed the constitutionality of the CTOP Act.[43] The Christian Lawyers Association contended that the Act violated Section 11 of the South African Constitution, which guarantees the right to life, by permitting abortions. The court dismissed this claim, ruling that constitutional rights do not extend to foetuses, thereby upholding the Act's provisions. Regarding abortion as emergency health care, the court's decision did not specifically focus on this aspect. The judgment primarily centred on the broader constitutional validity of the Act and the applicability of the right to life to foetuses. Consequently, the case did not provide detailed guidance on the provision of abortion services in emergency medical situations. However, the CTOP Act itself outlines the circumstances under which abortions may be performed, including provision for emergency situations, which ensures that abortions are accessible as a necessary medical intervention in emergencies to protect the health and life of the woman.

The CTOP Act defines the termination of pregnancy as "the separation and expulsion by medical or surgical means, of the contents of the uterus of

a pregnant woman"[14]. It applies to women of all ages, provided that their need to terminate is compliant with the conditions provided for in Section 2(1) which provides that a pregnancy may be terminated in one of three situations: (1) upon the request of the pregnant woman during the first 12 weeks of the pregnancy's gestation period; (2) upon the request of the pregnant woman between the 13th and 20th week of the gestation period provided that, upon consultation with the pregnant woman, a medical practitioner is of the opinion that the continued pregnancy poses a risk of injury to the woman's mental or physical health, presents a substantial risk that the foetus could suffer severe mental or physical abnormalities, would significantly impact upon the economic or social circumstances of the pregnant woman, or *stems from an act of rape or incest* (our emphasis); and (3) upon the request of the pregnant woman after the 20th week of the gestation period if, after consultation with another medical practitioner or a registered midwife, a medical practitioner is of the opinion that the continued pregnancy poses a risk of injury to the foetus, could result in the severe malformation of the foetus, or could endanger the life of the woman. Save for a termination requested within the first 12 weeks of the gestation period during which time a registered midwife may carry out the termination, all terminations during any other time must be undertaken by a medical practitioner.

Whilst the CTOP Act does not provide healthcare practitioners with a conscience clause, or a clause providing them with the ability to avoid rendering medical services on the grounds of their personal beliefs, Section 15(1) of the Constitution does offer them a refusal mechanism as it provides all persons with the right to freedom of conscience, religion and belief. This right may be limited, however, where the situation constitutes a medical emergency and where the available healthcare practitioners are employed by the state. Therefore, where a woman's pregnancy constitutes a medical emergency demanding termination of such a pregnancy, and where no other facilities are available to carry out the termination, state-employed healthcare workers may have their rights to freedom of conscience, religion and belief (Section 15(1)) limited to the extent that they are obligated to assist in carrying out the required termination. This limitation may be justified in terms of the so-called Limitations Clause (Section 36) of the Constitution. The termination will be deemed to be an emergency in any situation in which the continued pregnancy poses a severe danger to the health or life of the woman and/or the foetus. Common causes of such emergencies include where the pregnant woman suffers from illnesses such as pulmonary hypertension, severe preeclampsia, cancer or severe kidney disease.[44] Ectopic pregnancies and the prognosis of lethal foetal abnormalities may also constitute such emergencies.[45] In these circumstances, the termination of pregnancy will also be carried out irrespective of the gestational age of the foetus.

While the provisions discussed above primarily relate to situations in which the foetus will not survive the termination of pregnancy, some scholars argue that these principles could also apply to emergency caesarean sections resulting in live births, particularly when the pregnant person is a minor.[46] As noted earlier, the CTOP Act defines termination of pregnancy broadly as the separation and expulsion of the contents of the uterus, without specifying whether the foetus must be non-viable. This definition leaves room for interpretation and may, in emergency situations involving minors, justify medically necessary interventions such as caesarean sections, even if the foetus is born alive.

Section 129 of the *Children's Act* in South Africa outlines the consent requirements for medical treatment and surgical operations involving children.[47] It establishes the circumstances under which children can consent to their own medical care, as well as when parental or guardian consent is required. The Act specifies that children aged 12 years or older may consent to their own medical treatment and to the treatment of their child, provided they are sufficiently mature and have the mental capacity to understand the benefits, risks and social implications of the treatment. Similarly, children aged 12 or older may consent to surgical operations on themselves and their child, but this must be done with the assistance of a parent or guardian. For children under the age of 12, or those 12 or over who lack sufficient maturity or mental capacity, a parent, guardian or caregiver must provide consent for medical treatment or surgical procedures. In cases of emergency, where immediate medical treatment or surgical intervention is necessary to save the child's life or prevent serious health consequences, the Act allows for exceptions to the usual consent requirements. In such situations, the superintendent of a hospital or the person in charge may provide the necessary consent if obtaining parental or guardian consent is not feasible. These provisions aim to balance the rights of children to participate in healthcare decisions with the need for adult guidance and protection, particularly in cases involving significant medical interventions.

On the other hand, the CTOP Act allows that the termination of pregnancy may be provided to all pregnant persons, irrespective of their age, and without the consent of any other person. As such, a pregnant minor can obtain an abortion based solely on their own consent, without the consent of their parent(s) or guardian(s). It has been contended that this benefit also extends to situations in which a pregnant minor intends to deliver a live child but requires an emergency caesarean section in order to do so.[46] In these circumstances, the requirement to obtain the consent of a parent or guardian will be overridden by the provisions of the CTOP Act, thereby allowing the pregnant minor to obtain the necessary surgical intervention, including the 'termination' of pregnancy via caesarean section. McQuoid-Mason did warn that this option would be available only to pregnant minors with a gestation period of more than 20 weeks when the foetus is viable, and the continued pregnancy would pose a risk of injury to the foetus or risk the life of the pregnant minor.[46] It may be understood that where a pregnant minor elects to use this option for whichever reason, that such choice should be construed as them exercising their right to an early, safe and legal termination of pregnancy. The CTOP Act thus enables pregnant minors to consent to abortions without parental involvement, ensuring that their reproductive autonomy is respected, and this principle also extends to emergency caesarean sections in life-threatening situations. However, this autonomy raises ethical questions about the capacity and maturity required for informed decision-making in such cases.

The CTOP Act also permits healthcare providers to exercise conscientious objection, allowing them to decline participation in abortion procedures due to personal beliefs. However, this right is not absolute. In emergency situations in which a pregnant patient's life or health is at immediate risk, healthcare practitioners are legally obligated to provide the necessary care, regardless of personal objections. This ensures that the patient's right to life and health is prioritised over the provider's personal beliefs. In addition, while Section 15(1) of the Constitution protects healthcare providers' rights to freedom of conscience, this right is limited when a medical emergency arises. The Limitations Clause (Section 36) justifies compelling state-employed practitioners to provide abortion services if refusal would endanger a patient's life.

The *Mental Health Care Act* (MHCA)[48], in conjunction with the CTOP Act, provides for critical assistance to women in South Africa who experience rape or sexual violence, particularly when they suffer from mental health issues as a result and require an abortion as emergency health care. These laws collectively ensure access to necessary health care, uphold patient dignity, and protect the rights of individuals with mental health conditions. Survivors of rape or sexual violence often experience severe psychological consequences, including post-traumatic stress disorder, depression, anxiety or suicidal ideation. The MHCA ensures that these women receive appropriate mental health care and support services. The Act also mandates that healthcare providers offer treatment that respects the survivor's dignity and autonomy while ensuring the mental health condition does not impair access to necessary care. In this regard, the CTOP Act permits abortion up to 20 weeks if the pregnancy poses a risk to the woman's mental health, a common outcome of rape or sexual violence. Beyond 20 weeks, abortion is allowed if the pregnancy poses a severe threat to the woman's life or health (including mental health), or foetal viability. The MHCA ensures that women suffering from mental health conditions receive appropriate care and can access abortion services when needed. If the survivor lacks the capacity to consent due to severe mental illness, the healthcare provider can act in the patient's best interest or involve a guardian or curator to facilitate access to abortion. For survivors facing immediate psychological crises, such as suicidal ideation or severe trauma, the MHCA allows for urgent intervention. In such cases, abortion may be considered part of emergency health care under the CTOP Act, ensuring the woman's life

and health are safeguarded. Both Acts emphasise the survivor's rights to dignity, autonomy and appropriate medical care. The laws together create a framework where mental health care and reproductive rights intersect to provide holistic support to survivors of sexual violence.

Practical recommendations for medical practitioners

Abortion as medical emergency treatment in South Africa is firmly grounded in both domestic law, international guidelines and best practices. Medical practitioners have a legal and ethical duty to provide necessary care in such situations, prioritising the patient's life and health over personal beliefs. By following the practical recommendations below, practitioners can ensure that their actions align with the legal framework while upholding the dignity, autonomy and rights of patients.

1. Recognise medical emergencies

- Understand that emergencies include conditions that pose immediate risks to a woman's physical or mental health or her life.
- Refer to the Constitutional Court's definition of a medical emergency as "dramatic, sudden situations threatening health or life".
- Be alert to cases of sexual violence that may result in severe trauma or health complications, including unwanted pregnancies.

2. Ensure timely stabilisation

- Prioritise the stabilisation of the patient's health and prevent further deterioration.
- If unable to provide the necessary care, arrange an immediate transfer to a higher-level facility equipped to perform required interventions.

3. Fulfil legal obligations

- Comply with Section 27(3) of the South African Constitution and Section 5 of the NHA, which mandate emergency medical treatment.
- In emergencies, provide abortion care regardless of conscientious objections, as outlined in the CTOP Act.
- Balance the rights of healthcare practitioners to conscientious objection with the patient's right to emergency health care, particularly in state facilities.

4. Obtain and respect informed consent

- Clearly explain the medical procedure, risks and implications to the patient.
- For minors, ensure they understand the procedure and respect their right to consent under the CTOP Act without parental involvement.
- When a patient lacks capacity to consent (due to severe mental health issues), act in their best interest with appropriate legal consultation if necessary.

5. Provide mental health support

- Recognise the psychological impact of rape and sexual violence on survivors, including post-traumatic stress disorder, depression and anxiety.
- Collaborate with mental health professionals to ensure the survivor receives holistic care, including abortion if mental health risks justify the procedure.

6. Document thoroughly

- Maintain detailed records of the medical condition, treatment provided, consent process, and justifications for medical decisions.
- Ensure documentation aligns with legal and institutional policies for accountability and continuity of care.

7. Ensure access for minors

- Understand that minors are entitled to abortion care under the CTOP Act without parental consent.
- Be aware of additional safeguards, such as providing guidance to ensure they understand the implications of their decisions.

8. Advocate for training and protocols

- Advocate for regular training to keep healthcare practitioners updated on legal, ethical, and clinical guidelines for emergency abortion care.
- Establish clear institutional protocols for managing abortion-related emergencies, including rapid response mechanisms and referral systems.

9. Address stigma and resource constraints

- Work to reduce stigma associated with abortion care, especially in emergency contexts.
- Advocate for adequate resources, including trained personnel and medical supplies, to ensure timely and effective care.

10. Engage in advocacy and policy reform

- Contribute to institutional and public discussions on improving access to emergency abortion care.
- Advocate for policies that address systemic barriers, such as restrictive laws and lack of resources, that hinder care for survivors of sexual violence.

Conclusion

Rape as a weapon of war continues to inflict profound and multifaceted harm on individuals and communities worldwide. Beyond the immediate physical and psychological trauma, conflict-related sexual violence often leads to unwanted pregnancies, compounding the long-term impact on survivors. In such circumstances, access to safe abortion services emerges as an essential component of emergency health care, ensuring that survivors' rights to dignity, autonomy and health are upheld. International legal frameworks, such as the Geneva Conventions, CEDAW, and UN Security Council resolutions increasingly recognise the need for comprehensive reproductive health care, including abortion, in conflict settings. However, gaps in implementation – due to stigma, restrictive laws and inadequate resources – persist, leaving many survivors without the care they urgently need.

South Africa's legal framework, underpinned by the Constitution, the CTOP Act and the NHA, offers critical protections for abortion as emergency healthcare. These provisions, bolstered by international guidelines, mandate that healthcare practitioners prioritise the health and rights of women and minors, even in the face of conscientious objections. Moreover, the integration of mental health considerations ensures a holistic approach to addressing the needs of survivors of sexual violence.

Healthcare practitioners play a pivotal role in operationalising these legal protections. By identifying emergencies, prioritising stabilisation, and respecting patient autonomy, practitioners can bridge the gap between legal mandates and practical implementation. The need for continuous training, clear protocols, and advocacy efforts is essential to overcome barriers such as stigma and resource limitations.

Ultimately, the provision of safe abortion as emergency health care reflects not only a legal obligation but also a moral imperative to support survivors of conflict-related sexual violence. Strengthening global and domestic frameworks and ensuring their effective implementation is crucial to safeguarding the rights, dignity and well-being of survivors in the face of systemic and individual acts of violence.

This article has demonstrated that while South Africa's legal framework – anchored in the Constitution, the CTOP Act and the NHA – formally recognises abortion as a component of emergency health care, significant

gaps remain in its practical implementation. These gaps are shaped not only by legal ambiguities or provider conscientious objection, but also by broader systemic and institutional failures, including uneven service provision, lack of enforcement mechanisms and socio-political stigma. By situating the South African context within international legal norms, and grounding the analysis in both historical and current healthcare practices, this article underscores the urgent need for legal accountability, clearer operational guidelines and improved support for both patients and providers. Emergency abortion care is not just a clinical issue but a matter of reproductive justice, demanding coordinated legal, ethical and public health responses. Future reforms must prioritise structural equity, service delivery oversight and community-informed care models to ensure that the rights enshrined in law are fully realised in practice.

Data availability

There are no data pertaining to this article.

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We have no competing interests to declare. We have no AI or LLM use to declare.

Authors' contributions

D.N.: Conceptualisation, writing – original draft, writing – review and editing. M.B.: Conceptualisation, writing – original draft, writing – review and editing, supervision. Both authors read and approved the final manuscript.

References

1. Kirby P. How is rape a weapon of war? Feminist international relations, modes of critical explanation and the study of wartime sexual violence. Eur J Int Relat. 2013;19(4):797–821. https://doi.org/10.1177/1354066111427614
2. Walter D. Colonial violence: European empires and the use of force. Oxford: Oxford University Press; 2017.
3. Brook T. The Tokyo judgment and the rape of Nanking. J Asian Stud. 2001; 60(3):673–700. https://doi.org/10.2307/2700106
4. Brass PR. The partition of India and retributive genocide in the Punjab, 1946–47: Means, methods, and purposes 1. J Genocide Res. 2003;5(1):71–101. https://doi.org/10.1080/14623520305657
5. Taylor CC. Sacrifice as terror: The Rwandan Genocide of 1994. Abingdon: Routledge; 2020.
6. Hansen L. Gender, nation, rape: Bosnia and the construction of security. Int Fem J Politics. 2000;3(1):55–75. https://doi.org/10.1080/14616740010019848
7. Banwell S. Security, peace and development: Unpacking discursive constructions of wartime rape and sexual violence in Syria. Int J Peace and Dev Stud. 2018;9(2):15–30. https://doi.org/10.5897/IJPDS2018.0318
8. Alam M, Wood EJ. Ideology and the implicit authorization of violence as policy: The Myanmar military's conflict-related sexual violence against the Rohingya. J Glob Secur Stud. 2022;7(2), Art. #ogac010. https://doi.org/10.1093/jogss/ogac010
9. Boesten J. Sexual violence as a weapon of war in Ukraine. BMJ. 2022;377, Art. #o1172. https://doi.org/10.1136/bmj.o1172
10. Meger S. Rape of the Congo: Understanding sexual violence in the conflict in the Democratic Republic of Congo. J Contemp Afr Stud. 2010;28(2):119–135. https://doi.org/10.1080/02589001003736728
11. Directorate General of Human Rights and Legal Affairs, European Council. Overview of legal protection against sexual violence afforded to women during situations of armed conflict. Ad Hoc Committee on Preventing and Combating Violence against Women and Domestic Violence (CAHVIO). Strasbourg:Directorate General of Human Rights and Legal Affairs, European Council; 2009. Available from: https://rm.coe.int/1680593fc6
12. United Women, United Nations. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) [webpage on the Internet]. c1979 [cited 2025 Jun 18]. Available from: https://www.un.org/womenwatch/daw/cedaw/text/econvention.htm
13. United Nations Security Council. Resolution 2272 (2016). New York: UN Security Council; 2016 March 11. Available from: https://docs.un.org/en/S/RES/2272(2016)
14. Republic of South Africa. Choice on Termination of Pregnancy Act 92 of 1996. Available from: https://www.gov.za/sites/default/files/gcis_document/201409/act92of1996.pdf
15. Republic of South Africa. National Health Act 61 of 2003. Available from: https://www.gov.za/sites/default/files/gcis_document/201409/a61-03.pdf
16. The Constitution of the Republic of South Africa 1996. Available from: https://www.gov.za/documents/constitution/constitution-republic-south-africa-1996-04-feb-1997
17. De Londras F, Cleeve A, Rodriguez MI, Farrell A, Furgalska M, Lavelanet AF. The impact of provider restrictions on abortion-related outcomes: A synthesis of legal and health evidence. Reprod Health. 2022;19(1):95. https://doi.org/10.1186/s12978-022-01405-x
18. Wui Ling C. Walking the long road in solidarity and hope: A case study of the Comfort Women Movement's deployment of human rights discourse. Harv Hum Rts J. 2009;22:63. Available from: https://heinonline.org/HOL/Page?handle=hein.journals/hhrj22&div=6&g_sent=1&casa_token=&collection=journals
19. Ali RU. Hearts divided: A social overview of the partition of Punjab, 1947. J Res Soc Pakistan. 2020;57(1), Art. #233 Available from: https://pu.edu.pk/images/journal/history/PDF-FILES/17_57_1_20.pdf
20. Ranjan A. Women in war zones: Rape at the time of Bangladesh Liberation War. In: Ranjan A, Hashmi T, Abbas M, editors. The aftermath of the Bangladesh Liberation War of 1971. London: Routledge; 2024. p. 73–79. https://doi.org/10.4324/9781003463627-6
21. Snyder CS, Gabbard WJ, May JD, Zulcic N. On the battleground of women's bodies: Mass rape in Bosnia-Herzegovina. Affilia. 2006;21(2):184–195. https://doi.org/10.1177/0886109905286017
22. Totten S. The plight and fate of females during and following the 1994 Rwandan genocide. In: Totten S, editor. Plight and fate of women during and following genocide. New York: Routledge; 2017. p. 107–136. https://doi.org/10.4324/9781351298162-7
23. Prosecutor v. Jean-Paul Akayesu. International Criminal Tribunal for Rwanda (Appeals Chamber), Tanzania. Case number ICTR-96-4-A. Judgment decision date:1 June 2001.
24. Prosecutor v. Dragoljub Kunarac. International Tribunal for the Prosecution of Persons Responsible for Serious Violations of International Humanitarian Law. Case number MICT-15-88-ES.1. 2024
25. Committed in the Territory of the Former Yugoslavia since 1991 (Appeal Chamber). Case no.: IT-96-23& IT-96-23/1-A. Judgement decision date: 12 June 2002.
26. Mkhize N. Critical consideration of measures to curb the use of sexual violence in armed conflict in the Democratic Republic of the Congo. Afr Insight. 2021;50(4):19–36. https://hdl.handle.net/10520/ejc-afrins_v50_n4_a2
27. De Londras F, Cleeve A, Rodriguez MI, Farrell A, Furgalska M, Lavelanet AF. The impact of 'conscientious objection' on abortion-related outcomes: A synthesis of legal and health evidence. Health Policy. 2023;1(129), Art. #104716. https://doi.org/10.1016/j.healthpol.2023.104716
28. Harries J, Cooper D, Strebel A, Colvin CJ. Conscientious objection and its impact on abortion service provision in South Africa: A qualitative study. Reprod Health. 2014;11, Art. #16. https://doi.org/10.1186/1742-4755-11-16
29. Amnesty International. South Africa: Barriers to safe and legal abortion in South Africa. London: Amnesty International; 2017. Available from: https://www.amnesty.org/en/documents/afr53/5423/2017/en/
30. Pickles C. A promising future? Verfassungsblog: On Matters Constitutional. 2023 January 27. https://doi.org/10.17176/20230130-203017-0
31. United Nations. Convention (IV) relative to the protection of civilian persons in time of war (Fourth Geneva Convention) [document on the Internet]. c1949 [cited 2024 Nov 01]. Available from: https://www.un.org/en/genocideprevention/documents/atrocity-crimes/Doc.33_GC-IV-EN.pdf
32. Gaggioli G. Sexual violence in armed conflicts: A violation of international humanitarian law and human rights law. Int Rev Red Cross. 2014;96(894):503–538. https://doi.org/10.1017/S1816383115000211

33. United Nations. Convention on the elimination of all forms of discrimination against women New York [webpage on the Internet]. c1979 [cited 2025 Jun 18]. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-elimination-all-forms-discrimination-against-women

34. United Nations. Committee on the Elimination of Discrimination against Women. General recommendation no. 35 on gender-based violence against women, updating general recommendation no. 19. 2017 July 14. Available from: https://www.right-to-education.org/sites/right-to-education.org/files/resource-attachments/CEDAW_C_GC_35_8267_E.pdf

35. United Nations. Committee on the Elimination of Discrimination against Women General recommendation no. 30 on women in conflict prevention, conflict and post-conflict situations. 2013 October 18. Available from: https://www.ohchr.org/Documents/HRBodies/CEDAW/GComments/CEDAW.C.CG.30.pdf

36. United Nations. CEDAW General recommendation no. 24: Article 12 of the Convention (Women and Health) [document on the Internet]. c1999 [cited 2025 Jun 18]. Available from: https://www.refworld.org/legal/general/cedaw/1999/en/11953#:~:text=3.,large%20number%20of%20non%2Dgovernmental

37. L.C. v. Peru, CEDAW, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

38. United Nations Security Council. S/RES/1325. Security Council Resolution on women and peace and security [document on the Internet]. c2000 [cited 2025 Jun 18]. Available from: https://peacemaker.un.org/sites/default/files/document/files/2022/09/scresolutionwomenpeacesecuritysres13252000english0.pdf

39. World Health Organization (WHO). Abortion care guideline [document on the Internet]. c2002 [cited 2025 Jun 18]. Available from: https://iris.who.int/bitstream/handle/10665/349316/9789240039483-eng.pdf?sequence=1

40. Chiang C. Reproductive health needs in complex humanitarian emergencies: An analysis of Medecins Sans Frontieres' programs in the Democratic Republic of the Congo [master's paper]. Chapel Hill, NC: University of North Carolina; 2011. https://doi.org/10.17615/axdw-v679

41. Soobramoney v Minister of Health Kwazulu-Natal 1998 (1) SA 765 (CC).

42. Hodes R. The culture of illegal abortion in South Africa. J S Afr Stud. 2016; 42(1):79–93. https://doi.org/10.1080/03057070.2016.1133086

43. Christian Lawyers' Association of South Africa v Minister of Health (Reproductive Health Alliance as Amicus Curiae) 1998 (4) SA 1113 (T).

44. Shah S. Hypertensive disorders in pregnancy. In: Sachdeva M, Miller I, editors. Obstetric and gynecologic nephrology. Cham: Springer; 2019. p. 11–23. https://doi.org/10.1007/978-3-030-25324-0_2

45. Marion LL, Meeks GR. Ectopic pregnancy: History, incidence, epidemiology, and risk factors. Clin Obstet Gynaecol. 2012;55(2):376–386. https://doi.org/10.1097/GRF.0b013e3182516d7b

46. McQuoid-Mason DJ. Can the consent provisions in the Choice on Termination of Pregnancy Act, which do not require children to be assisted by a parent or guardian, be used for live births by caesarean section in emergency situations? S Afr J Bioeth Law. 2018;11(1), Art. #44.

47. Republic of South Africa. Children's Act 38 of 2005.

48. Republic of South Africa. Mental Health Care Act 17 of 2002.