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Conscientious objection to abortion: key considerations

Guidance document of the Working Group on discrimination against women and girls

Summary

The Working Group on discrimination against women and girls is deeply concerned about reports of individual and institutional denial of access to critical reproductive health-care services, particularly abortion care, due to conscientious objection. It has prepared the present document on key considerations for conscientious objection to abortion pursuant to Human Rights Council resolutions 15/23 and 50/18. This guidance document provides an overview of conscientious objection in the context of sexual and reproductive health rights, with a specific focus on abortion. It outlines the Working Group's concerns regarding the unchecked exercise of conscientious objection globally. It then makes recommendations for legal and policy reform aimed at enabling States that permit conscientious objection to regulate effectively the exercise thereof and at eliminating barriers to the realization of women's and girls' sexual and reproductive health rights. Ultimately, this guidance document is aimed at assessing conscientious objection within the framework of gender equality and at promoting a human rights-based approach that prioritizes the rights of women and girls.

I. Introduction

1. The Working Group on discrimination against women and girls is deeply concerned about reports of individual and institutional denial of access to critical reproductive health-care services, particularly abortion care, due to conscientious objection. In this guidance document, conscientious objection is defined as "the practice of health-care professionals refusing to provide abortion care on the basis of personal conscience or religious belief".[1]

2. Reports indicate that health-care providers and institutions are increasingly abusing the refusal to provide abortion care, creating a systemic issue that largely goes unsanctioned worldwide.[2] As the Working Group explained in its 2021 report to the Human Rights Council entitled "Women's and girls' sexual and reproductive health rights in crisis", the rights to reproductive health services, including safe abortion care, are essential to gender equality and are protected under international law.[3] When conscientious objection is abused, it constitutes a violation of the fundamental rights to autonomy and agency in reproductive health decisions.

3. Various United Nations human rights treaty bodies have emphasized that no woman or girl should face barriers or be denied sexual and reproductive health information and services due to a refusal of care or conscientious objection by health service providers.[4] For States that permit conscientious objection, there has been consistent concern about its impact on access to sexual and reproductive health services.[5] Therefore, United Nations treaty bodies have affirmed that States must establish and implement an effective regulatory framework to ensure that refusals of care do not undermine or hinder women's and girls' access to these vital services.[6]

4. The present guidance document provides an overview of conscientious objection in the context of sexual and reproductive health rights, with a specific focus on abortion. It outlines the Working Group's concerns regarding the unchecked exercise of conscientious objection globally. It then makes recommendations for legal and policy reform aimed at enabling States that permit conscientious objection to regulate effectively the exercise thereof and to eliminate barriers to the realization of women's and girls' sexual and reproductive health rights.

5. Drawing on compelling evidence from academics, practitioners and health-care providers, the guidance document highlights the barriers and hardships faced by women and girls seeking sexual and reproductive health services. These insights were gathered through consultations with the Working Group, observations during various country visits, and

[1] World Health Organization (WHO), *Abortion Care Guideline* (Geneva, 2022), p. xiii.

[2] Bernard M. Dickens, "Ethical misconduct by abuse of conscientious objection laws", *Medicine and Law*, vol. 25 (2006), pp. 513–522; see also Rebecca J. Cook and Bernard M. Dickens, "The growing abuse of conscientious objection", *Virtual Mentor: Ethics Journal of the American Medical Association*, vol. 8, No. 5 (2006), pp. 337–340; Parliamentary Assembly of the Council of Europe, "Women's access to lawful medical care: the problem of unregulated use of conscientious objection" (2010), available at https://pace.coe.int/en/files/12506/html.

[3] A/HRC/47/38, paras. 8 and 20.

[4] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), para. 43; Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999), para. 11; Committee on the Rights of the Child, general comment No. 15 (2013), para. 69; and Human Rights Committee, general comment No. 36 (2018), para. 8.

[5] See, for example, CCPR/CO/82/POL, para. 8; CCPR/C/POL/CO/6, para. 12; CCPR/C/POL/CO/7, para. 23; CCPR/C/COL/CO/7, para. 21; CCPR/C/ARG/CO/5, para. 11; CCPR/C/ITA/CO/6, para. 16; CEDAW/C/MEX/CO/9, paras. 41 and 42; CEDAW/C/ARG/CO/7, para. 33; CEDAW/C/CAN/CO/8-9, paras. 40 and 41; CEDAW/C/PRT/CO/7, paras. 42 and 43; E/C.12/POL/CO/5, para. 28; and CAT/C/POL/CO/5-6, para. 23.

[6] See, for example, Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016), paras. 14 and 43; Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999), paras. 11 and 13; A/66/254, para. 65 (m); CEDAW/C/HUN/CO/7-8, paras. 30 and 31 (d); CEDAW/C/POL/CO/7-8, para. 37 (b) and (c); CEDAW/C/ARG/CO/7, para. 33 (c); CEDAW/C/ITA/CO/7, paras. 41 (d) and 42 (d); and CCPR/C/ARG/CO/5, paras. 11 and 12. See also A/HRC/32/44, para. 93.

references from the World Health Organization (WHO) safe abortion policy guidelines (2022).[7] Ultimately, the present guidance document is aimed at assessing conscientious objection within the framework of gender equality and at promoting a human rights-based approach that prioritizes the rights of women and girls.

II. Global overview of conscientious objection in the context of abortion

6. At the national level, legal approaches to conscientious objection vary widely. The framing of regulatory provisions and the mechanisms and scope for enforcing these provisions differ across countries. Some countries do not explicitly address conscientious objection to abortions through their national laws, creating a regulatory gap that may allow for abuse and misuse. Even where such countries may have progressive abortion laws, the absence of a clear framework prohibiting, limiting or defining conscientious objection can hinder access to abortion services.[8]

7. In contrast, other countries have explicitly recognized a right to conscientious objection in the health-care context.[9] Some countries have incorporated conscientious objection in their constitutions, statutes or medical ethics laws, or have recognized it through their domestic high courts.[10] Where conscientious objection is authorized by law or policy, some countries acknowledge the limits to such a right if it interferes with a pregnant person's right to access timely care or with the need to address risks to the health of others.[11] For example, the Termination of Pregnancy Act, of Zambia, establishes that no person shall be required to participate in any treatment to which they have a conscientious objection, but it also notes that such objections cannot compromise any existing duty to save the life of or prevent grave permanent injury to the physical or mental health of a pregnant woman.[12]

[7] WHO, *Abortion Care Guideline.*

[8] See. for example, Amnesty International, "Barriers to safe and legal abortion in South Africa" (2017). See also South Africa, National Department of Health, "National clinical guideline for implementation of the Choice of Termination of Pregnancy Act" (2019), which outlines a standard protocol for a "direct provider's refusal to care".

[9] For example, Italy provides a right to conscientious objection under Law No. 194 of 22 May 1978 "on the social protection of motherhood and the voluntary termination of pregnancy". Art. 9 of this law provides that "health personnel and allied health personnel shall not be required to assist in the procedures referred to in sections 5 and 7 or in pregnancy terminations if they have a conscientious objection, declared in advance… Conscientious objection shall exempt health personnel and allied health personnel from carrying out procedures and activities specifically and necessarily designed to bring about the termination of pregnancy, and shall not exempt them from providing care prior to and following the termination." See https://www.freedomofresearch.org/wp-content/uploads/2019/11/9.1-Law-194-1978-on-protection-of-maternity-and-voluntary-interruption-of-pregnancy-English-trans.pdf.

[10] For example, the abortion laws of Argentina and Colombia seek to regulate the use of conscientious objection as it pertains to reproductive rights. See Beatriz Galli and Diya Uberoi, "Refusing reproductive health services on grounds of conscience in Latin America", *Sur – International Journal on Human Rights*, vol. 13, No. 24 (December 2016); Luisa Cabal, Monica Arango Olaya and Valentina Montoya Robledo, "Striking a balance: conscientious objection and reproductive health care from the Colombia perspective", *Health and Human Rights Journal*, vol. 16, No. 2 (2014), pp. 78–80 (discussing Argentina, Mexico and Uruguay); and https://www.redaas.org.ar/conscientious-objection-map.

[11] For example, Uruguay implemented regulations in 2012 that sought to regulate the limits of conscientious objection and clarify that the ability to claim such an objection may be revoked at any time. See Galli and Uberoi, "Refusing reproductive health services on grounds of conscience in Latin America".

[12] Termination of Pregnancy Act, *Laws of Zambia*, chap. 304 (13 October 1972), available at https://zambialii.org/akn/zm/act/1972/26/eng@1996-12-31. See also Ministry of Health, *Standards and Guidelines for Comprehensive Abortion Care in Zambia* (June 2017), p. 24, available at https://platform.who.int/docs/default-source/mca-documents/policy-documents/guideline/ZMB-RH-18-01-GUIDELINE-2017-eng-Consolidated-Updates-of-Standards-and-Guidelines-for-CAC-in-Zambia--MoH.pdf.

Individual conscientious objection

8. Provisions regulating conscientious objection for individual practitioners vary significantly between countries. It has been observed that 41 countries allow any health-care provider to invoke conscientious objection to abortion, regardless of their proximity to the provision of care, whereas only nine countries explicitly restrict conscientious objection to those who perform or are directly involved in providing abortions.[13] Moreover, another study found that only 21 countries stipulate directly that providers must carry out an abortion in emergency situations when the life of the woman/pregnant person is threatened.[14]

9. The Working Group notes that any human rights-based approach for States wishing to permit the exercise of conscientious objection requires narrowly defining individual health-care providers' ability to invoke conscientious objection. Additionally, referral mechanisms (and their correspondent services) must be in place to ensure that conscientious objection does not infringe upon women's and girls' access to health care. Furthermore, the Inter-American Commission on Human Rights issued a report clarifying that a provider's exercise of conscientious objection must be based on a provider's own convictions, and the patient must be referred to another professional who is willing and able to provide the sexual and reproductive health services that the patient seeks.[15] Thus, the Working Group emphasizes that any recognized approach to conscientious objection is conditional on the State's ability to protect the rights of others, specifically women and girls seeking to access sexual and reproductive health services. It cannot be recognized or exercised in an unconstrained manner.

10. Moreover, a human rights-based approach to conscientious objection also requires consideration of the professional ethical obligations of health service providers. The International Federation of Gynaecology and Obstetrics has affirmed that "the primary conscientious duty of health-care providers" is to treat, provide benefits to and prevent harm to patients as well as to refrain from denial of essential services.[16] The International Federation of Gynaecology and Obstetrics explained that conscientious objection was "secondary to this primary duty".[17] Furthermore, where conscientious objection is invoked, providers must make appropriate referrals to ensure that women and girls in need can access essential services in a timely manner.[18]

Institutional conscientious objection

11. In addition to allowing individual providers to invoke conscientious objection, some States enable and empower institutions to do so. Chile, France, the Republic of Moldova, and Uruguay formally recognize institutional conscientious objection,[19] while de facto institutional objection is permitted in many other countries. Conscientious objection at the

[13] A. Ramón Michel, D. Repka and S. Ariza, "Global map of norms regarding conscientious objection to abortion" (Buenos Aires, Red de Acceso al Aborto Seguro de Argentina and IPAS, 2021) (indicators "Allows any health provider to invoke CO" and "Allows only those who perform abortions to invoke CO"), available at https://www.redaas.org.ar/conscientious-objection-map. This number may not account for legal cases that limit the scope of conscientious objection. See also Supreme Court of the United Kingdom of Great Britain and Northern Ireland, *Greater Glasgow Health Board v. Doogan and Another*, [2014] UKSC 68, Judgment, 17 December 2014.

[14] Antonella F. Lavelanet, Brooke Ronald Johnson Jr. and Bela Ganatra, "Global Abortion Policies Database: a descriptive analysis of the regulatory and policy environment related to abortion", *Best Practice & Research Clinical Obstetrics & Gynaecology*, vol. 62 (2020), pp. 25 and 31.

[15] Inter-American Commission on Human Rights, "Access to information on reproductive health from a human rights perspective" (November 2011), para. 95. The Inter-American Commission confirmed in para. 99 that States should "establish referral procedures, as well as appropriate sanctions for failure to comply with their obligation".

[16] International Federation of Gynaecology and Obstetrics, "Conscientious objection: a barrier to care", October 2021.

[17] Ibid.

[18] Ibid.

[19] A. Ramón Michel, D. Repka and S. Ariza, "Global map of norms regarding conscientious objection to abortion" (Red de Acceso al Aborto Seguro de Argentina and IPAS, 2020), available at https://redaas.org.ar/wp-content/uploads/REDAAS_MapaOC_Indicadores-ReconocenLaOConstitucional-EN.pdf.

institutional level has also been reported as a pervasive practice even in countries with laws prohibiting it,[20] including in some religious or faith-based hospitals that continue to assert institutional objections despite a prohibition.[21] When the institution objects to the provision of abortion services on behalf of all staff members, abortion services are unavailable even where individual doctors are willing to provide them.[22] Institutions seeking to invoke conscientious objection in States that do not recognize this practice often accomplish this by asking new hires to "voluntarily" sign objections.[23] Whether individual providers object becomes moot in religious hospitals that refuse to provide abortion care in general. The issue persists even though private hospitals often rely on public funding and may be the only health-care providers in certain areas.[24] In Italy, for example, authorities or hospitals are legally obligated to ensure sufficient non-objecting providers for patients seeking care, in order to prevent de facto institutional objection. However, fulfilling this obligation can be challenging if job postings that list abortion provisions as a requirement are disallowed because of claims of religious discrimination.[25]

12. Any laws authorizing institutional conscientious objection are incompatible with a human rights-based approach to conscientious objection. The Working Group and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, as well as the authoritative interpretations of human rights treaty bodies, confirm that, where States permit conscientious objection, they must ensure that women's and girls' access to services is not limited, and that conscientious objection is a personal, not an institutional, practice.[26] The jurisprudence of the European Court of Human Rights[27] and various domestic courts[28] similarly affirms these limitations. States that permit conscientious objection are required to restrict it to the direct provider of the medical intervention and only to allow the practice where an alternative can be found for the patient to access treatment within the necessary time frame.[29] Regional human rights bodies, such as the African Commission on Human and Peoples' Rights, have stated that the exercise of conscientious objection is for "health personnel directly involved" and "not so for the institutions".[30] The Inter-American Commission on Human Rights, while discussing a case from a national court, noted factors relevant to conscientious objection, including that conscientious objection "is an individual, not an institutional or collective, decision".[31]

[20] La Izquierda Diario, "Aborto legal: el Hospital Privado de Córdoba se declaró 'objetor institucional'", 29 January 2021, available at https://www.laizquierdadiario.com/Aborto-legal-el-Hospital-Privado-de-Cordoba-se-declaro-objetor-institucional (in Spanish); and La Voz, "Aborto: objeción de conciencia en varios hospitales cordobeses", 30 January 2021, available at https://www.lavoz.com.ar/ciudadanos/aborto-objecion-de-conciencia-en-varios-hospitales-cordobeses (in Spanish).

[21] Lauren R. Fink and others, "'The fetus is my patient, too': attitudes toward abortion and referral among physician conscientious objectors in Bogotá, Colombia", *International Perspectives on Sexual and Reproductive Health*, vol. 42, No. 2 (2016), pp. 71 and 74.

[22] Wendy Chavkin, Laurel Swerdlow and Jocelyn Fifield, "Regulation of conscientious objection to abortion: an international comparative multiple-case study", *Health and Human Rights Journal*, vol. 19, No. 1 (2017), pp. 59 and 60.

[23] Ibid.

[24] Ibid. pp. 55 and 59.

[25] Ibid.

[26] See, for example, A/HRC/32/44, para. 93; A/66/254, paras. 24 and 65 (m); A/HRC/29/40/Add.3, para. 77; E/C.12/POL/CO/5, para. 28; CEDAW/C/POL/CO/6, para. 25; and CEDAW/C/SVK/CO/4, para. 29.

[27] See, for example, *R.R. v. Poland*, application No. 27617/04, Judgment, 26 May 2011, para. 206; and *P. and S. v. Poland*, application No. 57375/08, Judgment, 30 October 2012, para. 106.

[28] See, for example, Constitutional Court of Colombia, Judgment No. T-209/08, 28 February 2008, para. 4.3, available at https://www.globalhealthrights.org/wp-content/uploads/2013/10/Translation-T-209-08-Colombia-2008.pdf.

[29] A/HRC/32/44, para. 108 (g).

[30] African Commission on Human and Peoples' Rights, general comment No. 2 on article 14.1 (a), (b), (c) and (f) and article 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2014), para. 26.

[31] Inter-American Commission on Human Rights, "Access to information on reproductive health from a human rights perspective", para. 97.

III. Concerning trends in conscientious objection

Conscientious objection as a barrier to health care

13. The Working Group has expressed concerns about health-care providers invoking conscientious objection to justify refusing to share information about the termination of pregnancy. Denying this information has detrimental consequences for the health and safety of women and girls.[32] Evidence shows that care is often delayed, even in emergency cases where abortion is needed to save a pregnant woman's life,[33] indicating that conscientious objection contributes to increased abortion-related mortality and morbidity.[34]

14. The Working Group has also highlighted the heightened risks to life and health caused by such refusals during crises, such as natural disasters, conflict and other disruptions, which increase women's and girls' vulnerability.[35] The Working Group and the Human Rights Committee affirm that, given the importance of access to sexual and reproductive health services, including abortion services, for women's and girls' equality, States permitting conscientious objection must still ensure that women's and girls' access to these services is not limited.[36]

15. States that provide for conscientious objection must regulate all refusals of care and ensure that any legal recognition of conscientious objection does not create a barrier for women and girls exercising their rights to access sexual and reproductive health services.[37]

16. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has similarly concluded that laws permitting conscientious objection can violate the right to health when they create barriers to abortion services and information. Such barriers can make safe abortions and post-abortion care functionally unavailable, especially to low-income, displaced and young women, and reinforce abortion-related stigma.[38] Furthermore, refusal to provide sexual and reproductive health-care services exacerbates existing inequalities. Marginalized women and girls face greater difficulties in accessing services or obtaining referrals due to power dynamics between providers and patients, among other reasons. Therefore, conscientious objection disproportionately impacts the most marginalized and vulnerable patients, making access to abortion services difficult or impossible for many, even in countries where patients are legally entitled to care.

17. Non-governmental organizations in the field have confirmed that conscientious objection poses a significant barrier to health care, particularly for women and girls. The International Federation of Gynaecology and Obstetrics has recognized the unregulated invocation of conscientious objection to abortion to be a "widespread global phenomenon" that "constitutes a barrier to [abortion] services for many women and girls".[39] WHO has

[32] A/HRC/32/44, para. 82.

[33] WHO, *Abortion Care Guideline*, p. 61.

[34] Ibid. WHO has further observed that "some health workers claim conscientious objection and refuse abortion in the public sector, while providing abortion for payment in their private practices".

[35] A/HRC/47/38, paras. 27 and 77 (e).

[36] A/HRC/32/44, para. 93; see also CCPR/C/POL/CO/7, para. 24 (a); and CCPR/C/COL/CO/7, paras. 20 and 21.

[37] A/HRC/32/44, para. 93. Following its visit to Poland, the Working Group expressed concern about the ineffectiveness of the country's regulatory framework and improper invocation of conscientious objection, resulting in "abortion-free zones". It also criticized the requirement that emergency contraceptive pills be provided by doctors. This overregulation of access has enabled doctors and pharmacists to prevent access by refusing to prescribe or sell pills even though such exercise of conscientious objection is illegal. See A/HRC/41/33/Add.2, paras. 47, 51 and 85 (c).

[38] A/66/254, para. 24. Human rights bodies have criticized Italy for the high number of conscientious objectors and their distribution over the country, which has forced women to travel to other regions or abroad to obtain abortion care. See CCPR/C/ITA/CO/6, para. 16; European Committee of Social Rights, *International Planned Parenthood Federation – European Network (IPPF EN) v. Italy*, Complaint No. 87/2012, Decision on the merits, 10 September 2013; and European Committee of Social Rights, *Confederazione Generale Italiana del Lavoro (CGIL) v. Italy*, Complaint No. 91/2013, Decision on admissibility and the merits, 12 October 2015.

[39] International Federation of Gynaecology and Obstetrics, "Conscientious objection: a barrier to care".

similarly recognized that refusal of abortion care on the basis of belief or conscience is a "barrier to access to safe and timely abortion"[40] and that "unregulated conscientious refusal/objection can result in human rights violations, or lead women to seek unsafe abortion".[41]

Failure to provide timely referrals

18. State-sanctioned refusals to provide abortion services based on conscientious objection must be contingent on the provision of timely referrals, ensuring that access is not compromised by delays or denials. However, in practice, referral requirements are inconsistent. The International Federation of Gynaecology and Obstetrics asserts that "whenever the exercise of conscientious objection results in delays, increased burdens for women and girls, or no access at all, it should no longer be accepted as conscientious objection but defined as an unjustified denial of health services".[42]

19. Only 29 countries explicitly require that objecting providers refer patients seeking abortion services to another provider,[43] and the obligations imposed on providers to ensure an effective referral vary widely.[44] In 2015, for example, the Constitutional Court of Poland held that doctors were no longer required to provide a referral to another doctor willing and able to perform an abortion when they conscientiously objected.[45] Such regressions in the regulation of conscientious objection signal an erosion of existing legal protections for timely access to abortion care.

20. Furthermore, many existing referral mechanisms have posed additional barriers to accessing timely care, often requiring patients to navigate a "circuitous and burdensome" referral process.[46] These difficulties can become life-threatening if they cause a pregnancy to cross the legal time limit for an abortion or lengthen the period of gestation, necessitating more complex interventions or introducing new health risks.

Misuse of existing conscientious objection provisions

21. The Working Group is deeply concerned that conscientious objection has been misused and inconsistently invoked in various contexts without proper regard for women's and girls' sexual and reproductive health rights.[47] In some countries, health service providers can choose which abortions to perform on a case-by-case basis, depending on their subjective view of whether the abortion is justified.[48] This leads to ad hoc and inconsistent availability of services, which often reinforces gender biases. In other countries, the widespread use of conscientious objection has resulted in a lack of access to health-care providers across entire geographic areas. Moreover, where the law on conscientious objection is ambiguous or vague, many health service providers are uncertain about whether and how it is regulated and thus

[40] *Abortion Care Guideline*, p. 60; see also Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, paras. 8 and 14; A/53/38/Rev.1, part one, para. 109; A/52/38/Rev.1, part two, para. 353; and A/63/38, part two, paras. 42 and 43.

[41] WHO, *Abortion Care Guideline*, p. 60; see also CCPR/C/POL/CO/7, para. 23; European Court of Human Rights, *P. and S. v. Poland*, para. 106; and European Committee of Social Rights, *International Planned Parenthood Federation European Network (IPPF EN) v. Italy*.

[42] International Federation of Gynaecology and Obstetrics, "Conscientious objection: a barrier to care".

[43] Lavelanet, Johnson and Ganatra, "Global Abortion Policies Database", p. 31.

[44] In Mozambique, an objecting provider must ensure the individual is transferred to another health provider that will carry out the procedure. In Belgium, the obligation is satisfied if contact details of an abortion provider are given to the woman and all medical files are made available to the new provider. See Mozambique, *Boletim da República, Publicação Oficial da República de Moçambique I série* – No. 147 (2017), art. 5 (3); Fien De Meyer, "Abortion law reform in Europe: the 2018 Belgian and Irish Acts on termination of pregnancy", *Medical Law International*, vol. 20, No. 1 (2020); and Lavelanet, Johnson and Ganatra, "Global Abortion Policies Database", p. 31.

[45] A/HRC/41/33/Add.2, para. 51.

[46] WHO, *Abortion Care Guideline*, p. 61.

[47] Kathleen M. Morrell and Wendy Chavkin, "Conscientious objection to abortion and reproductive healthcare: a review of recent literature and implications for adolescents", *Current Opinion in Obstetrics and Gynecology*, vol. 27, No. 5 (2015), pp. 333 and 336.

[48] WHO, *Abortion Care Guideline*, p. 61.

lack knowledge about when abortion must legally be provided.[49] This uncertainty has led some health-care providers to improperly invoke conscientious objection due to fears of potential liability, complaints, lawsuits,[50] police harassment or legal punishment.[51]

22. The Working Group also acknowledges that conscientious objection should be based on individually held and genuine moral values.[52] The exercise of conscientious objection for "non-conscientious reasons" constitutes a misuse of conscientious objection.[53] Where abortion is stigmatized and criminalized, it may prompt the "defensive use" of conscientious objection.[54]

Adverse impact on health-care systems and health-care providers

23. Unregulated conscientious objection has consequences not only for abortion seekers but also for health systems and non-objecting health service providers. There is evidence that when conscientious objection is widespread, it strains health-care systems by increasing workloads for non-objecting providers and stigmatizing abortion provision, which in turn negatively impacts non-objecting providers' career decisions and, ultimately, reduces the availability of skilled providers.[55] For those working in health systems, a lack of regulation or unclear and unenforced regulation around conscientious objection can lead to administrative burdens, hesitance to offer abortion services, workplace conflicts, and weakness in the organizational structures that are needed for the delivery of safe abortion services.[56]

IV. Reframing conscientious objection from a gender perspective

24. Autonomy in reproductive decision-making is fundamental to women's and girls' rights to equality and privacy.[57] Reproductive autonomy is essential to matters of physical and psychological integrity. Human rights treaty bodies have consistently found that denying or restricting access to sexual and reproductive health services undermines women's and girls' reproductive autonomy, violates their rights to privacy and equality, and may infringe upon their rights to life, health, and freedom from torture or ill-treatment.[58] The widespread abuse of individual and institutional conscientious objection hinders women's and girls' ability to fully exercise these rights, underscoring the need for significant changes in the legal and policy approaches of countries that recognize conscientious objection.

25. Moving forward, States, institutions and health-care providers must recognize the inherent patriarchal bias and gender stereotypes that pervade health systems, structures, laws, policies and protocols. These prejudices surface when health-care providers express discomfort about providing abortions in cases of rape because they mistrust patients who cite rape as the reason for the abortion, or when they believe that the patient "acted irresponsibly"

[49] Stephanie Andrea Küng and others, "'We don't want problems': reasons for denial of legal abortion based on conscientious objection in Mexico and Bolivia", *Reproductive Health*, vol. 18, No. 1 (2021), p. 5.

[50] Ibid., pp. 5 and 6.

[51] Plurinational State of Bolivia, Defensoría del Pueblo, *Situación de la Interrupción Legal del Embarazo como Derecho Humano de las Mujeres* (2020), available at https://www.defensoria.gob.bo/uploads/files/situacion-de-la-interrupcion-legal-del-embarazo-como-derecho-humano-de-las-mujeres.pdf.

[52] Zoe L. Tongue, "On conscientious objection to abortion: questioning mandatory referral as compromise in the international human rights framework", *Medical Law International*, vol. 22, No. 4 (2022), p. 357, referring to Stephen W. Smith, "Individualised claims of conscience, clinical judgement and best interests", *Health Care Analysis*, vol. 26, No. 1 (2018), p. 83.

[53] Tongue, "On conscientious objection to abortion", p. 357.

[54] Ibid.

[55] WHO, *Abortion Care Guideline*, p. 61.

[56] Ibid.

[57] International Covenant on Civil and Political Rights, arts. 3 and 17.

[58] See, for example, *Llantoy Huamán v. Peru* (CCPR/C/85/D/1153/2003), paras. 6.4–6.6; and *L.C. v. Peru* (CEDAW/C/50/D/22/2009), para. 8.15.

in getting pregnant.[59] These decisions are often rooted in harmful, discriminatory stereotypes, keeping women and girls in subordinate positions by curtailing their autonomy and agency. When conscientious objection is over-inclusive and inadequately or unclearly regulated, it allows these discriminatory notions to permeate health-care practices. The harm extends beyond delays or denial of care, as women, girls and other pregnant persons often experience stigma, shame and stress when seeking to exercise their sexual and reproductive health rights in such contexts, thus undermining their dignity.

26. Given the grave impact of conscientious objection on the health and lives of women and girls, and its infringement on their autonomy, agency and human rights, it is necessary to clearly define and regulate the legal and ethical limits of health providers' ability to refuse services based on individual conscience and belief in health-care settings. The Working Group maintains that reproductive autonomy is crucial to recognizing the dignity of all human beings, their competence to make rational choices, and their right to make informed decisions. Thus, this autonomy must be preserved and accommodated in contexts that recognize conscientious objection.

V. Weighing the unqualified right to equality with the freedom of religion or belief

27. The unlimited exercise of conscientious objection in the context of abortion care denies and infringes on the sexual and reproductive health rights of women and girls and is in violation of their right to equality. States may choose to recognize conscientious objection if this recognition aligns[60] with legitimate aims and proportionality requiring the equal recognition and protection of the sexual and reproductive health rights of all women and girls.

28. The Special Rapporteur on freedom of religion or belief has explained that the "universal right to equality is unqualified in a way that the obligation to promote the right to manifest religion or belief, which can be subject to limitation where necessary to protect the rights of others, is not".[61] The Special Rapporteur expressed particular concern about "the use of conscientious objection by health-care providers and institutions unwilling to perform abortions … on religious grounds".[62] While reasonable accommodation can be a "pragmatic tool" for States to "overcome intolerance and discrimination based on religion or belief", the Special Rapporteur noted that "it is difficult to justify the accommodation of religious beliefs when the consequences are discriminatory and impose harm on others, especially on groups that may have long faced discrimination and marginalization".[63]

29. Thus, any protection that the State provides to individuals to manifest their religion or belief in health-care employment settings may not result in denying the right of women and girls to non-discrimination, physical and mental integrity, and access to reproductive health services. While everyone has the right to freedom of thought, conscience and religion, the right to manifest (or act on) those beliefs can be reasonably limited by the State to protect the health and freedom of others.[64] Reasonable accommodations for religious beliefs may not impose "a disproportionate or undue burden" on others' ability to exercise their rights.[65] Thus, States must properly regulate conscientious objection, including establishing mechanisms

[59] Küng and others, "'We don't want problems'", p. 6.

[60] A/HRC/41/33/Add.2, paras. 47, 51 and 85 (c).

[61] A/HRC/43/48, para. 68.

[62] Ibid., para. 43.

[63] Ibid., para. 71.

[64] Ibid., paras. 59 and 60 (citing Universal Declaration of Human Rights, art. 30; and International Covenant on Civil and Political Rights, art. 5).

See also European Court of Human Rights, *Eweida and Others v. United Kingdom*, applications No. 48420/10, No. 59842/10, No. 51671/10 and No. 36516/10, Judgment, 15 January 2013, para. 106. The European Court of Human Rights has confirmed that imposition of consequences for failing to perform a legal duty is an acceptable limitation to the right to conscientious objection.

[65] A/HRC/43/48, para. 65 (citing A/HRC/69/261, para. 59).

that provide accessible alternatives when recognition of conscientious objection makes the exercise of sexual and reproductive health rights, including abortion care, impracticable.

VI. Promising approaches and shifts

30. Key regional human rights bodies have provided meaningful guidance on the limits of conscientious objection in the context of abortion care. In its general comment No. 2 on article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, the African Commission on Human and Peoples' Rights stipulated that "States parties should particularly ensure that health services and health-care providers do not deny women access to contraception/family planning and safe abortion information and services because of, for example, requirements of third parties or for reasons of conscientious objection."[66] The African Commission stated further that the right to conscientious objection "cannot be invoked in the case of a woman whose health is in a serious risk, and whose condition requires emergency care or treatment".[67] Additionally, the Inter-American Commission on Human Rights has recognized that conscientious objection may not be used as "a mechanism for discrimination and the violation of women's fundamental rights".[68]

31. At the State level, several promising practices are beginning to emerge. Some countries, such as Ethiopia, Finland and Sweden, have adopted a human rights-based approach to conscientious objection that duly protects women's rights.[69] Ethiopia specifically prohibits health-care providers from refusing to provide abortion services, while Sweden and Finland have declined to recognize a right to conscientious objection in the context of abortion services.[70] Moreover, Norway has placed a legal duty on health-care facilities to ensure access and requires public hospitals to provide abortion care regardless of whether providers in the facility have invoked conscientious objection.[71]

32. In one notable case, a Swedish labour court held that a midwife who had not been hired by three women's clinics because she refused to provide abortions had failed to establish that the employment decision violated her right to manifest her religion. The court further held that any interference with religion was in pursuit of the legitimate aim of protecting the health of women seeking abortions and that the Government of Sweden had an obligation to guarantee access to abortion.[72]

33. Several countries also impose formal obligations on objecting providers,[73] including duties to register their objection, to provide reasons for invoking conscientious objection, to inform patients of their objections and to provide referrals. In Mexico, the Supreme Court of Justice recently held that "conscientious objection is not a restriction on the right to health" and "can never result in the denial of health services to people who come to health

[66] See para. 48.
[67] Ibid., para. 26.
[68] Inter-American Commission on Human Rights, "Access to information on reproductive health from a human rights perspective", para. 98.
[69] A. Ramón Michel, D. Repka and S. Ariza, "Global map of norms regarding conscientious objection to abortion" (countries listed under "Ban" indicator).
[70] Center for Reproductive Rights, "Law and policy guide: conscientious objection", available at https://reproductiverights.org/maps/worlds-abortion-laws/law-and-policy-guide-conscientious-objection (citing, in translation, Ethiopia, Food, Medicine and Health Care Administration and Control Council of Ministers Regulation No. 299/2013, art. 84: "A health professional may not refuse on grounds of personal belief to provide services such as contraceptive, legal abortion, and blood transfusions.").
[71] Chavkin, Swerdlow and Fifield, "Regulation of conscientious objection to abortion", pp. 55 and 60.
[72] Discussed in European Court of Human Rights, *Grimmark v. Sweden*, application No. 43726/17, Decision, 12 March 2020, paras. 14 and 15.
[73] A. Ramón Michel, D. Repka and S. Ariza, "Global map of norms regarding conscientious objection to abortion" (indicators "Requires formality to exercise CO" and "Imposes duties on those who exercise CO").

institutions".[74] Consequently, objecting providers must promptly inform their patients of their objection and refer them to non-objecting providers without delay.[75]

34. In 2021, in New Zealand, the High Court upheld statutory provisions of the newly passed Abortion Legislation Act which required conscientious objectors to abortion services to inform the patient "at the earliest opportunity" of their objection and how to access the contact details of the "closest provider".[76] The Court explained that the obligation to refer was "the quid pro quo of the right to conscientiously object at all".[77] The Court acknowledged the "nexus" between timely access to abortion care and women's fundamental human rights.[78]

35. Colombia has similarly recognized referral obligations for objecting providers, as well as, more broadly, a nexus between women's freedom of conscience and abortion care. The Colombian Constitutional Court has held that physicians who invoke conscientious objection in the context of abortion care must immediately refer their patient to a doctor who is willing to perform the procedure.[79] In 2022, the Colombian Constitutional Court further recognized the right to freedom of conscience for women as a component of their dignity, citing this as "a new reason to decriminalize abortion".[80] The Court emphasized that women's right to make decisions according to their own moral convictions and beliefs was disrupted when they were prevented from ending unwanted pregnancies.[81]

36. Most recently, in May 2023, the Constitutional Court of Spain defended narrow parameters for conscientious objection and additional obligations for objecting providers. The Court recognized a right to conscientious objection solely for providers directly involved in clinical operations, excluding those involved in "auxiliary, administrative or instrumental support actions". The Court reasoned that any further expansion of conscientious objection "would not only lack constitutional foundation, but would put the effectiveness of the health-care provision under consideration at extreme risk".[82] The Court also maintained that requiring providers to make any objections "in advance" and "in writing" are both "reasonable and proportionate conditions for exercising the right, which do not in themselves violate article 16 (2) (of the Constitution of Spain)".[83]

VII. Conclusions and recommendations of the Working Group

37. **The Working Group emphasizes the importance of adopting a human rights-based approach to realizing gender equality when regulating conscientious objection globally. States must ensure that women's and girls' unqualified right to equality, autonomy and privacy is central to all sexual and reproductive health laws, policies, and practices, including abortion care. The Working Group calls on States to ensure access to sexual and reproductive health services and information by strictly**

[74] Human Rights Office of the Supreme Court of Justice, "Extract of the Acción de Inconstitucionalidad 54/2018" (2021), pp. 1 and 2, available at https://www.scjn.gob.mx/derechos-humanos/sites/default/files/sentencias-emblematicas/summary/2022-06/Summary%20AI54-2018%20HRO.pdf.

[75] Ibid., p. 2.

[76] High Court of New Zealand, *New Zealand Health Professionals Alliance Incorporated v. Attorney-General*, [2021] NZHC 2510, Judgment, 23 September 2021, para. 53 (2), available at https://www.law.utoronto.ca/sites/default/files/documents/reprohealth/nz_2021_hpa_v_attorney-general.pdf.

[77] Ibid., para. 122.

[78] Ibid., para. 3.

[79] Constitutional Court of Colombia, Judgment No. T-209/08, para. 4.6 (citing Constitutional Court of Colombia, Judgment No. C-355/06 (2006)).

[80] Isabel C. Jaramillo Sierra, "The new Colombian law on abortion", *International Journal of Gynaecology and Obstetrics*, vol. 160, No. 1 (2023), p. 347.

[81] Ibid.

[82] Constitutional Court of Spain, Judgment No. 44/2023, 9 May 2023, available at https://www.boe.es/diario_boe/txt.php?id=BOE-A-2023-13955.

[83] Ibid.

regulating refusals of care based on conscience or religion.[84] States have due diligence obligations to ensure that health-care providers fully respect women's and girls' sexual and reproductive health rights, and must take all measures necessary to create an environment that facilitates the fulfilment of those responsibilities and promotes respect for those rights. In States that permit conscientious objection, the State has an affirmative obligation to ensure that the invocation of conscientious objection by health-care providers does not infringe upon the sexual and reproductive health rights of women and girls. Everyone seeking reproductive health care must be able to access such care without delay or judgment, in full exercise of her human rights.

38. **To ensure that conscientious objection does not interfere with or violate the sexual and reproductive health rights of women and girls, the Working Group makes the following recommendations:**

Clarify that conscientious objection by individual providers is subject to regulation and limitation and may not interfere with or violate the right to equality and sexual and reproductive health rights

39. **States wishing to recognize the exercise of individual conscientious objection must immediately implement a human rights-compliant framework for the exercise thereof. Where conscientious objection is permitted by law, it must be fully regulated, and include measures to ensure proper and timely referrals and access to services. Individual conscientious objection must be conditional on the State's ability to fulfil the right to equality and the sexual and reproductive health rights of women and girls within its jurisdiction. States should further clarify that conscientious objection will not be permitted in emergency situations.**

Make institutional conscientious objection impermissible

40. **As scholars have noted, institutional conscientious objection, including by means of *en masse* staff denials, reduces access to services, may undermine the goals of public funding, adversely impacts patient well-being, compromises medical professionalism and can be used to discriminate against patients.[85] Practically, conscientious objection at the institutional level can significantly restrict the availability of abortion services on a broader scale, constituting a systemic denial of the right to equality and sexual and reproductive health rights. Thus, this practice constitutes a human rights violation and must be prohibited.**

41. **The State is responsible for health care and must comply with its human rights obligations to ensure the availability and accessibility of health services to all without discrimination. Private hospitals often receive public funding and may be the only providers of health services in certain areas. The partial or total privatization of public services does not exempt the State from its international legal obligation to ensure non-discriminatory access to health-care services. States must prohibit the practice of institutional conscientious objection (including de facto institutional conscientious objection), to comply with their obligations to ensure equal access to health services.**

Decriminalize abortion

42. **Abortion must be decriminalized and incorporated within comprehensive legal and policy frameworks on health.[86] These frameworks must include provisions aimed at eliminating barriers stemming from harmful gender stereotyping and sexist attitudes, which underlie many refusals. By decriminalizing abortion, States would ensure greater access to reproductive health services and create greater certainty about the legality of**

[84] A/HRC/47/38, para. 77 (e).

[85] See, for example, International Federation of Gynaecology and Obstetrics, "Conscientious objection: a barrier to care"; Küng and others, "'We don't want problems'"; and Fink and others, "'The fetus is my patient, too'".

[86] A/HRC/47/38, para. 77 (b), recommending the decriminalization of abortion.

abortion. Without such certainty, physicians may invoke conscientious objection to avoid legal liability for providing an abortion.

Affirm the right to safe and legal abortion and recognize women's autonomy

43. **A comprehensive regulatory framework should affirm the right to safe and legal abortion, including abortion care, and recognize women's autonomy. To comply with international law, States must clarify that conscientious objection can only be exercised by an individual health service provider on the condition of an effective referral, and access, to an alternative provider. States must create and invest in systems capable of monitoring the use of conscientious objection routinely and preventing abuse of it.**

Ensure the availability of legal remedies and reparations

44. **Legal recourse must be made available to those denied an abortion due to the exercise of conscientious objection. Denial of abortion is not acceptable, as the right to a safe and legal abortion is protected under international law. To fully recognize the harms caused by the inappropriate exercise of conscientious objection, States must create appropriate avenues for accountability and reparations for those whose rights have been violated, and work to increase access to information about sexual and reproductive health rights.**

Regulate conscientious objection to abortion

45. **Based on the substantial evidence of the abuse of conscientious objection and its use to undermine access to abortion, the Working Group urges States to take steps to adopt a principled and pragmatic approach to address these claims and prevent systematic violations of women's and girls' human rights. States must prevent and reform laws that overextend conscientious objection and that allow sexist and patriarchal personal beliefs to determine the provision of health care. Policymakers must recognize that conscientious objection is often being exercised in ways that transgress acceptable ethical and legal boundaries.**

46. **The Working Group notes that other United Nations human rights bodies, the International Federation of Gynaecology and Obstetrics and WHO have issued many useful and practical recommendations to address the human rights concerns arising from the unregulated exercise of conscientious objection. These recommendations are consistent with and enable those from the Working Group, and include the following:**

(a) **Human rights treaty monitoring bodies and human rights mechanisms recommend that States:**

(i) **Organize health systems to ensure that sufficient non-objecting providers are hired and are distributed fairly across the country (in private and public health facilities);**[87]

(ii) **Implement clear regulation of conscientious objection** [88] **to ensure adequate enforcement of such regulation, including identifying, addressing and sanctioning non-compliance,**[89] **outlining clearly who may object to components of care,** [90] **and limiting the exercise of conscientious objection to individuals**

[87] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, para. 14.

[88] CEDAW/C/HUN/CO/7-8, paras. 30 and 31; CRC/C/SVK/CO/3-5, para. 41 (f); and CEDAW/C/POL/CO/7-8, para. 37 (b).

[89] CEDAW/C/HUN/CO/7-8, paras. 30 and 31; CRC/C/SVK/CO/3-5, para. 41 (f); and CEDAW/C/POL/CO/7-8, para. 37 (b).

[90] CEDAW/C/HUN/CO/7-8, paras. 30 and 31; CRC/C/SVK/CO/3-5, para. 41 (f); and CEDAW/C/POL/CO/7-8, para. 37 (b). See also CEDAW/C/ROU/CO/7-8, paras. 32 and 33; and Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, para. 43.

directly involved in the medical intervention (and not to those involved in auxiliary, administrative or instrumental support actions);[91]

(iii) **Prohibit institutional claims of conscience;**[92]

(iv) **Require prompt referrals to accessible non-objecting providers;**[93]

(v) **Ensure that conscientious objection is exercised in a respectful and non-punitive manner and prohibit conscientious objection in urgent or emergency situations.**[94]

(b) **The International Federation of Gynaecology and Obstetrics recommends that States:**

(i) **Educate health-care workers about the rights of women and girls;**

(ii) **Set clear standards on the regulation of conscientious objection;**

(iii) **Strictly regulate conscientious objection and hold health-care providers and others accountable for its misuse;**

(iv) **Establish strong referral processes;**

(v) **Train and sensitize providers about their obligations, including the duty to render care in emergency situations and post-abortion care;**[95]

(vi) **Train medical students to provide quality care;**

(vii) **Ensure access to information and quality, safe reproductive health services.**[96]

(c) **WHO recommends that States:**

(i) **Create strong monitoring and regulation practices where data are actively integrated into relevant programmes and systems;**[97]

(ii) **Structure services and policies to respect women's human rights, dignity, autonomy and equality;**[98]

(iii) **Conduct training for health-care workers to ensure respect for informed and voluntary decision-making.**[99]

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[91] A/HRC/32/44, para. 94; Working Group on discrimination against women and girls, "Women's autonomy, equality and reproductive health in international human rights: between recognition, backlash and regressive trends", position paper, October 2017, p. 7, available at https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf.

[92] CEDAW/C/ROU/CO/7-8, para. 33 (c); CEDAW/C/HUN/CO/7-8, paras. 30 and 31; and CRC/C/SVK/CO/3-5, para. 41 (f). See also A/HRC/32/44, para. 93.

[93] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, para. 43; A/66/254, para. 65 (m); Committee on the Elimination of Discrimination against Women, general recommendation No. 24 (1999) on women and health, para. 11; CEDAW/C/ROU/CO/7-8, para. 33 (c); and E/C.12/POL/CO/5, para. 28.

[94] Committee on Economic, Social and Cultural Rights, general comment No. 22 (2016) on the right to sexual and reproductive health, para. 43.

[95] See https://www.figo.org/resources/figo-statements/conscientious-objection-barrier-care.

[96] International Federation of Gynaecology and Obstetrics, "Conscientious objection: a barrier to care".

[97] WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2012), sect. 3.5.

[98] Ibid., sects. 3.2 and 4.3.

[99] Ibid., sect. 3.3.5.1.