T-388/2009

CONSCIENTIOUS OBJECTION AND ABORTION

A GLOBAL PERSPECTIVE ON THE COLOMBIAN EXPERIENCE

O'NEILL INSTITUTE
FOR NATIONAL & GLOBAL HEALTH LAW
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women's LINK worldwide

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Women's Link Worldwide, 2014
info@womenslinkworldwide.org
www.womenslinkworldwide.org

O'Neill Institute for National and Global Health Law,
Georgetown University, 2014
oneillinstitute@law.georgetown.edu
www.law.georgetown.edu/oneillinstitute

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INTRODUCTION. COMPARING PERSPECTIVES ON CONSCIENTIOUS OBJECTION TO ABORTION: COLOMBIA AT THE CENTER OF A WORLDWIDE INTERDISCIPLINARY DEBATE

1. THE COLOMBIAN CONTEXT

In 2006, with decision C-355/06, Colombia achieved a historical step forward in the area of reproductive rights. The existing total ban on abortion gave way to an acknowledgement of the right to abortion under certain circumstances:[1] when the pregnancy constitutes a danger to the life or physical or mental health of the woman, when the pregnancy is the result of rape, or when the fetus has serious deformations incompatible with life outside the womb.[2] Then began the struggle for effective implementation of the decision, and to no one's surprise, one of the most hotly contested issues has been the regulation of conscientious objection.

In framework of this struggle, the Constitutional Court has been one of the key actors. Since its issuance of decision C-355/06, the Court has ruled favorably on at least eight petitions of unconstitutionality for denial of access to legal abortion services.[3] In these subsequent rulings, the Court has not limited its analysis to the cases under review, but has addressed broader issues. For one, it has defined the right to legal and safe abortion as a fundamental right in cases in which abortion is decriminalized.[4] Furthermore, it has crafted specific rules to guide the implementation of decision C-355/06[5] such that access to this right will be not only permitted, but actively ensured by the state through the healthcare system.[6]

Decision T-388/09 is one of these rulings, particularly relevant to the issue of conscientious objection to abortion. Previous[7] and subsequent[8] decisions by the same Court have addressed the issue, but this ruling consolidated and expanded on rules set by case law, rules which have since been confirmed repeatedly. This is arguably the ruling in which the Court did the most to indicate the nature, basis, content, and proper use of conscientious objection in the context of abortion services in Colombia, as well as the limitations on it and who is entitled to claim it.

This ruling was the result of a *tutela* action[9] filed on behalf of a pregnant woman whose fetus had serious deformities incompatible with life outside the womb.[10] Although her case fell under one of the circumstances under which abortion is legal under decision C-355/06, the physician she was referred to

for the procedure improperly demanded a court order before performing the abortion. When the *tutela* action was filed, the judge of first instance recused himself from ruling on the case on the basis of conscientious objection and referred the case to his superior, who then told him that he could not legally refuse to rule on this basis. The objecting judge then decided to deny relief for reasons of conscience. On appeal, the action was decided in the woman's favor, and the abortion was performed. The case was selected for review by the Constitutional Court,[11] which took the opportunity to develop case law on the use of conscientious objection in the context of abortion, not only by judges, but also by healthcare professionals.

Based on the pluralist nature of the Colombian state and respect for the fundamental rights of freedom of thought, of conscience, and of religion, the Court recognized in its ruling that there does exist a right to conscientious objection under these constitutional norms, and that it may be claimed with regards to the practice in the provision of abortion services. However, it went on to note that this right, like any other constitutional right, is not absolute. There are certain limitations to it that arise from the same bases that give rise to constitutional objection itself—protection for human beings' moral integrity—and others based on respect for the fundamental rights of others. In the case of abortion, for the Court, it is women's rights to health, personal integrity, life, and, more broadly, their reproductive rights that are at stake.

As seen in the first article in this publication, which offers a comprehensive review of the standards set by decision T-388/09, these limitations have concrete consequences on who may claim conscientious objection to abortion in Colombia: only those persons who are directly involved in the procedure—not institutions—are entitled to do so. Furthermore, judicial officers are not entitled to claim conscientious objection, as their duty is to rule on the matters before them by applying the law, not their conscience. The limitations also have specific implications for what constitutes a *legitimate* conscientious objection—the content—and the conditions required to claim it. On this latter point, the Court established the obligation for an objecting healthcare professional to refer the patient to a provider who is willing and available to perform the service, and if there is none, the objecting professional may no longer claim conscientious objection, just as in the cases of medical emergencies.

The importance of this ruling in ensuring access to safe and legal abortion in Colombia is undeniable. Since, to date, no rules had been set in place by Congress or the Government to regulate the use of conscientious objection in the context of abortion,[12] the ruling provided much-needed clarification on the use of conscientious objection with respect to abortion, a necessary step in preventing it from being used to create barriers to access. This phenomenon has been occurring with much more frequency before the ruling was issued,[13] because many of the people and organizations that had fought to prevent the Constitutional Court from partially decriminalizing abortion in 2006 then turned to promoting the use of conscientious objection, not so much to protect the moral integrity of professionals as to erect hurdles against the effective implementation of decision C-355/06.[14] Furthermore, the ruling continues to hold importance whenever a new law or regulation is passed, as it must conform to the limitations set by the Court.

Even after decision T-388/09, abuses of conscientious objection to abortion continue to occur.[15] However, advocacy organizations and Colombian women now have a clear constitutional basis on which to demand their right to safe and legal abortion. Subsequent regulations established by state agencies that oversee public and private healthcare providers have adopted the letter and spirit of the rules set by the ruling, putting these legal tenets into practice.[16] And now public authorities, judges, and healthcare providers, whether public or private, face legal consequences if they fail to uphold the standards set by decision T-388/09. These can include disciplinary, ethical, or civil sanctions,[17] which have already been imposed in at least two cases.[18]

Particularly because of its importance, decision T-388/09 has been a target for legal challenges. Immediately after the ruling issued, three citizens and the Inspector General of Colombia[19] himself petitioned the Constitutional Court to reverse it, arguing, among others, that the creation of rules on conscientious objection to abortion went beyond the findings of decision C-355/06. Fortunately, the ruling withstood this first assault when the Court ruled to dismiss the petitions, confirming its authority to create case law to ensure the implementation of the constitutional rights that were recognized in 2006.[20]

More recently, in 2010 and 2011, the Office of the Inspector General issued guidelines for public officials involved in activities related to decisions C-355/06 and T-388/09, which referred to an alleged "*right of*

institutions to claim conscientious objection to abortion," despite the clear language to the contrary of the two rulings.[21] The confusion caused by these guidelines was not helped by the fact that the Office of the Inspector General carries out disciplinary investigations of public officials in Colombia.[22] After 1,280 Colombian women filed a *tutela* action demanding their right to accurate and impartial information on reproductive rights, the Constitutional Court ordered the Office of the Inspector General to issue, among other things, a retraction and remove this mention from its materials.[23] With this ruling, the standards set by decision T-388/09 were again protected.

2. TOWARD A GLOBAL AND INTERDISCIPLINARY DEBATE

The heated debate around the use of conscientious objection to abortion is not limited to Colombia or to developing countries. Anywhere abortion has been decriminalized to any extent, questions of what constitutes *legitimate* conscientious objection, as well as who can claim it, how, and when, have been and continue to be the subject of discussion. The recognition that this is a current, global, and key issue for access to safe and legal abortion, coupled with a conviction that the standards set by decision T-388/09 are a step in the right direction but are also subject to improvement, are what drove Women's Link Worldwide and the O'Neill Institute for National and Global Health Law at Georgetown University to join forces to publish this book in Spanish and English.

In this publication, the rules for conscientious objection set by the Colombian ruling will be analyzed from a range of perspectives, including women and men who exercise different professions and play different roles in the field of sexual and reproductive rights and health—academic scholars, political and legal activists, service providers, etc.—who live and work in different parts of the world where conscientious objection to abortion is currently a hotly debated issue, or will be in the near future (Latin America, Europa, Africa and the United States).

In Latin America, discussion of the regulation of conscientious objection is heating up as total criminalization of abortion becomes a thing of the past and effective implementation of these gains is sought, either

under a set of circumstances under which abortion is decriminalized—as in the case of Colombia in 2006—or legalization of abortion on demand within certain time limits, as in the case of Uruguay in 2012[24] and Mexico City in 2007.[25] For instance, if the proposal for decriminalization of abortion currently before the National Congress of Chile is passed,[26] conscientious objection will certainly be central to the subsequent debate. In the United States, controversy around this issue is the order of the day in the context of the comprehensive health system reform that included some reproductive health-care items in mandatory coverages. Many companies sought exemptions from these requirements based on conscientious objection claims, winning a recent victory before the United States Supreme Court.[27] In Europe, although there have not been major changes regarding the legality of abortion in recent years, the struggle to implement existing law has led to interesting debates both nationally and regionally. In Ireland, for instance, the issue has been the subject of debate since a 2013 law defined the circumstances under which legal abortion would be allowed, without regulating conscientious objection to abortion.[28] Finally, discussions of conscientious objection to abortion have not yet reached Africa, but they will soon. Since 2003, Africa is the only region of the world to have an international treaty including specific provisions that require states parties to permit and guarantee the right to termination of pregnancy under several circumstances: the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa—known as the Maputo Protocol.[29] As more countries ratify this treaty and its implementation is demanded domestically, the issue of conscientious objection will certainly take center stage, both nationally and regionally.

It is our hope that with the broad range of genders, professions, roles, and geographical locations represented in this book, we can help to launch a global dialogue. We hope, on one hand, that the Colombian debate will be valuable to other places in the world, and on the other, that it will lead to a *boomerang effect* in which other countries and regions fine-tune and expand on the Colombian standards, which in turn will contribute to the as-yet incomplete discussion in Colombia. And we hope that this feedback, or *cross-fertilization*, will help to clarify and strengthen rules on conscientious objection throughout the world, improving in turn access to safe and legal abortion.

3. THE AUTHORS AND THEIR CONTRIBUTIONS TO THE DEBATE

We begin our exploration of conscientious objection in the context of abortion with opening reflections by Carmen Barroso, PhD in Social Psychology, who has been involved in a broad range of professional activities in different world regions. After starting her career as a scholar in Women's Studies in her native Brazil, she turned to activism, helping found hundreds of women's groups in Africa, Asia, and Latin America. In her current capacity as Regional Director for the International Planned Parenthood Federation, she offers the perspective of sexual and reproductive healthcare services in Latin America and the Caribbean. In her article, she highlights what she considers the most valuable provisions of the Constitutional Court of Colombia's ruling, where other countries should follow the Court's lead: the protection of religious pluralism without failing to impose limitations on the use of conscientious objection. She argues that the ban on conscientious objection by private healthcare agencies is particularly relevant for Latin America and the Caribbean, given the great number and size of these agencies in the region.

However, Barroso suggests that the Colombian standards should be expanded on in two ways. First, it should be made clear, through mandatory training for objectors, what the difference is between cases in which there is a *legitimate* matter of conscience at issue from those in which simple prejudices and lack of scientific information are concealed behind alleged reasons of conscience. Second, she suggests that it should be recognized that it is also legitimate to claim conscientious objection to laws that restrict the provision of or funding for abortion, at least in cases in which the woman's life and health are in jeopardy. This use of conscientious objection, which we will refer to as proactive or positive conscientious objection, is raised again in the article on Latin America. It has also been used in Spain, in the case of laws restricting migrants having no regular residence permit access to healthcare services. We will explore proactive conscientious objection further in a case study from Spain, following the article on Europe.

After these opening reflections, the first article offers a comprehensive look at the standards set by decision T-388/09 for conscientious objection to abortion. No one is better suited to this task than Professor Bernard Dickens of the University of Toronto, an expert in integrating medicine, ethics, and law.

Dickens, a PhD in Law and renowned scholar, has published hundreds of articles on medical law, healthcare, and bioethics, particularly as regards reproduction issues, including abortion. In addition to his vast academic background, he chairs the Ethics Committee of the International Federation of Gynecology and Obstetrics (FIGO).

In his article, in addition to describing the rules set by decision T-388/09, Dickens points out compatibilities between this ruling and standards set by international human rights treaties, particularly the International Covenant on Civil and Political Rights. He goes on to note similar language in existing or developing regulations in other countries—such as the regulation of conscientious objection by public officials in the United States—as well as certain differences, in an analysis in which the Colombian standards come out ahead. The same may be said of a recent Scottish ruling—still awaiting a final ruling by the Supreme Court of the United Kingdom—that makes no distinction between medical personnel that is involved directly or indirectly in the termination of pregnancy procedure when determining whether to authorize the use of conscientious objection.[30] The author holds that the Supreme Court, in its review of this case, should adopt the parameters set by decision T-388/09, which, as we have seen, do make this distinction. Clearly, the ruling goes beyond the borders of Colombia and may shed light on regulations in other countries around the world.

Dickens reviews in detail who would be precluded from claiming conscientious objection because of the restriction establishing that only those practitioners who are directly involved in the termination of pregnancy procedure may claim it, and how this provision will apply to abortions induced by medications—two issues that the Constitutional Court's ruling is silent on. In the spirit of *cross-fertilization* that we wish to encourage, the author notes that certain European standards could be adapted to Colombia, particularly those that preclude pharmacists from claiming conscientious objection to filling prescriptions for contraceptives.[31]

From the Southern Cone, Mercedes Cavallo and Agustina Ramón Michel launch the global debate with an article on Latin America. The authors have both played many roles that have allowed them an excellent

vantage point for a regional analysis. Mercedes Cavallo is an attorney, holds a master's degree in Sexual and Reproductive Rights from the University of Toronto and teaches at the University of Palermo in Argentina. She has combined her work in the Argentine judicial system with national activism, including working for the Association for Civil Rights. She has also had the opportunity to be involved in public policy as a member of the Advisory Board for the Ministry of Health's Comprehensive Adolescent Health Program. Agustina Ramón Michel is also an attorney and a doctorate student in Law at the University of Palermo in Argentina. She is an adjunct researcher for the Center for Studies of the State and Society (CEDES), where she studies issues related to health and reproductive rights. She has been involved in litigation in her native Argentina, as well as national and regional technical assistance activities related to reproductive rights. The research she has published on abortion in Argentina and other Latin American countries, including Colombia and Mexico, is a resource for activism and training.

Rather than setting out to offer a detailed overview of the entire region in light of the Colombian ruling, the authors focus on two interrelated aspects that can be seen in the way conscientious objection works throughout Latin America. Undoubtedly, experts from other regions will recognize similar situations in their contexts and find value in the authors' observations. First, Cavallo and Ramón Michel note that in many cases, the real reasons behind healthcare professionals' claims of conscientious objection are not moral in nature. Instead, because of the state's failure to create favorable conditions for access to service, it becomes too problematic—*costly*—for healthcare providers to offer the service, so they instead claim conscientious objection as an excuse to deny service while still appearing to comply with the law. Second, the authors warn of the danger that this may lead to a situation in which conscientious objection, a notion meant to protect minority moral convictions within society, is instead twisted into a tool used to impose a certain morality. If Latin American states continue to fail to fulfill their duty to create favorable conditions for access to services, practitioners will continue to turn *en masse* to dubious claims of conscientious objection in order to cut costs, which will in turn lead to the triumph—almost inadvertently—of a certain morality at the expense of women's lives and health. In this context, decision T-388/09 represents an opportunity to start to differentiate between claims of conscientious objection that are *legitimate* and those that are not.

From the world of political and legal activism in the Global North, Louise Melling and Jennifer Lee draw lessons from the Colombian ruling that will be extremely valuable for the debate in the United States. Both authors work at the American Civil Liberties Union's (ACLU) Center for Liberty, which works for reproductive freedom, religious freedom, and freedom of belief, among other issues. They have both been involved in lawsuits filed in federal and state courts against laws restricting reproductive rights such as contraception and abortion, and they continue to campaign against the use of religion as a means of discrimination in the United States.

Melling and Lee find that the basis for the Colombian Court's analysis is completely different from that of judges and legislators in their country, which has direct implications for the use of conscientious objection to abortion. In Colombia, in addition to the rights of the objector, the harm that allowing conscientious objection may cause to the woman is also taken into account, particularly as regards her dignity. In the United States, on the other hand, only protection for the moral and religious conscience of the objector is considered.

Except in cases of medical emergency, the effect of this on the ground is that practitioners are allowed to refuse to provide abortion services without any requirement to refer the patient to another practitioner who is willing to perform the procedure. Also, in at least one case, people who were only remotely involved in the procedure have been allowed to object. Moreover, many states allow institutional claims of conscientious objection to abortion, with the same exception for medical emergencies. There are similar regulations regarding contraceptives. In some cases, pharmacies have been allowed to refuse to offer these products, and with the implementation of healthcare reforms that require employers to provide medical insurance for their employees, the United States Supreme Court recently ruled that small and medium-sized faith-based for-profit corporations may claim conscientious objection.[32] The authors note that what is missing here is a consideration that was included in T-388/09: employees cannot be required, directly or indirectly, to share the religious beliefs of the companies for which they work.

Melling and Lee hit the nail on the head by pointing out the perplexity of this situation, if we take into account the much broader scope of legal abortion in the United States than in Colombia, as women can obtain

abortion on demand in the United States, at least during a certain period of the pregnancy. This is one area in which, according to Melling and Lee, the Global North has something to learn from the Global South.

A European perspective is supplied by Ruth Fletcher, professor and medical law researcher at the Queen Mary University of London School of Law, who has taught classes on medical ethics and law. She has served as Associate Director for the Arts and Humanities Research Council Centre for Law, Gender and Sexuality of the Arts and Humanities Research Council in the United Kingdom. She has researched and published extensively on reproduction and sexuality as subjects of legal dispute. In her work, she has documented and criticized arguments and strategies for regulating abortion. Professor Fletcher is particularly interested in reproduction as a place where law and gender intersect.

Fletcher argues that the basis for the analysis included in decision T-388/09 may be of value for current discussions in Europe. She refers to it as a *harm reduction* model because it takes into account the consequences of conscientious objection for pregnant women and attempts to minimize them. The author considers this an appropriate approach, because this potential harm is what justifies placing limitations on conscientious objection. After offering a comprehensive look at the debates—involving national and regional courts, legislators, and regulatory bodies in Ireland, Italy, Poland, and the United Kingdom—the author examines how the standards set by decision T-388/09 could be valuable. First, she underscores the appropriateness of restrictions on institutional claims of conscientious objection in Ireland, a country with a strong Catholic presence in its healthcare institutions. Second, based on the prohibition on discrimination, she points to the importance of the Constitutional Court's justification for precluding persons who are indirectly involved in the termination of pregnancy procedure from invoking conscientious objection. Here, the author argues, like Dickens, that the Supreme Court of the United Kingdom should use the harm reduction model to revoke the Scottish case that seeks to eliminate the distinction between direct and indirect involvement.[33]

Fletcher also points to similarities between the Colombian standards and those of the European Court of Human Rights, both of which frame conscientious objection—implicitly or explicitly—as a right with considerable limitations, a position that was also recently upheld by the European Committee of Social

Rights in a claim against Italy for allowing unrestricted use of conscientious objection.[34] Another commonality noted by the author is the need for the healthcare system to ensure that there are enough non-objecting healthcare professionals available that women who request abortion services may be actually referred to a provider and the protection of conscience does not become a systematic denial of access to abortion. The Colombian Court was clear on this point in decision T-388/09, as was the European Court of Human Rights in two cases in which it ruled against Poland,[35] as well as the European Committee of Social Rights in the *IPPF-EN v. Italy* matter.

Our review of global perspectives concludes with an article by Charles Ngwena, PhD in Law and professor at the Center for Human Rights of the University of Pretoria, South Africa. In addition to his vast experience as a law professor at universities in Africa, the United Kingdom and North America, he is an editor and prolific writer on human rights and sexual and reproductive health, as well as bioethics and medical law, with a focus on Africa. Professor Ngwena shows that most African countries have abortion laws that, far from being a total ban, are in keeping with the spirit of the abovementioned Maputo Protocol,[36] if interpreted properly. However, he then paints a picture of a region in which very few laws address conscientious objection to abortion at all, those that do address it do so only superficially, and no domestic or regional court has ruled on the issue. In this context, as the implementation of domestic and regional regulations moves forward, the author anticipates that African courts and legislators will have to take up regulation of conscientious objection to abortion, and he argues that the Colombian ruling is a valuable tool to which they could, and should, resort. Professor Ngwena holds that decision T-388/09 has international value for two reasons: 1) because it is based on constitutional principles shared by Colombia and several African nations, and 2) because of its compatibilities with international human rights treaties that African nations have also ratified. It is possible to point out that, according to the author, here is a lesson that the *south* might learn from the *south*. And perhaps once African states begin to develop their own standards, they will offer new perspectives to the Global North as well as to Latin America.

Finally, in our last article, we set out to show how decision T-388/09 has been a boon to like-minded movements, such as the movement for marriage equality in Colombia. This contribution comes from

Manuel Páez, a Colombian attorney and professor at the Externado University of Colombia who has worked for Colombia Diversa, the leading non-governmental organization doing legal activism on this issue in the country. The author recounts how, after the Constitutional Court issued a ruling in favor of marriage equality, the Office of the Inspector General[37] encouraged the use of conscientious objection by notaries to refuse to implement it. Fortunately, decision T-388/09 included language indicating that judicial officers could not invoke conscientious objection and refuse to comply with applicable law, which helped to check the threat of abuse. These threats are not limited to Colombia. Melling and Lee note in their article that all sorts of United States for-profit businesses are looking for ways to refuse services to the lesbian, gay, bisexual, transgender and inter-sex (LGBTI) population on the basis of conscientious objection. In a broader sense, these examples show that advances in women's rights may contribute to promoting LGBTI rights, so scholars and activists from both movements should seek to build bridges in order to take full advantage of common arguments and strategies that can be beneficial for both causes.

With this diversity of perspectives from men and women in academia, activism, and service, with different professional backgrounds and from different regions of the world, each with a unique take on the new Colombian standards for conscientious objection to abortion, we hope to plant the seeds of a robust, global, and interdisciplinary conversation that leads to advances in access to safe and legal abortion worldwide, while respecting the human rights of all those involved.

NOTES

[1] This ruling was issued as a result of a writ of unconstitutionality filed by Women's Link Worldwide against the law criminalizing abortion in Colombia as part of the LAICIA project (High Impact Litigation: The Unconstitutionality of Abortion Law in Colombia). The case was at the center of a broad, robust social debate, which was informed by the long struggle by the women's movement to decriminalize abortion in Colombia, as well as by other sectors that supported the action. *See* Isabel Cristina Jaramillo and Tatiana Alfonso Sierra, chapters I, II, and III of *Mujeres, cortes y medios: la reforma judicial del aborto* (Bogotá: Universidad de los Andes and Hombre Editores, 2008); *see also* chapter I of *Un derecho para las mujeres: la despenalización parcial del aborto en Colombia* (Bogotá, Mesa por la Vida y la Salud de las Mujeres, 2009).

[2] *See* Constitutional Court [C.C.], May 28, 2009, Decision T-355/06, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), *available at*: http://www.corteconstitucional.gov.co/relatoria/2006/c-355-06.htm (accessed July 8, 2014).

[3] *See* Constitutional Court [C.C.], March 9, 2007, Decision T-171/07, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://www.corteconstitucional.gov.co/relatoria/2007/t-171-07.htm (accessed July 9, 2014); Constitutional Court [C.C.], November 20, 2007, Decision T-988/07, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://-www.corteconstitucional.gov.co/relatoria/2007/t-988-07.htm (accessed July 9, 2014); Constitutional Court [C.C.], February 28, 2008, Decision T-209/08, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://www.corteconstitucional.gov.co/relatoria/2008/t-209-08.htm (accessed July 9, 2014); Constitutional Court [C.C.], October 2, 2008, Decision T-946/08, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://www.corteconstitucional.gov.co/relatoria/2008/t-946-08.htm (accessed July 9, 2014); Constitutional Court [C.C.], May 28, 2009, Decision T-388/09, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm (accessed July 9, 2014); Constitutional Court [C.C.], July 22, 2010, Decision T-585/10, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://www.corteconstitucional.gov.co/relatoria/2010/t-585-10.htm (accessed July 9, 2014); Constitutional Court [C.C.], August 25, 2012, Decision T-636/11, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://www.corteconstitucional.gov.co/relatoria/2011/t-636-11.htm (accessed July 9, 2014); Constitutional Court [C.C.], November 3, 2011, Decision T-841/11, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://-www.corteconstitucional.gov.co/relatoria/2011/t-841-11.htm (accessed July 9, 2014). Due to the barriers that still exist to full implementation of decision C-355/06, some women who have been denied termination of pregnancy services have turned to non-governmental organizations for legal representation in their claims before the healthcare and justice systems. Of note is the work of the Mesa por la Vida y la Salud de las Mujeres, a coalition of people and organizations that offer legal accompaniment to women seeking legal abortions, among other support services.

[4] *See* Decision T-355/06; Decision T-585/10 and Decision T-841/11.

[5] For more on these rules, *see Lo que hay que saber sobre el aborto legal en Colombia. Lineamientos constitucionales para el ejercicio del derecho al aborto en Colombia (2006-2013)* (Bogotá: Women's Link Worldwide, 2013).

[6] Nonetheless, obstacles to implementation persist. *See* Dalen Annika, *La implementación de la despenalización parcial del aborto en Colombia*, Document No. 11, eds. Kingdom of the Netherlands and Centro de Estudios de Derecho, Justicia y Sociedad (Bogotá: Dejusticia). *See also* Chaparro Nina *et al.*, *Lejos del derecho. La interrupción voluntaria del embarazo en el Sistema General de Seguridad Social en Salud*, Colección Dejusticia, ed. Centro de Estudios de Derecho, Justicia y Sociedad (Bogotá: Dejusticia).

[7] *See* Decision T-171/07; Decision T-209/08; Decision T-946/08. Decision C-355/06 itself addressed this issue as well.

[8] *See* Decision T-585/2010.

[9] A *tutela* action is a quick, simple procedural mechanism created by the 1991 Colombian Constitution to protect fundamental rights. Specifically, article 86 of the Constitution reads, "*every person has the right to file a* tutela *action before a judge, at any time or place, through a preferential and summary proceeding, for himself/herself or by whomever acts in his/her name for the immediate protection of his/her fundamental constitutional rights when that person fears they may be violated by the action or omission of any public authority. [...] In no case more than ten days shall elapse between filing the* tutela *action and its resolution. The law will establish the cases in which the* tutela *action may be filed against private individuals entrusted with providing a public service or whose conduct may affect seriously and directly the collective interest or in respect of whom the applicant may find himself/herself in a position of subordination or vulnerability*."

[10] *See* Decision T-388/09.

[11] Under article 86 of the 1991 Colombian Constitution and article 33 of Decree 2591 of 1991, the Constitutional Court is empowered to select at its discretion any ruling on *tutela* issued by a lower court for review. The Court may then confirm, reverse, or modify the ruling.

[12] Article 5 of Decree 4444, issued by the Colombian president in 2006, placed certain limitations on conscientious objection to abortion. Specifically, it limited its use to individuals—precluding collective objection—and to direct service providers. However, this regulation was temporarily suspended in 2006 and permanently revoked in 2012 for technical reasons by the Council of State of Colombia, the country's highest administrative court.

[13] *See Un derecho para las mujeres: la despenalización parcial del aborto en Colombia* (Bogotá: Mesa por la Vida y la Salud de las Mujeres, 2009), 46.

[14] The Court became aware of this phenomenon through reports filed by government agencies and non-governmental organizations in the case that led to the issuance of decision T-388/09. The reports consistently cited conscientious objection as a barrier to access. Decision T-388/09 includes a summary of the reports under number 7.4.

[15] *See supra* note 6, Dalen Annika, *La implementación de la despenalización parcial del aborto en Colombia*, 29. *See also* Chaparro Nina *et al*., "Lejos del derecho. La interrupción voluntaria del embarazo en el Sistema General de Seguridad Social en Salud," Colección Dejusticia, Centro de Estudios de Derecho, Justicia y Sociedad (Dejusticia), Bogotá, November 2013.

[16] *See* Circular Externa 003 of 2013, April 26, 2013, Diario oficial [DO] (Colom.) and Circular 043 of 2012 November 30, 2012, Registro distrital 5152 [RD] (Colom.).

[17] *See* Decision T-209/08 and Decision T-388/09.

[18] In 2009, the Caldas Medical Ethics Tribunal sanctioned an objecting physician to a one-month suspension for failing to refer a woman requesting the service to another professional who was available and willing to perform the procedure. The decision was confirmed on appeal by the National Medical Ethics Tribunal (Tribunal Nacional de Ética Médica [TNEM] Sala Plena, November 24, 2009, Proceso 680 *Superintendencia Nacional de Salud v. Doctor XX*, Gaceta Jurisprudencial [GJ] [June 2013] [p. 21] [Colom.]). Similarly, the Hospital Universitario San Ignacio, a private Catholic institution, was fined approximately $5,000 by the Bogotá Health Department for violations including invoking institutional conscientious objection to abortion (Dirección de Desarrollo de Servicios de Salud de Bogotá D.C. [DDSS], November 16, 2008, Resolución No. 1254, Consideraciones del Despacho [Colom.]). This sanction was confirmed on appeal, but reduced to about $3,500. (Secretaría Distrital de Salud de Bogotá D.C. [SDSB], November 30, 2009, Resolución N° 1277, Consideraciones del Despacho).

[19] In Colombia, the Inspector General's duties include enforcement of court rulings, protection of human rights, and discipline of all public officials except judges and the president (articles 277 and 278 of the 1991 Colombian Constitution). He is empowered to remove officials from office if they commit a serious enough offense. In 2009, Alejandro Ordóñez Maldonado was elected Inspector General for Colombia. He was reelected in 2013, and his term will expire in 2017. Before taking office, Ordóñez had published several books. In one of his books, he wrote that "*any citizen, whether carrying out public duties or not, may claim conscientious objection when he is asked to perform an action allowed or regulated by our legal system or by an international instrument manifestly contrary to natural order or divine law, and what is more, once the appropriate constitutional review is completed, public officials should have the right to disobey laws if these laws are in violation of divine law*" (Alejandro Ordóñez Maldonado, *Ideología de género: utopía trágica o subversión cultural* [Bogotá: Universidad Santo Tomas, 2006]). In another of his books, he describes his concerns regarding

human rights activism in this way: "*the main goal of today's cultural revolution is to dissolve the principles and values on which the Christian family is founded, as a heterosexual, monogamous, indivisible, and fertile union; they wish to remove these obstacles at all costs, through the approval, in principle, of divorce, contraception, abortion, and homosexual marriage, and they are close to achieving this first phase*" (Alejandro Ordóñez Maldonado, *El Nuevo derecho, el Nuevo orden mundial y la revolución cultural* [Bogotá: Ediciones Doctrina y Ley Ltda., 2007]). Now, three years after the partial decriminalization of abortion in Colombia, it is Ordóñez, an avowed opponent to legal abortion, who is charged with enforcing decision C-355/06. As Inspector General, he has called for the reversal of every ruling on abortion issued by the Constitutional Court during his term. All these actions thus far have been dismissed by the Court. *See* Constitutional Court, [C.C.], August 5, 2010, Auto 283/2010, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://-www.corteconstitucional.gov.co/relatoria/autos/2010/a283-10.htm (accessed July 9, 2014) and Constitutional Court [C.C.], February 28, 2012, Auto 038/2012, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://www.corte-constitucional.gov.co/relatoria/autos/2012/a038-12.htm (accessed July 9, 2014).

20 Auto 283/2010.

21 Circular 021, Guidelines and recommendations related to enforcement of Orders 3 and 4 of Decision T-388 of 2009, July 27, 2011 (Colom.), *available at*: http://www.procuraduria.gov.co/portal/media/file/CIRCULAR_T-388_DE_2009_-29jul.pdf and Circular 029, May 13, 2010 (Colom.).

22 Constitution of Colombia [CP], Art. 277.

23 Constitutional Court, [C.C.], August 10, 2012, Decision T-627/12, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), http://www.corteconstitucional.gov.co/relatoria/2012/t-627-12.htm (accessed July 9, 2014). In this decision, the Inspector General was ordered to retract several misleading statements about different reproductive rights, including emergency oral contraception and legal abortion. The ruling was the result of strategic litigation led by Women's Link Worldwide that established the right to reproductive information on demand for the first time in Colombia.

24 On October 22, 2012, Uruguayan legislators passed Law 18.987, decriminalizing abortion during the first twelve weeks of pregnancy if several requirements are met. After this period, the same law establishes that if certain additional requirements are met, it is legal to terminate a pregnancy in cases of serious risk to the health of the woman, fetal deformations incompatible with life outside the womb, and pregnancy that is the result of rape.

25 On April 25, 2007, the Legislative Assembly of the Federal District issued a decree reforming the Federal District Penal Code to classify abortion as a crime only when performed after twelve weeks of pregnancy, and adopting certain measures to ensure that the healthcare sector would provide access to service. (*See* Decreto por el que se reforma el Código Penal para el Distrito Federal y se adiciona La Ley de Salud para el Distrito Federal, Gaceta Oficial del Distrito

Federal [GODF], No. 70, April 26, 2007). In addition, even before this decriminalization decree, the revised Code listed under article 148 the following circumstances under which abortion does not carry criminal liability: when the pregnancy is the result of rape, when the health of the pregnant woman is in serious jeopardy, when the fetus has genetic or congenital disorders that may result in life-threatening physical or mental harm, and when the abortion is the result of negligence on the part of the pregnant woman.

26 Pablo Cádiz, "Los proyectos de ley sobre despenalización del aborto que Bachelet podría patrocinar," *La Tercera*, May 28, 2014, *available at*: http://www.latercera.com/noticia/politica/2014/05/674-579951-9-los-proyectos-de-ley-sobre-despenalizacion-del-aborto-que-bachelet-podria.shtml (accessed July 1, 2014).

27 *See* Sylvia Burwell, *Secretary of Health and Human Services, et al., petitioners v. Hobby Lobby Stores, Inc., et al.* 573 U.S. 354 (2014).

28 These are when there is a real and substantial risk of loss of the woman's life from a physical illness, by way of suicide, or due to a medical emergency. *See* Protection of Life During Pregnancy Act 2013 (Act No. 35/2012) (Ir.), *available at*: http://www.irishstatutebook.ie/pdf/2013/en.act.2013.0035.pdf (accessed July 9, 2014).

29 The circumstances are "*in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus*." *See Ibid.*, art. 14.2.c.

30 *Doogan and Wood v. Greater Glasgow and Clyde Health Board* [2013] CSIH 36, *available at*: http://www.scotcourts.gov.uk/opinions/2013CSIH36.html (accessed July 9, 2014).

31 *Pichon and Sajous v. France*, No. 49853/99, Eur. Ct. H.R. (2001), *available at*: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-22644 (accessed July 9, 2014).

32 *See supra* note 27.

33 *See supra* note 30.

34 Eu. Committee of Social Rights, *IPPF-EN v. Italy*, Complaint No. 87/2012 (September 3, 2013), *available at*: http://www.coe.int/t/dghl/monitoring/socialcharter/NewsCOEPortal/CC87Merits_en.asp (accessed July 9, 2014).

35 *P. and S. v. Poland*, No. 57375/08, Eu. Ct. H.R. (2012), available at: http://hudoc.echr.coe.int/sites/fra/pages/search.aspx?i=001-114098 (accessed July 9, 2014); *R.R. v. Poland*, No. 27617/04,Eur. Ct. H.R. (2011), *available at*: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-104911 (accessed July 9, 2014).

36 *See supra* note 24.

37 *See supra* note 19.

II

T-388/2009. EXCERPTS FROM THE COLOMBIAN CONSTITUTIONAL COURT DECISION

Bogota D.C., May 28, 2009.

The Eight Division (*Sala Octava de Revisión*) of the Constitutional Court, comprised by Honorable Justices Juan Carlos Henao Pérez, Jorge Iván Palacio Palacio and Humberto Antonio Sierra Porto, who chairs the panel, exercising its constitutional and legal authority, prescribed by articles 86 and 241.9 of the Constitution and articles 33 and following of Decree 2591 of 1991, issues the following

DECISION

On the *tutela* action filed by BB on behalf of his partner AA against SaludCoop EPS (private health insurance company).

Writing for the Court: Honorable Justice Humberto Antonio Sierra Porto.

I. BACKGROUND

1. Preliminary Clarification

Because the present case deeply involves the dignity of the woman involved, the Court has decided not to use her name, as a means of guaranteeing her privacy, good name and honor. Accordingly, it has taken measures to protect her identity by replacing her name and that of her partner with the letters AA and BB, respectively.

Additionally, in the conclusion of the decision, the Court will order the Secretary of this Court and the judges of first and second instance to maintain the woman's privacy throughout this process.

2. Facts

1.- As recounted by the petitioner, in April of 2006, his long-term partner experienced stomach problems (constipation), which caused her to visit a physician. The physician that attended to his partner ordered tests to determine the type of illness from which she was suffering. Once the test results were obtained, he ordered a transvaginal ultrasound (record, docket 1 at page 1).

2.- The petitioner claimed that on April 18, 2006, the results of the ultrasound confirmed a normal pregnancy of 8.1 weeks. He added that on May 16, the physician performed another ultrasound, which confirmed that the pregnancy had progressed to 12.3 weeks (record, docket 1 at page 1).

3.- The petitioner expressed that on July 18, 2006, the young woman underwent a more thorough test called an "*OBSTETRIC ULTRASOUND WITH A BIOPHYSICAL PROFILE, which determined the presence of a OSSEOUS (BONY) MALFORMATION*." Based on this test, he added, an ultrasound of degree level III was recommended to complement it (record, docket 1 at page 1).

4.- The petitioner maintained that on July 22, 2006, his partner underwent this new recommended test, which produced the following result:

> "*1.- Gravid uterus with estimated fetal age of 19 weeks, podalic. 2.- Fetal doppler normal. 3.- Biophysical profile 06/06 4.- FINDINGS COMPATIBLE WITH SKELETAL DYSPLASIA AFFILIATED WITH SHORTENING OF THE FEMUR AND HUMERUS BILATERALLY; COMMENT: a detailed 3D echo and specialized gynecologic evaluation is recommended*" (capitalization included in the original text, Record, docket 1 at page 1).

5.- The petitioner affirmed that on July 29, 2006, AA underwent the test "*detailed 3D echo and specialized gynecologic evaluation*," recommended by the treating physician and the results were the following:

"*1.- We consider a single fetus, with multiple malformations with severe signs of osseous (bony) dysplasia, which compromise principally the upper and lower extremities. 2.- We also observe severe intrauterine growth retardation with percentiles less than two percent. 3.- The bony dysplastic changes establish in the differential diagnosis the possibility of imperfect osteogenesis, for which the differential diagnosis could be diastrophic dysplasia or thanatophoric dysplasia, which should be taken into account in deciding the management*" (record, docket 1 at page 2).

6.- The petitioner indicated that Francisco Osorio had recommended convening a Medical Board consisting of the following specialists: "*JORGE LINERO, FRANCISCO OSORIO, EVER MELÉNDEZ, all obstetrician/gynecologists (OBGYNs), and CLAUDIA FERRIGNO, medical coordinator, and the Board had determined that it was necessary* '*to terminate the pregnancy due to the noted clinical diagnosis and the ultrasound of degree Level III*'" (underlining added by the petitioner, record, docket 1 at page 2).

7.- The petitioner explained that SaludCoop had produced a document in which it authorized hospitalization "*for a pregnancy of 23 weeks, for a single fetus, with multiple malformations with severe signs of osseous (bony) dysplasia*" and recommended that the pregnancy be terminated. The procedure was authorized under authorization No. 4032358 and the patient was sent to the city of Barranquilla (record, docket 1 at page 2).

8.- He explained that in Barranquilla the SaludCoop Clinic, gynecologist JORGE DE ÁVILA, attended to his partner and determined "*that the procedure should be performed in accordance with the Colombian Constitution, which requires the pregnancy to be terminated under these circumstances*." Nevertheless, prior judicial authorization was required in order to perform the surgical procedure (record, docket 1 at page 2).

3. Legitimacy of the Action

In the present case, Mr. BB brings a *tutela* action on behalf of his partner, whose rights were allegedly affected, because Ms. AA was suffering various illnesses that prevented her from exercising her rights on her own behalf when the *tutela* action was filed.

As noted on page 81 of the main docket, since mid-August of 2006, Ms. AA has experienced pain in the form of contractions with increasing intensity, migraines and vaginal bleeding, which was confirmed during an evaluation conducted by SaludCoop EPS (private health insurance company).

4. *Tutela* Action

AA's partner, acting on behalf of his partner, demands that the pregnancy be terminated and genetic and pathology tests be ordered and that "*the costs must be covered by health service provider SaludCoop, whether or not they are covered by POS (compulsory health plan), or, alternatively, by the governmental fund of solidarity and guarantees (FOSIGA) [sic]*." He also demands that he be reimbursed for the payments made before the *tutela* action was filed and decided, since for these purposes, he incurred debts that must be paid. With regard to his long-term partner's suffering, it is necessary to perform the abortion as soon as possible to avoid causing major trauma to his partner as well as to him, since it is not "*easy to suffer this trauma when it is [their] first baby together and she has lost two others under different circumstances, which must be analyzed by all scientific means possible so that they may bring healthy children with promising futures into the world*."

[…]

6. Intervention of the Respondent Entity

SaludCoop EPS (private health insurance company) considers that in the present case, the *tutela* action is inadmissible. It finds, on the one hand, that BB, who acts on behalf of his partner, requests that an abortion be performed on the young woman, a procedure that has not be denied by the EPS. It considers, on the other hand, that he who acts on behalf of the young woman has not successfully demonstrated his inability to pay, which means that is it not possible to request procedures that are not covered by POS. It alleges that in the case that the requested protections were granted, STATE-FOSIGA (the governmental fund of solidarity and guarantees) be brought in "*to directly assume the costs generated by the services solicit-*

ed by the claimant, which cannot be provided by EPS (private health insurance company) because they are not included in the POS."

7. Decisions Subject to Review

7.1. Preliminary Matter: The Conflict of Interest of the Second Penal Municipal Judge of Santa Marta

The judge of first instance declared that he had a conflict of interest because, for reasons of conscience, he could not hear the *tutela* action (pages 33 and 34). In his opinion, the unborn child is a person from the moment of conception and, as a result, according to the preamble and article 11 of the National Constitution, its life should be protected from that moment onward. According to the judge of first instance, article 18 of the National Constitution guarantees freedom of conscience and, therefore, ensures that, given his Christian formation, he is not obligated for any reason or under any circumstance to order the termination of a pregnancy because it would conflict with his "*PERSONAL beliefs, based in biblical principles like those expressed in chapter 20, verse 13: 'thou shall not kill'*" (capitalization added by the judge of first instance). For these reasons, the judge of first instance determined that ordering the termination of a pregnancy would mean a rejection of Divine Law. As such, he decided to declare his conflict of interest and ordered the transfer of the *tutela* action to the Judicial Office for reassignment to another judge.

In the ruling issued on August 25, 2006, the Second Penal Circuit Judge of Santa Marta decided not to enforce the conflict of interest claim raised by the Second Penal Municipal judge of Santa Marta because she considered the grounds of a conflict of interest claim to be narrow and interpreted restrictively. In her opinion, the religious beliefs of a judicial official should not "*strip him or her of the obligation to comply with the mission entrusted to him or her by the Constitution and the law*." These beliefs, in her opinion, do not constitute "*a conflict of interest according to the law when the grounds for a conflict of interest do not take into account the religious beliefs, political inclinations or ethical conceptions of judicial officials*."

In the judge's opinion, those who work in the administration of justice cannot allow themselves "*to be influenced by this type of interference, which proves to be a remnant of the past, fortunately overcome, where justice was influenced by such subjective conceptions of the judicial official*." For these reasons, and once the grounds required for such an impediment to succeed were rejected, the judge held that the Second Penal Municipal Judge of Santa Marta had the competence to hear *tutela* action.

7.2. Decision of First Instance

In the ruling issued on August 31, 2006, the Second Municipal Penal Judge of Santa Marta decided to reject the *tutela* action. He grounded his decision in a conscientious objection claim, which, in turn, he supported using the same reasons he had relied upon to justify the conflict of interest claim discussed above.

7.3. Decision of Second Instance

In the ruling issued on September 8, 2006, the Second Penal Circuit Judge of Santa Marta overturned the ruling on the *tutela* action and granted protection of the fundamental constitutional rights to human dignity, to free development of the person and to health in connection with life and also ordered Salud-Coop EPS (private health insurance company) to terminate the young woman's pregnancy within forty-eight hours for the reasons outlined in the decision. She also ordered the entity to perform diagnostic tests "*on the fetus and the parents, as recommended by the treating physicians, and provide the young woman any necessary psychological treatment*."

[…]

II. CONSIDERATIONS AND REASONING

[…]

2. Presentation of the Case and the Legal Issues under Review

The petitioner, who acts on behalf of his long-term partner, requested the termination of pregnancy due to grave fetal malformations—in accordance with decision C-355 of 2006, through which the Constitutional Court, interpreting articles 122, 123 and 124 of Law 890 of 2004, concluded that the practice of abortion is lawful under certain circumstances, which include "*serious malformations of the fetus that make it nonviable, as certified by a physician*," and also demanded that the EPS (private health insurance company) conduct any necessary diagnostic tests on the young woman to determine the causes of the fetal malformation.

After presenting the evidence in the case, it was confirmed that based on the results of the medical tests performed on the young woman, the doctors diagnosed multiple malformations and likely osseous (bony) dysplasia of the fetus, which led to their decision to convene a Medical Board with the participation of physicians and specialists who reached the conclusion that it was necessary to terminate the pregnancy as soon as possible.

Once the authorization for the termination of pregnancy was given, the respondent entity agreed to perform the procedure but the physician gynecologist Jorge de Ávila requested judicial authorization before carrying out the surgical procedure. However, SaludCoop EPS (private health insurance company) refused to carry out the diagnostic tests necessary to determine the reasons for the fetal malformations. The EPS (private health insurance company) alleged that these services were not included in the compulsory health plan (POS) and that it had not been proven that petitioner was unable to pay, which is why the respondent entity insisted that it was therefore not possible to apply the exceptions provided for by constitutional jurisprudence to claim services outside the POS.

The judge of first instance declared that he had a conflict of interest because he could not hear the *tutela* action for reasons of conscience (pages 33 and 34). In the ruling issued on August 25, 2006, the Second Penal Circuit Judge of Santa Marta decided not uphold the conflict of interest claim that was raised because she considered the grounds of a conflict of interest claim to be narrow and interpreted restrictively. Accordingly, she held that the Second Penal Municipal Judge of Santa Marta had the competence to hear the *tutela* action.

Once the case was remanded to the judge of first instance for a ruling, the judge of first instance refused to grant the protection sought by the *tutela* action (pages 59 to 65). In the decision, he relied on the right to conscientious objection, derived from article 18 of the National Constitution, as the basis for not ordering the termination of the pregnancy. He found that the application of this right extended to the judicial authorities of the Republic since, in his opinion, these authorities are also "*human beings with philosophical, religious, cultural, etc. formations*." For these reasons, he decided to reject the *tutela* action.

In the decision of second instance, which was grounded in the decision of September 8, 2006, the Second Penal Circuit Judge of Santa Marta overturned the ruling on the *tutela* action and granted protection of the young woman's fundamental constitutional rights to human dignity, to free development of the person and to health in connection with life (pages 91 to 102); she also ordered SaludCoop EPS (private health insurance company) to terminate the young woman's pregnancy within forty-eight hours for the reasons expressed in the decision. Similarly, she ordered the entity to perform diagnostic tests "*on the fetus and the parents, as recommended by the treating physicians and provide the young woman any necessary psychological treatment*."

Given these facts, the Court finds it necessary to resolve the following legal issues in the present case:

> i) What is mandated by the Constitutional Court's decision C-355 of 2006 in the area of the sexual and reproductive rights of women?

ii) What practical consequences arise for the EPSs (private health insurance company), the IPSs (healthcare providers, public or private) and the medical personnel to ensure they are in compliance with decision C-355 of 2006?

iii) Can judicial officials declare themselves conscientious objectors in the execution of their functions and, consequently, abstain from resolving a case that they have been assigned to hear, especially where the case involves a protection of fundamental rights?

[…]

4.4. Conclusions about the Sexual and Reproductive Rights of Women

Given the prior discussion, the following can be concluded:

i) Women who find themselves under one of the circumstances outlined in decision C-355 of 2006 enjoy the right to decide, free from pressure, coercion, manipulation, and, in general, any kind of inadmissible requirements, to terminate a pregnancy. It is also the right of women under these circumstances to freely choose to carry a pregnancy to term.

ii) All women should be provided with sufficient, comprehensive and adequate information that permits them to fully and freely exercise their sexual and reproductive rights, which includes the right to be informed of the Court's holding in decision C-355 of 2006 […].

iii) Abortion services under the circumstances outlined in decision C-355 of 2006 must be **available throughout the entire country**—provided in accordance with referral and counter-referral principles—and pregnant women who require these services should be able to access them at all levels of care.

iv) Health professionals and, in general, health personnel that provide services to women seeking abortions are obligated to fully guarantee a patient's confidentiality and, consequently, must respect these women's right to privacy and dignity. Doctor-patient confidentiality is a principal obligation of health professionals when providing this service.

v) Neither women who choose to terminate a pregnancy under the circumstances outlined in decision C-355 of 2006 nor those who provide these services can be victims of discrimination or conduct that in any way limits access to their place of work or educational centers, interferes with their affiliation to the general system, or subjects them to professional risks.

vi) Departments, districts and municipalities are obligated to ensure that **sufficient abortion services are available through the public network**, with the purpose of guaranteeing pregnant women effective access to voluntary abortion services in conditions of quality and safety.

vii) No service provider entity—whether public or private, religious or secular—can refuse to terminate the pregnancy of a woman who finds herself under one of the circumstances outlined by decision C-355 of 2006—regardless of pregnant woman's social security affiliation and regardless of her social or economic condition, age, ability to pay, sexual orientation or ethnicity.

viii) It is categorically prohibited to impose obstacles, requirements or barriers to the practice of abortion, under the circumstances in which it is permitted, in addition to those already established by case C-355. The inadmissible barriers include, among others:

[…]

- Alleging collective conscientious objection that triggers, in turn, institutional and unfounded conscientious objection claims.

- Entering into agreements—individual or collective—to refuse to provide abortions.
- Making use of forms or letters of support indicating that none of the doctors at a given hospital are willing to provide voluntary abortion services, as medical professionals would become victims of discrimination when applying for jobs or, once hired, feel pressured to abstain from providing abortions.

[…]

5. Conscientious Objection: Direction and Implications in a Social Democratic, Participatory and Pluralistic Legal State, Like Colombia (Articles 1 and 7 and Subsequent)

5.1. Conscientious Objection as a Fundamental Right and its Relationship to the Legal Order

As mentioned previously, an important aspect of the matter *sub judice* is the relative nature of conscientious objection in general and, in particular, the question of whether those who serve as judicial authorities in a social democratic and pluralistic legal state can conscientiously object to hearing and deciding a matter brought before them or whether they base their ruling on personal convictions rather than on valid regulations.

When responding to these considerations, it is important to note that the Colombian constitutional text has specific characteristics that distinguish it from other Constitutions; not only due to its length but also due to the manner in which it regulates different aspects of social, political, cultural and institutional life under the same doctrine, which is a participatory and pluralistic democracy that is respectful of human dignity.

Beginning with the first constitutional article, is it clear that the Fundamental Law characterizes Colombian state as a social democratic and participatory legal state, respectful of human dignity and accepting of pluralism. According to this precept:

> "*Colombia is a **social legal state**, organized as a unified and decentralized Republic, with autonomy among its territories, **democratic, participatory and pluralistic**, founded in **respect for human dignity**, in the work and solidarity of its people and in the prominence of the general public interest*."

One of the distinctive characteristics of the state is, therefore, its acceptance of pluralism. Its acceptance of pluralism has at least three dimensions: to be a society that i) expressly admits and expressly promotes diversity (article 7);[1] ii) appreciates, in a positive way, the different existing aspirations and valuations,[2] including the special protection of freedom of religion,[3] freedom of conscience and thought,[4] as well as freedom of expression[5] and iii) establishes the legal, political and social channels that serve to resolve possible conflicts that arise due to valid differences that exist at any given moment.

The Constitution highlights, as a result, the conditions that are necessary to make diversity a social and cultural reality as well as the extent to which these conditions allow for the very different aspirations, world views and ideologies that exist within a heterogeneous society. The legislature has, of course, a leading role recognizing pluralism and diversity.[6] In that sense, all policies should be designed in a way does not overlook differences and allows for the manifestation of different ideological, cultural, ethnic and social nuances.

Of course, the work of the legislature and the actions of public authorities and individuals are also subject to limits, without which the Constitution would merely be a reflection of arbitrary decisions made by the legislature. This would lead to a closed and totalitarian order in which values that are determined in a dogmatic, absolute and exclusionary manner dominate the legislature or a situation in which each public authority or each individual could act in conformance with her own criteria without considering that fact that she is acting in a disproportionate and unjust manner and without recognizing the necessity of guaranteeing respect for the rights of others and for pluralism to achieve at the least a minimum level of integrity and social cohesion, as required by the Constitution (article 1). Precisely in order to avoid this, the Colombian Constitution sets limits. The constitutional text represents, as a result, not only the driving force behind legislative work but also the limits of state action.

One of the limits, maybe the most important, to the power to exercise these functions is the need to protect fundamental rights, understood in this context as spheres of individual autonomy that are insurmountable for the legislator or the administration of a democratic and pluralistic state. The right to conscientious objection derives from this context, as it is intended to preserve individual convictions whether they are ideological, religious or moral.[7] This Court has ruled on conscientious objection on several occasions, in the context of military service,[8] education,[9] taking an oath,[10] employment obligations[11] and healthcare provision,[12] among others.

In general, conscientious objection arises when complying with a regulation would require individuals to act in a way that their conscience prohibits.[13] In other words, conscientious objection assumes an incompatibility between a legal norm and a moral norm.[14] There is no room to argue that the norm conflicts with the greater community's sense of justice, even though the individual resists complying with norm due to her own moral convictions. Those that conscientiously object "*do not allege that the norm is unlawful or seek a change in the laws or programs promoted by a government*."[15] It is an individual who "*follows the Law, but compliance poses problems with her most intimate moral convictions, with her critical conscience*."[16] The central idea is that individuals breach a legal duty for moral reasons and seek to preserve their own moral integrity, which does not support the proposition that other people must "*adhere to the beliefs or actions of the objector*."[17]

The link between conscientious objection and the rights to freedom of thought, freedom of religion and freedom of conscience is very strong up until the point where conscientious objection becomes the obligatory logical conclusion of these liberties. From that perspective, state interference in certain achievements in an individual's life is impermissible or requires a higher burden of justification. That way, those who conscientiously object enjoy *prima facie* a presumption of moral correctness. Meanwhile, the state must provide arguments that would justify an intervention in this field, which is normally immune to any kind of interference.

This concept has been articulated in other countries' legal systems like the one in the U.S.—in both the federal and state legislatures in almost all states of the union—even though conscientious objection in

the case of abortion is not expressly addressed in the Constitution; similarly in France, following the Constitutional Council's decision on November 23, 1977, it has been understood that conscientious objection in the area of abortion has both constitutional and legal validity;[18] and, finally, it is worth mentioning that Spain has recognized the right to conscientiously object among medical personnel who participate in the termination of a pregnancy.

However, the obligation to comply with the law is founded upon, among other bases, the possibility of exercising right to freedom of conscience. Of course, this right is not absolute and may have limits because, without limits, it would be impossible to adopt measures that are binding upon all individuals. Similarly, it is impossible to discuss accepted norms freely if there is no guarantee of the right to freedom of conscience.

This does not involve, as a result, verification of whether conscientious objectors' convictions are just or unjust, correct or erroneous. In principle, the very existence of these convictions would justify an objection for reasons of conscience. **The problem arises when an individual's moral convictions are externalized with the purpose of evading a legal duty and, as a consequence, interferes with the rights of other individuals**. In other words: when the act of conscientiously objecting interferes with the ability of third persons to exercise their rights, then it becomes an issue of limits on the exercise of fundamental rights, that is, "*a clash between individual rights and the values, principles, rights or goods protected by the legal duty*."[19] We find ourselves, then, faced with the problem of determining the limits of fundamental constitutional rights.[20]

The right to conscientious objection may, therefore, trigger or unleash consequences for third persons. **It is therefore impossible to characterize conscientious objection as a right that affects solely those who exercise it**. When one objects for reasons of conscience, a legal duty has necessarily been breached, "*with greater or lesser social implications*."[21] The question then becomes what are the limits to conscientious objection—which *prima facie* may seem justified—given the negative impact it can have on the rights of third persons.

Of course, the protection of rights is given preferential treatment inside the Constitution's objectives. The direction and scope of the Constitution's limits must promote the broadest possible protections for fundamental rights, which means that interpretations of the limits must rely on strict criteria that will guarantee protection of these rights. Nonetheless, it is not always possible to set forth clear legal criteria for determining which rights are given priority and to what degree they are given priority in cases where rights are in conflict or where rights conflict with legally-protected goods. Attempting to establish general criteria that resolve all such conflicts once and for all is not the solution under these circumstances. Although it may be true that it is possible to establish some guiding principles, the right to object to the disregard of a legal obligation due to motives of conscience, should be analyzed in the light of circumstances of each individual case.

The guidelines might mention the degree of importance—as established by doctrine—that is given to "*a legal good or value, or right that is protected by breach of a legal duty*."[22] They also might address the "*the degree of reversibility of the injury that such a breach causes*."[23] When conscientiously objecting involves marginal or minimal interference with the rights of third persons or when an individual's conscientious objection does not impact any of these rights, there is no reason to limit the right to conscientious objection. The same is true when the legal duty impacts only the interests of the conscientious objector or benefits the individual.

The situation is distinct with regard to regulations that contain obligations intended to protect the interests of specific individuals, as established by decision C-355 of 2006. Women who are under the assumption that, based on the interpretation of the Constitution, were endorsed by the Court are concerned that if they are in such cases, they are not penalized when they decide to voluntarily terminate their pregnancy. This case dealt with sufficiently important interests that justified restricting freedom of conscience, which, if permitted under the circumstances, would violate women's fundamental constitutional rights to health, personal integrity and life in conditions of quality and dignity. It would also violate their sexual and reproductive rights and cause them irreversible harm.

It is important to note a how conscientious objection should be handled under a variety of circumstances. As the Court noted in decision C-355 of 2006, one situation for example is that which physicians may face when conscientiously objecting to providing an abortion because performing the procedure directly conflicts with their moral convictions. Conscientiously objecting under these circumstances is not punishable when it is feasible for another healthcare professional to provide the voluntary termination of pregnancy and it is provided in a manner that protects the rights of the pregnant women who seeks an abortion under the circumstances in which it is permitted.

This is not the case when the state or a private health promoting entity (EPS) fails to ensure the presence of a sufficient number of healthcare professionals to protect the rights of women, as required by decision C-355 of 2006. If there is only one healthcare professional that can perform voluntary termination of pregnancy—under the circumstances that it is permitted under—then they should perform the termination, regardless of whether the physician is affiliated with a hospital that is private or public, religious or secular. Under these circumstances, the restriction of the physician's freedom of conscience is entirely legitimate—both proportional and reasonable—because it protects the right to life and health [among others] of the pregnant woman; in other words, under these conditions the failure to provide a voluntary termination of pregnancy causes direct and irreversible harm to the pregnant woman and infringes upon her fundamental constitutional rights. Individuals, consequently, cannot conscientiously object when the act of objecting would lead serious violations of fundamental rights.

This statement is based, in part, i) on the relational character of the rights that protect the free exercise of liberties but only to the extent that they do not result in abuse or unjustified, disproportionate or arbitrary interference with the rights of other individuals. ii) It also requires that people recognize their duty to promote conduct that is supportive, just and equitable and respectful of the general public good. Without engaging in this kind of conduct, the comprehensive development of individuals and society as a whole would be very difficult and fairly unlikely. iii) Finally, it highlights the special role that healthcare professionals play within society, especially when their work entails providing public services, which requires them to assume a relationship with those that seek those services and imposes duties on them that cannot be postponed or avoided.

In practice, one of the main challenges related to limiting the right to conscientious objection is the need to set priorities. As discussed earlier, it is not feasible to establish general rules or criteria for determining the limits of the right to conscientious objection and its limits should instead be determined on a case-by-case basis. In the case of pregnant women who seek abortion under the circumstances outlined in decision C-355 of 2006, healthcare professionals can object to terminating a pregnancy for reasons of conscience if and only if there is a guarantee that the pregnant woman will have access to the procedure in conditions of quality and safety, that she will face no additional barriers that interfere with her ability to access necessary healthcare services and that her fundamental constitutional rights to life, sexual and reproductive health, personal integrity and human dignity will be respected.

With regard to the aforementioned, it important to note that the Constitutional Court established in decision T-209 of 2008 that "*conscientious objection was not an absolute right*" and insisted that "*health professionals should provide abortions in a timely manner in conformance with decision C-355 of 2006 and that is was their obligation to refer a pregnant woman to a health professional who could and would provide said procedure*." In decision T-209 of 2008, the Court added:

> "*ii) in the case of those health professionals who are unable to provide abortions for reasons of conscience, they are provided an opportunity to conscientiously object; iii) they can always conscientiously object when 'the claim is legitimately grounded in religious convictions,' so that the claim is not based on whether or not the physician supports abortion; and, iv) conscientious objection is not an absolute right and its exercise is limited by the Constitution's protection of fundamental rights, which extend to women and therefore cannot be violated*" (underlining not included in the original text).

In accordance with the above-mentioned, it is important to note that limits also exist with respect to who can exercise the right to conscientious objection; the Court has clearly stated that conscientious objection only applies to personnel that are directly involved in performing the medical procedure necessary to terminate the pregnancy. Conversely, this right does not extend to administrative personnel, medical

personnel who perform only preparatory tasks and medical personnel who provide care during the patient's recovery phase.

Accordingly, the right to conscientious objection does not protect personnel who take the patient's medical history, manage the institution's files, receive new patients, clean the facilities, etc. because of the difficulty in determining how their work interferes with legitimate moral, philosophical or religious convictions; similarly, this right does not extend to personnel that prepare the patient for the procedure, offer guidance as to the consequences of the procedure, provide psychological assistance prior to the abortion, etc.; finally, conscientious objection by medical personnel that help patients in the recovery phase following the procedure is impermissible because their refusal to do this kind of work cannot be based in any legitimate moral, religious or psychological convictions and merely indicates that they disapprove of conduct that has already taken place, which is not a proper basis for a conscientious objection claim, as has been discussed previously.

Finally, the Court considers the need for formal limits, in the sense of developing certain requirements and procedures for individuals who wish to conscientiously object under the specific circumstances in which it is permitted. In the case of medical personnel that participate directly in the abortion procedure and conscientiously object with respect to that particular procedure, the individual should do so in writing and indicate:

> i) The reasons why performing the abortion in this specific case goes against her most intimate convictions, for which general language presented on behalf of a group will not suffice, nor objections presented by any person other than the person who is conscientiously objecting; and
>
> ii) The alternative healthcare professional who is prepared to provide the patient with the requested procedure. The conscientious objector must be sure that an alternative healthcare professional is available and is willing and able to perform the abortion at the time that it is required.

Accordingly, the rights-based and plural nature of fundamental rights is respected, standards are developed to prevent conscientious objection from becoming a barrier for patients who choose access the essential healthcare service of abortion and conscientious objection is exercised in a responsible and strict manner.

It is therefore clear that conscientious objection is a right that protects individuals' privacy **in the most intimate sphere**—a person's thoughts and conscience—so that is can be shaped with sufficient freedom from interferences by the state or by those who are not permitted to enter into this sphere. When exercising this right, and with the power of its relational character, there are limits that cannot be exceeded, under penalty of illegitimately exercising the right.

5.2. Conscientious Objection as an Individual Right and Not an Institutional or Collective Right

It is important to emphasize that legal persons do not have the right to conscientious objection and, as a result, healthcare providers (IPS) cannot oppose the practice of voluntary termination of a pregnancy. A conscientious objection claim is not based on an individual's opinion regarding a specific issue; on the contrary, it is grounded in the most intimate and deeply-rooted convictions of an individual. Legal persons cannot experience intimate and deeply-rooted convictions. Though they can embody principles such as free enterprise or represent the fundamental rights of their individual members, legal persons cannot possess an ethical or moral character transmitted to them by natural human beings.

Highlighting the inability of legal persons to exercise the right to conscientious objection, in addition to fully addressing the essence of the right, is an effective mechanism for preventing legal persons that provide healthcare services from limiting the freedom of their individual employees who might be coerced by the restrictive positions imposed on them by these institutions' managerial staff.

Under these circumstances, it is not necessary to differentiate between public and private legal persons. This is because conscientious objection in the medical context addresses the provision of *public* healthcare services by the state-run public healthcare system and involves the protection of patients' fundamental

rights. It does not involve a private institution that provides healthcare under conditions as established by an agreement between private parties; on the contrary, it involves the implementation of the public healthcare system, created and administered by the state and financed by public resources. Although certain private legal persons have the opportunity to participate under these circumstances, the regulation of private institutions is generally very different from that of public institutions. When public institutions are the primary provider of a [public] service, private autonomy should be drastically reduced, especially when the services involve the protection of fundamental rights like the right to health, life and free development of personality, among others.

5.3. Judicial Authorities Cannot Conscientiously Object to Hearing or Deciding a Case that is Presented before Them

Conscientious objection is a right that receives extensive protection in the private sphere—when it doesn't involve the violation of the rights of third persons. However, it is impermissible for someone acting as a public authority to conscientiously object. Those serving in that capacity cannot excuse themselves from carrying out their constitutional and legal duties for reasons of conscience, since that practice would be a clear violation of articles 2 and 6 of the National Constitution. According to article 2:

> "*The essential goals of the state are: to serve the community, to promote general prosperity, and to guarantee the effectiveness of the principles, rights, and duties stipulated by the Constitution; to facilitate the participation of all in the decisions that affect them and in the economic, political, administrative, cultural life of the Nation; to defend national independence, maintain territorial integrity, and ensure peaceful coexistence and the enforcement of a just order. The authorities of the Republic are established in order to protect all persons residing in Colombia, in their life, dignity, property, beliefs, and other rights and freedoms, and in order to ensure the fulfillment of the social duties of the state and individuals*."

Article 6 establishes:

> "*Each person is only individually responsible before the authorities for violations of the Constitution and the laws. Civil servants are responsible for the same reason, and likewise for omission or acting 'ultra vires' in the exercise of their functions*."

The articles set forth the role of public authorities and, with regard to conscientious objection, the substantial differences between the depth and scope of the duties of these authorities and that of individuals not acting in this capacity. When an individual voluntarily serves as a judicial authority and assumes responsibilities involving the exercise of jurisdictional activity, one of their most important obligations is to ensure strict compliance with valid laws.

Accordingly, a judicial servant's decision is not grounded in his or her own free will. Under these circumstances—according to article 230 of the Constitution—a judge is obligated to decide the case that is before him or her on the basis of the principles founded in the Constitution and other relevant legal regulations. When interpreted broadly, his or her primary duty is to apply the law and, as a result, the decisions cannot be grounded in convictions that are religious, political, philosophical or otherwise unrelated to the duties as a judge. This does not mean that as a private individual they cannot have the possibility of exercising their fundamental rights; it means that, in their work as an administrator of justice, personal convictions do not relieve them of the duties that derive from the public appointment. These duties include administering justice, based solely in the law, so that decisions are grounded in state law and not in the personal opinions of the public authorities. In other words, laws rather than individuals govern states, this being the only way to construct and consolidate a state based on the rule of law.

Additionally, permitting judicial authorities to conscientiously object to the application of an established legal precept results in unjustly precluding and arbitrarily impeding access to the administration of justice. It is important to note that judicial duties involve protecting fundamental constitutional rights that have, in turn, come into existence through great efforts on the part of groups, like women, that have been historically discriminated against.

Similarly, it is important to note that the achievements that have led to the acknowledgment of fundamental rights are not always well received by all sectors of society and are frequently vulnerable to attack. These attacks are often led by those who are trying to impose an absolute and exclusive point of view that is incompatible, as previously discussed, with the acceptance of plurality and with the need to protect and promote cultural diversity, as is stipulated by articles 1 and 7 of the National Constitution and many of its other precepts.[24]

It follows that the judicial authorities should leave aside their personal convictions so that the Rule of Law can be developed to ensure that individuals' right to access justice is met and through this channel, assure that their fundamental constitutional rights are respected and protected. A judicial official's personal convictions cannot serve as an obstacle to prevents individuals from obtaining timely and due process.

As a result, those who voluntarily become members of the judicial branch should leave aside their considerations of conscience when exercising their duties as judicial officers and should simply apply the valid law. The Constitution, however, protects these individuals when they act in the private sphere, permitting them to act in accordance with the mandates of their conscience and protecting them from impermissible interferences on the part of the state or other individuals.

This discussion thus far expressed, cannot be complete without a reference to a related topic that also implicates judicial authorities' obligation to ensure adequate protection of important rights: the time it takes judges to issue a decision regarding a writ for protection of fundamental rights.

Writs for protection of fundamental rights should be decided within the timeframe established by article 86 of the Constitution and article 29 of Order 2591 of 1991 in order to assure the protection of the fundamental right and to avoid causing any additional harm.

It is of particular importance to note that the judge, especially under the given circumstances, should use all means made available to him or her by the legal system to avoid violating a fundamental right; accord-

ingly, the 10 days in which a judge must issue a decision is only the maximum time limit under article 86 of the Constitution so, if the circumstances require, the judge should always make every effort to issue a decision in a timeframe that effectively protects the threatened or violated right.

Any failure on the part of the judge to comply with these obligations can give rise to an irreversible situation for a pregnant woman and the state would be held liable for inactivity of its officials. Under these circumstances, it would be important to consider the feasibility of bringing an action for recovery (*acción de repetición*) against the official that failed to effectively protect the woman's rights.

5.4. Conclusions

In conclusion, respect for the right to conscientious objection involves the following:

i) Conscientious objection is a fundamental constitutional right that, like all rights within the normative framework, must guarantee protection and encouragement of cultural diversity (article 1 and article 7 of the Constitution) and therefore cannot be exercised in an absolute manner.

ii) The exercise of fundamental constitutional right to conscientious objection receives very extensive protection in the private sphere by way of article 18 that can only be limited in the event that in its practice it interferes with the rights of third persons.

iii) Only medical personnel whose duties involve direct participation in the procedure leading to the termination of pregnancy can conscientiously object; *per contra* this is an option that does not exist for administrative personnel, medical personnel that only perform preparatory tasks and medical personnel who provide care during the patient's recovery phase.

iv) Physicians who conscientiously object must explain their objection in writing and indicate the reasons why they are unable perform the termination of pregnancy.

v) With regard to the practice of induced abortion, the Court stresses in decision C-355 of 2006 the need to ensure that the allowed *prima facie* exercise of conscientious objection by healthcare professionals who act as direct service providers could be restricted when its exercise imposes a disproportionate burden on women who decide to terminate their pregnancy under any of the circumstances established by this decision.

vi) With regards to the manifestation of intimate and inalienable moral, philosophical or religious convictions, conscientious objection is a right does not extend to legal persons.

vii) Individuals who voluntarily serve as judicial authorities cannot conscientiously object in an attempt to avoid complying with a regulation that has been adopted in accordance with constitutional tenants and that, as a result, is legitimate and valid, as it would be a rejection of what is established under article 2, of which among its goals are to "*guarantee the effectiveness of the principles, rights and duties established in the Constitution*" and to protect "*all persons living in Colombia, in their lives, honor, property, beliefs, and other rights and freedoms, and ensuring the fulfillment of the social duties of the state and individuals*." Claiming conscientious objection is thusly inadmissible under these circumstances, as it would translate into an unjustified hindrance in the administration of justice and linked to a serious, arbitrary and disproportionate restriction on fundamental constitutional rights, even more, where many of these rights developed out of struggles led by sectors of the society that have historically been discriminated against and whose successes have generally not been well-received by many sectors of society that, shielded by their conscientious objections, try to project their private convictions in the public sphere, using an domineering and exclusionary rationale that is entirely contrary to the mandate of protecting and stimulating cultural diversity as specially established by the Constitution (articles 1 and 7).

[…]

7. The Present Case

[…]

Page 33 of the record, docket 1, includes a statement written by the Second Penal Municipal Judge of Santa Marta on August 23, 2006, in which he declares his conflict of interest with regard to hearing and deciding the present *tutela* action in the following terms:

> "*After analyzing the present* tutela *action based on Order 2591/91, a conflict of interest is declared for the following reasons: / In accordance with the Civil Code, that which exists in the womb of the woman is not a person but, according to my feelings, a life. This is in accordance with the Constitutional Court's decision T-179 of 1993, which is known as the legal literature regarding NASCITURUS and in which the Constitutional Court expressed: / 'Nasciturus is the term used to describe the unborn which has yet to be born. The discussion around whether the nasciturus is a person or not has been a standard discussion in legal literature'* (emphasis added by the judge) */ In the aforementioned case, the Constitutional Court also said: / 'Constitutionally, the protection of the unborn can be found in the Preamble and article 11 (in the right to life).' / The previous statement, in conjunction with article 18 of the National Constitution, that, in my capacity as a Judge of the Republic, guarantees my freedom of conscience, in other words, my CHRISTIAN formation. UNDER NO CIRCUMSTANCE WILL I ORDER the termination of a pregnancy because, based on my PERSONAL convictions, founded in the biblical principles expressed in chapter 20, verse 13 'thou shall not kill' violates Devine Law, for which I declare myself INCAPABLE of resolving the present* tutela *action, as it goes against my conscience. / Based on the above, the present* tutela *action is to be submitted to the Judicial Office for reassignment. May it be registered*" (capitalization and emphasis added by the judge).

In the ruling issued on August 31, 2006, the Second Penal Municipal Judge of Santa Marta refused to decide the *tutela* action. He grounded his decision in the right to conscientious objection. With regards to this decision, he said:

"*I wanted to record in writing […] that, much to my regret, the present action [was declared] incapable of being heard under the Institution of CONSCIENTIOUS OBJECTION, which was constitutional as it was established in article 18 of the Constitution*." He added that the case presently before him presented a "*conflict between the law and the individual's conscience that the National Constitution allowed under the Institution of CONSCIENTIOUS OBJECTION and therefore there was no crime or offense*" (capitalization added by the judge).

[…]

[That] article 18 [was] part of the supreme law and [there was] nothing that would [indicate] the exclusion of judges of the Republic, who [were] human beings with a philosophical, religious, cultural, etc. orientation. [He finally added] that he "*[had] not been able to remain calm when asked by a person in the street, who [had expressed to him]: 'Judge, tell me something, is a fetus of 6 months really alive? And when they remove it alive, how do they kill it? Do they strangle it? Do they inject it or leave it on the operating table until it dies?' A passerby had asked him that question and it had [prevented him] from sleeping*." After citing some doctrinal passages, he concluded that he could not grant the relief sought for the reasons outlined above.

As discussed above, the reviewing Court—Second Penal Circuit Judge of Santa Marta—overturned the decision issued by the Court of first instance on all grounds and granted protection of the petitioner's fundamental constitutional rights to human dignity, to free development of the person, to life and to health, just as EPS SaludCoop was ordered to terminate the young women's pregnancy within forty-eight hours for the reasons expressed in the decision. She also ordered the entity to perform diagnostic tests "*on the fetus and the parents, as recommended by the treating physicians, and provide all necessary psychiatric care to the young woman*."

For these reasons, the present case was brought without a cause of action since, in accordance with the report produced by the designated attorney of the Office of the Protection of Minors and Families and in

compliance with the decision of the Court of second instance, the termination of pregnancy was performed on September 9, 2006. Nonetheless, given the current matter's constitutional importance and the need to comply with the obligations of decision C-355 of 2006 and assist the Constitutional Court by achieving interpretive unity, the Court considered it necessary to clarify that the judge of first instance acted in a way that is incompatible with current law, first, by refusing to hear the *tutela* action for reasons of conscience and, later, by refusing to provide protection based on religious arguments that are completely unacceptable in a social, democratic, participative, and pluralist state like Colombia (article 1 of the National Constitution).

[…]

The fact that decision C-355 of 2006 was only recently decided and that the issues involved are of a particularly difficult nature means that this case cannot be treated as an ordinary case and it will be obligatory in futures cases to: require copies from both the District Attorney's office and the Sectional Judicial Board (*Consejo Seccional de la Judicatura*) to establish competence. This does not prevent the Court from stressing the gravity of the conduct of the judge of first instance and the need to ensure that such conduct does not occur again, and as a result, it emphasizes that the rejection of the Constitutional Court's decisions has consequences, especially when this type of conduct negatively affects the protection of fundamental rights.

Here, the Court should highlight, again, that however strong and respectable the religious beliefs of judicial authorities are in the context of their personal lives, these authorities cannot abstain from hearing and deciding a case based on considerations of conscience and neither can they decide cases based on their own moral convictions and ignore their obligation to decide cases in conformance with current law, which, as it was indicated, encompasses not only the laws, in a strict sense, but also the Constitution, the block of constitutionality, and jurisprudence dealing with the constitutionality of the laws and the rejection of constitutional jurisprudence when it directly violates constitutional and legal precepts or administrative acts of general character, as the Constitutional Court held in decision C-335 of 2008. In other words: it

is forbidden for those who exercise jurisdiction to do so on the basis of moral valuations or abstain from applying current and established law in accordance with National Constitution because they consider it to be incompatible with their own religious, moral, cultural or ideological beliefs. If they do act in this way, their conduct is subject to the previously mentioned decision and amounts to a breach of legal duty. Penal and disciplinary sanctions, consequently, may result.

The Constitutional Court has insisted, and continues to reiterate in the present decision, that judicial authorities cannot conscientiously object to authorizing requests for voluntary abortions by pregnant women who find themselves under one of the circumstances outlined in decision C-355 of 2006.Moreover, there is no regulation in the Colombian legal system that permits judicial authorities to declare a conflict of interest—as was alleged by the judge of first instance—to abstain from hearing and deciding *tutela* actions under these circumstances. On the one hand, and for reasons indicated in the present decision, judicial authorities must decide cases based on law and not based on conscience. On the other hand, the grounds for a conflict of interest claim in the case of judicial authorities are narrow—they do not include conscientious objection—and are restrictively interpreted, for their exercise, as it was explained, constitutes an obstacle to accessing the administration of justice and, as a result, an unjustified refusal of justice and a lack of protection of fundamental constitutional rights, in violation with the National Constitution (articles 2 and 6).

[…]

Relying on what was discussed above, the Court will uphold the decision and reasoning of the judge of second instance in the present case. Additionally, the Court will urge the Ministry of Social Welfare, as well as the National Ministry of Education, the National Attorney General's Office and the Office of the Public Defender, to immediately design and implement massive campaigns that promote sexual and reproductive rights and help ensure that women throughout Colombia can freely and effectively exercise these rights by increasing awareness about the holdings of decision C-355 of 2006 and the present case, and conduct due follow-up on such campaigns to assess their impact and efficacy. These campaigns should focus on transmitting comprehensive information about the topic in simple, clear and sufficiently illustrative terms.

Similarly, the Court will insist that the National Superintendent of Health adopt indispensable measures requiring EPSs (private health insurance company) and IPSs (healthcare providers)—whether public or private, secular or religious—to employ the necessary medical professionals and other suitable personnel to provide abortions under the circumstances outlined in decision C-355 of 2006, while abstaining from imposing additional impermissible requirements—such as those enumerated by the Court in legal conclusion number 8 of this decision—that prevent women from exercising their fundamental constitutional rights. This obligation should apply in all territories and should be carried out in accordance with the principles of referral and counter-referral, ensuring that the public network of healthcare service providers offers voluntary abortions at the department, district and municipal levels.

[…]

III. DECISION

[…]

RESOLVES:

[…]

SECOND.- UPHOLDS, based on the considerations expressed and developed in the present decision, the ruling issued on September 8, 2006 by the Second Penal Circuit Judge of Santa Marta, which overturns the ruling on the *tutela* action issued by the judge of first instance on all grounds and grants protection of AA's fundamental constitutional rights to human dignity, to free development of the person and to health in connection with life.

THIRD.- ORDERS the Ministry of Social Welfare, as well as the National Ministry of Education, the National Attorney General's Office and the Office of the Ombudsman, to promptly design and implement massive

campaigns promoting sexual and reproductive rights that help ensure that women throughout Colombia can freely and effectively exercise their rights by increasing awareness about the holdings of decision C-355 of 2006 and the present case, and URGES these same entities to monitor the campaigns in order to assess their impact and efficacy. The campaigns should focus on transmitting comprehensive information about the topic in simple, clear and sufficiently illustrative terms.

FOURTH.- ORDERS the National Superintendent of Health to promptly adopt indispensable measures requiring EPSs (private health insurance company) and IPSs (healthcare providers)—whether public or private, secular or religious—to employ the necessary medical professionals and other suitable personnel to provide voluntary abortions under the circumstances outlined in decision C-355 of 2006, as well as abstain from imposing additional impermissible requirements—such as those enumerated by the Court in legal base number 8 of this decision and in accordance with the requirements outlined in legal base number 31 of this decision. This obligation extends to all territorial levels and should be carried out in accordance with the principles of referral and counter-referral, ensuring, in this manner, that health providers within the public networks at the department, district and municipal levels provide voluntary abortions under the circumstances established in decision C-355 of 2006.

FIFTH.- COMMUNICATES the present decision to the National Superintendent of Health, the Office of the Ombudsman and the Office of National Attorney General so that, within the scope of their functions, they comply with the present decision and inform the Constitutional Court of such compliance within three-months.

[…]

NOTES

[1] Article 7 of the National Constitution provides: "*the state recognizes and protects the ethnic and cultural diversity of the Colombian Nation*."

[2] The aspiration of a constitutional norm like the one from 1991 is, within the judicial, factual, and economic possibilities, the full realization of the values and principles enshrined in the Preamble: "*in the exercise of their sovereign power, represented by their delegates to the National Constituent Assembly, invoking the protection of God, and in order to strengthen the unity of the Nation and ensure to its members life, peaceful coexistence, work, justice, equality, understanding, freedom, and peace*."

[3] Article 19: "*freedom of religion is guaranteed. Every individual has the right to freely profess his/her religion and to disseminate it individually or collectively. All religious faiths and churches are equally free before the law."*

[4] Article 18: "*freedom of conscience is guaranteed. No one will be importuned on account of his/her convictions or beliefs or compelled to reveal them or obliged to act against his/her conscience."*

[5] Article 20: "*every individual is guaranteed the freedom to express and diffuse his/her thoughts and opinions, to transmit and receive information that is true and impartial, and to establish mass communications media. The latter are free and have social responsibility. The right to make corrections under conditions of equity is guaranteed. There will be no censorship."*

[6] The Legislature has very broad power of configuration not only, and above all, because it is intended to represent society as a whole (majority and minority), which is not present in other public authorities but rather because of the way it makes decisions: through debate, through discussion and publicity (articles 132 to 187 of the Constitution). This is what grants Congress a greater level of legitimacy.

[7] Marina Gascón Abellán, *Obediencia al Derecho y Objeción de Conciencia*, Centro de Estudios Constitucionales, Madrid, 1990, p. 202.

[8] Decisions T-409 de 1992, C-511 of 1994, C-561 of 1995, T-363 of 1995, C-740 of 2001, T-355 of 2002, T-332 of 2004.

[9] Decisions T-539a of 1993, T-075 of 1995, T-588 of 1998, T-877 of 1999, T-026 of 2005.

[10] Decisions T-547 of 1993, C-616 of 1997.

[11] Decisions T-982 of 2001, T-332 of 2004.

[12] Decisions T-411 of 1994, T-744 of 1996, T-659 of 2002, T-471 of 2005.

13 *Ibid*., p. 203.

14 *Ibid*., p. 203.

15 *Ibid*., p. 204.

16 Lidia Casas, "La objeción de conciencia en salud sexual y reproductiva. Una ilustración a partir del caso chileno." In: *Más allá del Derecho. Justicia y Género en América Latina*, Luisa Cabal and Cristina Motta, (comps.), Bogotá, Siglo del Hombre Editores, p. 275.

17 *See supra* note 7, p. 217.

18 *See* Escobar Roca Guillermo, *La objeción de conciencia en la Constitución española*, Ed. Centro de Estudios Constitucionales, Madrid, 1993, p. 148-149.

19 *Ibid*., p. 281.

20 *Ibid*., p. 281-282.

21 *Ibid*., p. 225.

22 *See supra* note 7, p. 226.

23 *Ibid*.

24 A paradigmatic case was presented recently in Spain following the legalization of marriage between same-sex couples. Regarding this possibility, voices rose advocating the right of judges and public authorities (whether they were civil servants and judicial officers of the civil registration or mayors or councilors) to be excused on grounds of conscience in participating in the celebration of such unions. Various sectors of society and particularly the Executive Committee of the Spanish Episcopal Conference expressed their disapproval of the same-sex marriage bill and claimed the right to conscientious objection by public authorities to refrain from participating in the celebration of these unions. Cf. http://www.fluvium.org/textos/cultura/cul271.htm. The Vatican also expressed its opinion to express their dissent. The Spanish government reacted quickly highlighting the fact that this was a compromised conquest "*with a conception of dignity and freedom in an open and pluralistic society*." Cf. http://www.deia.com/es/printed/2005/04/26/plowing/-d2/110577.php.

III

OPENING REFLECTIONS FROM AN ADVOCACY PERSPECTIVE

CARMEN BARROSO

CARMEN BARROSO

A native of Brazil, Carmen was a professor of the Sociology Faculty at the University of Sao Paulo, Brazil, and a Senior Researcher with the Carlos Chagas Foundation, where she created Brazil's first and foremost women's studies center.

From 1991 to 2003 she was the Director of the MacArthur Foundation's Population and Reproductive Health program. Under her leadership, the program funded hundreds of local organizations in Africa, Asia and Latin America, and helped bring the voices and experiences of women from the Global South to the international policy forum, remarkably at the landmark 1994 International Conference on Population and Development.

Since 2003, Carmen has served as the Regional Director of International Planned Parenthood Federation/Western Hemisphere Region. Through its forty-one Member Associations in the Americas and the Caribbean, IPPF/WHR provides nearly thirty-three million services annually.

She has served on several boards and international commissions. Currently she serves on the board of the International AIDS Alliance, is co-chair of the Pan-American Health Organizations Panel on Gender and Health, and is a member of the Independent Expert Review Group of the Global Strategy on Women and Children's Health, appointed by the Secretary General of the UN.

Carmen holds a Ph.D. from Columbia University in Social Psychology. She has received numerous academic and public service awards and honors. Most recently she was named among the world's one hundred most influential leaders for maternal health by Women Deliver. Dr. Barroso has published numerous articles in professional journals and popular media in Brazil and internationally, and has consulted for numerous international and intergovernmental agencies.

My heart was broken when I read this case. It is not at all uncommon, but still shocking to learn about the saga of a young woman who had to go through lengthy legal battles to obtain the interruption of pregnancy to which she was legally entitled.

I write this not from the perspective of a scholar, but rather as someone who has promoted the right to safe and legal abortion for decades in a variety of capacities. Early in my career, I co-authored a book on abortion published by the Feminist Front in Sao Paulo,[1] and in the 1990s, I funded groups fighting for abortion rights in Latin America, Africa and Asia, including Catholics for Choice and GIRE in Mexico. Currently, as Regional Director for the International Planned Parenthood Federation/Western Hemisphere Region, I work with local organizations that not only provide family planning to diminish the need for abortion, but also promote the right to access to safe abortion services when the need emerges.

From different vantage points, I have always kept both a passion for changing the fate of women who should not need to risk their lives to exercise their right to control their own bodies and a pragmatist's eye, always looking for the most effective way to make that a reality under different social, cultural and political circumstances. I believe that both my commitment to this cause and my strategic approach have been fueled by the strong respect for hard evidence and solid rational arguments that I started learning from my father—a philosophy teacher, among other things—and continued through the rigors of statistics courses in graduate school. I share this personal history to explain how much I have appreciated this elaborate analysis by the Court, and also to give a better understanding of my comments.

Let me start by what I found especially valuable in the Court's decision. First, the decision's grounding on the notion of a pluralistic society is extremely encouraging, especially in Latin America, where we have been struggling to establish the separation of church and state with still mixed success. Again and again, in every public debate about abortion, we find ourselves arguing that individuals who are anti-choice have no right to impose their point of view as absolute and exclusive in a society with a plurality of views. For the sake of coherence—if not for the sake of political calculus that would indicate higher

probability of gaining undecided allies—it follows that we should also defend religious freedom and its consequences within the limits established by a legal higher order.

Here, again, the Court's comments were very felicitous. The right to conscientious objection is not absolute, nor can it infringe upon the ability of another individual to exercise her rights. Using well known legal principles of proportionality, reasonableness, and reversibility, it establishes important conditions that limit the right (what has come to be called "*conscientious objections to provide abortion*") and should be applied to other countries as well: only individuals, not institutions, have the right to object; only individuals directly involved in providing the service can object; and objectors have the obligation to refer to other person able and willing to provide the service.

The categorical prohibition of objections by private institutions providing public services could have a strong impact in a region where healthcare is often provided by publicly funded religious institutions with distinct private values. Actually, the Court went even further in ordering institutions to have enough abortion providers to be able to respond to their clients' needs. It is interesting that the Court based its decision both on logical arguments (only individuals have a conscience) and on practical considerations (there must be enough providers), both of which are very valid.

The only point I think the Court did not go far enough is in its refusal to establish general rules and criteria even though this case illuminates on several very useful ones. It establishes, for instance, that the individual who claims a conscientious objection should present in writing both the reasons for objecting and a referral to a colleague who agrees to perform the interruption. This very wise recommendation should apply to all cases. There are other points in which a very important concern is raised but no recommendation ensued. Important examples are the notions of urgency and irreversibility that especially apply to pregnancies and their rapid development to the nine-month deadline. Ten days are given when it comes to judges, but no such precision is spelled out for healthcare providers. Clear rules efficiently enforced at the service facility level are urgently needed to ensure the timely provision of abortion services to all women facing circumstances similar to those faced by plaintiff in the matter object of this book.

On a more general level, and perhaps not under the Court's purview, we urgently need a better definition of what constitutes *conscience*. The boundaries between religion, morality, ideology and politics need to be better defined, and we need a discussion on whether all reasons are equally valid for objections. I suspect that much of what passes for core values is actually nothing more than a package of inherited habits, prejudices and misinterpretation of medical data. I would like to propose an idea for debate: the informed conscientious objection. The legitimate authorities in a society that respects the rule of law—the courts—could designate a panel of experts to prepare a short curriculum on women's rights and abortion that conscientious objectors would need to take before they can object. I know that I can be accused of taking a page from the perverted informed consent of the anti-choice book, but offering an opportunity for educating over-extended medical personnel would do no harm if the curriculum is solidly based on evidence.

The other direction towards which we need to move is recognizing conscience in the provision of abortion, as Lisa H. Harris has recently raised in the *New England Journal of Medicine*.[2] Drawing inspiration from the classic Carol Joffe book *Doctors of Conscience: The Struggle to Provide Abortion before and after Roe v. Wade*[3]—which portrayed skilled mainstream doctors who were led by their conscience to put everything on the line to provide compassionate safe abortions before they were legal in the United States—she argues that it is important to balance the current emphasis on negative duties with the positive ones. Here is Joffe's description of how those doctors were conscientious:

> "*They did so with little to gain and much to lose, facing fines, imprisonment, and loss of medical license. They did so because the beliefs that mattered most to them compelled them to. They saw women die from self-induced abortions and abortions performed by unskilled providers. They understood safe abortion to be lifesaving. They believed their abortion provision honored the dignity of humanity and was the right—even righteous—thing to do. They performed abortions for reasons of conscience*."[4]

Joffe also argues that an imbalance in the application of the notion of *conscience* has important legal consequences. For instance, there was no exemption for those who conscientiously objected to the Global Gag

Rule, a former policy that prevented organizations receiving U.S. foreign assistance from using their own funds to provide information, services, or referrals for legal abortion in their countries.[5]

Also, according to Harris, a pernicious and pervading consequence of the imbalance is the reinforcement of the stigma attached to abortion:

> "*[T]he equation of conscience with non-provision of abortion contributes to the stigmatization of abortion providers. If physicians who offer abortion care don't have a legitimate claim to act in 'good conscience,' like their counterparts who oppose abortion, the implication is that they act in 'bad conscience' or lack conscience altogether. This understanding reinforces images of abortion providers as morally bankrupt. Such stereotypes may deter doctors from offering abortion services, thereby contributing to provider shortages. More important, stereotyping may have dangerous consequences: sociologists confirm that harassment and violence are extreme extensions of stigmatization*."[6]

The Colombian decision was a landmark ruling and deserves to be studied and expanded. Given the restrictive laws that exist in some countries in our region, we have many respected professionals who are risking their careers and reputation to defend women's rights. A concerted effort to apply a more balanced definition of conscience would have a lot of experience to draw from and would benefit many, many women by protecting the professionals who dare to serve them.

NOTES

[1] Frente de Mulheres Feministas, *O Que e o Aborto?* (Sao Paulo: Cortez, 1980).

[2] Lisa H. Harris, "Recognizing Conscience in Abortion Provision," *New England Journal of Medicine* 367 (2012): 981-983.

[3] Carol Joffe, *Doctors of Conscience: The Struggle to Provide Abortion before and after Roe v. Wade* (Boston: Beacon Press, 1995).

[4] *Ibid*.

[5] The Global Gag Rule—or Mexico City Policy—was first imposed by the Reagan administration in 1984 at the United Nations International Conference on Population in Mexico City. It was rescinded in 1993 by President Clinton, reinstated in 2001 by President George W. Bush, and once again rescinded by President Obama in 2009.

[6] *See supra* note 2, p. 982.

IV

JURISPRUDENCE FROM THE CONSTITUTIONAL COURT OF COLOMBIA ON CONSCIENTIOUS OBJECTION

BERNARD M. DICKENS

BERNARD M. DICKENS

LL.B., LL.M., Ph.D. (Law-Criminology), LL.D. (Medical Jurisprudence, London), LL.D. (Sherbrooke, h.c.), O.C., a member of the English Bar and the Ontario Bar, and an Officer of the Order of Canada, Bernard is Professor Emeritus of Health Law and Policy in the Faculty of Law, the Faculty of Medicine and the Joint Centre for Bioethics at the University of Toronto. He is co-editor of ethical and legal issues of the *International Journal of Gynecology and Obstetrics* and, since 2003, has chaired the Ethics Committee of the International Federation of Gynecology and Obstetrics (FIGO).

Professor Dickens' writings include over 435 publications, including books, chapters in books, articles and reports, primarily in the field of medical and health law. With Rebecca J. Cook and Mahmoud F. Fathalla, he co-authored *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law*, published in 2003 by Oxford University Press. His latest book, co-authored with Rebecca J. Cook and Joanna N. Erdman, is *Abortion Law in Transnational Perspective: Cases and Controversies,* published in August 2014 by the University of Pennsylvania Press, which is also forthcoming in Spanish.

1. INTRODUCTION

The Constitutional Court of Colombia, in its decision C-355 of 2006, determined the conditions under which abortion may be lawfully induced in Colombia. Decision T-388/09[1] concerned a medically advised and judicially authorized abortion of a severely impaired fetus of about 23 weeks' gestational age, which required surgery. In decision T-388/09, the Court revisited decision C-355/06 on abortion. Decision T-388/09 illustrates how a practitioner's conscientious claims not to participate in abortion procedures should be balanced with women's conscientious claims of access to medically managed abortion care. Ultimately, it consolidated the law regarding:

a) the scope of legitimate claims to conscientious objection to participate in procedures directed to this end;
b) the lawful limits of such claims; and
c) legitimate claimants.

While the Constitutional Court has thereby clarified the law for Colombia on conscientious objection and abortion, its jurisprudence transcends that single country and its particular constitutional provisions. The Court's judgment fits comfortably within and illuminates international jurisprudence on conscientious objection, and it is fully consistent with related international treaty law.

The Colombian Constitutional Court addressed women's rights to healthcare in Colombia when practitioners may properly invoke their rights of conscientious objection to participation in lawful abortion procedures. The Court recognized that the purpose of training and qualifying as a physician (which may require heavy public investment) is to deliver rather than withhold or obstruct medical care.[2] Accordingly, licensed practitioners who provide lawful medical treatment can only deny patients care that they are capable of rendering as an exceptional concession. The concession depends on patients having practical alternative means of access to medically indicated treatment, since the goal of the national commitment to healthcare is to serve the needs of patients rather than the spiritual or other interests of health service providers.

The Court drew on its 2006 jurisprudence on the legality of abortion to rule that a physician's claim to conscientious objection is defensible only when it is feasible for the patient to receive timely and appropriate abortion care from another healthcare professional who is qualified and willing to provide it.[3]

The Court ruled that the free exercise of liberties, such as of conscientious objection, is necessary but only to the extent that it does not result, even inadvertently, in the abuse or unjustified, disproportionate, or arbitrary interference with the rights of others. Qualified practitioners' objection to participate in the delivery of legal abortion services is acceptable only if there is a guarantee that pregnant women will have access to legal services of appropriate quality and safety, without additional barriers that interfere with their access to healthcare beyond their immediate providers' objection, and without restricting their constitutional rights to life and to sexual and reproductive health, or respect for their personal integrity and human dignity.

The Court upholds the political and philosophical principle of the Rule of Law against claims of obedience to a *higher* or *divine* law as variously interpreted by religious or comparable authorities that are not democratically accountable. It is respectful of religious freedom and freedom of conscience, and of the need to show equal respect for the conscientious choice of resorting to lawful abortion and to refrain from participation in lawful abortion procedures. The Court maintains the balance required by international treaty law, which shows that claims invoking a right to conscientious objection cannot be absolute. For instance, article 18(1) of the International Covenant on Civil and Political Rights (ICCPR) provides that "*everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom [...] in public or private, to manifest his religion or belief in worship, observance, practice and teaching*." However, article 18(3) provides that "*freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others*."

Therefore, the right to conscientious objection is limited by certain interests, such as health and the protection and respect of others' fundamental rights and freedoms.

This article provides a brief overview of the right to conscientious objection in relation to abortion, defining its scope and limits. The article highlights the importance of decision T-388/09 in developing clearer standards for when a right to conscientious objection can be invoked in this context, taking a close look at the decision and outlining the extent to which the decision informs the debate and provides guidance on who can invoke the right to conscientious objection and when. Given the importance of public officers, such as judges, to access to abortion care, the article devotes an entire section to them.

2. THE LEGITIMATE SCOPE OF THE RIGHT OF CONSCIENTIOUS OBJECTION

The Court established that the right of conscientious objection to participating in abortion procedures is legitimately available when two primary conditions are met: 1) when the objector would otherwise be legally obliged to undertake an act of *direct participation* in an abortion procedure, and 2) when the affected woman seeking the lawful abortion has a feasible alternative for accessing a timely procedure.[4]

According to the Court, *direct participation* in abortion, relates to its surgical preparation, management, and performance. Conscientious objection is accordingly available to nurses who immediately prepare patients for surgery, surgeons, anesthetists, and surgical nurses. Excluded from the category of *direct participants* are healthcare workers who provide routine care to patients, such as hospital admission, providing general comfort prior to patients' preparation for surgery, and rendering post-operative care to surgical patients. Included in this category are also physicians-in-training required to observe surgical procedures and health facility administrative staff members. Administrative personnel immediately involved in a patient's abortion procedure can include physicians, nurses, or, for instance, midwives, or hold office in a religious hierarchy, such as, ordained ministers. However, acts like admitting patients seeking abortion into health facilities, scheduling surgery space and time for abortion procedures, approving patients for safe post-operative discharge, and the financial management of insurance coverage for abortion procedures are not considered *direct participation* that can legally justify claims of conscientious objection. Similarly, more remote actors such as office personnel, ambulance attendants, and pharmacists dispensing routine medications are not considered *direct participants* in patients' medical procedures.[5]

Examples given in decision T-388/09 to explain what is considered direct and indirect participation did not address non-surgical abortion through administration within a few weeks of determination of pregnancy of abortifacient drugs, particularly mifepristone and misoprostol. The administration of these drugs is designed to achieve what is now often called *medication abortion* or *medical abortion*, as opposed to surgical abortion. However, the principles set out by the Constitutional Court seem to apply to medical abortion because the Court's reasoning is not based on the type of procedure but in the rights implicated in the abortion, which are the same whether the abortion is medical or surgical. This means physicians or others with lawful prescribing authority are allowed to conscientiously object to prescription of abortifacient drugs, as well as to physicians and nurses caring for women who propose, on a non-emergency basis, to experience the consequent expulsion of their uterine contents in a healthcare facility—not at home. It is worth noting that the European Court of Human Rights has ruled, however, that pharmacists cannot invoke conscientious objection when refusing to dispense prescribed contraceptive drugs in a way that effectively bars or obstructs patients' access to them.[6] This principle could likewise apply to dispensing abortifacient drugs, since the act of dispensing such drugs is not considered *direct participation* in their use.

Nurses managing prostaglandin-based abortions under physician supervision are considered *direct participants*, entitled to the legal protection afforded to their supervising physicians[7] and to invoke conscientious objection. In this procedure, physicians initiate the action by inserting thin catheters into each patient's womb and cannulas into their veins. Nursing staff members then monitor the administration of prostaglandin and oxytocin, adjusting the flow as necessary. They then attend to patients directly as their uterine contents are expelled to achieve termination of pregnancy. Both physicians and attending nurses are therefore direct participants in actually conducting such abortions. In contrast, nurses or other staff who clean operating theatres following procedures or provide post-operative recovery care do not fall into this category.

The Court considered that it is not feasible to establish general rules or criteria to determine limits of the right to conscientious objection, since limits should instead be determined on a case-by-case basis. However, it cited and reaffirmed decision C-355 of 2006 to find that, in principle, an objecting practitioner is

obliged to refer a patient denied abortion, or other care that the practitioner conscientiously objects to provide, to another practitioner who is able and willing to provide it. The Court found that the state or governmental system responsible for healthcare services and/or insurance must ensure the presence of a sufficient number and distribution of healthcare professionals to protect the rights of women to medically indicated legal abortion services. If only a single practitioner is practically available who can perform a timely legal abortion that a woman requests, that practitioner is legally required to perform the procedure. This is so whether the practitioner is affiliated with a public or private hospital, either religious or secular. In this case, the restriction on the practitioner's freedom is proportional and reasonable, since continuation of the woman's unwanted pregnancy would cause direct, irreversible, and potentially lifelong harm to her, as well as infringe on her fundamental constitutional rights. Accordingly, practitioners, their professional associations and/or governmental healthcare authorities may relieve practitioners of this legal responsibility by establishing means of patients' timely referral to other practitioners willing and able to provide abortion and comparable medical services.[8]

Invoking the right to conscientious objection also requires that it be done only in good conscience. It has been observed that sometimes, physicians who raise conscientious objections to participate in abortion services in public hospitals, for fear of attracting social stigma, will later provide them in private facilities with greater confidentiality and usually for higher fees and sometimes in clinics where the physicians hold proprietary interests.[9] There was no evidence of this before the Constitutional Court, however, and the Court did not address such deceptive claims to conscientious objection. Similarly, the Court did not address what an adequate religious foundation of conscience entails in other countries, since in Colombia, claims to conscientious objection to abortion almost invariably derive from adherence to Roman Catholicism.

The Court's focus on preventing the right to conscientious objection from causing women to suffer serious and irreversible harm and a denial of their constitutionally-protected right to life confirms that conscience cannot be invoked to deny such care when continuation of pregnancies would endanger women's lives or permanent health. However, the doctrine of *double effect*, which the Roman Catholic Church has accepted

in principle, dictates that "*no wrong is involved in performing a legitimate procedure for a proper reason when an effect follows that is improper to achieve for its own sake*."[10] In other words, the legitimate goal of saving life or health characterizes the procedure, and the termination of the endangering pregnancy is an incidental, unwanted but unavoidable secondary effect that creates no culpability.[11] Therefore, terminating a pregnancy that saves or protects the health of the woman does not offend conscience.

3. LIMITS OF CONSCIENTIOUS OBJECTION

As addressed above, limits of permissible conscientious objection are implicit beyond what the Court recognized as the legitimate scope of objection. The Court's purpose was not to define or circumscribe the scope of conscientious objection in pedantic terms, but to address the wider challenge to democratic law presented by claims to religious conscience. The Court cited constitutional provisions designed to secure a participatory and pluralistic democracy that is respectful of human rights, including religious rights without favoring one religion over another and without forcing individuals to conform to religiously-inspired values or priorities that they do not voluntarily share. Each person's moral or conscientious conviction should be protected and respected where doing so would not significantly undermine others' equal entitlement to their own moral or conscientious convictions. The Court found this particularly pertinent in the abortion context, since decision C-355 of 2006 protects women's and girls' interests in access to abortions that are lawful within the terms and meaning of that decision. C-355/06 dealt with interests of sufficient importance to women's constitutional rights to life, health, personal integrity and dignity, and security against irreversible harm, to justify restricting freedom of conscience.

To give effect to the earlier judgment, the Court limited reliance on conscientious objection to medical personnel involved in abortion procedures. However, they must state their objection in writing for each case, indicating the reasons for their objection in that specific case. The objection must reference the particular facts of the case, without general language or reinforcement by other persons or agencies, such as religious authorities. The writing must also indicate the available, willing alternative practitioner to whom

the patient will be referred and who will be able to perform the abortion when it is required. Violation of these standards could signify penalties for illegitimate exercise of the right to conscience.

The Court was pointed in its observation that individuals' fundamental rights under the Constitution, which include rights to lawful abortion in conditions specified in its 2006 ruling, are not always well received. Attacks against such rights are often grounded in absolutist perspectives that are incompatible with the principles of plurality and cultural diversity. The Court did not expressly hold the Roman Catholic Church authorities responsible for leading this type of attack in Colombia, but alluded to the disdain that the Church authorities have expressed towards politically-made, democratic laws that depart from the Church's interpretation of divine law, which is often invoked to buttress claims of conscientious objection.[12]

With respect to the judge's claim of conscientious objection (see Public Office Holders, below), the Court immediately observed that judicial authorities should leave aside their personal convictions so that the Rule of Law can develop to protect individuals' fundamental constitutional rights and ensure that such rights are respected. The Rule of Law, which protects legislation created by secular, democratically-elected legislators and makes legislators accountable, may be contrasted with religiously-interpreted natural law, particularly Roman Catholic natural law. This so-called *law* is based on the claim that universal human reason can discern universal, objective, moral laws that, for instance, may justify civil disobedience to state legislation. In the Roman Catholic tradition, the tenets of natural law are revealed to councils appointed by Popes, and Papal declarations of doctrine made ex cathedra have been held since 1870 to be doctrinally infallible, and to require obedience.[13] The Court made clear that in Colombia (a democratic, pluralistic state respectful of everyone's religious and other convictions), conscientious objection is subject to lawful limits that protect women's constitutional rights, among others, to lawful abortion. The Rule of Law requires and justifies obedience to law made under the state's Constitution, rather than to principles believed to be divinely revealed to a democratically unaccountable religious leadership.

Individuals remain free, under article 18(1) of the International Covenant on Civil and Political Rights (ICCPR), and its various constitutional and other legal analogies, to freedom of thought, conscience and

religion. The limit is set by article 18(3) of the ICCPR on how one may "*manifest one's religion or beliefs*." Manifesting religion or beliefs is "*subject only to such limitations as are prescribed by law and are necessary to protect [...] the fundamental rights and freedoms of others*." The Constitutional Court prescribed such legal limits on conscientious objection in the interest of protecting women's fundamental rights to lawful abortion.

Employers are usually required to accommodate their employees' religious observances as far as they reasonably can, but not to an extent that frustrates the purposes of their employment. For instance, healthcare providers with conscientious objections to abortion should not be offered, and should not accept, positions that would unavoidably require such violation of their consciences.[14] Nurses who object to abortion should be replaced, when possible, by alternative, non-objecting nurse colleagues when direct participation in abortion procedures is required, without compromise to the objecting nurses' employment and career prospects. Subject to employers' duties of reasonable accommodation, however, employees who object have to decide whether to suppress manifestations of their convictions, or seek other employment that is compatible with their preferences.[15]

4. THE ENTITLEMENT TO CONSCIENTIOUS OBJECTION

It has been seen that only physicians, nurses, anesthetists and others who would be direct participants in an abortion procedure are entitled to exemption on the ground of their conscientious objection. The Constitutional Court clearly stated that health facilities, notably hospitals, cannot claim conscientious objection as a corporate or collective entitlement.[16] This is of international significance in light of the number of countries where religiously affiliated hospitals exist. Indeed, in the U.S. and Canada, for instance, Catholic agencies are employing their financial and political influence to achieve mergers with non-Catholic hospitals, especially those under economic pressure.[17] This may be in order to create new hospital institutions that follow Roman Catholic directives, and therefore restrict delivery of healthcare services to which the Church objects, particularly abortion services.

The Constitutional Court's rejection of the right of a medical institution (such as a hospital, clinic, and medical school) to invoke conscientious objection to accommodate abortion is consistent with Roman Catholic doctrine. Abortion is regarded in the Catholic tradition as a mortal sin, constituting *death of the soul* unless the offender is granted absolution. However, an artificial legal *person*, such as a hospital corporation, does not have a soul to be kept in repair, and accordingly no conscience, or right of conscientious objection.[18] As a human right, the "*right to freedom of thought, conscience and religion*" protects living human beings and not the entities that they create for social, commercial or other purposes—even if these entities are deemed *legal persons* under other areas of law.

In C-355 of 2006, the Court held that a hospital cannot claim a right of conscientious objection. A hospital as a corporate entity cannot itself practice medicine or directly participate in medical procedures. The Court repeated this ruling in T-388/09, specifically that institutions are categorically prohibited from alleging a collective conscientious objection, from entering into agreements, individual or collective, to refuse to provide abortions, and from indicating that none of the physicians at the hospital will participate in provision of abortion services. The last prohibition was based on the fear that the C-355/06 holding would discriminate against medical professionals applying for appointment to a hospital, or deter one appointed from providing an abortion when medically required, when legal, and when requested by a patient. The Court emphasized the need to prevent institutions that provide healthcare services from limiting the freedom of individual employees who are conscientiously committed to their patients' care, and who might be coerced by doctrinal restrictions or directives imposed by managerial staff.[19]

Hospitals, whether publicly funded or established and administered by religious institutions aiming to care for the sick, are frequently assets to the communities in which they are located. Additionally, outside larger population areas, hospitals may be the only healthcare facilities to which residents of their catchment areas can effectively turn for necessary medical care beyond the most basic services. When hospitals induce or encourage communities to depend on their services for care, they and/or their medical service providers cannot be allowed to prevent delivery of such care by invoking grounds of conscientious objec-

tion, unless individuals reasonably relying on them are promptly referred to alternative sources of accessible, appropriate and willingly provided care.

Among members of Christian religious denominations, Roman Catholics are distinguishable from for instance Jehovah's Witnesses in many ways. The former exert international influence through the status of the Holy See (e.g., the Vatican), whereas the latter have no comparable influence. The former church, claiming to be the Universal Church to which everyone should belong, opposes national and international advocacy and implementation of policies contrary to its teachings, whereas members of the latter church reject use of blood transfusions and blood products in their own individual health treatment but do not call or campaign for such transfusions and products to be denied to those of different beliefs.

One may speculate about the propriety and ethical observance of a community being dependent for health services upon a Jehovah's Witness hospital that conducts surgical and related procedures but prohibits provision of blood transfusion services, or use of blood products such as plasma. However, some communities are dependent upon Roman Catholic hospitals that deny provision of abortion, modern forms of birth control and comparable services that offend Catholic conscience. Such restrictions in religiously-affiliated hospitals would contradict the pluralism required by the Constitution of Colombia.

5. PUBLIC OFFICE HOLDERS

A remarkable feature of the case leading to the Constitutional Court's decision was that, when physicians recommended termination of the plaintiff woman's pregnancy but—un-required—judicial approval was sought in advance to ensure legality, the trial judge declined to exercise his jurisdiction on grounds of conflict of interest based on his conscientious objection to declare the abortion lawful. When his claim of conflict of interest was rejected by a higher judge and the case was returned to him for a decision, he rejected the action once again on grounds of his conscientious objection to the procedure. The Constitutional Court condemned this as a gross violation of the judicial function, and of the Rule of Law. Public officers, the Court explained, cannot cater discharge of their public duties to their own personal beliefs.

Judges, in particular, cannot apply the law that they pledge to uphold by subordinating its principles and provisions to their individual religious or other belief systems.

Judges enjoy freedom of thought, conscience and religion in their personal or private lives, but like health-care professionals, pharmacists,[20] midwives,[21] and others, they are not free "*to manifest [their] religion or beliefs*" to deny others their fundamental legal rights and freedoms. Responsibility and accountability to respect the legal rights of others, such as of women to lawful abortions, is of special significance in the performance of public office. In the same way that fire-fighters cannot choose whose property they will try to preserve against fire and whose they will passively let burn, on the basis of their personal convictions and beliefs, judges cannot decide whether or not to try any case assigned to them that they are otherwise qualified to hear, or determine such a case on the basis of their personal convictions rather than according to the law.

The Court's ruling fits within an emerging jurisprudence that distinguishes between the conscientious and/or religious convictions public officers may hold in their private lives and the beliefs that they may legitimately manifest in discharge of their public duties. In *Rodriguez v. Chicago*, the U.S. 7th Circuit Court of Appeal held that a police officer appointed to defend an abortion clinic against a hostile crowd could not refuse on the ground of his conscientious objection to the procedures performed in the clinic.[22] A Canadian provincial Court of Appeal has similarly held that, although religious celebration of marriage may be refused to same-sex couples proposing lawful marriage by officers of religious bodies (e.g., churches), on grounds of the officers' freedom of religion, marriage commissioners empowered by government to solemnize non-religious marriages cannot discriminate on grounds of sexual orientation and refuse to discharge their public responsibilities on the basis of their personal religious convictions.[23] Such cases confirm that public officers must serve the public neutrally, without favor or disfavor on religious or other personal grounds. As in the private sector, they cannot accept office while refusing to discharge any of its required functions on grounds of their personal beliefs or conscience, or subordinate their responsibilities required by their office to their personal religious or other interests.

6. CONCLUSION

The Constitutional Court of Colombia has directed its attention to specific characteristics of the country's National Constitution that distinguish it from other Constitutions. The Court points to the constitutional requirement that the country be regulated as a participatory, pluralistic democracy respectful of human dignity. Acceptance of pluralism not only admits but promotes diversity and recognizes the special protection of freedom of all religious views. Implicit in this approach to interpretation and application of the Constitution is that no religious denomination or institution has priority over any other and that no religious or non-religious viewpoint can frame the agenda of national development. Religious freedom accommodates respect for religious difference—including what any particular religion may consider sin or heresy—and denies ascendancy to one religion or religious denomination over any other. The constitutional framework provides for all that individuals are empowered or required to do, as well as what they are prohibited from doing.

A contrast may be drawn with the predominance of the Roman Catholic Church in the development and interpretation of law among Colombia's neighbors, where senior church leaders consciously influence and may intimidate senior politicians and judges. The respect and deference that governments and courts should pay to individual conscience was explained, however, by Pope John Paul II in 1991.[24] His address on respect for conscience may appear narrowly as a self-serving call for governments of repressive, atheistic communist countries to respect Catholic conscience, but his words also have salience outside that context. The Pope observed that "*[a] serious threat to peace is posed by intolerance, which manifests itself in the denial of freedom of conscience to others. The excesses to which intolerance can lead has [sic] been one of history's most painful lessons*."[25] He added that "*freedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the state is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses*."[26]

The Constitutional Court of Colombia has interpreted and applied the National Constitution in this spirit, by protecting the rights of women over their own bodies in access to lawful abortion and by limiting the abuse of conscientious objection that has the purpose or effect of denying such rights.

NOTES

[1] Constitutional Court [C.C.], May 28, 2009, Decision T-388/09, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), *available at*: http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm (accessed July 28, 2014).

[2] *Ibid*., at sec. 4.2.

[3] *Ibid*., at sec. 4.3.

[4] *Ibid*., at sec. 5.1.

[5] *See Ibid*. The Constitutional Court's analysis distinguishing between direct participation in abortion and administrative management of abortion patients is similar to the one found in the 2012 decision in *Doogan v. Wood* by the Outer House of the Scottish Court of Session. *See Doogan and Wood v. Greater Glasgow and Clyde Health Board* [2012] CSOH 32, *available at*: http://www.bailii.org/scot/cases/ScotCS/2012/2012CSOH32.html. In this case, two midwives claimed religiously-based rights of conscientious objection when required to delegate, supervise, and/or support staff of their facility that treat patients for medical or surgical abortion. Their claims were based on their position as the hospital's labor ward-coordinators in a ward that provided care to women delivering babies, terminating pregnancies by abortion or, for instance, having removal of dead fetuses. Their claims to rights of conscientious objection were found by the Outer House to be inapplicable. It was held that the midwives were not directly participating in abortion procedures since such employment involved management and leadership of personnel, particularly delegating direct patient care to midwives, which included providing them with supervision and support, and rendering similar services to nursing auxiliaries such as ensuring supervision, training and education. They did not provide one-to-one care of individual patients. As such, their rights would be neither absolute nor unrestricted, even though the claims reflect important and legitimate human rights (para. 75). However, the Inner House reversed the decision in 2013, finding the distinction between direct and indirect participation unimportant and failing to address patients' rights under the European Convention on Human Rights (para. 69). The case is currently pending appeal before the UK Supreme Court and may go further to the European Court of Human Rights.

[6] *Pichon and Sajous v. France*, No. 49853/99, Eur. Ct. H.R. (2001), *available at*: http://hudoc.echr.coe.int/sites/eng/-pages/search.aspx?i=001-22644. As a decision on the admissibility rather than the merits of the claim, however, the case may be more of persuasive than compelling authority; *see* Mark Campbell, "Conscientious Objection, Healthcare and Article 9 of the European Convention on Human Rights," *Medical Law International* 11(4) (2011): 284-304.

[7] Royal College of Nursing of the U.K. v. Department of Health and Social Security, [1981] 1 All England Reports 545 (House of Lords).

[8] *See* Holly F. Lynch, *Conflicts of Conscience in Health Care: An Institutional Compromise* (Cambridge: MIT Press, 2008).

[9] Anibal Faundes, Graciana Alves and María José Duarte, "Conscientious Objection or Fear of Social Stigma and Unawareness of Ethical Obligations," *International Journal of Gynecology and Obstetrics* 123 (2013): S57-S59.

[10] Bernard Dickens and Rebecca Cook, "The Scope and Limits of Conscientious Objection," *International Journal of Gynecology & Obstetrics* 71(1) (2000): 71-77 (citing Joseph M. Boyle, "Toward Understanding the Principle of Double Effect," *Ethics* 90 [1980]: 527-538).

[11] Philippa Foot, "The Problem of Abortion and the Doctrine of Double Effect," *Oxford Review* 5 (1967): 5-15.

[12] Julieta Lemaitre, "Catholic Constitutionalism on Sex, Women, and the Beginning of Life," in *Abortion Law in Transnational Perspective: Cases and Controversies*, eds. Rebecca J. Cook, Joana Erdman and Bernard M. Dickens (Philadelphia: University of Pennsylvania Press, 2014,) 239-257.

[13] *See* Dena S. Davis, "Contraception, Abortion, and Health Care Reform: Finding Appropriate Moral Ground," *Miss. C. L. Rev* 29(2) (2010): 379-386. *Contrast* J. Finnis, *Natural Law and Natural Rights* (Oxford: Clarendon Press, 1980), *with* Nicolas Bamforth and David A.J. Richards, *Patriarchal Religion, Sexuality and Gender: A Critique of New Natural Law* (Cambridge: Cambridge University Press, 2007).

[14] In the Scottish case of *Doogan v. Wood* (*see supra* note 5), the midwives were required to supervise, but not directly participate in, the provision abortion services as part of their work responsibilities. They remained free to hold their religious convictions, but not to manifest convictions incompatible with the legal terms of employment they had accepted.

[15] *See* the discussion in Mark Campbell M. *See supra* note 6.

[16] *See supra* note 1, at sec. 5.2.

[17] Bernard M. Dickens, "The Right to Conscience" in *Abortion Law in Transnational Perspective: Cases and Controversies*, eds. Rebecca J. Cook, Joana Erdman and Bernard M. Dickens (Philadelphia: University of Pennsylvania Press, 2014), 236.

[18] *See supra* note 1, at sec. 5.2.

[19] *See* Bernard Dickens and Rebecca Cook, "Conscientious Commitment to Women's Health," *International Journal of Gynecology and Obstetrics* 113 (2011): 163-166.

[20] *See supra* note 1.

[21] *Ibid.*, at sec. 4.3.

[22] *Rodriguez v. Chicago*, 156 F. 3rd 771 (7th Circuit, 1998).

[23] Klebuc and others, [2011] SKCA 3 (Saskatchewan Ct. App.), *available at*: http://www.christianlegalfellowship.org/-files/christianlegalfellowship/Interventions/marriage%20act/marriage_commissioner_reference_decision_saskatchewan_court_of_appeal.pdf.

[24] Pope John Paul II, "If You Want Peace, Respect the Conscience of Every Person." Message of His Holiness Pope John Paul II for the XXIV World Day of Peace, Vatican City, January 1, 1991 (http://www.vatican.va/holy_father/john_pauli/-messages/peace/documents/hf_jp-ii_mes_08121990_xxiv-world-day-for-peace_en.html).

[25] *Ibid*., at ¶ 11.

[26] *Ibid*., at ¶ 24.

V

THE GLOBAL DEBATE

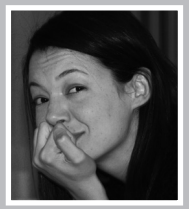
V/a

CONSCIENTIOUS OBJECTION TO LEGAL ABORTION (OR THE REACTION TO THE *PROBLEM* OF LEGAL ABORTION) IN LATIN AMERICA

MERCEDES CAVALLO and
AGUSTINA RAMÓN MICHEL

MERCEDES CAVALLO

Attorney with a law degree from Torcuato di Tella University (2007), a Master Degree in Sexual and Reproductive Rights from the University of Toronto (2009), postgraduate in Women and Human Rights from the University of Chile (2011), and a Master's Candidate in Criminal Law from Torcuato di Tella University (2014). During 2007 and part of 2008, Mercedes served as Administrative Undersecretary to the Supreme Court of Argentina. In 2010, upon her return from Toronto, she practiced as a trial attorney for the firm JC Abogados y Asociados. From November 2011 to March 2013, she served as Director of the Economic, Social, and Cultural Rights Area of the Association for Civil Rights. She is currently the Secretary for the Fourth Federal Criminal and Correctional Court of Buenos Aires. Since March 2011, Mercedes has been a member of the Advisory Board for the Ministry of Health's Comprehensive Adolescent Health Program, where she has done consultation and provided capacity-building. Mercedes currently teaches Legal Theory at Argentina's University of Palermo.



AGUSTINA RAMÓN MICHEL

Agustina holds an LL.B. from the University of Tucumán (Argentina) and is a Ph.D. student (currently on leave) in the School of Law at the University of Palermo (Argentina). She has received a Doctoral Fellowship from the Argentine National Scientific and Technical Research Council (CONICET). During 2013-2014 she was a Fulbright scholar and an LL.M. student at the University of Texas at Austin. She also pursued postgraduate studies in international relations and negotiations at the University of San Andrés/FLACSO (Argentina). Since August 2007, Agustina has been a member of the research team at the Department of Health, Economics and Society at the Centro de Estudios de Estado y Sociedad (CEDES) in Buenos Aires, where she has worked on projects funded by the World Health Organization, the United Nations Population Fund, the University of Bergen, New York University and Harvard University. She is currently an Adjunct Researcher at CEDES. Agustina is also a professor at the University of Palermo and at the University of San Andrés. She has received several fellowships and has participated in the University of Palermo-Yale Law School cooperation program. She has also participated in reproductive rights cases in Argentina

1. INTRODUCTION

Although protected our countries' Constitutions, freedom continues to have a precarious foothold in Latin America and the Caribbean (LAC). Freedom of conscience, freedom of religion, and freedom of choice on issues related to sexuality and reproduction are some of its forms. However, conscientious objection (CO), in the framework of essential legal abortion services, seems to pit these freedoms against each other when healthcare professionals[1] claim an exemption from the medical and legal requirement to fulfill a woman's request for voluntary termination of pregnancy, arguing that the request goes against their deepest moral convictions.

At the same time, the use of CO also raises questions of equality, to the extent that it implies refusing to comply with a norm that applies to all, and it is the most economically and socially disadvantaged women who are at risk for the greatest harm from the use of CO in the area of sexual and reproductive health.

In recent years, CO has become an issue in the area of health and sexual and reproductive rights (HSRR) in several countries in LAC;[2] some have even incorporated it into legislation on legal abortion.[3]

One of the reasons why we as political communities are willing to allow a person to be exempted from fulfilling a duty that the rest of the group must perform is to protect moral integrity. However, when it comes to issues of sexuality and reproduction, we must differentiate between an institution meant to protect personal moral integrity and a tactic used to camouflage the barriers that persist in the design and implementation of policies and regulations for legal abortion.[4]

CO has been identified as one of the chief barriers to accessing legal abortion, but is CO a barrier? What are the dynamics, practices, beliefs, and perceptions behind CO? Are healthcare professionals refusing to perform a procedure that goes against their deepest moral convictions, or has conscientious objection become a way to avoid having to provide legal abortion services in LAC because it is too *costly* for medical professionals to do so?

The challenge is to determine the different ways in which conscientious objection is manifested, identifying *best practices* in local legal systems, and stepping up efforts to differentiate legitimate claims of conscientious objection from other factors. These tasks are vital for preventing conscientious objection from becoming a legal obstacle to sexual and reproductive rights, like a Trojan horse barging into the medical field and undoing efforts to ensure that women can decide whether and when to become mothers.

With this understanding, in this article, we will first set out to define the phenomenon of CO in the provision of legal abortion, from a perspective that we feel is respectful of constitutional rights as well as the needs and expectations of women. Secondly, we will outline factors that may make the provision of legal abortion more *costly* for medical professionals than claiming conscientious objection and refusing the service. Thirdly, we will point to certain measures related to the design and implementation of public policy that are meant to counter the inappropriate use of CO and prevent other behaviors, dynamics, and positions from being disguised as conscientious objection. Then we will conclude with a few final observations.

2. THE VALUE AND IMPLICATIONS OF CONSCIENTIOUS OBJECTION

Every healthcare professional enters the healthcare system with religious, ethical, and moral beliefs and political convictions, which, along with her educational and professional experience, will inform her conscience. As Sepper[5] rightly points out, medical training, both technical and ethical, can be expected to guide her in her day-to-day practice; but from time to time, situations may come up that require more attention and moral judgment that can place her fundamental beliefs at odds with ethical duties and legal requirements.

CO is a mechanism designed to protect a person's core moral values when these are at odds with actions required by public obligations, as in the case of a healthcare professional who claims conscientious objection in a legal abortion case.[6] In this sense, CO is a way of placing individual ethical and moral criteria above what the law requires.[7]

Perhaps the greatest value of conscientious objection lies in its ability to protect persons whose moral convictions are different from those of society or that are held by a minority.[8] Whether based on natural law, religious doctrine, or secular moral theories, CO has served as a refuge for moral freedom. It has been used throughout history to resist laws and the state. Though it shares some of the characteristics of civil disobedience, it differs from civil disobedience in its lack of political motivation, among other things.[9]

However, although conscientious objection may be valuable as offering protection, as members of a political community, we also expect the rules to be applied with some measure of equality. To the extent that the law seeks to be universal based on expectations of obedience and CO provides a means to avoid fulfilling a duty that must be performed by the rest of the group to which the requirement applies, it should only be claimed when the moral integrity and core moral convictions of the person are at stake.[10] Precisely because of the exceptional nature and implications of CO, the Constitutional Court of Colombia has held that in order for a healthcare professional to object to performing an abortion, he must specify the reasons why the abortion runs counter to his deepest convictions.[11]

This suggests that not all individual moral beliefs have the same weight, and that not all of them can serve as the basis for a CO claim. The belief at issue, notwithstanding its origin (religious or moral), must play a fundamental and decisive role in the person's life.[12] In other words, complying with the legal duty at issue must represent a threat to the person's moral world view.

Moreover, the use of CO implies that the healthcare professional recognizes the required act as legal, although she finds it morally at odds with her world view.[13] CO is not an anarchistic or revolutionary act, and it is not meant to question institutional decisions.[14] In the case of legal abortion, the person objecting is not contesting the legality of the practice, but asking to be exempted from participating in it for reasons of conscience, not because of other factors, such as clinical or professional concerns.[15] Therefore, a conscientious objector to legal abortion is not casting doubt, for instance, on the fact that termination of pregnancy performed in appropriate conditions is a safe procedure.

Leaving regulatory matters aside for the moment, it should be noted that in the context of legal abortion, CO is valid only when there is another equally qualified and accessible professional available. This is because CO may not be used in such a way that another person's rights are seriously affected. In other words, the validity of refraining from performing an act depends upon whether third parties' rights are violated. It was on this basis that the Constitutional Court of Colombia held that the limitations on the use of conscientious objection are determined by the rights of others. The Court emphasized that a healthcare professional must ensure that there is another professional available to perform the termination of pregnancy. The Court specified that if there is no other professional available to perform the abortion, freedom of conscience must be restricted so as to not jeopardize women's rights to health, personal integrity, and life in conditions of quality and dignity.[16] The protection of women's rights led the Court to establish a duty for public and private healthcare service providers to ensure accessibility.[17]

It must be noted that conscience is made up not only of those moral convictions that are at odds with a legal requirement (in the situation at hand: participation in a legal abortion procedure). Every person's conscience is informed by multiple sources of beliefs and values, and by the same token, every person is part of a pluralistic community, with all the rights and responsibilities it entails, some of which require performing actions that may run counter to one's beliefs.

Therefore, a healthcare professional who claims conscientious objection does so in a complex regulatory environment: the practice of medicine itself is based on a set of convictions, values, compromises, experiences, rules, and regulations, which must be considered when assessing a morally complex situation.[18] This means that the founding principles of medicine, such as beneficence, non-maleficence, and informed consent, should play a key role in the professional's thought process and final decision.[19]

This suggests that CO also has a moral cost related to the decision not to fulfill certain legal, professional, and moral principles and requirements that are designed to guide the conduct of persons providing healthcare services. Refusing to assist a woman requesting termination of pregnancy means sidelining oneself and not participating on the basis of a moral conflict.[20] Do we not face situations all our lives in which

our principles, morals, intuition, experiences, and emotions seem to be at odds with each other? Is a quest for *moral purity* the answer?[21]

Whatever the case, just as we recognize that some professionals may have to grapple with a moral dilemma, it must also be noted that a woman's choice to abort is a morally acceptable decision, and that in many places in LAC, it is a decision that is made in a context that is hostile and indifferent to the needs of women, particularly certain groups of women.[22] By the same token, the decision by a healthcare professional to fulfill his duty to assist with a legal abortion is morally laudable, particularly if we take into account the highly adverse context in which most healthcare services must be provided in the region.

It must not be overlooked that what is at stake in discussions of CO is not just a question of morality and proper professional conduct; it is a matter of public health policy regarding reproduction and sexuality. Given the harm and potential harm that it can wreak—on the individual woman, on groups of women who may eventually require legal abortion services, and on HSRR policy—CO requires that we limit its definition to those situations of insurmountable moral conflict that justify failing to fulfill a legal requirement in the hotly debated area of reproduction and sexuality.

This leads us to believe that there are at least three key points that must be taken into account. First, broad protection for CO appears relatively reasonable in contexts in which access to the HSRR service is ensured, but not in regions where serious obstacles to access exist. The discussion, as well as legal and individual approaches to the issue, should be framed in terms that define the decision to terminate a pregnancy as a morally defensible one, not simply *tolerable* for certain societies or legal systems, and not some sort of burden that healthcare professionals *must bear*.

Second, although many persons have profound religious convictions that make it difficult for them to participate in certain procedures, a look at the issue of CO throughout history reveals that religion and creed have been used to restrict freedoms and impose ideas of public morality. Therefore, CO claims on this basis must be subject to rigorous political scrutiny.

Third, it must be noted that part of the enjoyment of democratic freedoms is the availability of valuable moral choices. If the healthcare system does not provide incentives for professionals to perform legal abortions, and if it does not work to raise awareness that a woman's decision to carry a pregnancy to term or terminate the pregnancy is a morally respectable one, the result will not only be a lack of access to service, but also the imposition of a single acceptable morality—the morality that has dictated the form and content of penal codes throughout LAC for so many decades. We would find ourselves in a paradoxical situation where an institution (CO) meant to protect a minority is used by the majority to deny rights, disregard the needs of a group (women requiring an abortion), undermine the legitimacy of professionals (those who are willing to fulfill their duties), and impose one morality on everyone.

Thus far, we have considered the limitations on and justifications for CO from a conceptual perspective. We will now turn to the use of CO in the context of sexual and reproductive rights in LAC.

3. THE CONTEXT: THE USE OF CONSCIENTIOUS OBJECTION AS A RESPONSE TO THE *PROBLEM* OF LEGAL ABORTION

CO, understood as a mechanism to protect the integrity of persons facing a moral conflict between duties, is valuable and worthy of protection, as we have seen above.[23] However, core moral or religious convictions do not seem to be what drives some healthcare professionals to conscientiously object to legal abortion in many facilities throughout LAC.

The first step, in defining and regulating CO in HSRR, is to understand the influence of other factors related to the state's failure to promote respect for women's rights, including fears, prejudices, and resistance on the part of professionals. Furthermore, in many LAC countries, CO is used by the healthcare sector as a response to something that is perceived as a problem: legal abortion.[24]

Therefore, activists who advocate for the right to legal and safe abortions must set CO aside for a moment, and ask two questions:

a) What are the factors that make legal abortion a problem for the healthcare professional who must perform the procedure?

b) What steps can be taken to counter this resistance?

We will venture some possible answers below.

a) What Are the Factors that Make Legal Abortion a Problem for the Healthcare Professional Who Must Perform The Procedure?

Abortion is a procedure that involves several parties, directly or indirectly. First, there is the woman who requests an abortion; second, the healthcare sector is called upon to perform the procedure if the woman requests it;[25] third, it falls to the state to regulate it and ensure access. However, when it comes to the factors that make abortion problematic, the chain of responsibility is inverted. First, the state, through criminalization, under-regulation, and lack of institutional policies, takes the lion's share of the responsibility for lack of access. Second, the healthcare sector, through denial of service, is next on the chain of responsibility for lack of access, if a clear regulatory framework has been established regarding circumstances under which abortion is decriminalized.

Somehow, the state deals with legal abortion by passing on the costs of its own ineffectiveness, inaction, or lack of political will to the healthcare sector, which in turn uses the institution of CO to pass these same costs on to women, who pay with their lives, health, integrity, and freedom.

Legal abortion is a sort of *hot potato* that the state passes to healthcare professionals by failing to fulfill its duties, and that healthcare professionals then pass to women by failing to fulfill the duties that are incumbent on the healthcare sector. In this sense, conscientious objection becomes a crutch for professionals who shirk their duties.

But what makes abortion *costly* or *problematic*? There are a multitude of factors that manifest in different ways. In the political and social arena, these factors mean that abortion is seen as stigmatizing, morally

wrong, and forbidden, even in circumstances in which it is expressly allowed. In the governmental sphere (regulatory/legal), these factors contribute to the perception that legal abortion is associated with undesirable legal consequences—criminal, civil, and/or administrative sanctions—or they at least create legal uncertainty. In the healthcare system sphere, these factors mean that legal abortion is associated with lack of professional prestige, exposure to possible intimidation and threats, and the performance of a medical procedure that many professionals find unpleasant.[26]

In the *political and social sphere*, factors include the following:

- *Gender-based stereotypes about the role of women in society, associated with reproduction and motherhood, consider women who have an abortion as 'deviant.'* Social control over women's bodies justifies, and needs, abortion to be criminalized.[27]
- *The influence of the Catholic Church*[28] *as one of the most strident opponents in LAC.* The Church's power in the political arena has allowed the notion of abortion *as a sin* and the antithesis between *pro-life* and *anti-life* groups to predominate in many institutions, schools, universities, hospitals, and the people who work and study in them.[29] Although this is clearly changing in the region, religious representations operate in different ways.
- *Efforts by conservative groups to encourage the political use of CO.*[30]
- *The forms that public debate on abortion in LAC takes.* In the context of a debate characterized by incendiary politics,[31] lack of information, and empty discourse, it becomes extremely difficult to understand the issue—in its criminal policy, public health, and gender equity dimensions.

In the *governmental sphere (regulatory/legal)*, factors include the following:

- *The criminalization of abortion, even when legal exceptions exist, as is the case in many Latin American and Caribbean countries, causes abortion to be seen as a legal problem for anyone who performs the procedure.* In this sense, defining abortion as a crime is perhaps one of the main causes of the *paralyzing effect* on healthcare professionals.[32]
- *The failure to include legal abortion services in HSRR programs.*[33]

- *Under-regulation of legal abortion policies.* This includes lack of protocols, as well as the existence of protocols that impose arbitrary or unclear requirements. This regulatory situation complicates the task of professionals, whose chief concern should be protecting their patient's health, not avoiding criminal liability or complying strictly with the sophisticated procedures imposed on them.[34]
- *The continued presence of abortion as a surgical procedure in the mind of decision-makers, healthcare professionals, and policymakers, despite the widespread use of misoprostol by women.*[35] Despite the widespread use of misoprostol (and to a lesser extent, combined regimen mifepristone) in the region, medical abortion (induced by medications) seems not to have made inroads among key stakeholders (except women). This places limitations on the ways of providing the service and the institutions that can offer it, given that not all providers have qualified professionals available or the necessary equipment for a surgical abortion. This also places limitations on who can readily access the service, since surgical abortion costs more than medical abortion because it requires hospitalization, anesthesia, etc. Finally, the perception of abortion as only a surgical procedure reinforces the image of abortion as *painful* or *uncomfortable* and reinforces the role of the healthcare professional from a medical-hegemonic perspective in which patients are subjects to be protected.
- *The lack of approval for misoprostol and mifepristone in the appropriate dosages with obstetric-gynecological indications.* Administrative hurdles to the approval of drugs for medical abortion are prejudicial not only to women, but to healthcare professionals as well.[36] It may be less problematic for a healthcare professional to prescribe or even administer drugs, while for women, it may be more convenient, affordable, and in some cases, safer, to use medications—as they have been doing more and more in recent years.[37]
- *The failure to frame legal abortion services as a professional duty contributes to the idea that the provision of decriminalized abortion is optional for physicians.*[38]
- *The lack of sanctions against healthcare professionals who fail to fulfill their duty to assist women who request legal abortions.* The judicial branch has a key role to play in enforcing regulations that allow abortion and in applying sanctions for violations. The lack of adjudication of liability

reinforces the idea that provision of legal abortions is not a medical duty on a par with others —governed by the rules of the medical profession, patients' rights, etc.—but rather, again, an optional action.[39]

- *The failure to investigate and sanction groups and persons who intimidate non-objecting professionals.* One of the reasons healthcare professionals hesitate to assist women seeking abortions is the prospect of being subjected to intimidation by organizations, individuals, and/or government officials. The lack of legal sanction for this harassment—along with the lack of institutional support—contribute to the idea that performing legal abortions (meaning, complying with the law) leads to trouble.[40]

In the *health system sphere*, factors include the following:

- *The lack of legitimizations of healthcare professionals who perform abortions vis-à-vis the perception of the lower political and professional cost associated with 'appointing' oneself an objector.* In medical organizations, professionals who perform legal abortions are often denigrated. This situation, coupled with the impunity that objecting professionals enjoy, discourages healthcare professionals from performing abortions.
- *When women seek abortion services later in the pregnancy.* When a woman requests an abortion, healthcare professionals are not indifferent to the stage of the pregnancy. Even non-objecting professionals may be hesitant to perform abortions in cases of late second-trimester pregnancies, for instance. There are circumstances under which the termination of a late-stage pregnancy is imperative (such as health complications for the woman), but there are other circumstances in which the woman's delay in seeking services stems from lack of information, lack of empowerment, or prior experiences of institutional abuse (her own or that of others). Late-stage pregnancies usually require surgical procedures, which must be performed on more developed fetuses, which may have an emotional impact on healthcare professionals.
- *Anti-abortion positions of professional associations and medical schools.* There are some codes of medical ethics that stipulate the absolute defense of life from conception, with no exceptions. These positions have a double effect on healthcare professionals, at both the symbolic and practi-

cal levels, since it not only implies the disapproval of the medical community that they belong to, but also the possibility of being sanctioned by bodies that have disciplinary authority.

- *Refusal by insurers to cover damages stemming from legal abortions in malpractice policies.* In some countries, malpractice policies taken out by healthcare professionals exclude the performance of abortions under any circumstances from covered activities. In these cases, in light of the risks of health complications for the abortion patient, this lack of coverage may discourage the practice.

b) What Measures May Be Taken to Overcome These Barriers?

A review of the factors that make legal abortion a problem that healthcare professionals do not wish to assume reveals that CO is sometimes used to evade the obligation to perform a procedure that may seem costly or inconvenient. Ultimately, the practice of legal abortions falls to a small number of healthcare professionals (always the same ones) who are committed to women's HSRR.

In this section, we will propose measures to reduce the *cost* that healthcare professionals must face, so that it is *less costly* for the healthcare professional to comply with the law and perform legal abortions than to claim CO and refuse to perform the service. The goal is to eliminate from the realm of CO those refusals that are based on reasons other than the healthcare professional's most intimate moral or religious convictions.

In the *political and social sphere*, some measures include the following:

i) In the public abortion debate:

- Discuss the role of criminal law in society.
- Problematize the dimensions related to socioeconomic status, age, ethnicity, and rural areas.
- Question traditional gender roles.
- Cast light on the extremely high rate of unsafe abortions as a cause of maternal mortality.
- Show the historical ineffectiveness of criminalizing abortion.

- Distribute reputable scientific literature on the issue.
- Legitimize women as decision-makers on personal issues such as whether to become mothers or not, and when.

ii) In the debate on conscientious objection:

- Thoroughly explore the moral implications of claiming conscientious objection, which means refusing to perform a procedure for a patient.
- Raise awareness of the discriminatory effects of CO, given that women who are most likely to encounter objecting healthcare professionals are the same women who face the most serious barriers to safe abortion services in the first place.
- Reflect on the role that healthcare professionals and healthcare institutions should play in neutralizing or compensating for, and not reinforcing or multiplying, inequality or experiences of marginalization and degrading treatment.
- Bring decision-makers in the healthcare sector into the debate.
- Interview women and publicize the perceptions and opinions of women who have encountered *objecting* healthcare professionals.

In the *governmental sphere (regulatory/legal)*, some measures include the following:

- Decriminalize and legalize abortion.
- Incorporate abortion services into HSRR policies (so that abortion will not be considered an isolated practice that may be excluded from healthcare services).
- Include abortion in healthcare educational curricula. This would allow abortion to be reframed as one of many medical procedures, all the while sensitizing healthcare professionals to the issue and preparing them to provide quality services.[41]
- Transfer normative and legal frameworks from domestic violence and gender violence into healthcare services (or strengthen these frameworks where it has already been incorporated into legislation). This would allow the refusal of services to be considered, for instance, as cases of institutional or obstetric violence.
- Reward successes in legal abortion services.

- Approve misoprostol and mifepristone at appropriate dosages with obstetric-gynecological indications.[42]
- Activate and use institutional mechanisms for international coordination of healthcare policy at the federal level (such as COFESA in Argentina). These forums offer an opportunity for health ministers of different countries to support one another, recognize common issues, and identify differences that require special attention in their respective contexts (including regulation of CO).
- Map the issue to identify and understand the current situation on the availability of healthcare professionals who are willing to fulfill their obligations and how many are claiming, or would claim, CO.[43]
- Launch informational campaigns on the right to access to information and legal abortion services. This measure could help encourage some women to seek services earlier in the pregnancy.
- Require malpractice policies to cover legal abortion procedures. Malpractice coverage would provide healthcare professionals with peace of mind and reassurance when providing the service.
- Sanction abuses of CO or arbitrary refusals of service. Legal or administrative sanctions against professionals who fail to fulfill their duties would lend credence to existing legal frameworks and the defense of women's rights.
- Improve financial incentives for professionals who perform surgical abortions as well as medical abortions.

In the *health system sphere*, some measures include the following:

- Promote, within the provision of services, opportunities for exchanges between healthcare professionals who most support the practice of abortion and those who most oppose it. The exchange of opinions encourages empathy, the coming together on common experiences, and the areas for finding common ground and coordination.
- Promote the link between post-abortion care and legal abortion. The goal is to reflect on the processes involved in this care as a means of encouraging a willingness for change, for continuity.
- Using existing forums (professional associations, conferences, etc.) to offer legal and scientific training on the issue. This measure may help ensure that abortion issues are discussed in those professional contexts that are the most firmly opposed to abortion.

4. CONCLUSION

Presently, in several LAC countries, change is afoot with regards to reproductive rights, including and particularly with respect to abortion.[44] Precisely, in these valuable processes of destabilization of practices, tacit agreements and beliefs, a botched approach to CO could bring major setbacks to these early advances and the future of HSRR policy.

A fundamental question in the context of many jurisdictions in the region is: how do we protect the conscience of healthcare professionals within the framework of the early stages of the development of institutional responses to women requiring abortion services? We believe that the first steps include offering valuable moral choices, pointing out the implications of refusing to comply with the day-to-day requirements of healthcare, and remembering that we are undergoing a process of change that requires us to deal with some uncertainty and uneasiness if we are to be part of a political community that provides attainable conditions to people, and that people's autonomy and responsibility must be taken seriously.

CO is a means of ensuring moral pluralism and guaranteeing that people are not made to violate their moral integrity by fulfilling the obligations that we have as members of a political community. Taken as such, it would seem that OC claims and measures in the context of legal abortion emerged with a standard-setting mission, or at least a discourse, that is supportive of diversity. However, we must not act impulsively on the basis of "liberal guilt," encouraging a recognition of CO without requiring any additional effort, not only to create effective regulation, but also to expose factors that do not amount to CO, but that are concealed behind the legal recognition of CO and may serve to thwart efforts for greater access to HSRR.

Any democratic state must be committed to creating space for the coexistence of multiple beliefs. But in order for this commitment not to become a mockery by some against others, we must take into account the facts on the ground. For instance, it is clear that in the arena of reproduction and sexuality, there are

significant barriers and imbalances of power among healthcare professionals and between healthcare professionals and women. In this context, the current discussion of CO does little to foster understanding of current realities. It is not healthcare professionals who claim CO who are being subjected to pressure to violate the dictates of their conscience, but those who do choose to fulfill their duties to provide abortion services against a backdrop of isolation without legitimacy, lack of institutional support, and intense political backlash.

While legal abortion may be met with the use of conscientious objection as a moral shield, it is also true that conscientious objection itself poses important questions about the moral obligations and responsibilities of healthcare professionals in the provision of services.[45] In other words, the role that healthcare professionals play, their ethical and legal obligations, and the implications of claiming CO in the area of HSRR indicate that moral conflicts between individual convictions and legal obligations do not amount to a sufficient basis for claiming CO.

When the possibility of legal termination of pregnancy causes discomfort, fear, or resistance in the medical community, the state and other influential actors should defuse this anxiety by issuing an immediate response to issues, in this case the use of CO. Otherwise, we will likely do no more than reinforce the *status quo* and waste the opportunities for dialogue, reflection, and progress in the recognition of women's right to make decisions regarding motherhood.

In conclusion, CO is a tool that has great democratic value, to the extent that it helps to protect the moral integrity of a person and build true pluralism. However, this does not mean that we may disregard the contexts, practices, and dynamics in which it is deployed, in the case, access to legal abortion in healthcare settings, because experience shows that many of the moral conflicts in question may simply be part of a reaction to a complex process of change.

NOTES

[1] To avoid constantly using "he/she," we will use masculine and feminine pronouns interchangeably. In both cases, we are referring to all persons regardless of gender, except in those cases where the reference to gender is clear or we otherwise specify.

[2] In this work, we will discuss the use of CO by healthcare professionals in the context of healthcare in LAC, making reference to several countries. We do not intend to offer a comprehensive overview of the region.

[3] *See* concerns voiced by the FLASOG Committee for Sexual and Reproductive Rights in Luis Távara, Second Latin American Congress on Reproductive Rights Law (conference, Costa Rica, November 28-30, 2011), *available at*: http://-www.sguruguay.org/attachments/article/168/RelatoFinaldpfObjeciónConc.pdf (accessed June 20, 2014). For Colombia, *see* Diana Bernal Camargo, "Aborto y objeción de conciencia," *Revista Red Bioética/UNESCO*, Year 3, 2(6) (2012): 11-22, *available at*: http://www.unesco.org.uy/shs/red-bioetica/fileadmin/shs/redbioetica/Revista_6/Revista Bioetica6b-11a22.pdf (accessed August 20, 2012). For Brazil, *see* Debora Diniz, "Conscientious Objection and Abortion: Rights and Duties of Public Sector Physicians," *Rev Saúde Pública*, 45(5) (2011): 981-985; Antonio Fuchs, "Aborto legal: um debate ético entre médicos e juízes," Escola Nacional de Saúde Pública, May 13, 2011, *available at*: http://www.ensp.fiocruz.-br/portal-ensp/informe/site/materia/detalhe/25348 (accessed August 20, 2012). For Argentina, *see* Marcelo Alegre, "Objeción de conciencia y salud sexual y reproductiva," Hoja Infomativa No. 10, *Por la despenalización del aborto* (June 2009); Sonia Ariza, "La objeción de conciencia sanitaria en el mundo: su regulación," in *Aborto: Razones para su legalización*, comp. P. Bergallo, & R. Michel, (2014) (mimeo). For Chile, *see* Lidia Casas Becerra and Claudia Dides Castillo, "Objeción de conciencia y salud reproductiva en Chile: dos casos paradigmáticos," *Acta bioeth* 13(2) (2007), *available at*: http://www.scielo.cl/scielo.php?pid=S1726-569X2007000200007&script=sci_arttext (accessed June 17, 2014). For Mexico, *see* Dora María Sierra Madero, "La protección jurídica de la objeción de conciencia en México," Chapter 7 of *La objeción de conciencia en México: bases para un adecuado marco jurídico* (Mexico City: National Autonomous University of Mexico, 2002), *available at*: http://biblio.juridicas.unam.mx/libros/libro.htm?l=3083. For Uruguay, *see* Francisco Coppola, "Interrupción voluntaria del embarazo y objeción de conciencia en Uruguay," *Revista Médica Uruguaya* 29(1) (2013): 36-39, *available at*: http://www.ginea.org/wp-content/uploads/2013/03/Articulo-Coppola-RMU_2013.pdf; *El Observador*, "Presentan procedimiento para declarar objeción de conciencia a abortos," July 16, 2013, *available at*: http://www.elobservador.com.uy/noticia/255319/presentan-procedimiento-para-declarar-objecion-de-conciencia-a-abortos/ (accessed May 10, 2014).

[4] By legal abortion, we mean cases in which termination of pregnancy is permitted by law, whether based on gestational age or certain grounds on which it is legal.

[5] Elizabeth Sepper, "Taking Conscience Seriously," *Virginia Law Review* 98 (2002): 1533, *available at*: http://www.virginialawreview.org/sites/virginialawreview.org/files/1501.pdf (accessed June 17, 2014).

[6] *See supra* note 3, *Diniz*, "Conscientious Objection and Abortion: Rights and Duties of Public Sector Physicians."

[7] Elizabeth Castillo Vargas, "Objeción de conciencia médica," *Profamilia*, 2005. Healthcare professionals' right to refuse legal and mandatory services for reasons of morality is provided explicitly by some Constitutions, as well as in some human rights treaties, such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), and the American Convention on Human Rights (ACHR). But these legal instruments impose certain requirements, limitations, and exceptions on legitimate claims of conscientious objection. *See* Wendy Chavkina, Liddy Leitmana, and Kate Polin, "Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences, and Policy Responses," *International Journal of Gynecology & Obstetrics* 123(3) (2013): 41-56. For more information on the use of conscientious objection in accordance with human rights standards, *see* Center for Reproductive Rights (CRR), "Objeción de Conciencia y Derechos Reproductivos: Estándares Internacionales de Derechos Humanos," July 2013, *available at*: http://reproductiverights.org/es/document/objecion-de-conciencia-y-derechos-reproductivos-estandares (accessed June 17, 2014); Latin American Consortium against Unsafe Abortion (CLAI), Center for Studies of the State and Society (CEDES), and Latin American Federation of Obstetrics and Gynecology Societies (FLASOG), "Misoprostol. Regulaciones y barreras en el acceso al aborto legal. Regulación del uso obstétrico del misoprostol en los países de América Latina y El Caribe," *available at*: http://www.clacaidigital.info:8080/xmlui/bitstream/handle/123456789/489/regulaciones_2013.pdf?sequence=1 (accessed June 17, 2014).

[8] Mark R. Wicclair, "Reasons and Healthcare Professionals' Claims of Conscience," *American Journal of Bioethics* 7(6) (2007): 21.

[9] *See supra* note 3, Alegre, "Objeción de conciencia y salud sexual y reproductiva," 6; C. Donda, Objeción de Conciencia, Alcance y limitaciones (conference, Seminario Nacional "Bioética y Aborto no Punible," La Plata, Argentina, June 27, 2007).

[10] Mark R. Wicclair, "The Moral Significance of Claims of Conscience in Healthcare," *American Journal of Bioethics* 7(12) (2007): 30-31. *See supra* note 8, at p. 22.

[11] Constitutional Court [C.C.] May 28, 2010, Decision T-388/09, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), ¶ 53, *available at*: http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm (accessed June 17, 2014).

[12] *See supra* note 10, Wicclair, "The Moral Significance of Claims of Conscience in Healthcare," 22.

[13] *See supra* note 3, Diniz, "Conscientious Objection and Abortion: Rights and Duties of Public Sector Physicians."

[14] *See supra* note 3, at p. 6. *See supra* note 7, Castillo, "Objeción de conciencia médica."

[15] *See supra* note 8.

[16] *See supra* note 11. Decision T-388/09; Constitutional Court [C.C.] November 27, 2009, Decision T-209/08, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), *available at*: http://www.corteconstitucional.gov.co/relatoria/autos/2009/-a279-09.htm (accessed June 17, 2014).

[17] *See supra* note 11. For other conditions that apply to conscientious objection claims, *see*, for example, Ariza "La objeción de conciencia sanitaria en el mundo: su regulación" (CDR), "Objeción de Conciencia y Derechos Reproductivos: Estándares Internacionales de Derechos Humanos;" Castillo, "Objeción de conciencia médica;" Rebecca. J. Cook, Mónica Arango Olaya, and Bernard M. Dickens, "Healthcare Responsibilities and Conscientious Objection," *International Journal of Gynecology and Obstetrics*, 104 (2009): 249_252; B. M. Dickens, "Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical," *Medicine and Law* 28(2) (2009): 337-347.

[18] Martha Minow, "On Being a Religious Professional: The Religious Turn in Professional Ethics," *University of Pennsylvania Law Review* 150(2) (2009): 661-668.

[19] *See supra* note 5, p. 1.537.

[20] Louis Jacques Van Bogaert, "The Limits of Conscientious Objection to Abortion in the Developing World," *Developing World Bioethics* 2(2) (2002): 131-143.

[21] *Ibid*., at 135.

[22] The case of *Beatriz* in 2013 in El Salvador illustrates this context and the institutional abuse faced by many women in the region. *Beatriz* was a 22-year-old Salvadorian woman who requested therapeutic abortion because of her poor physical health (systemic lupus erythematosus, aggravated by lupus nephritis and rheumatoid arthritis) and the fact that the fetus was anencephalic, as shown by medical examinations. In light of her life-threatening condition, treating physicians recommended she undergo termination of pregnancy. However, they refused to perform the procedure for fear of criminal liability, and the pregnancy continued until 26 weeks. The case was taken to court, and on May 28, 2013, the Court's Constitutional Chamber denied the petition for termination of pregnancy, filed on April 11, despite Beatriz's request and the support of local, regional, and global organizations. On May 29, the Inter-American Court of Human Rights issued provisional measures for her, but she was still unable to have the abortion performed. *Beatriz* remained hospitalized in San Salvador until she gave birth to a baby girl by cesarean section on June 3. The baby died hours later of complications related to anencephaly. *See* Matter of B., Provisional Measures, Court Order, Inter-Am. Ct. H.R. (May 29, 2013), *available at*: http://www.corteidh.or.cr/docs/medidas/B_se_01ng.pdf (accessed August 30, 2014); Matter of B., Provi-

sional Measures, Court Order, Inter-Am. Ct. H.R. (August 19, 2013), *available at*: http://www.corteidh.or.cr/docs/medidas/B_se_02.pdf (accessed August 30, 2014).

23 *See supra* note 6.

24 Rebecca J. Cook and Bernard M. Dickens, "The Growing Abuse of Conscientious Objection," *Ethics Journal of the American Medical Association* 8(5) (2006): 337-340; Chavkina, Leitmana, and Polin, "Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences, and Policy Responses."

25 Or in the case of medical abortion, prescribe medications and provide follow-up treatment if necessary, etc.

26 Due to space constraints, we will not fully explore each factor described here. This is not intended to be an exhaustive list, but to illustrate barriers that exist in different arenas.

27 Paola Bergallo, "La liberalización del aborto: contextos, modelos regulatorios y argumentos para su debate," in *Aborto y Justicia Reproductiva* (Buenos Aires: Editores del Puerto, 2011).

28 In certain countries, like Brazil, this occurs with evangelical churches as well, where groups associated with evangelical churches have formed the evangelical bloc of representatives in parliament. *See* Julieta Lemaitre Ripoll, *Laicidad y resistencia: movilización católica contra los derechos sexuales y reproductivos en América Latina*, Colección de cuadernos Jorge Carpizo, 6 (México: Instituto de Investigaciones Jurídicas, 2013), *available at*: http://catedra-laicidad.unam.-mx/wp-content/uploads/2013/08/Colección-Jorge-Carpizo-–-VI-–-Laicidad-y-resistencia-–-Julieta-Lemaitre-Ripoll.pdf (accessed May 10, 2014). This does not mean that evangelical groups have not taken a position on the issue in other countries as well. *See*, for example, Daniel Jones, Ana Azparren, and Santiago Cunial, "Derechos reproductivos y actores religiosos: los evangélicos frente al debate sobre la despenalización del aborto en la Argentina contemporánea (1994-2011)," *Espacio Abierto Cuaderno Venezolano de Sociología* 22(1) (2013): 110-133, *available at*: http://www.-redalyc.org/pdf/122/12226119007.pdf (accessed May 10, 2014).

29 *See* Julieta Lemaitre Rippol, *Laicidad y resistencia: movilización católica contra los derechos sexuales y reproductivos en América Latina*, 5-6; José Manuel Morán Faúndes and María Angélica Peñas Defago, "¿Defensores de la vida? ¿De cuál 'vida'? Un análisis genealógico de la noción de 'vida' sostenida por la jerarquía católica contra el aborto," *Sexualidad, Salud y Sociedad-Revista Latinoamericana* 15 (2013): 15-25, *available at*: http://www.e-publicacoes.uerj.br/index.php/-SexualidadSaludySociedad/article/viewFile/4503/6180 (accessed May 10, 2014); Juan Marco Vaggione, "La cultura de la vida. Desplazamientos estratégicos del activismo católico conservador frente a los derechos sexuales y reproductivos," *Religião e Sociedade, Rio de Janeiro* 32(2) (2012): 59-63, *available at*: http://apps.who.int/iris/bitstream/10665/77079-/1/9789243548432_spa.pdf?ua=1 (accessed June 17, 2014); Juan Marco Vaggione, *Laicidad y sexualidad*, Colección de

cuadernos Jorge Carpizo,16 (Mexico: Instituto de Investigaciones Jurídicas, 2013): 19-35, *available at*: http://catedra-laicidad.unam.mx/wp-content/uploads/2013/08/Colección-Jorge-Carpizo---XVI---Laicidad-y-sexualidad---Juan-Vaggione.pdf (accessed June 17, 2014).

30 *See Ibid*., Vaggione, *Laicidad y sexualidad*; *Ibid.*, Vaggione, "La cultura de la vida. Desplazamientos estratégicos del activismo católico conservador frente a los derechos sexuales y reproductivos." *See supra* note 24, Cook and Dickens, "The Growing Abuse of Conscientious Objection."

31 For instance, in Colombia, Deputy Prosecutor Hoyos filed criminal charges for libel and defamation against human rights activist Mónica Roa for filing a *tutela* action for violations of access to HSRR information.

32 In certain countries with fairly broad legal abortion laws, these laws are rarely or never enforced, leading to a lack of access to legal abortion services comparable to that of countries that criminalize abortion entirely. For an example in Argentina, *see* Human Rights Watch, *¿Derecho o Ficción? La Argentina no rinde cuentas en materia de salud reproductiva* (New York: Human Rights Watch, 2010), *available at*: http://www.hrw.org/es/reports/2010/08/10/derecho-o-ficci-n-0 (accessed June 17, 2014).

33 Agustina Ramón Michel, "Aborto: según quién?" in *Sexualidades, Desigualdades y Derechos: Reflexiones en torno a los derechos sexuales y reproductivos*, eds. Juan Manuel Morán Faundés, M.C. Sgró Ruata and Juan Marco Vaggione (Córdoba: Ciencia, Derecho y Sociedad Editorial, 2012).

34 *See supra* note 7, CLACAI, CEDES and FLASOG, "Misoprostol. Regulaciones y barreras en el acceso al aborto legal. Regulación del uso obstétrico del misoprostol en los países de América Latina y El Caribe," 38-39.

35 The conceptualization of abortion as a surgical procedure led to the issuance, in Entre Ríos Province, Argentina, of a healthcare protocol limiting the provision of the service to only those institutions with the most sophisticated facilities. *See* Resolution 974 MS, Health Ministry for the Province of Entre Ríos, May 4, 2012, Entre Ríos Province B.O. 10 (Arg.).

36 Word Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (Second Edition) (Geneva, 2012), *available at*: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 (accessed August 30, 2014).

37 *See*, for example, Lesbianas y Feministas por la Descriminalización del Aborto, *Lanzamiento de la línea: aborto, más información, menos riesgo* (2009), 9 min. 27 sec.; Latin American Consortium against Unsafe Abortion; *available at*: http://www.clacaidigital.info:8080/xmlui/handle/123456789/421; Oliveira Aráujo, *El acceso a la tecnología en la política pública* (video of presentation to the First Latin American Conference on the Prevention and Treatment of Unsafe Abortion, Lima, Peru, June 29-30, 2009), *available at*: http://www.clacaidigital.info:8080/xmlui/handle/123456789/34 (ac-

cessed June 17, 2014); Nina Zamberlin, Mariana Romero, and Silvina Ramos, "Latin American Women's Experiences with Medical Abortion in Settings where Abortion Is Legally Restricted," *Reproductive Health* 9(34) (2012), *available at*: http://www.reproductive-health-journal.com/content/9/1/34 (accessed June 17, 2014); Nina Zamberlin and Sandra Raiher, "Revisión del conocimiento disponible sobre experiencia de las mujeres con el uso del misoprostol en América Latina," Latin American Consortium against Unsafe Abortion (January 2010), *available at*: http://www.clacaidigital.info:-8080/xm-lui/bitstream/handle/123456789/25/InformeFinal_Revision_Miso_Argentina.pdf?sequence=1) (accessed May 10, 2014).

38 *See supra* note 11.

39 In Argentina, the leading case in professional liability was the *Ana María Acevedo* matter, in which a medical team that refused to perform a therapeutic abortion for a woman who later died of facial cancer was charged with breach of duties of a public servant and reckless endangerment. *See* Fifth District Court of Santa Fe, Criminal Division, August 11, 2008, "Resolución 1576, recurso ordinario," Libro de fallos Fo. 471, 43, Santa Fé Province (Arg.).

40 In Argentina, a woman from Entre Ríos with a severe heart condition was unable to have a legal abortion because, as she was about to enter the operating room, a doctor claiming to be a judge rushed in and told the treating physicians that they were committing a crime. The procedure was canceled and the patient was transferred to a Buenos Aires hospital to continue with her pregnancy. *See* Mariana Carbajal, "Consecuencias de una negativa," p. 12, December 21, 2011, *available at*: http://www.pagina12.com.ar/diario/sociedad/3-182980-2011-12-09.html (accessed May 10, 2014).

41 *See supra* note 17, Cook, Arango Olaya, and Dickens, "Healthcare Responsibilities and Conscientious Objection."

42 *See* Luis Távara-Orozco, Susana Chávez, Daniel Grossman, Diana Lara, and Martha María Blandón, "Disponibilidad y uso obstétrico del misoprostol en los países de América Latina y el Caribe," *Revista Peruana de Ginecología y Obstetricia* 54 (2011): 253-263, *available at*: http://www.redalyc.org/articulo.oa?id=323428190006 (accessed May 10, 2014).

43 *See supra* note 7, Chavkina, Leitmana, and Polin, "Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences, and Policy Responses."

44 For example, in Argentina, Brazil, Chile, Costa Rica, El Salvador, Ecuador, and Uruguay.

45 *See supra* note 20, Van Bogaert, "The Limits of Conscientious Objection to Abortion in the Developing World." Bernard M. Dickens, "The Ethical Responsibilities of Conscience," *IPPF Medical Bulletin* 43(4) (2009): 3-4.

V/b

LESSONS FROM COLOMBIA TO THE UNITED STATES: AN INSTRUCTIVE FRAMEWORK FOR ANALYZING CONSCIENTIOUS OBJECTION TO ABORTION

LOUISE MELLING
and JENNIFER LEE

LOUISE MELLING

Louise Melling is Deputy Legal Director of the American Civil Liberties Union (ACLU) and the Director of its Center for Liberty, which encompasses the ACLU's work on reproductive freedom, women's rights, LGBT rights and AIDs, and freedom of religion and belief. Before assuming her current role, Louise was Director of the ACLU Reproductive Freedom Project, in which capacity she oversaw nationwide litigation, communications research, public education campaigns and advocacy efforts in the state legislatures. She has been with the ACLU since 1992, serving in several roles before becoming the Director of its Reproductive Freedom Project in 2003 and Deputy Legal Director in 2010. Louise is a graduate of Yale Law School and Oberlin College.

JENNIFER LEE

Jennifer Lee is a staff attorney in the Reproductive Freedom Project at the American Civil Liberties Union (ACLU) in New York City, where she uses litigation and advocacy to protect and increase access to abortion and to combat the use of religion to deny reproductive healthcare. She is a graduate of the University of Chicago Law School and Yale University.

In 2009, the Constitutional Court of Colombia issued a powerful decision addressing the propriety of conscientious objection in the provision of abortion services. The Constitutional Court offers a framework for considering objections to the fundamental right of abortion. The decision provides a model that we only wish would guide courts and policy makers in other countries, including the United States, as they wrestle with religious objections to fundamental rights.

At every turn, the Colombian Court does something remarkable from the perspective of U.S. advocates: it considers not only the objector, but also the consequences of recognizing the objection. From that flows consideration of women's access to abortion, the ability of healthcare professionals to provide abortion, and women's dignity. This analysis is a striking departure from American law and policy.[1]

1. THE CONSEQUENCES OF CONSCIENTIOUS OBJECTION

The Constitutional Court's decision begins with a robust respect for the right of conscience and conscientious objection, grounded in the democratic nature of the state and its commitment to pluralism. Acceptance of pluralism, the Court explains, means that the state "*appreciates, in a positive way, the different existing aspirations and valuations, including the special protection of freedom of religion, freedom of conscience and thought, as well as freedom of expression*."[2] That, however, is not what makes the decision noteworthy—at least from the perspective of the United States. We too share a commitment to religious exercise and its diversity.

What is noteworthy is what follows, namely the express and thoughtful consideration the Court gives to the consequences of the objection for others.

> "*When one objects for reasons of conscience, a legal duty has necessarily been breached, 'with greater or lesser social implications.' The question then becomes what are the limits to conscientious objection—which prima facie may seem justified—given the negative impact it can have on the rights of third persons*."[3]

From this follow the three other noteworthy points of this decision, holdings to limit any harm that might flow from recognition of the conscientious objection.

1.1. Ensuring a Woman's Access to Abortion

Guided by its concern for the consequences of conscientious objection, the Court establishes clear limits on the rights of individual healthcare professionals to exercise rights of conscience: they can object if and only if the woman is otherwise guaranteed access to abortion. The Court states:

> "*[H]ealth care professionals can object to terminating a pregnancy for reasons of conscience if and only if there is a guarantee that the pregnant woman will have access to the procedure in conditions of quality and safety, that she will face no additional barriers that interfere with her ability to access necessary healthcare services and that her fundamental constitutional rights to life, sexual and reproductive health, personal integrity and human dignity will be respected*."[4]

In so concluding, the Court emphasized "*the special role that healthcare professionals play within society*."[5] The stance is significant. It recognizes the role of physicians, who are entrusted to provide care. It recognizes that a right to abortion requires that the woman receive the care. And it recognizes the dignity of the woman seeking services.

From the perspective of the United States, it is a remarkable stance. Our law reflects no such concern with ensuring women's access to abortion. Rather, forty-six states have statutes that permit individual healthcare providers to refuse to provide abortion services.[6] The statutes do not condition the refusals on someone else providing the service.[7] Federal law reinforces this regime. Federal funds of different sorts are conditioned on government programs not *discriminating* against individual healthcare providers who refuse to provide abortions and even those who refuse to provide a referral.[8] There is one exception: U.S. law requires that hospitals ensure access to abortions in cases of medical emergencies.[9] In such cases, the hospitals can require individuals to provide the abortion, even over a religious objection, if there is no one else to step in to provide the care.

In short, the protections for women seeking abortions in the United States are much more limited than those set forth in the Colombian Court's decision.[10]

1.2. Protecting Providers Who Want to Offer Services

Second, the Colombian Court rules that corporations or institutions "*do not have a right to conscientious objection*."[11]

Indeed, the reasoning of the Court suggests the idea of an institutional conscience is inconsistent with the very notion of conscientious objection.[12] Speaking of conscientious objections, the Court states, "*the central idea is that individuals breach a legal duty for moral reasons and seek to preserve their own moral integrity, which does not support the proposition that other people must 'adhere to the beliefs or actions of the objector.'*"[13] An institutional objection, however, necessarily requires those who work at the institution to adhere to the beliefs of the objector. As the Court stated:

> "*Highlighting the inability of legal persons to exercise the right to conscientious objection, in addition to fully addressing the essence of the right, is an effective mechanism for preventing legal persons that provide healthcare services from limiting the freedom of their individual employees who might be coerced by the restrictive positions imposed on them by these institutions' managerial staff*."[14]

Again, from the perspective of the United States, this ruling is remarkable. In the United States, any number of laws accord institutions—and in particular hospitals—the right to refuse to provide abortions. Federal law prohibits hospitals from exercising this right of refusals in the context of emergencies.[15] But short of that, the statutes do not impose many other limitations on the right of institutions to refuse to provide abortions.[16] This is true despite the consequences institutional refusals can have for patients, for the training of medical professionals, and for the medical professionals who work in the hospitals refusing to provide care.[17]

U.S. law doesn't stop there. The United States Supreme Court recently ruled that closely held for-profit corporations can claim an exemption based on religious beliefs to a federal law requiring insurance plans to cover contraception.[18] Notably the Court held that for-profit entities could make a religious liberty claim, emphasizing that protecting the free exercise rights of corporations "*protects the religious liberty of the humans who own and control those companies*." Moreover, the Court failed to consider adequately the precise tension the Colombian Court identified: that granting corporations religious exercise rights may burden the rights of employees working for that corporation, who may not share those same religious beliefs.

What the decision will mean going forward remains to be seen, but the language of the majority opinion is expansive when addressing the ability of institutions to assert religious freedom claims under the law at issue and, in some respects, breaks down the separation between corporations and individuals made in the Colombian Court decision.[19]

This is not the only context in the United States in which for-profit institutions are asserting a right of conscience. Pharmacies have asserted an institutional right to refuse to fill prescriptions for birth control because of religious objections; some courts have held that pharmacies can claim such a right.[20] And in several states, businesses—including cake shops, inns, floral shops—are objecting on the grounds of religion to complying with state laws and local ordinances prohibiting discrimination based on sexual orientation.[21] The Colombian decision thus stands in marked contrast to the U.S. legal climate where hospitals' right to object is presumed, and now arts and crafts' stores too enjoy this right.

1.3. Respecting Women's Dignity

Finally, the Colombian Court limits not only when individuals may assert a right of conscientious objection to abortion, but also who may assert that right. The Court held that only personnel *directly* involved in performing the procedure can conscientiously object. The right to object does not extend to personnel who take the "*medical history, manage the institution's files, receive new patients, clean the facilities*," or help patients in recovery, among others.[22]

Again, this issue is under debate in the U.S. In at least one case, a court suggested that an employee could refuse to clean equipment following an abortion because of her religious opposition to abortion.[23] In New Jersey, nurses sued a public hospital, claiming a right to refuse to participate in pre- and post-operative treatment for women who obtained abortions.[24]

To this, the Colombian Court says no, in powerful tones. The right to refuse to treat women recovering from abortion, the Court explains, "*merely indicates that they disapprove of conduct that has already taken place, which is not a proper basis for a conscientious objection claim*."[25] In other words, the Court recognizes that to say those in ancillary roles can object is to say that abortion, and the women who have abortions, are untouchable. It is to say the clerk can claim a right not be tainted by touching the file, the nurse by checking blood pressure, and the staff by cleaning the floors. It is, in the American tradition, like affixing a scarlet letter A on the woman's medical gown.

2. CONCLUSION

And therein lies the great power of the Colombian Court decision. It recognizes the harm to women who seek abortion in allowing claims of conscience without careful limits. But it does something more, something more powerful and notable. It recognizes the harm to a woman's dignity—and the stigma—when she is turned away, and thus shunned, because she seeks an abortion. The right to an abortion is to be accorded respect, and the woman who seeks it, dignity.

This is very different from the United States where the right to an abortion is constitutionally protected in more circumstances than in Colombia. But in the United States, courts have reasoned that the government can use its power to prefer childbirth and thus disfavor abortion;[26] states can ban insurance plans from covering abortion, despite its protected status;[27] and states can bar institutions receiving public funds, including hospitals, from providing abortions.[28] It all amounts to a curious status where the state can actively discourage and make more difficult the exercise of a right protected by the Constitution. In disfavoring abortion, we clearly disfavor the woman seeking abortion as well. We can close the doors of

our hospitals to abortion, and thus to the women who seek it, to the women who make a choice other than motherhood. We applaud the Constitutional Court of Colombia for taking a stance that should take Colombia in a different direction, to respect the human dignity and decisions of women.

NOTES

[1] This commentary is based on a translation of excerpts of the decision supplied to the authors by Women's Link Worldwide.

[2] Constitutional Court [C.C.], May 28, 2009, Decision T-388/09, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), sec. 5.1, *available at*: http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm (accessed July 28, 2014).

[3] *Ibid.*

[4] *Ibid.* This discussion, of course, applies to those abortions that are legal in Colombia—those where the pregnancy poses a threat to the woman's life or health; the pregnancy results from reported rape, incest, or non consensual artificial insemination; or the fetus has conditions incompatible with life. *See* Decision Excerpts at 12 (referencing Decision C-355 of 2006 of the Court); *see also* [Rebecca Cook], *C-355/2006: Excerpts of the Constitutional Court's Ruling that Liberalised Abortion in Colombia* (Madrid: Women's Link Worldwide, 2007), *available at*: http://www.womenslinkworldwide.org/wlw/new.php?modo=detalle_proyectos&tp=publicaciones&dc=40 (accessed July 19, 2014).

[5] *Ibid.*

[6] *See* "State Policies in Brief: Refusing To Provide Health Services," *Emergency Contraception* (New York, Washington D.C.: Guttmacher Institute, March 1, 2014), *available at*: https://www.guttmacher.org/statecenter/spibs/spib_EC.pdf (accessed July 19, 2014).

[7] Adam Sonfield, "Rights vs. Responsibilities: Professional Standards and Provider Refusals," *The Guttmacher Report on Public Policy* 8, No. 3 (2005): 7-9.

[8] *See* 42 U.S.C. § 300a-7 (2012); *see also* Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, § 508(d)(1), 123 Stat. 3034, 3280.

[9] *See* Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(b) (requiring hospitals confronted with individual facing emergency medical condition either to stabilize or to transfer patient).

[10] To some extent, the differing approaches in the two countries may reflect the different healthcare systems. The difference in approaches is not, however, fully explained or compelled by the different structure of the healthcare systems. State laws in the United States need not, for example, provide such sweeping exemptions for healthcare providers who object to abortion and even referrals.

[11] *See supra* note 2, at sec. 5.2.

[12] The Court's language sweeps broadly but its reasoning appears to apply to institutions that hire and serve those of different faiths, where a claim of conscience would impose the institution's views on others. We embrace the decision to the extent it rests on this reasoning. *See Religious Refusals and Reproductive Rights: The Report* (New York: American Civil Liberties Union, 2002), *available at*: https://www.aclu.org/reproductive-freedom/religious-refusals-and-reproductive-rights-report (accessed July 19, 2014).

[13] *See supra* note 2.

[14] *Ibid.* at sec 5.2.

[15] *See supra* note 9.

[16] *See* "State Policies in Brief: Refusing to Provide Health Services" (noting that 44 states have laws that permit institutions to refuse to provide abortion services, with some of the laws limiting the refusals to private institutions and one limiting it to religiously affiliated institutions); *see also* Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, § 508(d)(1), 123 Stat. 3034, 3280 (prohibiting recipients of certain federal funds from "*discriminat[ing]*" against any institutional healthcare entity because it "*does not provide, pay for, provide coverage of, or refer for abortions*").

[17] *See* Lori Freedman, *Willing and Unable: Doctors' Constraints in Abortion Care* (Nashville: Vanderbilt University Press, 2010).

[18] *Burwell v. Hobby Lobby Stores, Inc.*, Nos. 13-354, 13-356, 2014 WL 2921709 (U.S., June 30, 2014). In issuing the decision, the Court was addressing a claim of religious liberty arising under a federal law, the Religious Freedom Restoration Act (RFRA). The decision does not rest on the Constitution under which the businesses claims would surely have been rejected.

[19] The cases decided by the U.S. Supreme Court are among two of more than ninety challenges to the federal rules requiring coverage of contraception in health plans. "Challenges to the Federal Contraceptive Coverage Rule," American Civil Liberties Union, *available at*: https://www.aclu.org/reproductive-freedom/challenges-federal-contraceptive-coverage-rule (accessed July 1, 2014).

[20] *See Stormans, Inc. v. Selecky*, 586 F. 3d 1109 (Ct. of App., 9th Circuit 2009); *Morr-Fitz, Inc. v. Quinn*, 364 Ill. Dec. 597 (Appellate Court, 4th Dist. 2012).

[21] *Craig v. Masterpiece Cakeshop*, Final Agency Order, CR 2013-0008 (Colom. Admin. Ct. May 30, 2014); *Cervelli and Bufford v. Aloha Bed and Breakfast*, Order Granting Plaintiffs' and Plaintiff-Intervenor's Motion for Partial Summary Judgment, No. 11-1-3103-12-ECN (Haw. 1st Cir. Ct. Apr. 11, 2013); Human Rights Comm'n, *Wathen v. Beall Mansion Bed & Breakfast*, No. 2011-SP-2486-2487-2488-2489 (Nov. 1, 2011); *Elane Photography, LLC v. Willock*, 309 P. 3d 53 (N.M.

2013), *cert. denied*, 134 S.Ct. 1787 (2014); *Settlement Agreement, Baker and Linsley v. Wildflower Inn*, No. 183-7-11 (Vt. Super. Ct. Aug. 23, 2012); *Ingersoll v. Arlene's Flowers*, Inc., Complaint, No. 12-3-00871-5 (Wash. Super. Ct. Apr. 18, 2013); *see also* Micheal Hill, "Complaint: NY Wedding Site Banned Same-Sex Couple," *The Big Story*, *available at*: http://bigstory.ap.org/article/complaint-ny-wedding-site-banned-same-sex-couple (accessed March 24, 2014).

[22] *See supra* note 2.

[23] *Tramm v. Porter Mem'l Hosp*., No. H 87-355, 1989 U.S. Dist. LEXIS 16391 (N.D. Ill. Dec. 22, 1989).

[24] Defs. 'Br. in Opp'n to Pls.' Appl. for Prelim. Inj. Relief at 10, *Danquah v. Univ. of Med. & Dentistry of N.J.*, No. 11-cv-6377 (D. N.J. Nov. 22, 2011). The case settled. Transcript of Proceedings at 6, *Danquah v. Univ. of Med. & Dentistry of N.J*., No. 11-cv-6377 (D. N.J. Dec. 22, 2011).Notably, in its recent decision exempting closely held for-profit businesses from the contraceptive coverage requirement, the U.S. Supreme Court rejected the notion that the businesses role—providing insurance for contraception—was too indirect to implicate the corporations' religious freedom rights. Instead, it accepted the corporations' arguments that providing such comprehensive health insurance had the effect of enabling or facilitating commission of an immoral act by another, and thus "*substantially burdened*" the corporations' religious exercise.

[25] *See supra* note 2, at sec. 5.2.

[26] *Planned Parenthood of Southeastern Pa. v. Casey*, 112 S. Ct. 2791 (Supreme Court 1992).

[27] *See Coe v. Melahn*, 958 F.2d 223 (8th Cir. 1992); *ACLU v. Praeger*, 815 F. Supp. 2d 1204 (D. Kan. 2011).

[28] *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 (Supreme Court 1989).

V/c

CONSCIENTIOUS OBJECTION AND HARM REDUCTION IN EUROPE

RUTH FLETCHER

RUTH FLETCHER

Ruth Fletcher is a Senior Lecturer in Medical Law at Queen Mary, University of London, where she teaches undergraduate and postgraduate law students. She has published widely on issues of health, law and feminism, with a particular interest in struggles over access to abortion care. Over the years, Ruth has collaborated with healthcare professionals and human rights activists on working through, with and around law on social justice projects. Her current projects include conscientious objection and harm reduction, human rights critiques of Irish abortion regulation (including collaborations with the Irish Family Planning Association and Doctors for Choice), and a longer-term project on the significance of women's abortion travel for regulation and reproductive justice. Ruth is editor of the journal *Feminist Legal Studies* and co-investigator of the ReValuing Care Network.

1. INTRODUCTION

Conscientious objection to the provision of healthcare raises important philosophical and practical questions. Is it justifiable for a healthcare professional to act against a legal obligation on the grounds that such an action would bring her in conflict with her personal ethical beliefs and commitments? How would a health service accommodate conscientious objection without compromising the delivery of healthcare that is lawful, necessary, and often the result of significant political struggle? The nature and limits of conscientious objection (CO) has been much discussed in the literature[1] mainly in terms of a clash between public duties and personal interests. The Colombian Constitutional Court's decision T-388[2] is particularly significant as a legal precedent that intervenes in this debate by addressing the *scope* of any legal interest in CO and the *limits* on any such interest. The Court discusses these limits in light of CO's potential to harm the legally recognized interests of third parties, including the fundamental rights of women seeking access to lawful abortion care.

This chapter responds to that discussion by considering the Court's reasoning as a contribution to a harm reduction approach to conscientious objection in abortion care.[3] In particular, I focus on the significance of such an approach for responding to regulatory issues that are currently being debated in Europe in relation to conscientious objection and abortion care. Part 1 argues that the Court's focus on the kind of circumstances and relationships which engage a legal right to CO points towards a prima facie need to establish that the objector will be harmed if her objection is not legally accommodated. This provides helpful guidance on the distinction between institutional and individual objectors, between direct and indirect participation, and between public and private dimensions, when it comes to deciding the legitimate scope of CO. Part 2 argues that the Court's elaboration of the limits on the legitimate exercise of CO helps us identify a legal test for the *nature* and *effects* of harm as a limit on CO. In making this argument, I illustrate how such a harm reduction approach to CO throws light on the regulatory issues that have arisen recently in Ireland,[4] Italy,[5] Poland,[6] and the UK[7] in relation to the role of CO in abortion care.

Before going on to make this argument I will first summarize the key aspects of decision T-388 for the purposes of this chapter. Decision T-388 saw the Colombian Constitutional Court address conscientious

objection in circumstances where a judge had excused himself from adjudicating an action concerning a termination of pregnancy on grounds of conscience and conflict of interest. The action requested an order for a termination of pregnancy due to grave fetal malformations in accordance with decision C-355 of 2006, interpreting articles 122, 123, and 124 of the Criminal Code.[8] The reasoning of the judge at first instance, the Second Penal Municipal Judge, was not accepted by the Second Penal Circuit Judge on transfer. She held that conflict of interest did not include the religious beliefs or moral conscience of judicial officials. The action was returned to the Second Penal Municipal Judge for adjudication, at which point he denied the order for a termination of pregnancy due to grave fetal malformations. At second instance, the Second Circuit Penal Judge overturned this decision ordering a termination of pregnancy within 48 hours and the performance of diagnostic tests on the fetus and parents. She did this in light of the need to protect the woman's fundamental constitutional rights to human dignity, free development of the person and to health in connection with life.

Although the termination was performed in September 2006, three legal issues came before the Constitutional Court given the constitutional significance of the matter: 1) What is mandated by the Constitutional Court's decision C-355 of 2006 in the area of the sexual and reproductive rights of women? 2) What practical consequences arise for health promoting entities, healthcare providing institutions, and medical personnel to ensure that they are in compliance with decision C-355 of 2006? And 3) Can judicial officials declare themselves conscientious objectors in the execution of their functions, and consequently, abstain from resolving a case that they have been assigned to hear, especially where the case involves a protection of fundamental rights? In reverse order, the Court ruled that judicial officials could not declare themselves conscientious objectors given their obligation to enforce the law. Secondly, healthcare providing institutions cannot oppose abortion practice, as corporations do not have a right to conscientious objection. Thirdly, the Court elaborated on women's sexual and reproductive rights holding, among other things, that "*women who find themselves under one of the circumstances outlined in decision C-355 of 2006 enjoy the right to decide, free from pressure, coercion, manipulation, and, in general any kind of inadmissible requirements, to terminate a pregnancy"; and that "it is categorically prohibited to allege collective conscientious objection that triggers, in turn, institutional and unfounded conscientious objection claims*."[9]

2. WHEN DOES THE LEGAL RIGHT TO CONSCIENTIOUS OBJECTION ARISE?

Although some argue that healthcare professionals should not be able to refuse healthcare on grounds of conscience,[10] certain legal systems have explicitly recognized a legal right to CO in the context of abortion care and others have recognized CO implicitly as an aspect of freedom of conscience. The four European jurisdictions under consideration here have specific domestic legal provisions which recognize a right to conscientiously object to the provision of lawful abortion.[11] All of them are also parties to the European Convention on Human Rights and Freedoms, and are obliged by the jurisprudence on article 9 ECHR as it relates to freedom of conscience and belief.[12] In Colombia, the right to conscientious objection is protected by article 18 of the Constitution, which guarantees freedom of conscience. In decision T-388, the Constitutional Court made two important points about the context and nature of this freedom, which have a bearing on its legal interpretation. The Court noted that Colombia's constitutional text had specific characteristics in light of its status as a doctrine of "*a participatory and pluralistic democracy that is respectful of human dignity*."[13] This legal acceptance of moral pluralism both underpins the commitment to CO, as a preservation of individual convictions "*whether they are ideological, religious or moral*"[14] and makes it limited "*because, without limits, it would be impossible to adopt measures that are binding upon all individuals*."[15] Secondly, the Court said that the "*central idea is that individuals breach a legal duty for moral reasons and seek to preserve their own moral integrity, which does not support the proposition that other people must 'adhere to the beliefs or actions of the objector*.'"[16] This understanding conforms with the view that conscientious objection is a right that results from respect for the moral integrity of the individual.[17] As the Court said "*conscientious objection arises when complying with a regulation would require individuals to act in a way that their conscience prohibits. In other words conscientious objection assumes an incompatibility between a legal norm and a moral norm*."[18] This understanding helps explain why CO will usually have a narrow scope.[19] Everyone is under a duty to abide by legal norms and any derogation from a legal obligation to provide healthcare has to be restrictive. CO aims to prevent or reduce the psychic harm that would be a violation of an individual's moral integrity. But the legal scope of that interest in harm reduction will be limited given its nature as dissent within a pluralist framework of lawful norms. This helps explain why the ECtHR has found that article 9 jurisprudence does not accept that

every religious belief or practice will justify CO.[20] Rather CO will only be engaged by those beliefs to which the individual is personally and intimately committed and which put the individual in conflict with legal obligations.

In *Pichon and Sajous v. France*, the ECtHR held that pharmacists' refusal to sell contraceptives to women who had valid prescriptions did not fall within the scope of article 9.[21] The Court has recently had an opportunity to consider the scope of religious practice or belief as protected by article 9. *Eweida and others v. UK* (2013)[22] clarified that article 9 imposes an obligation on the state to make a "*reasonable effort to accommodate the manifestation of religious belief*." But the Court considered that the right was extensively limited (an issue I pick up in 2.1 below), and gave the state a wide margin of appreciation where the limitation of the right to manifest religious belief was clearly done in pursuit of some public interest, including health and safety in a hospital ward, and the pursuit of equality objectives, on behalf of gay men and lesbians in the context of one application. As I argue below, and as the Polish abortion cases indicate,[23] there are considerable limits on CO. But we need first to understand the objectives underpinning such legal recognition of CO, in order to clarify the parameters of the circumstances and relationships that engage such a right.

2.1. Non-Institutional Claimants

The grounding of the right to conscientious objection in an individual's moral integrity is an important factor in understanding why CO will not normally apply to corporate persons.[24] The Colombian Court held that "*it is categorically prohibited to allege collective conscientious objection that triggers, in turn, institutional and unfounded conscientious objection claims*."[25] Although institutions may indeed have an ethos or a code of ethics, this is a matter of fact and results from a group's adoption of certain principles and values as that ethos. Ethos in this descriptive sense is qualitatively distinct from the moral integrity that is part of the individual's critical and psychological being. Asking hospitals or corporate persons to act against their ethos or policy means asking those institutions to act against a rule that they have adopted for the sake of a conflicting value. It does not entail asking to act against an intimate, psychological com-

mitment because institutions cannot have that critical faculty. As the Court explained legal (i.e. corporate) persons "*cannot experience intimate and deeply rooted convictions*."[26]

The question of whether institutions should be able to claim CO has come up recently in a Europe-wide context and in the particular jurisdiction of Ireland where legislation to implement a right to life-saving abortion has been adopted. ECtHR jurisprudence holds that companies and associations cannot rely on article 9,[27] so that it is unlikely that article 9 would be recognized as giving rise to an institutional kind of CO. But the European Parliamentary Assembly, an institution of the EU rather than the Council of Europe, has recently adopted a Resolution that protects hospitals and institutions, as well as individuals, against discrimination or coercion because of a refusal to perform an abortion.[28] The Resolution does not create legally enforceable obligations as such, but is a policy document that can have a persuasive effect.

In Ireland, the *Protection of Life in Pregnancy Act*, 2013[29] has authorized 25 hospitals, including two Catholic hospitals, to perform terminations of pregnancy in circumstances where there is a threat to the pregnant woman's life. The Bill originally had a provision that would have excluded the application of the right to conscientious objection to hospitals.[30] However, this provision was dropped from the final version and the 2013 Act is now silent on the matter. In the wake of the passing of the 2013 Act, the question has arisen as to whether the Catholic hospitals, the Mater and St Vincent's, will be obliged to perform terminations, as authorized by the Act.[31] One of the Board members of the Mater, Fr. Doran, stated publicly that he was concerned about the possibility of the Act requiring the Mater to perform abortions, as this would breach their ethos.[32] In September 2013, the Mater announced that it would be complying with the terms of the 2013 Act.[33] Fr. Doran has since resigned from the Board. It would seem that the hospital has agreed to abide by the terms of the Act in its provision of public and private healthcare, and not to invoke some kind of collective CO to the performance of life-saving terminations which may not conform with Catholic doctrine. But the issue is bound to continue to be contested and has generated a great deal of media coverage and public commentary, including from an anti-choice campaigner who has called for the nuns in the Mater to take a test case.[34] Legal reasoning such as the Colombian ruling, which explains why hospitals should not be legally recognized as qualifying for CO, has an important contribution to make to this debate.

2.2. Direct Participants

The distinction between direct and indirect involvement in abortion care is another important feature of the debate about who qualifies for conscientious objection. One of the ways in which healthcare policies have limited the pool of people who may invoke CO is by specifying that only direct participants in abortion care may rely on CO. In this way, administrative staff or other people who may be involved in the support of women who receive abortion care, without actually providing the surgical or medical abortion, are excluded from the scope of CO. Indirect participants complain that they are still complicit in something that they find morally objectionable in these circumstances,[35] but supporters of the distinction argue that there has to be limits on the scope of CO, particularly where it may have discriminatory effects.[36]

This particular debate is on its way to the UK Supreme Court in the case of two senior midwives who co-ordinate the Labour Ward of a Glasgow hospital.[37] They argue that they should be able to invoke CO under section 4 of the *Abortion Act*, 1967 against delegating, supervising and supporting staff who provide abortion care.

Decision T-388 is clear in providing legal support for the view that conscientious objection does not extend to those who are indirectly involved in abortion care. The Court referred to an earlier decision where it had "*clearly stated that conscientious objection only applies to personnel that are directly involved in performing the medical procedure necessary to terminate the pregnancy. Conversely, this right does not extend to administrative personnel, medical personnel who perform only preparatory tasks and medical personnel who provide care during the patient's recovery phase*."[38] This approach supports the pre *Doogan and Wood* position, where law and policy on CO in abortion care provided that s 4 did not apply to indirect participation. In *R v. Salford Area Hospital Authority ex parte Janaway* [1989] 1 AC 537 (hereinafter *Janaway*) the House of Lords ruled that a secretary in a doctor's surgery could not rely on CO under section 4 in order to be excused from typing an abortion referral letter on the grounds that objectors did not legitimately include indirect participants, and she was an indirect participant. Professional guidance to doctors, nurses and midwives has provided that indirect participants may not rely on CO. In 2012, the Outer House

of the Scottish Court of Session agreed with the status quo and found that delegation, supervision and support of staff providing abortion care was indirect participation which did not give rise to legal claim to CO under section 4.[39] But in 2013, the Inner House disagreed on appeal and found that the distinction between direct and indirect participation was not meaningful or desirable (*Doogan and Wood*, 2013). The question is now on its way to the Supreme Court for adjudication and if that Court agrees with the Inner House, the legal scope of CO could be considerably expanded under the Abortion Act, 1967. The interpretation that I offer of the Colombian Court's reasoning however, provides a justification for why the UK Court should not do away with the legal distinction between direct and indirect participation.

Decision T-388 offers two clues as to why the distinction between direct and indirect participation matters. The Constitutional Court said that one of the reasons why indirect participation is excluded is "*because of the difficulty in determining how their work interferes with legitimate moral, philosophical or religious convictions*."[40] In other words, the subjective view of the objectors as to their complicity is not the only factor that matters. There is a need for some kind of external scrutiny as to whether the kind of work they are doing does actually, factually and normatively, interferes with convictions which may give rise to CO. Some kinds of indirect care, such as the provision of genetic testing during pregnancy, will give rise to claims of CO from the objector's perspective. But it is arguably factually incorrect to describe genetic testing as indirect participation in abortion care since this is diagnostic care which pregnant women should receive irrespective of whatever decision she may make about continuing a pregnancy or ending it before term. Secondly, allowing someone to object to care of an individual who may have an abortion in the future or someone who has had an abortion in the past may be unreasonable if it amounts to discriminatory treatment. Where a refusal to treat a person amounts to a judgment of that person as less worthy of healthcare treatment because of something that they have done or might do, the refusal becomes person-specific and not act-specific, and is discriminatory in principle. Where such discrimination is unlawful, the breach of equality norms operates as a kind of legally recognized harm that limits conscientious objection (considered below). Where such discrimination is not clearly unlawful, but unethical as a breach of a norm of equal treatment, it operates as a kind of justification for excluding those indirectly involved in abortion care from the scope of conscientious objection.[41]

Contrary to the finding of the Scottish Court, but in keeping with the ruling in the Colombian Court, the legal distinction between direct and indirect participation cannot be considered solely from the subjective perspective of the conscientious objector. Rather the Court ought to have regard to the objectives underpinning the lawful recognition of CO, that is the legal protection of the moral integrity of the individual where there is a conflict between legal duty and personal moral views, and ask which acts of participation are necessary to achieve that protection. Secondly, a court needs to have regard to the perspective of the receivers of abortion care, as they are owed legal obligations not to discriminate against in their receipt of lawful healthcare.

2.3. A Public Role with a Private Dimension

In the context of abortion care, a healthcare provider who wishes to refuse abortion provision usually raises conscientious objection. The facts of decision T-388 were distinctive in raising the question of a whether a judge could refuse to authorize a termination, which prima facie met the legal grounds. As a result the Court had the opportunity to consider the different kinds of public and private contexts in which CO may be raised, and has provided some useful legal reasoning in that regard. In short, as far as the Court was concerned, CO is not engaged when the objector is exercising a wholly public or a wholly private role. Rather, CO is typically engaged by those who are performing a public role (such as healthcare provision) with a private dimension in the form of space for personal convictions.

The Court was very explicit in finding that "*judicial authorities or those acting as a public authority*" have clear public duties to serve the community under the Constitution. "*A judicial employee's decisions are not grounded in her own free will*" and "*those serving in that capacity cannot excuse themselves from carrying out their constitutional and legal duties for reasons of conscience*."[42] Interestingly, the Court also justified this position in more historical and contextual terms. Fundamental constitutional rights have been hard won and the judiciary had a particular role to play in protecting those rights from populist attack.[43]

Some might argue that even judges should not be subject to an absolute obligation to follow the law in all circumstances, but again political context is significant here. Some recognition of a judicial conscience may

be justifiable in so-called *bad law* situations where the system is authoritarian and unjust. But given the pluralist and liberal democratic context for Colombia's constitutional rights, there was no space for legal recognition of any judicial permission not to apply the law on grounds of conscience.

The Court also commented that CO "*does not involve a private institution that provides healthcare under conditions as established by an agreement between private parties*."[44] The Court did not develop the reasoning in this regard but appeared to be thinking about private healthcare arrangements where it is unimaginable that CO would come up. The assumption is that providers would not have entered into contractual arrangements to provide health services to which they object. However, in a European context, it is getting increasingly difficult to observe clear public/private distinctions even in the context of healthcare which is funded from the tax base, such as the UK's National Health Service.[45] As public commissioners of healthcare are authorized to commission and pay for health services from private providers, these contracts take on some public functions and are becoming accountable to public norms to some extent. Although conscientious objection is still unlikely to be brought up by an employee of a private abortion provider, the private nature of that organization may not be a good enough reason to deny the application of CO if it has taken on some public functions.

3. HOW IS CONSCIENTIOUS OBJECTION LIMITED?

Conscientious objection is usually a limited and not an absolute right. Most legal rights are limited by reference to the rights of others and public interests, and significant limitations are probably justifiable in the case of conscientious objection. This is because conscientious objection arises out of a context where there is usually a pre-existing legal obligation on the objector to provide the healthcare which is the focus of her objection. As the Colombian Constitutional Court notes: "*the right to conscientious objection may therefore trigger or unleash consequences for third parties. It is therefore impossible to characterize conscientious objection as a right that affects solely those who exercise it*."[46] This recognition of necessary limits to CO is also evident in the jurisprudence of the ECtHR and in national laws on CO in a European context. As Daly comments, the ECtHR has consistently held that the right to conscientious objection is limited (2013). In

particular, a person does not necessarily have the right to act on their beliefs in a professional or public services context. In the successful complaint against Italy for a failure to ensure access to abortion services,[47] the IPPF-EN cited the Italian Constitutional Court's ruling that the protection accorded to the freedom of conscience "*cannot be considered unlimited and unconditional. It rests primarily with the legislature to establish a balance between individual conscience and ensuing rights, on the one hand, and the overall, mandatory duties of political, economic and social solidarity that the Constitution (article 2) requires, on the other, so that the public order is safeguarded and consequent burdens are shared by all, without privileges*."

Even though it is trite law that CO is a limited right, in practice healthcare professionals have been known to act as if their CO is absolute. The ECtHR felt the need to criticize the Polish doctors in *P. and S. v. Poland* for effectively assuming an absolute right to CO. The Court said: "*On the whole, the Court finds that the staff involved in the applicants' case did not consider themselves obliged to carry out the abortion expressly requested by the applicants on the strength of the certificate issued by the prosecutor*."[48] Given the significant practice of healthcare professionals justifying refusals of care as a form of CO, it is important to restate the settled legal position that CO is limited and that refusals of care may not be justified. A more contested legal issue is not the fact of limitations per se, but the scope of such limitations and the kinds of harms that count in limiting CO. I will first examine the legal meaning of a limiting harm in this context, before considering the kinds of limits that harm prevention and reduction entail.

3.1. Limiting Harms

When abortion law recognizes interests that may justify a termination of pregnancy, it is recognizing interests which may be harmed by the exercise of CO. The criteria for harms that limit CO are provided by the criteria for lawful termination. These will vary between legal regimes but typically range over women's interests in life, health, well-being, autonomy, freedom from degrading treatment, dignity and equality. As the Colombian decision makes clear, if abortion laws recognize grounds for lawful abortion such as injury to a woman's health and well-being, or a compromising of her self-determination and dignity, then these are harms which limit the exercise of CO.

This reasoning supports the argument made by the IPPF-EN in their complaint against Italy as they argued successfully, that "*the unsatisfactory implementation of the provision means that the rights to life and health are irreparably sacrificed, as well as the woman's right to self-determination, expressly recognized in the Italian Constitution (articles 2, 13 and 32)*." It also provides another reason why the Scottish 2013 decision is flawed. If grounds for lawful abortion provide the legal criteria for recognizing harms that limit CO, the Outer House did not consider the scope of unlawful harms properly. The Scottish Court read the exclusion of emergency abortions from CO in section 4 of the *Abortion Act*, 1967 as the only circumstances in which CO did not apply.[49] But the harms that should count in calculating whether CO is limited in a particular case, are all the harms anticipated by the Act, not just the harm that is the prevention of life-saving emergency treatment. A risk to a woman's physical or mental health is a harm that makes abortion legitimate under the Act.[50] Therefore, risk to women's physical or mental health is a harm whose prevention limits the exercise of CO. If the exercise of CO in a particular set of factual circumstances would compromise a woman's physical or mental health, then the person asserting CO could only do so if she can show that the woman's health will not actually be overly compromised, e.g. because she can access another abortion provider without undue delay.

Settled legal grounds for abortion provide explicit recognition of harms which limit the exercise of CO. But as with any area of law, there will be borderline issues of interpretation. In the UK, the harm of denying women's autonomy is not explicitly recognized in domestic law as a legal ground for abortion. But as Prochaska pointed out in relation to *Doogan and Wood*, the UK courts have an obligation under section 3 of the *Human Rights Act* 1998 to interpret the Abortion Act, 1967, in light of human rights protections under the European Convention.[51] A woman's right to private and family life under Art 8 *could* operate as a lawful interest which a court should take taken into consideration when determining the kinds of harm that may lawfully limit CO.[52] It may be unlikely given UK courts have not engaged with Convention rights to any significant degree when interpreting the *Abortion Act*, 1967. But it is certainly legally possible that a future court could draw on relevant legal sources, such as article 8 ECtHR, to read a more autonomy-oriented ground into the legal criteria for abortion in an appropriate fact situation. By analogy, article 8 is also a relevant legal source for considering the legal limits on conscientious objection. Therefore, there

is a second category of quasi-legal or borderline harms justifying abortion, which *may* operate as limits on CO, and anyone arguing for CO limits would be justified in drawing on this second category in legal argumentation. Similarly, the Italian complaint about the regulation of CO in light of rights to health and non-discrimination under articles 11 and E respectively of the European Social Charter has demonstrated how local law may be interpreted in light of the Charter. CO may be held accountable to standards of harm prevention, in the form of the Charter in this instance, as applied to legally accepted grounds for abortion.

3.2. Effects of Limiting Harms

After the first question about what counts as a harm, there is a second question as to the legal effects of such a harm on the exercise of CO. Some harms operate as a *trump*, while others operate to put *conditions* on the exercise of CO. We can see this when we consider that most CO laws specify that healthcare professionals cannot rely on CO to deny a woman life-saving abortion care. The Italian law for example provides that a doctor, whose personal intervention is necessary for saving the woman from imminent danger to her life, cannot raise conscientious objection. The best way to interpret these legal restrictions on CO is to identify them as recognizing that any prima facie right to CO will be trumped by the duty to prevent harm in the form of a threat to the woman's life. It is not that the only harm which limits CO is a threat to a woman's life. Rather the *effect* of this threat of substantial harm is to act as a trump. The circumstances which trigger such a trumping of CO will usually be rare given that there must be no other way to accommodate the woman's interest in survival. But it is clear that there are legal moments when an interest in CO to protect the objector's psychological being has to be put aside given the need to avoid the greater harm of a woman losing her life or suffering significant injury.

In other circumstances, harm prevention will operate to impose conditions on CO. We can see this when we observe how the limiting of CO translates into a series of standards and obligations, which objectors and their employers must meet. In effect, the law is saying that objectors should show that they are only breaching their duties to provide healthcare as far as is necessary in order to protect their psychological well-being in light of the need to prevent harm to others. The Colombian Constitutional Court's decision

T-388 provides a clear general statement of the kind of limits that operate: "*healthcare professionals can object to terminating a pregnancy for reasons of conscience if and only if there is a guarantee that the pregnant woman will have access to the procedure in conditions of quality and safety, that she will face no additional barriers that interfere with her ability to access necessary healthcare services and that her fundamental constitutional rights to life, sexual and reproductive health, personal integrity and human dignity will be respected*."[53] This emphasis on the need to guarantee access and eliminate any additional barriers that may arise in the exercise of CO (or its equivalent) is also evident in the ECtHR's approach. As Westeson points out,[54] the ECtHR was categorical in both *R.R.* and *P. and S.* in declaring that "*states are obliged to organize the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation*."[55]

The duty to refer and the standard of timeliness are well-recognized means of implementing this duty to guaranteed unobstructed access to lawful abortion care.[56] The Colombian Constitutional Court stated: "*the conscientious objector must be sure that an alternative healthcare professional is available and is willing and able to perform the abortion at the time that it is required*."[57] In Europe, national laws and policies commonly recognize an objector's obligation to refer and a health authority's obligation to provide lawful healthcare in a timely manner.[58] The ECtHR has also emphasized the importance of these standards in relation to lawful abortion care. In *P. and S. v. Poland*, the failure to provide a referral for abortion was part of the applicants' evidence that they had not been provided with an effective means to exercise their rights.[59] In *R.R. v. Poland* the failure to refer for genetic testing, which was required under domestic legislation, gave rise to a breach of her Art 3 and Art 8 rights.[60] The delays experienced by R.R. and by P. and S. in trying to claim a lawful right to abortion were clear breaches of the standard of timeliness. In R.R., it was 8 weeks after the initial request and beyond the lawful time period for abortion before she received the genetic test results. The Court stated with regard to the breach of P. and S.'s convention rights: "*the events surrounding the determination of the first applicant's access to legal abortion were marred by procrastination and confusion. The applicants were given misleading and contradictory information. They did not receive appropriate and objective medical counseling which would have due regard to their own*

views and wishes. No set procedure was available to them under which they could have their views heard and properly taken into consideration with a modicum of procedural fairness."[61] The Court also noted that timeliness in the delivery of lawful healthcare was even more important in the context of pregnancy.[62]

The complaint against Italy raised a different kind of limit—adequate staffing—on the practice of conscientious objection in the context of rights to health and non-discrimination under the European Social Charter.[63] The argument here was that the state was failing to deliver appropriate standards of safe and lawful abortion because there was a dearth of personnel willing to provide abortion care in public hospitals. In a different context, Raz has put the argument this way: "*the conscientious exemption from a duty to participate in administering the right is allowed because, and so long as, it does not threaten the provision of the service*."[64] The IPPF-EN argued successfully that the *low number of abortion providers* puts barriers in the way of women's access to lawful abortion care. The risk of delayed access in relation to individual women rendered the whole *safe and timely* service unsustainable. This argument is supported by the reasoning of the Colombian Constitutional Court as it found that the rights of pregnant women were not protected "*when the state or the governmental system responsible for healthcare insurance (EPS) fails to ensure the presence of a sufficient number of healthcare professionals*."[65]

The need to prevent harm places formal as well as substantive limits on CO. Regulators need to ensure that proper procedures are in place in order to guide the exercise of CO and allow objectors their psychological integrity while ensuring that public health and women's interests are appropriately protected.[66] Formal limits usually include a requirement that the objector provide her reasons in writing. *R.R. v. Poland* noted the need for formal reporting of CO under section 39 of the Polish Medical Profession Act 1996. This requires objectors to make a "*record of their refusals and the grounds for them*"[67] and "*to inform the patient where the medical service concerned can be obtained […]. Doctors employed in healthcare institutions are also obliged to inform their supervisors of the refusal in writing*."[68] Westenson argues that a European regulatory standard of requiring refusals in writing has been established as a result to the ECtHR decisions in *R.R.* and *P. and S.* (2013). The Colombian Constitutional Court provided some further guidance on the standard required of refusals when it specified that the objector must explain why "*perform-*

ing the abortion in this specific case goes against her most intimate convictions" and notes that "*general language presented on behalf of a group will not suffice, nor objections presented by any person other than the person who is conscientiously objecting*."[69] Any bad faith reliance on conscientious objection, in order to try and minimize one's workload for example, will clearly fall foul of this standard. But vague and general language should also be insufficient, as they do not provide evidence as to why the objector's personal conscience requires refusal.

4. CONCLUSION

Like the Colombian Constitutional Court, I believe that the need to reduce harm to abortion-seeking women justifies limiting any legal right to conscientious objection. Unlike some pro-choice healthcare professionals and advocates,[70] I think that anti-abortion doctors, nurses and midwives ought to have a legal right to conscientious objection. They have, or should have, this legal right for much the same reason that a pregnant woman has or should have a right to decide whether to continue a pregnancy or not. A woman should not be compelled to carry a pregnancy to term against her judgment of her intimate needs because this would be to harm her psychological well-being and sense of self, even if her health per se is not threatened by the pregnancy. A healthcare provider should not be compelled to care for a patient in a way that would require her to act against her intimate convictions. In a more critical language, feminists have long argued for *a room of one's own*' or *the imaginary domain*[71] in the name of preserving some kind of safe space for conscientious reflection. To me, the right to CO is a legal version of this, which ought to be recognized even if we do not agree with how it is used.[72] Given this understanding it is especially important to stand up against misrepresentations and misuses of CO which seek to deploy conscience on behalf of entrenched institutional power.[73] In highlighting the scope of the right to conscientious objection in terms of its individual, direct and public dimensions, and in explaining how violations of women's fundamental rights operate as harms that limit CO, the Colombian Constitutional Court has performed a valuable and helpful service.

NOTES

[1] Mark Campbell, "Conscientious Objection, Health Care and Article 9 of the European Court of Human Rights," *Medical Law International* 11 (2011): 284-304; Mark Campbell, "Conscientious Objection and the Council of Europe," *Medical Law Review* 19 (2011): 467-475; Bernard Dickens and Rebecca Cook, "Conscientious Commitment to Women's Health," *International Journal of Gynecology and Obstetrics* 113(2) (2011): 163-166, *available at*: http://papers.ssrn.com/abstract=1832549; Bernard Dickens, "Conscientious Objection: A Shield or a Sword?" in *First Do No Harm: Law, Ethics and Healthcare*, ed. S.A.M. McLean (Aldershot, UK: Ashgate, 2006), 337-351; Rebecca Dresser, "Freedom of Conscience, Professional Responsibility, and Access to Abortion," *The Journal of Law, Medicine and Ethics* 22(3) (1994): 280-285; Carole Joffe, *Doctors of Conscience: The Struggle to Provide Abortion before and after Roe v. Wade* (Boston: Beacon Press, 1996); Lori Kantymir and Carolyn McLeod, "Justification for Conscience Exemptions in Health Care," *Bioethics* 28(1) (2014): 16-23, *available at*: http://onlinelibrary.wiley.com/doi/10.1111/bioe.12055/abstract; Mark Wicclair, *Conscientious Objection in Healthcare: An Ethical Analysis* (Cambridge: Cambridge University Press, 2011).

[2] Constitutional Court [C.C.] May 28, 2010, Decision T-388/09, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), ¶ 53, *available at*: http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm (accessed June 17, 2014).

[3] Joanna Erdman, "Access to Information on Safe Abortion: A Harm Reduction and Human Rights Approach," *Harvard Journal of Law and Gender* 34 (2011): 413-462; *available at*: http://papers.ssrn.com/sol3/papers.cfm?abstractd_-id=1884387; Katherine Romero and Sarah Houlihan, *Maternal Mortality, Unsafe Abortion and the Harm Reduction Model: The Legal Platform* (Women's Link Worldwide, 2012), *available at*: http://www.womenslinkworldwide.org/wlw/-new.php?modo=detalle_proyectos&dc=66.

[4] Eoin Daly, "Talk of Religious Freedom often Obscures Wish to Defend institutional Catholicism," *The Irish Times*, August 15, 2013, *available at*: http://www.irishtimes.com/news/social-affairs/talk-of-religious-freedom-often-obscures-wish-to-defend-institutional-catholicism-1.1494336; Eoin Daly, "Religious Freedom Arguments in the Abortion Debate," *Human Rights in Ireland Blog*, August 12, 2013, *available at*: http://humanrights.ie/civil-liberties/religious-freedom-arguments-in-the-abortion-debate/?utm_source=feedburner&utm_medium=email&utm_campaign=Feed%3A+humanrights-%2FkxLu+%28Human+Rights+in+Ireland%29; Ruth Fletcher, "Peripheral Governance: Administering Transnational Health Care Flows," *International Journal of Law in Context* 9 (2013): 173, *available at*: http://papers.ssrn.com/sol3/-papers.cfm?abstract_id=2395895; Ruth Fletcher, "Submission to the Health Committee of the Irish Oireachtas on the Protection of Pregnancy in Life Bill, 2013," *Human Rights in Ireland*, *available at*: http://humanrights.ie/criminal-justice/guestpost-ruth-fletchers-submission-to-the-oireachtas-abortion-hearings/ (accessed July 18, 2014); Irish Family

Planning Association to Human Rights Committee, *Comments of the Irish Family Planning Association (IFPA) in respect of the Fourth Periodic Review of Ireland under the International Covenant on Civil and Political Rights (ICCPR)* (submission Civil Society Organizations for the session, 2014), *available at*: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=626&Lang=en.

5 Eu. Committee of Social Rights, *IPPF-EN v. Italy*, Complaint No. 87/2012 (September 3, 2013), *available at*: http://www.coe.int/t/dghl/monitoring/socialcharter/NewsCOEPortal/CC87Merits_en.asp.

6 Johanna Westeson, "Reproductive Health Information and Abortion Services: Standards Developed by the European Court of Human Rights," *International Journal of Gynecology and Obstetrics* 122 (2013): 173-176; *R.R. v. Poland* App. No. 27617/04, Eu. Ct. H.R. (2011), *available at*: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-104911; *P. and S. v. Poland*, No. 57375/08, Eu. Ct. H.R. (2012), *available at*: http://hudoc.echr.coe.int/sites/fra/pages/search.aspx?i=001-114098.

7 *Doogan and Wood v. Greater Glasgow and Clyde Health Board* [2013] CSIH 36, *available at*: http://www.scotcourts.gov.uk/opinions/2013CSIH36.html; Louise Finer, "Conscientious Objection in Scotland: A Worrying Precedent," *RHM Blog*, May, 2013, http://rhmatters.wordpress.com/tag/doogan-and-wood/; Elizabeth Prochaska, "Abortion and Conscientious Objection: What about Human Rights?," *UK Human Rights Blog*, May 22, 2013, http://ukhu-manrightsblog.com/2013/05/22/comment-abortion-and-contentious-objection-what-about-human-rights-elizabeth-pro-chaska/.

8 *See supra* note 2, at sec. 1(2).

9 *Ibid.* at sec. 4.4.

10 Julian Savulescu, "Conscientious Objection in Medicine," *British Medical Journal* 332 (2006): 294-297, *available at*: http://www.bmj.com/content/332/7536/294; C. T. Gallagher *et al*., "The Fox and the Grapes: An Anglo-Irish Perspective on Conscientious Objection to the Supply of Emergency Hormonal Contraception without Prescription," *Journal of Medical Ethics* 39(10): 638-642; *pre-publication version available at*: http://uhra.herts.ac.uk/bitstream/handle/2299/11838/-The_Fox_and_the_Grapes_vR1a.pdf?sequence=2; J. Paul Kelleher, "Emergency Contraception and Conscientious Objection," *Journal of Applied Philosophy* 27(3) (2010): 290-304; Christian Fiala and Joyce Arthur, "'Dishonourable Disobedience': Why Refusal to Treat in Reproductive Healthcare Is Not Conscientious Objection," *Psychosom. Gynaecol. Obstetrics* (forthcoming), *available at*: http://dx.doi.org/10.1016/j.woman.2014.03.001.

11 In Ireland, sec. 17 of the *Protection of Human Life during Pregnancy Act*, 2013 allows CO in non-emergency situations and subject to a duty to refer on. *See* Protection of Life During Pregnancy Act 2013, No. 35/2013 (Ir.), *available at*: http://www.oireachtas.ie/viewdoc.asp?fn=/documents/bills28/acts/2013/a3513.pdf. In Italy, article 9 of Law No. 194 allows health personnel and allied health personnel to opt out of taking part in procedures for the termination of

pregnancy if they decide to raise conscientious objection. *See supra* note 5, *IPPF-EN v. Italy*. In England, Wales and Scotland, section 4 of the *Abortion Act*, 1967 authorizes CO. *See* Abortion Act, 1967 (Eng.), *available at*: http://www.-legislation.gov.uk/ukp-ga/1967/87/contents and *Doogan and Wood v. Greater Glasgow and Clyde Health Board* [2013]. In Poland, under section 39 of the *Medical Profession Act* (ustawa o zawodzie lekarza), 1996, a doctor may refuse to carry out a medical service, invoking her or his objections on the ground of conscience; *see supra* note 6, *P. and S. v. Poland*.

12 *See supra* note 1, Mark Campbell, "Conscientious Objection, Health Care and Article 9 of the European Court of Human Rights;" Adriana Lamackova, "Conscientious Objection in Reproductive Health Care: Analysis of Pichon and Sajous v. France," *European Journal of Health Law* 15(1) (2008): 7-43.

13 *See supra* note 2, at sec. 5.1.

14 *Ibid.*

15 *Ibid.*

16 *Ibid.*

17 *See supra* note 1, Mark Wicclair, *Conscientious Objection in Healthcare: An Ethical Analysis*; Mark Campbell, "Conscientious Objection, Health Care and Article 9 of the European Court of Human Rights." *See* Elizabeth Sepper, "Taking Conscience Seriously," *Virginia Law Review* 98 (2012): 1501-1575, *available at*: http://papers.ssrn.com/sol3/papers.cfm?-abstract_id=1888375.

18 *See supra* note 2, at sec. 5.1.

19 Elizabeth Sepper, "Contraception and the Birth of Corporate Conscience," *Am. U. J. Gender, Soc. Pol'y & Law* 303 (2014): 276, *available at*: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2289383.

20 *See supra* note 6, *P. and S. v. Poland*; *Pichon and Sajous v. France*; *supra* note 1, Mark Campbell, "Conscientious Objection, Health Care and Article 9 of the European Court of Human Rights"; *supra* note 4, Eoin Daly, "Religious Freedom Arguments in the Abortion Debate"; *supra* note 6, Johanna Westeson, "Reproductive Health Information and Abortion Services: Standards Developed by the European Court of Human Rights."

21 *See supra* note 1, Mark Campbell, "Conscientious Objection, Health Care and Article 9 of the European Court of Human Rights."

22 Applications Nos. 48420/10, 59842/10, 51671/10, 36516/10 Eu. Ct. H.Rr, *available at*: http://hudoc.echr.coe.int/-sites/fra/pages/search.aspx?i=001-115881.

23 *See supra* note 6, *P. and S. v. Poland*.

[24] Mala Corbin, "Corporate Religious Liberty: Why Corporations are not entitled to religious exemptions," *American Constitution Issue Brief* (2014), *available at*: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2384136; Ruth Fletcher, "Conscientious Objection and Harm Reduction in Abortion Care" in Mary Donnelly and Claire Murray eds. *Emerging Issues in Irish Health Care Law* (Manchester University Press, forthcoming); *supra* note 19, Elizabeth Sepper, "Contraception and the Birth of Corporate Conscience."

[25] *See supra* note 2, at sec. 5.2.

[26] *Ibid.*

[27] *See Company X v. Switzerland* 16 DR-85 Eur. Ct. H.R. [Eu. Comm'n of H.R.] (1979) and *Verein Kontakt-Information-Therapie v. Austria* 57 DR 81 Eur. Ct. H.R. (1988); *supra* note 1, Mark Campbell, "Conscientious Objection, Health Care and Article 9 of the European Court of Human Rights."

[28] Eur. Par. Ass., *The Right to Conscientious Objection in Lawful Medical Care*, Res. 1763 (2010), *available at*: http://assembly.coe.int/ASP/XRef/X2H-DW-XSL.asp?fileid=17909&lang=EN; *supra* note 1, Mark Campbell, "Conscientious Objection and the Council of Europe."

29 Protection of Life During Pregnancy Act 2013 (Act No. 35/2012) (Ir.), *available at*: http://www.irishstatutebook.ie/pdf/2013/en.act.2013.0035.pdf.

[30] *See* Ruth Fletcher, "Submission to the Health Committee of the Irish Oireachtas on the Protection of Pregnancy in Life Bill, 2013," *Human Rights in Ireland*, *available at*: http://humanrights.ie/criminal-justice/guestpost-ruth-fletchers-submission-to-the-oireachtas-abortion-hearings/ (accessed June 10, 2014).

[31] *See* Ruth Fletcher, Richie Keane, Mark Murphy and Veronica O'Keane, "Submission to the UN Human Rights Committee for Ireland's Review under the International Covenant of Civil and Political Rights," *Doctors for Choice* (2014), *available at*: http://www.ccprcentre.org/doc/2014/06/INT_CCPR_CSS_IRL_17440_E.pdf (accessed July 1, 2014).

[32] Kitty Holland, "Mater Board Priest says hospital can't carry out abortions," *The Irish Times*, August 7, 2013; *supra* note 4, Irish Family Planning Association to Human Rights Committee, *Comments of the Irish Family Planning Association (IFPA) in Respect of the Fourth Periodic Review of Ireland under the International Covenant on Civil and Political Rights (ICCPR).*

[33] Kitty Holland, "Mater Hospital to Comply with Legislation," *The Irish Times*, September 25, 2013. 138.

[34] Breda O'Brien, "Mater Hospital Nuns Must Stand up to Bullying," *The Irish Times*, October 5, 2013.

[35] For an explanation *see supra* note 1, Mark Campbell, "Conscientious Objection, Health Care and Article 9 of the European Court of Human Rights" (referring to Daniel Oderberg: "*when I say that this conclusion was in principle a reason-*

able one, I mean that the claims of conscience do not discriminate between an act of wrong doing as principal and an act of wrong doing as accomplice. If I have a conscientious objection to my participation in X as principal, then, as a matter of consistency, I will also object to my contribution to X as accomplice." Daniel Oderberg, "The Ethics of Co-operation in Wrongdoing," in *Modern Moral Philosophy: Royal Institute of Philosophy Supplement*, No. 54, ed. Anthony O'Hear [Cambridge: Cambridge University Press, 2004], 203-227 *at fn* 67).

36 *See* the explanation in the General Medical Council's Guidelines: "*you may choose to opt out of providing a particular procedure because of your personal beliefs and values, as long as this does not result in direct or indirect discrimination against, or harassment of, individual patients or groups of patients. This means you must not refuse to treat a particular patient or group of patients because of your personal beliefs or views about them. And you must not refuse to treat the health consequences of lifestyle choices to which you object because of your beliefs*" (*Good Medical Practice*, 2nd ed. (General Medical Council, 2013), ¶ 8, *available at*: http://www.gmc-uk.org/guidance/good_medical_practice.asp.

37 *See supra* note 7, *Doogan and Wood v. Greater Glasgow and Clyde Health Board* [2013]; Angus Howarth, "Catholic Midwives Abortion Case Goes to Top Court," *The Scotsman*, June 25, 2013, http://www.scotsman.com/-news/health/catholic-midwives-abortion-case-goes-to-top-court-1-2975012 (accessed June 10, 2014); Louise Finer, "Conscientious Objection in Scotland: A Worrying Precedent," *RHM Blog*, May, 2013, http://rhmatters.wordpress.-com/tag/doogan-and-wood/.

38 *See supra* note 2, at sec 5.1.

39 *Doogan and Wood v. Greater Glasgow and Clyde Health Board* [2012] CSOH 32, *available at*: http://www.bailii.org/-scot/cases/ScotCS/2012/2012CSOH32.html.

40 *See supra* note 2, at sec. 5.1.

41 *See supra* note 1, Lori Kantymir and Carolyn McLeod, "Justification for Conscience Exemptions in Health Care."

42 *See supra* note 2, at sec. 5.3.

43 *Ibid.*

44 *Ibid*., at sec. 5.2.

45 Allyson Pollock, *NHS plc: The Privatisation of our Healthcare* (London: Verso, 2005); Kenneth Veitch, "Social Solidarity and the Power of Contract," *Journal of Law and Society* 38(2) (2011): 189-214.

46 *See supra* note 2, at sec. 5.1.

47 *See supra* note 5, *IPPF-EN v. Italy.*

[48] *See supra* note 6, *P. and S. v. Poland*, ¶ 108.

[49] *See supra* note 7, *Doogan and Wood v. Greater Glasgow and Clyde Health Board* [2013], ¶ 32.

[50] *Britain's Abortion Law. What it Says, and Why* (British Pregnancy Advisory Service, 2011), *available at*: http://www.-bpasresources.org/product_info.php?ID=11244.

[51] *See supra* note 7, Elizabeth Prochaska, "Abortion and Conscientious Objection: What about Human Rights?"

[52] *See* Daniel Fenwick, "'Abortion Jurisprudence' at Strasbourg: Deferential, Avoidant and Normatively Neutral?," *Legal Studies* 34(2) (2014): 214-24.

[53] *See supra* note 2, at sec. 5.1.

[54] *See supra* note 7, Johanna Westeson, "Reproductive Health Information and Abortion Services: Standards Developed by the European Court of Human Rights."

[55] *See supra* note 6, *P. and S. v. Poland*, ¶ 206 (citing *R.R. v. Poland*, No. 27617/04, Eur. Ct. H.R. [2011]*, available at*: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-104911).

[56] *See supra* note 1, Mark Campbell, "Conscientious Objection, Health Care and Article 9 of the European Court of Human Rights": 293; *supra* note 17, Elizabeth Sepper, "Taking Conscience Seriously," *Virginia Law Review* 98 (2011), p. 1501-1575.

[57] *See supra* note 2, at sec. 5.1.

[58] *See supra* note 36, Good Medical Practice, ¶ 52.

[59] *See supra* note 6, *P. and S. v. Poland*, ¶ 81.

[60] *See supra* note 6, *R.R. v. Poland*, ¶ 107.

[61] *Ibid.,* at ¶ 108.

[62] *Ibid.,* at ¶ 111.

[63] *See supra* note 5, *IPPF-EN v. Italy*.

[64] Joseph Raz, "Death in our Life," *Journal of Applied Philosophy* 30(1) (2013): 3.

[65] *See supra* note 2, at sec. 5.1.

[66] *See supra* note 6, *R.R. v. Poland*, ¶ 127.

[67] *Ibid*., at ¶ 61.

[68] *Ibid*., at ¶ 73.

[69] *See supra* note 2, at sec. 5.1.

[70] *See supra* note 10, Christian Fiala and Joyce Arthur, "'Dishonourable Disobedience': Why Refusal to Treat in Reproductive Healthcare Is Not Conscientious Objection," *Psychosom. Gynecol. Obstetrics* (forthcoming), available at: http://-dx.doi.org/-10.1016/j.woman.2014.03.001.

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[72] Ann Ferudi, "Abortion: Why Doctors Should Have the 'Right to Refuse,'" *The Independent Blogs*, 7 October 2010 http://blogs.independent.co.uk/2010/10/07/abortion-why-doctors-should-have-the-'right-to-refuse'/ (accessed June 13, 2014).

[73] Michael Thomson (2013) "Abortion Law and Professional Boundaries," *Social and Legal Studies* 22 (2013): 191-210; *supra* note 4, Eoin Daly, "Talk of Religious Freedom often Obscures Wish to Defend Institutional Catholicism."

V/d

PROACTIVELY USING CONSCIENTIOUS OBJECTION TO PROVIDE HEALTH SERVICES FOR MIGRANTS WITHOUT RESIDENCE PERMIT: A BRIEF CASE STUDY FROM SPAIN

WOMEN'S LINK WORLDWIDE

Spain offers a rare example of proactive—as opposed to defensive—use of conscientious objection. Conscientious objection has been regularly used to react to rules that mandate people to do something, for example join an army. This time, it was used in Spain to refuse to obey a law that in some way prohibits the individual from engaging in an activity. In the face of a law that severely restricts the right to healthcare for undocumented immigrants, healthcare providers designed and implemented protests based on the right to conscientious objection in order to continue offering healthcare to this population. Furthermore, this activism was not limited to healthcare providers; it spread to ordinary citizens and local governments throughout the country and has resulted in a constitutional challenge to the law, among other responses.

Even though this brief case study does not directly concern abortion, the legal and ethical arguments raised by organizations in Spain in order to strengthen the right to conscientious objection could enrich advocacy efforts to increase access to safe abortion services in restrictive contexts.

1. FACTUAL BACKGROUND

During the 1980s and against the backdrop of the transition to democracy in Spain,[1] the public health model was re-conceptualized from a tax-based system of health services to health as a universal right for all. Thus, beginning with the 1986 General Health Law[2] until 2011, all public health legislation adopted approaches supporting health as a universal right. For example, article 46 of the General Health Law established one of the fundamental characteristics of the National Health Service: the extension of services to the entire population. Similarly, in 2003, the Law of Cohesion and Quality[3] acknowledged that both citizens and non-citizens were entitled to receive healthcare to fulfill the universal right to health.

This movement towards a universal right to health in Spain came to an abrupt halt in 2012. In September of that year, Royal Decree Law 16/2012 (April 20) "*Urgent measures to ensure the sustainability of the national health system and improve the quality and safety of its services*"[4] came into effect. The law restricts access to healthcare for individuals without legal immigration status. In particular, article 3 states

that non-registered or unauthorized foreigners residing in Spain are to receive health assistance only in cases of emergency. Such emergencies are defined as serious illness or accident and maternity care. Undocumented minors (less than 18 years old) are to receive health assistance under the same conditions as Spanish citizens.

Before this reform, migrants with no residence permit were entitled to free medical care once they registered with the local government of the community where they lived. This typically involved presenting a passport together with proof that one was living within the community.[5] As a result of the reform, those seeking to access health services are additionally required to prove legal resident status. Those who cannot prove it are not entitled to public healthcare unless some exceptional circumstances set out in the new law are present, such as emergencies, serious illness and maternity care. Undocumented individuals must now pay annual premiums to the state or pledge to pay medical fees in order to access to the same health services that Spanish citizens and legal residents receive for free.

The Government defended the action on a number of bases. Initially, it cited economic reasons and the need to reduce public spending in the midst of a severe economic crisis. Later, it stated that it was applying European regulations and attempting to curb health tourism. Paradoxically, the decision of the Spanish government came at a time when the European Union Agency for Fundamental Rights (FRA) issued an opinion that migrants with no residence permit should be entitled by law to access all forms of essential healthcare, such as the ability to see a doctor or to receive necessary medicines, and that continuity of care should be guaranteed, especially in the case of infectious diseases.[6]

1.1. National Reaction

Five Spanish autonomous regions (Catalonia, Andalusia, Asturias, Canary Islands and the Basque Country) announced that they would not apply the new law. These communities put mechanisms in place to ensure continued free access to healthcare for all. Four of the communities have filed a constitutional complaint before the Constitutional Court.

1.2. International Response

In its 2012 Concluding Observations on Spain, the Committee on Economic, Social and Cultural Rights expressed concern over the introduction of the law and its curtailment of the rights of immigrants with no residence permit to access public health services.[7] It recommended that the state ensure universal healthcare pursuant to its international obligations and that the reforms do not limit the access to health services based on immigration status. The Committee also recommended that Spain assess the impact of any potential cuts in healthcare access on the most disadvantaged and marginalized individuals. Similarly, subsequent to his visit to Spain, Mutuma Ruteere, the United Nations Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance, stated in his 2013 report that he "*deeply regrets*" the amendments introduced by the law "*which curtail the right of undocumented migrants to access to public health services as provided in several international human rights instruments ratified by Spain*" and recommended a review of this "*regrettable development*" to ensure that access to healthcare services is provided to all regardless of their migration status.[8]

2. LAW ON CONSCIENTIOUS OBJECTION IN SPAIN

Article 16(1) of the Spanish Constitution states that "*[f]reedom of ideology, religion and worship of individuals and communities is guaranteed, with no other restriction on their expression than may be necessary to maintain public order as protected by law*."[9] The Spanish Constitutional Court has confirmed that conscientious objection is included in article 16(1) and, as part of the Constitution, it is directly applicable without further implementing regulations needed, especially in the context of fundamental rights.[10]

3. ADVOCACY CAMPAIGNS

Civil society organizations launched a series of campaigns in reaction to the implementation of the law, including *Derecho a Curar* [The Right to Cure] and *Yo SÍ, Sanidad Universal.*

3.1. *Derecho a Curar* (The Right to Cure)

In July 2012, *Médicos del Mundo* (Physicians of the World) and SEMYFC (*Sociedad Española de Medicina Familiar y Comunitaria*), the largest national general practitioners' organization, launched a campaign called *Derecho a Curar* (The Right to Cure).[11] The campaign calls on health professionals working in a wide range of fields, including nursing, pharmacy, administration and social work to respond to the law by "*exercising their rights to individual and collective resistance and conscientious objection*" and support the provision of medical care to all persons, regardless of immigration status.[12] Here, in contrast with the T-388/09 standard, conscientious objection is defended as a collective right.

Citing the Hippocratic Oath in the World Medical Association's (WMA) adoption of the Geneva Declaration in 1948, the campaign organizers explained that the medical profession has "*consistently embraced a deontological code that has expressed a firm commitment to provide public healthcare a fair and non-discriminatory manner*."[13] They also based the campaign in the WMA Declaration of Lisbon on the Rights of the Patient which clearly states that when legislation denies patients their rights, physicians should pursue appropriate means to assure or to restore them. The campaign platform states:

> "*We cannot accept administrative decisions that deprive any person living in Spanish territory of his or her right to health, and we are individually and collectively committed to advocating and ensuring access to healthcare for all people in need of medical attention and treatment*."[14]

The campaign organizers addressed many of the purported underlying reasons for the introduction of the law. On the issue of medical tourism, they stated that this is very different from immigration. According to a study conducted by *Médicos del Mundo*, only four percent of the subjects surveyed cited access to national healthcare as a motive for immigrating to Spain.

Examining the reform from a cost analysis perspective, the campaign organizers noted that people with no residence permit will no longer have primary care consultations and instead will be forced to visit

emergency rooms when urgent medical situations arise. Denial of more comprehensive care can lead to conditions that require hospitalization or more intensive treatments, both of which are more expensive and, in the case of certain pathologies, less efficient from a medical standpoint. Furthermore, although immigrants make up more than ten percent of the population, they account for only 5 percent of primary care consultations.

Álvaro González, President of *Médicos del Mundo*, stated the following when describing the law and its impact:

> "*From a rights perspective, it's not just; from an economic perspective, it's inefficient; from a public health perspective, it's a dangerous decree, as contagious-infectious diseases don't understand administrative barriers; and from the ethical perspective, it's not justifiable as it infringes the deontological right of health professionals*."[15]

3.2. *Yo SÍ, Sanidad Universal*

Yo Sí, Sanidad Universal is a "*campaign of civil disobedience*" comprised of both healthcare service providers and patients.[16] Interestingly, unlike the Colombia's Constitutional Court decision T-388/09, they instead argue that administrative staff has the right to conscientiously object to the exclusion of individuals with no residence permit from the public health system.[17]

The objective of the campaign is thus multi-faceted. It seeks to ensure access to health services, to promote civil disobedience in relation to the relevant provisions of the law and to raise awareness about the issue. In addition to inviting healthcare service providers and patients to conscientiously object, the campaign includes a strategy to encourage those who can freely access the public health system to accompany to medical appointments and centers those who cannot.[18] Accompanying others help to assess the situation on the ground, to analyze how users with and without access to the healthcare system are being affected by the law and to create a social fabric of citizens in support of universal healthcare.

4. LESSONS FOR SAFE ABORTION ACTIVISTS AND SUPPORTERS

A proactive or positive use of conscientious objection like the one proposed by *Derecho a Curar* and *Yo SÍ, Sanidad Universal* may serve to increase access to safe abortion services where the law continues to be highly restrictive. As discussed earlier in this book by Dr. Carmen Barroso, Cavallo and Michel Ramon, health professionals willing to provide abortion services in such contexts should be entitled to conscientiously object to laws which prohibit them from offering abortion services that could save a woman's or a girl's life or protect their physical or mental health. Consequently, they cannot be prosecuted or otherwise sanctioned for acting according to their conscience in providing this service. Likewise, they cannot be forced by law to violate doctor-patient confidentiality by reporting women who seek medical attention to the authorities.

NOTES

[1] From 1939 to 1975 Spain was ruled by the dictatorship of Francisco Franco. Upon his death, Spain began to move towards democracy. In 1978 Spain passed a new Constitution, along with other comprehensive legal reforms.

[2] Ley 14/1986 (B.O.E. 1986, 102) (Spain), *available at*: http://www.boe.es/diario_boe/txt.php?id=BOE-A-1986-10499 (accessed July 19, 2014).

[3] Ley 16/2003 (B.O.E. 2003, 128) (Spain), *available at*: http://www.boe.es/buscar/doc.php?id=BOE-A-2003-10715 (accessed July 19, 2014).

[4] R.D.L. 16/2012 (B.O.E. 2012, 98) (Spain), *available at*: http://www.boe.es/boe_catalan/dias/2012/04/24/pdfs/BOE-A-2012-5403-C.pdf (accessed July 19, 2014).

[5] Robert Simones, September 25, 2010, "Prime Minister Rajoy's 'Recortes Sanitarios' for Undocumented Immigrants in Spain May Face Constitutional Challenges," *Blog of the UC Davis Journal of International Law*, 2010, *available at*: http://-jilp.law.ucdavis.edu/blog/posts/-prime-minister-rajoys-recortes-sanitarios-for-undocumented-immigrants-in-spain-may-face-constitutional-challenges.html (accessed July 19, 2014).

[6] European Union Agency for Fundamental Rights, *Migrants in an Irregular Situation: Access to Healthcare in 10 European Union Member States* (Luxembourg, 2011), 9, *available at*: http://fra.europa.eu/sites/default/files/fra_uploads/-1771-FRA-2011-fundamental-rights-for-irregular-migrants-healthcare_EN.pdf (accessed July 19, 2014).

[7] U.N., Committee on Economic, Social and Cultural Rights, Forty-eighth session, *E/C.12/ESP/CO/5, Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant* (April 30-May 18, 2012), *available at*: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbol-no=E%2fC.12%2fESP%2fCO%2f5&-Lang=en (accessed July 16, 2014).

[8] U.N., Human Rights Council, Twenty-third session, *A/HRC/23/56/Add.2, Report of the Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intolerance*, Mutuma Ruteere, *available at*: http://www.ohchr.org/Documents/HRBodies/HRCouncil/RegularSession/Session23/A-HRC-23-56-Add-2_en.pdf (accessed July 19, 2014).

[9] Constitución Española [C.E.] [Constitution]. Dec. 29, 1978, B.O.E. 311, art. I, §2, cl. 16(1), (Spain), *available at*: http://www.tribunalconstitucional.es/es/constitucion/Paginas/ConstitucionIngles.aspx (accessed July 19, 2014).

[10] S.T.C. 53/1985, April 11, 1985 (B.O.E. 119, 10-25) (Spain), *available at*: http://www.boe.es/buscar/doc.php?id=-BOE-T-1985-9096 (accessed July 19, 2014).

[11] Sociedad Española de Medicina Familiar y Comunitaria, Formato de Registro de Objetor, *available at*: http://objecion.semfyc.es/ (accessed July 19, 2014).

[12] "Reasons to Protest against the Healthcare Reform," Médicos del Mundo (2013), *available at*: http://www.medicosdelmundo.org/derechoacurar/manifiest/ (accessed July 19, 2014).

[13] *Ibid.*

[14] *Ibid.*

[15] Álvaro González, "Las consecuencias de la reforma sanitaria en España" (Médicos del Mundo), 2 min., 16 sec; online video from *La Piedra del Alquimista Blog*, https://www.youtube.com/watch?feature=player_embedded&v=Ma7i4Gty3Pc (accessed July 19, 2014).

[16] "Por una sanidad universal", Yo Sí, Sanidad Universal, http://yosisanidaduniversal.net/portada.php (accessed July 19, 2014).

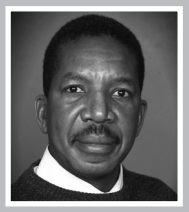
[17] "Instrucciones para la objeción de conciencia (al Real Decreto Ley 16/2012)" (manual guide, Yo SÍ, Sanidad Universal, n.d.), http://yosisanidaduniversal.net/media/blogs/materiales/instrucciones_objecion.pdf (accessed July 19, 2014).

[18] "Manual para grupos de acompañamiento" (manual guide, Yo SÍ, Sanidad Universal, n.d.), http://yosisanidaduniversal.net/media/blogs/materiales/manual_acompanamiento.pdf (accessed July 19, 2014).

V/e

DECISION T-388/2009. A COMMENTARY ON A DECISION OF THE CONSTITUTIONAL COURT OF COLOMBIA FROM AN AFRICAN REGIONAL PERSPECTIVE

CHARLES NGWENA



CHARLES NGWENA

LL.B., LL.M. (Wales University), LL.D. (Free State University), and Barrister-at-Law, Charles Ngewa is Professor of Law at the Centre for Human Rights, University of Pretoria, South Africa. He has taught at law schools in the United Kingdom, Swaziland, South Africa, the United States and Canada. He has published widely on issues at the intersection between human rights and healthcare, including HIV/AIDS and reproductive and sexual health with a focus on the African region. He is also a disability rights expert.

Professor Ngwena serves on editorial committees and editorial boards of a number of international journals. He is Convening Editor of the *African Disability Rights Yearbook* and Section Editor for Law and Bioethics of *Developing World Bioethics*. He also serves on the editorial boards of *Medical Law International* and *Journal of African Law*. He is a co-editor of *Employment Equity Law,* with J.L. Pretorius and E. Klink, which was first published in 2001 by Butterworths and continues to be published annually. With Rebecca Cook, he is co-editor of *Health and Human Rights* (Ashgate, 2007) and, with Ebenezer Durojaye, he is co-editor of the forthcoming book *Strengthening Sexual and Reproductive Rights in the African Region through Human Rights* (Pretoria University Law Press).

1. INTRODUCTION

In decision T-388/09, the Colombian Constitutional Court addressed the intersection between a woman's constitutional right to abortion and the right to conscientious objection to the provision of abortion and abortion-related services, including judicial oversight of such healthcare services. It held that the right to conscientious objection in the abortion context only applies to personnel directly involved in the performance of a procedure for the termination of pregnancy. Furthermore, the Court held that the right does not extend to judicial officers adjudicating a case where abortion is at issue. In reaching this conclusion, the Court took the opportunity to also address the broader parameters of the rights and obligations attendant to conscientious objection within a healthcare context. This commentary reflects on lessons that can be learnt from the Colombian decision for the development of constitutional law and human rights principles and standards for regulating conscientious objection in the African region.

Decision T-388/09 situates the right to conscientious objection within a framework of not just constitutionalism, but also international human rights. For these reasons, the decision has transnational appeal. In this connection, the decision is potentially instructive for African domestic courts and African regional treaty bodies, which do not have precedents of their own on the right to conscientious objection but have obligations to interpret and apply laws that recognize women's right to abortion in given circumstances. All the fifty-four states comprising the African Union have domestic laws that regulate abortion. However, in the majority of states, the laws are silent on conscientious objection. Furthermore, there is no African state where the right to conscientious objection has arisen before the courts. At the regional level, the picture is similar. The Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol),[1] which supplements the African Charter on Human and Peoples' Rights (African Charter),[2] explicitly recognizes women's right to abortion as a human right. However, African regional treaty bodies have never been called upon to interpret or apply the human right to abortion that is guaranteed by the Maputo Protocol. They have yet to develop human rights standards for implementing access to abortion, including standards for regulating the right to conscientious objection.

In seeking to draw comparative law lessons from the Colombian decision, it serves well to begin with an overview of African abortion laws.

2. AN OVERVIEW OF AFRICAN ABORTION LAWS

African abortion laws are a colonial bequest.[3] The influence of colonial abortion laws is visible in the restrictive nature of many domestic laws, as well as in the toll of unsafe abortion-related illnesses, disabilities and deaths that is causally linked to restrictive laws.[4] The cardinal premise in abortion laws, which were transplanted to colonies from Europe, was that abortion was illegal and a mortal sin.[5] Saving the life of the pregnant woman, understood in a narrow medical sense, was the only permitted exception to the criminalization of abortion.[6] Several African countries have retained unaltered colonial abortion laws.[7] Furthermore, where there have been reforms at the domestic level, they have tended to be incremental in contrast to, for example, more radical reforms that have been instituted in the former colonizing countries.[8]

At the same time, in the last three decades or more, an increasing number of African states have reformed their laws to broaden the grounds for abortion ostensibly to provide women with access to safe abortion.[9] Some, albeit a tiny minority, have reformed their laws radically to recognize mere requests or socioeconomic circumstances as grounds for abortion. Cape Verde,[10] South Africa,[11] Tunisia,[12] Zambia[13] and to a point Ethiopia,[14] fall into this category. Several other jurisdictions have reformed their laws to recognize rape, incest, risk to the health of the pregnant woman or risk to the health or life of the foetus as grounds for allowing abortion. It is particularly significant that approximately 50 percent of African states now recognize the threat to the pregnant woman's health as a ground for abortion.[15] The significance of the health ground lies in its potential to substantially widen the gateway to safe abortion. When health is interpreted in accordance with the holistic conceptualization of health in the preamble of World Health Organization's (WHO) Constitution,[16] it has the capacity to implicitly encompass socioeconomic circumstances that impact adversely on women with unwanted pregnancies and, thus, widen substantially the numbers of women eligible for abortion.

Domestic reforms aside, a historic development in the African region have been the recognition of abortion as a discrete human right. In 2003, the African Union adopted the Maputo Protocol to supplement and augment the protection of women's rights under the African Charter, which was perceived as providing insufficient protection.[17] The Protocol was adopted in order to promote gender equality and protect women's rights to substantive equality and non-discrimination against the historical backdrop of a region with embedded gender-based discrimination.[18] The Maputo Protocol, which has been ratified by more than two-thirds of African states, is the first international treaty to recognize abortion as a human right.[19] It situates abortion within a broader compass of sexual and reproductive rights as human rights.[20]

Article 14 of the Maputo Protocol recognizes a woman's right to "*medical abortion*" in cases of sexual assault, rape or incest or where the pregnancy poses a risk to the life or health of the pregnant woman, or to the life of the foetus.[21] Article 26 of the Protocol enjoins state parties to adopt all necessary measures, including budgetary measures, to fulfill the rights guaranteed by the Protocol. State obligations arising from article 14(2)(c) require implementation at the state level—not just in terms of merely recognizing the grounds for abortion, but also establishing the infrastructure, including the dissemination of health information and provision of healthcare services for the termination of pregnancy under safe conditions. In one sense, the right to abortion guaranteed by the Protocol should be understood as an obligation of restraint. It prohibits the state from interfering with the woman's decision to have a safe abortion in the permitted circumstances. In another sense, it should be understood as a positive obligation of the state to take steps to fulfil the realization of the right.

Notwithstanding reforms at the domestic level, women seeking an abortion have found it difficult to realize the abortion under exceptions to the criminalization of abortion. On the whole, abortion laws in the region have remained unknown or beyond the reach of women with unwanted pregnancies, as have abortion services. There has been very little effective implementation of the law at the domestic level, including raising public awareness about the legality of abortion and the availability and location of safe abortion services. Generally, information about the legality of abortion has also not been disseminated to healthcare professionals who are deterred from providing even lawful services for fear of prosecution.[22]

Only a handful of countries have developed and implemented guidelines and protocols to clarify, for example, what constitutes risk to health as a ground for abortion not just for women seeking abortion, but also for healthcare professionals who have the competence and responsibility to provide abortion services.[23] Consequently, whilst the Maputo Protocol is groundbreaking, its abortion guarantees have, thus far, remained largely token and unimplemented—even in ratifying countries.

3. CONSCIENTIOUS OBJECTION CLAUSES OF AFRICAN ABORTION LAWS: SOME EXAMPLES

The majority of domestic laws in the African region do not expressly address conscientious objection such that the issue is implicitly governed primarily by conscience clauses in domestic Constitutions as well as broader human rights state obligations. Most African abortions laws are contained in penal codes, which, among other areas of criminal regulation, proscribe abortion subject to implied or express exceptions, but without specifically addressing conscientious objection. Domestic laws, such as the Zambian Termination of Pregnancy Act of 1972, that solely regulate abortion and contain a conscientious objection clause are an exception to the rule.[24] The Zambian Act was modelled after the British Abortion Act of 1967.[25] Section 4(1) of the Zambian Act provides that "*no person shall be under any duty, whether by contract or any statutory or other requirements, to participate in any treatment authorized by this Act to which he has a conscientious objection*." This is subject to section 4(2), which provides that the exercise of the right to conscientious objection "*shall not affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman*."

Although the content of conscientious objection clause in the Zambian Act does not address all the attendant rights and duties, it at least highlights the nature of the right to conscientious objection as a relative, rather than absolute, right that should be exercised in juxtaposition with (rather than in isolation from) the duty to protect the life and health of the woman seeking abortion. Furthermore, the clause is supplemented by guidelines that attend to the broader aspects of conscientious objection. In this regard, the guidelines impose certain duties.[26] They require that the pregnant woman be provided

with adequate information, including her right to abortion, and that she be referred to an alternative healthcare provider.[27] The guidelines also limit the scope of the right to conscientious objection by stating that it can only be invoked by an individual, and not by a group or an institution, and that it applies only to the actual procedure and the person performing the abortion, and not to "*broader services*" or "*support personnel*."[28]

The conscientious objection clause in the Zimbabwean Termination of Pregnancy Act of 1977[29] provides a sharp contrast to its Zambian counterpart.[30] Section 10 of the Zimbabwean Act states: "*Notwithstanding any law or agreements to the contrary, no medical practitioner or nurse or person employed in any other capacity at a designated institution shall be obliged to participate or assist in the termination of a pregnancy*."

The Zimbabwean Act differs from its Zambian counterpart in three respects. Firstly, the Zimbabwean Act makes no attempt, at all, to also convey any corresponding obligations that come with the right to conscientious objection. Secondly, it does not limit the scope of the protected acts to the actual procedure for the termination of pregnancy. It extends the scope of protected acts to acts of assistance. Thirdly, it includes, within its protective ambit, persons not employed as healthcare professionals.

The general paucity of laws and guidelines that address conscientious objection in the African region justifies looking beyond African boarders for instructive approaches and jurisprudence. The draconian nature of the conscientious objection clause of the Zimbabwean Termination of Pregnancy Act illustrates a conscience clause that operates as an unfettered right without regard to the pregnant woman's constitutional and human rights. It is well outside the bounds of what would be implicitly permissible not just under the treaties that Zimbabwe has ratified[31] but also under its own Constitution.[32] The clause sends the message that healthcare professionals can invoke conscientious objection without the need to balance it with the rights to health and life of the women seeking abortion. The Zimbabwean clause highlights the need to ensure that in both design and implementation, domestic abortion laws should not disproportionately limit women's reproductive rights.

4. DECISION T-388/2009

4.1. The Scope of Conscientious Objection

The approach of the Colombian Constitutional Court in setting the parameters of the right to conscientious objection in decision T-388/09 is tenable. The rationale behind the right to conscientious objection is to protect the personal convictions of those who actually perform an abortion procedure rather than those who merely assist or facilitate such a procedure.[33] Decision T-388/09 is an instance where the invocation of the right to conscientious objection fell well outside the parameters that are recognized as placing a conscientious objector in an invidious position between complying with a legal duty and being faithful to their personal convictions. The person who invoked the right to conscientious objection was a judicial officer. Such an office holder could not be remotely described as closely involved in performing an abortion.

The right to conscientious objection does not extend to situations where the objector has a tenuous association with abortion. The Colombian Constitutional Court emphasized that it is only healthcare personnel who are *directly* involved with performing abortion who can invoke the right and not, for example, personnel who perform preparatory tasks or provide post-abortion care.[34] In this respect, the decision of the Court is in line with the approach of other jurisdictions. For example, in *Janaway v. Salford Area Health Authority*,[35] the House of Lords (the highest domestic court of the United Kingdom) held that the right to conscientious objection under the Abortion Act of 1967 did not cover an administrative assistant's refusal to type a letter of referral for abortion. According to the House of Lords, the act of typing a referral letter was marginal and preliminary to the actual procedure of abortion. It highlighted that the conscience clause of the 1967 Act[36] should not be understood as including, within its protective ambit, *any* procedures that can be associated with termination of pregnancy.

But as the Court of Session of Scotland underlined in the case *Doogan and Wood*,[37] adopting too narrow or rigid of an approach that only recognizes conscientious objection by healthcare professionals who *actually* perform the procedures for the termination of pregnancy may do injustice to health professionals who

closely assist in the termination of pregnancy or are closely involved in the administration of treatment but without prescribing or actually performing the procedure that terminates the pregnancy. The practicalities of delivering care to patients in the health sector is that, for example, while the doctor may perform the actual surgical procedure that terminates pregnancy, nurses and midwives are usually closely involved in the care of the patient. This would be the case, for example, for the nurse who provides assistance in theatre to a gynecological surgeon performing a dilatation and curettage to terminate a pregnancy. To argue that such a nurse is not entitled to exercise the right to conscientious objection would serve to nullify the rationale of conscientious objection. A case-by-case determination is necessary in each individual case to determine whether the extent of involvement of the health professional claiming the right to conscientious objection is close and substantial enough as to amount to direct involvement.

Widening the scope of conscientious objection beyond procedures that are immediate and integral to the performance of abortion would be administratively and constitutionally unworkable. Including all procedures that are preparatory to abortion or associated with post-abortion care would render the right to abortion hostage to a potentially limitless number of third parties.[38] It would mean, for example, that auxiliary personnel instructed to transport the patient to theater for surgical abortion can also object on the grounds of conscience and so can the factory worker who participates in the manufacture of surgical equipment that is used in surgical termination of pregnancy. The list of personnel who can object is virtually endless and this approach could fundamentally undermine the organization and provision of health services by the state. Ultimately, it would be tantamount to recognizing an unfettered right to conscientious objection in a way that not just nullifies a woman's right to abortion, but also undermines other attendants rights such as her rights to life and health as the woman's rights will most likely take second place to those who object to abortion.

Where a domestic Constitution has democratic legitimacy[39] and is committed to promoting diversity and vindicating the rights of all constitutionally protected persons, and not just conscientious objectors, it would be a contradiction to permit judicial officers to claim a right to conscientious objection to abortion. Permitting the very custodians of the country's Constitution to treat the interpretation and enforcement

of constitutionally guaranteed rights as a *menu á la carte* would undermine access to justice in a manner that is serious and arbitrary.[40] Ultimately, it undermines the rule of law, as citizens can no longer count on the judiciary to vindicate their rights. As the Court recognized, the fundamental rights of individuals who belong to historically marginalized groups and whose fundamental rights have been historically denied by dominant political and religious discourses would be particularly adversely affected.[41]

4.2. Striking a Balance between Conflicting Rights

A significant portion of the judgment in decision T-388/09 addresses the attendant duties of individual healthcare professionals, healthcare institutions and the state. Healthcare providers have the competence as well as direct legal and ethical responsibilities to provide healthcare services, including abortion services. Cognizant of the historical criminalization and stigmatization of abortion in the healthcare sector, and strong religious opposition to abortion,[42] the Court sought to strike a balance between protecting freedom of conscience and protecting the constitutional rights of women to abortion and attendant services. Striking a balance ensures that the fundamental right to conscientious objection is not exercised absolutely, but in a manner that accommodates the equally compelling fundamental rights of women seeking abortion services.

Requiring healthcare professionals to immediately refer women to other healthcare professionals serves to protect not just women's rights to abortion and reproductive autonomy, but also their rights to health, life and dignity but without compelling the conscientious objector to perform an abortion. The exercise of the right to conscientious objection invites reciprocal obligations that are ultimately tethered to the achievement of substantive equality. The right to conscientious objection is subject to accommodating women's constitutional rights and international human rights. Considering that time is of the essence for women seeking abortion and that abortions are safer in the first trimester, it is particularly significant that the Court placed emphasis on ensuring that referral is expeditious not only in the sense of the mere act of referring, but also in ensuring the actual availability of an alternative healthcare provider willing to perform the abortion. Delays in referral or referrals that do not translate into tangible alternative access can substantially

erode or altogether deny women's right to abortion. In particular, denial of timely access to safe, legal abortion renders poor women especially vulnerable to unsafe abortions outside the formal healthcare sector.

In some jurisdictions, it is a clearly accepted principle that conscientious objection cannot be invoked in an emergency or where failure to render treatment would pose a risk to the life of the pregnant women or would seriously endanger her health. Zambia is an example. Section 4(2) of the Zambian Termination of Pregnancy Act is a legislative implementation of this principle. It establishes that conscientious objection does not apply where abortion is necessary to save the life or to prevent grave permanent injury to the health of the pregnant woman. The Colombian Court followed this approach. It held that conscientious objection does not apply where there is only one healthcare provider and the provision of abortion care services is necessary to protect the life and health of the woman.[43] According to the Court, conscientious objection does not apply if its exercise would cause the pregnant woman to suffer direct and irreversible harm through failure to provide the care she needs.[44] Refusal to provide healthcare that is necessary to avert serious and irreversible harm is tantamount to abandonment and invites actionable negligence.[45]

As part of balancing conflicting fundamental rights, the Colombian Constitutional Court sought to ensure that the burden of accommodating women's right to access abortion services does not fall solely on the shoulders of the conscientious objector, but is shared with the state. The state has a duty to organize healthcare services in a way that ensures the adequate availability of not just abortion services, but also healthcare providers willing to perform abortions. This serves to assure that the exercise of the right to conscientious objection does not leave the woman seeking abortion abandoned and without a meaningful alternative. In other words, the duty of the state to provide non-discriminatory alternatives to healthcare providers who conscientiously object to performing abortion is subject to the state's firstly ensuring that the established healthcare system does not lack services for adequate provision of abortion services as that would also be discriminatory to women.

The duty of immediate referral incumbent on the healthcare professional and the duty of the state to ensure adequate provision of accessible abortions services—including an adequate pool of healthcare profes-

sionals who are willing and have a duty to perform abortions—are instructive obligations for the African region. The obligations signify an important amplification of the constitutional obligations attendant to the right to conscientious objection in a way that promotes substantive equality for women domestically. Equally significant, the obligations serve to domesticate equality and non-discrimination norms that have been articulated by General Recommendation 24 of the Committee on the Convention to Eliminate All Forms of Discrimination against Women (CEDAW Committee) in particular.[46] In clarifying the normative content of article 12 of CEDAW, which guarantees women a right to health on the basis of equality, the Committee has stated:

> "*Measures to eliminate discrimination against women are considered to be inappropriate if a health-care system lacks services to prevent, detect and treat illnesses specific to women. It is discriminatory for a state party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be taken to ensure that women are referred to alternative health providers*."[47]

The CEDAW Committee's statement implicitly reinforces that the exercise of the right to conscientious objection cannot be at the exclusion of the state obligation to fulfill women's right to reproductive health-care and substantive equality. Failure to refer women to alternative service providers could easily perpetuate systemic discrimination and historical disadvantage. Recognizing a duty to accommodate women's reproductive health, when the right to conscientious objection is invoked, is an integral part of guaranteeing women substantive equality.[48] Substantive equality seeks to erase systemic forms of domination and material advantage that are associated with race, gender, disability and other vectors of inequality.[49] The test for whether health services meet a substantive equality standard is not whether the services treat men and women in identical ways according to a universally abstract standard, but whether they respond adequately to the particular needs of men as men and women as women in a context where sex and gender differences are valued equally.[50]

The Court's implicit commitment to substantive equality is also evident in the order made by the Court. The order was framed as a structural interdict. It required the respective organs of state to report to the Court within the period allotted, stating how they have complied with the decision. Part of the order required respective organs of state to immediately design and implement campaigns to promote sexual and reproductive rights and educate the public about the Court's decision. The emphasis that the Court placed on ensuring that the rights and obligations involving conscientious objection should not only be reflected in sexual and reproductive programmes but should also become known to stakeholders, including women, is significant. It highlights the Court's awareness that the tangibility of rights partly depends on whether they are implemented in a transparent way and whether right-holders have knowledge of their rights.

The approach of the Colombian Constitutional Court underscores that even when a claim of conscientious objection is conceded, women's reproductive health services must remain accessible. The Committee on Economic, Social and Cultural Rights (CESCR), in its interpretation of the normative content of article 12 (right to health) of the International Covenant on Economic, Social and Cultural Rights (ICESCR) has underscored the importance of understanding rights and the services in question as one of the standards used for determining whether healthcare services meet the right to health normative element of "accessibility."[51] According to the CESCR, one of the requirements of accessibility is that health services must be organized in a manner that makes them accessible to everyone, especially the most vulnerable or marginalized sections of the population, without discrimination.[52]

4.3. Protection of Personal Convictions

In some jurisdictions, there is a growing practice of institutions that have a public duty to provide health services refusing to provide certain services, such as abortion services, on the ground of conscientious objection.[53] Decision T-388/09 held that freedom of conscience cannot be claimed by a group or by an institution. The approach of the Colombian Court in this regard is analogous to that of the French Constitutional Court.[54] In 2001, the French Constitutional Court upheld the constitutionality of domestic legislation, which repealed provisions of a domestic Code of Public Health that permitted heads of de-

partments of public health facilities to refuse to allow the departments for which they were responsible to provide abortion services.

One rationale for denying institutions the right to conscientious objection, as the Colombian Court observed, is that it is a right grounded in the most intimate and deeply-rooted personal convictions.[55] Freedom of conscience is an individual rather than collective right that is based on individual or personal convictions. Therefore, though institutions such as hospitals or clinics have legal personality, they cannot claim to have religious conscience for example.[56] The other rationale for denying institutions the right to conscientious objection is to ensure equality among users of public health services.[57] The challenge, however, is that domestic laws do not generally provide express guidance on whether institutions can invoke conscientious objection, and that the policies or practices of individual institutions are not always monitored or challenged. Consequently, women seeking access to safe abortion are placed at the mercy of the goodwill of the individual institutions.

5. CONCLUSION

When called upon to adjudicate on a conflict between the right to conscientious objection and a woman's right to safe abortion services, African domestic courts can draw guidance from the juridical standards that where established by the Colombian Constitutional Court in decision T-388/09. To the extent that the Colombian Court also drew from international human rights, decision T-388/09 is also instructive to African treaty-monitoring bodies, including the African Court on Human and Peoples' Rights, which has advisory and contentious jurisdictions.[58] Whether the call for adjudication arises at the domestic level in a constitutional law context before domestic courts or in a human rights law context at the regional level before the African treaty-monitoring bodies, the standards set in decision T-388/09 serve well for any judicial exercise aimed at striking a fair balance between the fundamental rights of conscientious objectors and those of women seeking an abortion. Equally, the Colombian decision lends itself as an important juridical resource and advocacy tool for human rights practitioners, civil society and NGOs that seek to promote women's sexual and reproductive health, including access to abortion as a human right.

Historically, the criminalization of abortion has served to stigmatize a health service that only women need.[59] If applied in an unfettered manner, the right to conscientious objection can serve to accentuate the stigmatization of abortion. Stigmatization of abortion deters women seeking abortion services from approaching the formal health sector and provides an incentive for recourse to unsafe abortion procedures outside the health sector. Decision T-388/09 is a lesson in reframing law to construct a standard of equality that is inclusive and values the woman seeking abortion in the same way that it values the conscientious objector.[60]

NOTES

[1] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, art. 14(2)(c), Nov. 25, 2005, AHG/Res. 240 (XXXI).

[2] African Charter on Human and Peoples' Rights, Oct. 21, 1986, 1520 U.N.T.S. 217.

[3] Charles Ngwena, "Access to Legal Abortion: Developments in Africa from a Reproductive and Sexual Health Rights Perspective," *South African Public Law* 19(2) (2004): 328.

[4] World Health Organization, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, 6th ed. (Geneva: World Health Organization, 2011), 6-8.

[5] Rebecca J. Cook and Bernard M. Dickens, "Human Rights Dynamics of Abortion Law Reform," *Human Rights Quarterly* 25(1) (2003): 8-9.

[6] Reva Siegel, "Reasoning from the Body: A Historical Perspective on Abortion Regulations and Questions of Equal Protection," *Stanford Law Review* 44(2) (1992): 277.

[7] Countries falling into this country are: Angola, Central African Republic, Congo (Brazzavile), Cote d'Ivoire, Democratic Republic of Congo, Egypt, Gabon, Guinea-Bissau, Libya, Madagascar, Malawi, Mauritania, Sao Tome and Principe, Senegal, Somalia, Sudan, South Sudan, Tanzania, and Uganda. *See* Center for Reproductive Rights, "The World's Abortion Laws Map 2013 Update," accessed April 11, 2014, http://reproductiverights.org/sites/crr.civicactions.net/files/documents/AbortionMap_Factsheet_2013.pdf; Charles Ngwena, "Access to Safe Abortion as a Human Right in the African Region: Lessons from Emerging Jurisprudence of UN Treaty-Monitoring Bodies," *South African Journal on Human Rights* 29(2) (2013): 408-9.

[8] Charles Ngwena, "An Appraisal of Abortion Laws in Southern Africa from a Reproductive Health Perspective," *Journal of Law, Medicine and Ethics* 32(4) (2004): 712.

[9] Eunice Brookman-Amissah and Josephine Banda Moyo, "Abortion Law Reform in Sub-Saharan Africa: No Turning Back," *Reproductive Health Matters* 12(24) Supplement (2004): 227; Reed Boland and Laura Katzive, "Developments in Laws on Induced Abortion: 1998-2007," *International Family Law Planning Perspectives* 34(3) (2008): 115-16; Charles Ngwena, "Access to Safe Abortion as a Human Right in the African Region: Lessons from Emerging Jurisprudence of UN Treaty-Monitoring Bodies," *South African Journal on Human Rights* 29(2) (2013): 408-10.

[10] Law No. 9/III/86 (1986) (Cape Verde) (allowing abortion on request in the first trimester among other grounds).

[11] The South African Choice on Termination of Pregnancy Act No. 92 (1996) (CTOPA) as amended permits abortion on request in the first trimester (section 2[1][a] of the Act), and on socio-economic circumstances in the second trimester (section 2[1][b][iv] of the Act) among other grounds. Choice on Termination of Pregnancy Act 92 of 1996 § 2 (S. Afr.).

[12] Ley No. 65-24 (Jul. 1, 1965), art. 214 (Tunis.) (allowing abortion on request in the first trimester among other grounds).

[13] Art. 12(2) of the Zambian Constitution permits abortion that is procured in accordance with an Act of Parliament. CONST. OF ZAMBIA of 1991 § 1, 1 LAWS OF Rep. of Zambia (2010) § 12(2). Section 3(2) of the Zambian Termination of Pregnancy Act of 1972, which is modeled on the British Abortion Act of 1967 as amended, permits socio-economic circumstances to be taken into account when determining whether risk to the life of the pregnant woman or risk to her physical or mental health or risk to the physical or mental health of any existing children of the pregnant woman, as grounds of abortion under the Act, are satisfied. Termination of Pregnancy Act of 1972 § 304, 3(2), Laws of Rep. of Zambia (1972).

[14] Criminal Code (2004) (Eth.), art. 551 (inter alia, allowing abortion on the ground that a pregnant minor is on account of minority status, unable to discharge the responsibility of motherhood).

[15] *See supra* note 7, Center for Reproductive Health, "The World's Abortion Laws Map 2013 Update."

[16] World Health Organization, *Constitution of the World Health Organization*, 45th ed. (New York, NY: World Health Organization, 2006), Preamble.

[17] Fareda Banda, *Women, Law and Human Rights: An African Perspective* (Oxford: Hart Publishing, 2005), 66-82; Frans Viljoen, *International Human Rights Law in Africa*, 2nd ed. (Oxford: Oxford University Press, 2012), 252-55.

[18] *Ibid.*

[19] At the time of writing, the Women's Protocol has been ratified by 36 states: Angola, Benin, Burkina Faso, Cameroon, Cape Verde, Ivory Coast, Comoros, Congo, Djibouti, Democratic Republic of Congo, Equatorial Guinea, Gabon, Gambia, Ghana, Guinea-Bissau, Guinea, Kenya, Libya, Lesotho, Liberia, Mali, Malawi, Mozambique, Mauritania, Namibia, Nigeria, Rwanda, South Africa, Senegal, Seychelles, Swaziland, Tanzania, Togo, Uganda, Zambia, and Zimbabwe. African Union, "List of Countries Which Have Signed, Ratified/Acceded to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa," African Union, last modified February 21, 2013, http://au.int/en/sites/default/-files/Rights%20of%20Women.pdf.

[20] Charles G. Ngwena, "Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa," *Human Rights Quarterly* 32(4) (2010): 786.

[21] The term "medical abortion" must be understood purposively as encompassing both surgical and medical techniques for procuring safe abortion in the formal health sector. *Ibid.*, at p. 847.

[22] Brooke R. Johnson *et al*., "Reducing Unplanned Pregnancy and Abortion in Zimbabwe Through Postabortion Contraception," *Studies in Family Planning* 33(2) (2002): 195.

[23] Ethiopia, Ghana and Zambia are the main examples in this regard. Their guidelines are respectively: Family Health Department, Federal Democratic Republic of Ethiopia, *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia* (Addis Ababa: Federal Democratic Republic of Ethiopia, 2006), http://phe-ethiopia.org/resadmin/uploads/attachment-161-safe_abortion_guideline_English_printed_version.pdf; Republic of Ghana, *Prevention and Management of Unsafe Abortion: Comprehensive Care Services, Standards and Protocols* (Republic of Ghana, 2006); Ministry of Health, Government of the Republic of Zambia, *Standards and Guidelines for Reducing Unsafe Morbidity and Mortality in Zambia* (Lusaka: Government of Zambia, 2009).

[24] Termination of Pregnancy Act of 1972 Cap. 304, Laws of Rep. of Zambia (1972).

[25] Abortion Act (1967) § 87.

[26] Ministry of Health, Government of the Republic of Zambia, *Standards and Guidelines for Reducing Unsafe Morbidity and Mortality in Zambia* (Lusaka: Government of Zambia, 2009).

[27] *Ibid.*

[28] *Ibid.*

[29] Termination of Pregnancy Act of 1977, ch. 15, 10, as amended by the Criminal Law (Codification and Reform) Act of 2004, ch. 9, 23 (Zim.).

[30] Termination of Pregnancy Act of 1972 cap. 304, 26, LAWS OF REP. OF ZAMBIA (1995) (Zam.).

[31] Zimbabwe has ratified the CCPR, CESCR, CEDAW and the African Charter among other treaties.

[32] Among other pertinent rights, Zimbabwe's Constitution guarantees the following rights: life (section 48); human dignity (section 51); freedom from degrading treatment (section 53); equality and non-discrimination (section 56); and freedom of conscience (section 60). CONST. OF ZIMBABWE of 1979 (as amended by Act No. 20 of 2013).

[33] Bernard M. Dickens and Rebecca J. Cook, "The Scope and Limits of Conscientious Objection," *International Journal of Gynecology & Obstetrics* 71(1) (2000): 72, 74-76.

[34] Constitutional Court [C.C.], May 28, 2009, Decision T-388/09, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), sec. 5.1, *available at*: http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm (accessed July 28, 2014) (referencing Decision T-209/08 [2008]).

35 *Janaway v. Salford Area Health Auth.*, [1988] 3 All ER 1079 (H.L.). *See also* United States cases that reached the same conclusion on similar facts: *Spellacy v. Tri-Cnty*. Hosp., 395 A.2d. 998, 998 (Pa. Super. Ct. 1978); *Erzinger v. Regents of the Univ. of California*, 187 Cal. Rptr. 164, 167-68 (Cal. Ct. App. 1982).

36 Abortion Act, 1967, c. 87, § 4(1).

37 *Doogan and Wood v. NHS Greater Glasgow & Other* [2013] CSIH 36, P876/11. The citing of *Doogan and Wood* case is not intended to signify agreement with the actual decision. Rather, it is an endorsement of the principle of a case-by-case approach to assess whether the healthcare professional claiming conscientious objection had direct involvement in the termination of pregnancy. The actual holding in the *Doogan and Wood* case (para. 38) that conscientious objection should be given a "*wide interpretation*" and "*should extend to any involvement in the process of treatment, the object of which is to terminate a pregnancy*," I would argue, detracts from the principle of direct involvement enunciated in the *Janaway* case as to swing the pendulum unduly in favor of the conscientious objector.

38 Charles Ngwena, "Conscientious Objection and Legal Abortion in South Africa: Delineating the Parameters," *Journal for Juridical Science* 28(1) (2003): 15.

39 Martha I. Morgan "Emancipatory Equality: Gender Jurisprudence under the Colombian Constitution," in *The Gender of Constitutional Jurisprudence*, Beverley Baines and Ruth Rubio-Marin eds. (Cambridge: Cambridge University Press, 2005), 75.

40 *See supra* note 34, at sec. 5.2.

41 *Ibid.*

42 *Ibid.*

43 *Ibid*., at sec. 5.1.

44 *Ibid*.

45 Rebecca J. Cook, Bernard M. Dickens, and Mahmoud Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law* (Oxford: Oxford University Press, 2003), 141.

46 U.N. Committee on Elimination of Discrimination Against Women, General Recommendation 24 (article 12 of the Convention [Women and Health]), 20th Sess., para. 11, A54/38/Rev. 1., chap 1 (Feb. 5, 1999).

47 *Ibid*., at para. 11.

48 Rebecca J. Cook and Susannah Howard, "Accommodating Women's Differences Under the Women's Anti-Discrimination Convention," *Emory Law Journal* 56(4) (2007): 1039. 170.

[49] Catherine Albertyn, "Substantive Equality and Transformation in South Africa," *South African Journal on Human Rights* 23, pt. 2 (2007): 253.

[50] *See supra* note 48, at p. 1.040-41.

[51] U.N. Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights), 22d Sess., para. 12(b), U.N. Doc. E/CN.12/2000/4 (2000).

[52] *Ibid*.

[53] In Slovakia and Poland, for example. *See* Christina Zampas and Ximena Andión-Ibañez, "Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice," *European Journal of Health Law* 19(3) (2012): 249-50.

[54] Constitutional Court [CC], Decision No. 2001-446DC, June 27, 2001, Rec. 74, paras. 11-17 (Fr.), *available at* http://www.conseil-constitutionnel.fr/conseilconstitutionnel/root/bank_mm/anglais/a2001446dc.pdf (accessed on April 11, 2014); Zampas and Andión-Ibañez, "Conscientious Objection to Sexual and Reproductive Health Services," 249-50.

[55] *See supra* note 34, at sec. 5.1(1).

[56] *See supra* note 33, at p. 76-77.

[57] *Ibid*., at para 15.

[58] Protocol to the African Charter on the Establishment of an African Court on Human and Peoples' Rights, June 10, 1998, OAU Doc. OAU/LEG/MIN/AFCH/PROT(I) Rev.2 (entered into force June 25, 2004). Once operational, a new court—the African Court of Justice and Human Rights—will supplant the African Court as part of a merger between the African Court and the Court of Justice of the African Union African Union, "Protocol on the Statute of the African Court of Justice and Human Rights Merging the African Court on Human and People's Rights," art. 2, July 1, 2008, http://-www.au.int/en/sites/default/files/PROTOCOL_STATUTE_AFRICAN_COURT_JUSTICE_AND_HUMAN_RIGHTS.pdf.

[59] Rebecca J. Cook and Bernard M. Dickens, "Reducing Stigma in Reproductive Health," *International Journal of Gynecology and Obstetrics* 125(1) (2014): 89.

[60] *See supra* note 48, at p. 1.040.

VI

CONSCIENTIOUS OBJECTION IN COLOMBIA: A THREAT TO MARRIAGE EQUALITY

MANUEL YASSER PÁEZ

MANUEL YASSER PÁEZ

Attorney and Master in Public Law from the Externado University of Colombia, he holds a degree in Right to Equality and Non-Discrimination from the National Council for the Prevention of Discrimination (CONAPRED) and the Institute for Legal Research of the National Autonomous University of Mexico (Mexico City). Manuel Yasser Páez is a Research Professor at the Externado University of Colombia, where he has taught several undergraduate and graduate level courses, including a class on Emerging Human Rights. He currently serves as Assistant Magistrate of the Superior Council of the Judiciary of Colombia. He worked as an attorney for the non-governmental organization Colombia Diversa in 2012 and 2013, with a focus on same-sex marriage. Colombia Diversa, founded in 2004, is Colombia's leading LGBT rights organization and is currently leading the movement for marriage equality in the country.

As of this writing, marriage equality does not yet exist in Colombia. In strict terms, what exists is the possibility for notaries, and particularly civil judges, to decide to formalize the family bond formed by two people of the same sex through the legal institution of civil marriage under domestic law in effect since 1876.

This may appear to be a subtle distinction, but it has broad implications. It creates a unique circumstance in which same-sex couples face a total lack of legal assurances and find themselves at the whim of the textual construction or legal interpretation of each notary or judge authorized to officiate marriages in the country. As a result, it is a manifest disregard for the principle of equality and the fundamental rights of lesbian, gay, bisexual, and transgender (LGBT) persons, resulting, in large measure, from the confusing language of decision C-577/11, issued by the Constitutional Court in 2011.

To understand this unique situation, we will briefly detail the content and the rulings adopted in this decision. After reviewing the legal causes behind the selective and arbitrary application of the law that same-sex couples face regarding civil marriage, we will examine how certain local judicial officers' use of conscientious objection has become a threat to equal access to marriage, and how the standard created by decision T-388/09[1] regarding circumstances in which public servants may not use conscientious objection has helped to counter this effect.

Decision C-577/11 was met with consternation on the part of both supporters and opponents of same-sex marriage. Its ambivalent legal effects, complex argumentation, and confusing language (particularly toward the end) were seen by many as a *partial victory* in the march toward full equality for people of diverse sexual orientations or gender identities.

This was because, although the decision did explicitly include language to i) recognize same-sex couples' status as *families* under the 1991 Colombian Constitution, ii) affirm their right to enjoy the same prerogatives provided under local laws to families made up of persons of opposite sexes, and iii) recognize the current lack of legal protections for same-sex couples, it failed to lay out the logical legal consequences of this recognition, nor did it amend the language of article 113 of the Civil Code, which pro-

vides that "*marriage is a solemn contract by which a man and a woman*" come together in order to live together, among other things.

Nonetheless, in the body of the ruling as well as in its final orders, decision C-577/11 provided the conceptual tools needed for Colombian notaries and judges to choose to officiate civil marriages for same-sex couples. In fact, although it established that it was up to the Congress of Colombia to pass legislation to define the kind and name of any contract for LGBT couples to formalize their families,[2] it also noted that the degree of protection offered by such a contract should be greater than that of a civil union,[3] and not lesser than that of civil marriage. It set a reasonable time limit for the passage of such legislation (two years, which were up on June 20, 2013), and decreed that once this period was up, same-sex couples could "*go to a competent notary or judge to execute and formalize their contractual bond*."[4]

On this last point, the Court added that its decision was compulsory, so the affected public servants would be prohibited from refraining or refusing to grant same-sex couples their right to execute a contractual bond with the same effects as heterosexual marriage, "*to the extent that they may be attributed to this kind of union*."[5]

This legal language, arcane to say the least, led to multiple interpretations and regulatory uncertainty, which set off a broad national debate involving many government and social sectors, both for and against marriage equality.

On the eve of the deadline set by the Constitutional Court for the passage of a law defining a contract for LGBT couples, high government officials' positions became manifest, as they rejected the possibility of allowing them access to the institution of marriage.

Some quarters began to suggest, encourage, and even authorize (without legal basis) the use of conscientious objection to refuse to officiate same-sex marriages after June 20, 2013.

The Inspector General for Colombia was perhaps the greatest proponent of this approach. For instance, in statements to the press in May, he asserted that judges and notaries had the right to claim conscientious objection, and called for this right to be respected.[6] Furthermore, he noted that this right could only be limited by statute (such a statute does not exist in Colombia to date), and that it could not be inferred from the text of decision C-577/11 that this right does not apply to such cases.[7]

Then, on June 7, 2013, the Inspector General issued Circular No. 013 of 2013,[8] in which he ordered the employees of his agency in charge of managing other public servants to "*ensure that the fundamental right of freedom of conscience of judges and notaries is respected, as well as that of any other public or private employee who performs public duties related to the fifth resolution of decision C-577 of 2011*,"[9] and encouraged judges and notaries throughout the country to exercise this right when they feel that officiating marriages between persons of the same sex goes against their conscience.

In support of the order and the argument that public servants are entitled to invoke this right, the Inspector General noted the following: 1) article 18 of the Political Constitution recognizes the right of conscientious objection for all, making no distinction between private parties and state agents, and this interpretation, according to him, has been supported by the Constitutional Court;[10] 2) freedom of conscience includes the freedom to "*refuse to comply with a legal requirement*"; 3) conscientious objection is an immediately applicable right under article 85 of the Constitution, and it therefore may be claimed through a *tutela* action without need for existing regulation; and finally, along the same lines, 4) no administrative or legal authority is competent to determine under what facts conscientious objection is appropriate, because only the Congress of Colombia is empowered, by constitutional mandate, to make this determination.

The effects of Circular No. 013 on sectors opposed to marriage equality were huge. Once it was issued, the Inspector General and other government officials, as well as social organizations such as the Catholic Church, began to incorporate the right to object to the gay marriages in their public discourse.[11] For instance, Monsignor Rubén Darío Salazar, President of the Episcopal Conference of the Catholic Church, encouraged notaries to use conscientious objection in order "*not to formalize the contractual bond to which*

same-sex couples are now entitled."[12] He claimed that "*conscientious objection is a right granted by the Constitution*," and that all notaries may therefore exercise it. He also called on the Superintendent of Notaries and Registries not to require notaries to "*do something against their conscience*."[13]

Nonetheless, other high-level government officials categorically rejected the notion of using conscientious objection as a tool to deny rights to the LGBT population. Among these were the Vice-President of Colombia,[14] the President of the Corporation of Judges and Magistrates,[15] the Superintendent of Notaries and Registries,[16] and the President of the Collegiate Union of Colombian Notaries.[17] It should be noted that the latter two have always argued that decision C-577/11 did not authorize marriage per se, but only the possibility of executing a contract for couples that would be *different* from marriage, specifically designed for same-sex couples. Against this polarized backdrop, notaries and judges set about to comply with the June 20, 2013 decision, most of them uncertain what the Constitutional Court meant with its 2011 ruling, and unclear on what were their obligations to same-sex couples.

In an effort to help protect the rights of LGBT persons, the advocacy organization Colombia Diversa launched an awareness and legal training campaign, seeking to facilitate access to the precedents set by the Constitutional Court on issues related to the protection of sexual minorities and clarify the limits on conscientious objection in the Colombian legal system. With this goal, among others, the organization distributed relevant information to competent notaries and judges in seven major cities throughout the country and participated in conferences for not only the public but for judicial officers notaries in particular, emphasizing that conscientious objection cannot be claimed when one is "*acting in the capacity of a public authority*." This effort was certainly aided by the fact that the Constitutional Court had already set this standard for voluntary termination of pregnancy cases in decision T-388 of 2009, considering that this ruling lent credence to the argument that judges and notaries could not claim conscientious objection here either.

The months following June 2013 saw the first actual applications for marriage filed by same-sex couples before judges and notaries. It has been a mixed bag, but from the start, notaries nationwide adhered to a union agreement to refuse to authorize marriage contracts in such cases.

Colombian judges, on the other hand, have used the functional autonomy granted to them under the Constitution to issue every imaginable sort of decision. Although there have not yet been reports of judges who have refused to rule on petitions filed by same-sex couples on the basis of conscientious objection,[18] each judge has had to face the challenge of interpreting and deciphering the legal effects of decision C-577/11 to apply it to each specific case. This will continue to be the case at least until the Constitutional Court rules on the issue again.

All this has led to a situation in which a few couples have obtained decisions ruling them formally married under civil laws governing marriage, but the hopes of the vast majority of same-sex couples seeking access to the institution of marriage have been met with disappointment, and still others have agreed to execute odd, one-off contracts that have no name, drafted by the judicial officer hearing the matter according to his or her understanding of the Constitutional Court's decision.

The way conscientious objection was framed in terms of same-sex marriage, particularly after the Inspector General's statements, was one of the factors that influenced the positions adopted by judges and notaries regarding marriage equality. Its deterrent effect and its construction as a means of disregarding the law, though impossible to quantify, were felt nationwide by those who had advocated for marriage equality. Notaries who had announced to the media that they would officiate gay marriages refused to do so once their union encouraged them to disobey the Constitutional Court's ruling, on the grounds of conscience objection, among other reasons. Employees of several notary offices in Bogotá reportedly threatened to claim conscientious objection if they were required to execute these contracts. Many judges, on their part, have cited legal reasons to refuse to marry same-sex couples in a clear attempt to frame in legal terms their moral and subjective objections to marriage equality. Nonetheless, it appears that the clear constitutional precedents set by the Constitutional Court of Colombia in rulings such as decision T-388 of 2009, which denied the right of conscientious objection to state officials, may have been a factor in the decision of some government entities that, unlike the Office of the Inspector General, opted not to use conscientious objection as another tool for discrimination and social exclusion of LGBT persons.

NOTES

[1] Constitutional Court [C.C.] May 28, 2010, Decision T-388/09, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), ¶ 53, *available at*: http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm (accessed June 17, 2014).

[2] Constitutional Court [C.C.] July 26, 2011, Decision C-557/11, *Gaceta de la Corte Constitucional* [G.C.C.] (Colom.), Sec. 4, *available at*: www.corteconstitucional.gov.co/relatoria/2011/c-577-11.htm (accessed March 31, 2014).

[3] In Colombia, since the Constitutional Court issued decision C-075 of 2007, same-sex couples in Colombia have had access to civil unions (*uniones maritales de hecho*), a concept established in 1990 to protect heterosexual couples who opt to form a family without executing a marriage contract.

[4] *See supra* note 2, Resolution 5.

[5] *Ibid.,* section 7.

[6] "Ordóñez dice que notarios pueden objetar conciencia en matrimonios gay," *Diario ADN*, May 10, 2013, *available at*: http://diarioadn.co/actualidad/colombia/objeci%C3%B3n-de-conciencia-en-matrimonios-gay-1.59478 (accessed March 31, 2014).

[7] *Ibid.*

[8] Office of the Inspector General, *Circular Número 013 de 2013: Directrices, Recomendaciones y Peticiones en relación con el cumplimiento del resuelve quinto de la Sentencia C-577 de 2011* (Bogotá, Colombia, June 7, 2013, *available at*: http://www.procuraduria.gov.co/portal/media/file/portal_doc_interes//121_Circular%20013%20de%202013%20PGN-%20SENTENCIA%20C577%2020111.pdf [accessed March 31, 2014]).

[9] The *public duties* referred to here are same-sex marriage contracts.

[10] The language of the Circular reads as follows: "*this fundamental right* [conscientious objection] *is guaranteed under article 18 of the Constitution, using the indeterminate pronoun 'nobody,' meaning that no person's freedom of conscience, including that of public servants (such as members of public agencies, as provided under article 108 of the Constitution and in Decisions C-859 of 2006, Magistrate Jaime Córdoba Triviño; and C-036 of 2007, Magistrate Clara Inés Vargas Hernández; or other public officials such as the Inspector General of the Nation, as recognized under Order 327 of 2010, Magistrate Humberto Antonio Sierra Porto), may be violated*."

[11] *See* for example statements by the Delegate for Children and Adolescents for the Office of the Inspector General, Ilva Miryam Hoyos. *See* "Jueces y notarios podrán objetar conciencia en matrimonio igualitario," *Emisora Last fm*, June

20, 2013, *available at*: www.lafm.com.co/noticias/juecez-y-notarios-si-podran-140015#ixzz2xfBO5f8Y (accessed March 31, 2014). *See also* "Ordóñez pide a notarios ejercer objeción de conciencia," *Revista Semana*, June 19, 2013, *available at*: www.semana.com/nacion/articulo/ordonez-pide-notarios-ejercer-objecion-conciencia/348192-3 (accessed March 31, 2014).

12 "Comunidad LGBTI no tiene derecho ni al matrimonio ni a la familia: Iglesia," *Diario El Espectador*, June 18,2013, *available at*: www.elespectador.com/noticias/actualidad/comunidad-lgbti-no-tiene-derecho-ni-al-matrimonio-ni-fa-articulo-428567 (accessed March 31, 2014).

13 "Notarios deben alegar objeción de conciencia: Episcopado," *Diario Vanguardia Liberal*, June 18, 2013, *available at*: www.vanguardia.com/actualidad/colombia/212897-notarios-deben-alegar-objecion-de-conciencia-episcopado (accessed March 31, 2014).

14 "No debe acudirse a objeción de conciencia para negar uniones LGBTI: Angelino Garzón," *Diario El Espectador*, June 19, 2013, *available at*: www.elespectador.com/noticias/politica/no-debe-acudirse-objecion-de-conciencia-negar-uniones-l-articulo-428738 (accessed March 31, 2014).

15 "Jueces no pueden argumentar objeción de conciencia para negar matrimonio homosexual," *Diario El Espectador*, June 19, 2013, *available at*: www.elespectador.com/noticias/judicial/jueces-no-pueden-argumentar-objecion-de-conciencia-nega-articulo-428786 (accessed March 31, 2014).

16 "Notarios no podrán argumentar objeción de conciencia en uniones homosexuales," *Diario El Espectador*, April 24, 2013, *available at*: www.elespectador.com/noticias/politica/articulo-418032-notarios-no-podran-argumentar-objecion-de-conciencia-uniones-hom (accessed March 31, 2014).

17 "En matrimonios gay no cabe objeción de conciencia: Notarios," *Emisora RCN*, June 14, 2013, *available at*: www.-rcnradio.com/noticias/en-matrimonios-de-parejas-del-mismo-sexo-no-cabe-objecion-de-conciencia-notarios-71867#-ixzz2xfIyhE8f (accessed March 31, 2014).

18 "Procurador persiguió sistemáticamente a parejas del mismo sexo durante el 2013," Colombia Diversa, *available at*: http://www.matrimonioigualitario.org/2013/12/procurador-persiguio-sistematicamente_4742.html (accessed June 19, 2014).

VII

CONCLUSIONS

The use of conscientious objection to refuse the provision reproductive healthcare is widespread,[1] and many countries across the globe have been struggling to define the limits to conscientious objection to abortion. Colombia's Constitutional Court has come the closest to providing a practical solution to the problem. The contributors to the publication have shown that decision T-388/09 is already shaping the debate around conscientious objection and abortion. Given the significance of the decision, we felt it necessary to create the space where not only its importance would be stressed, but also where experiences could be shared. It is through this exchange that we could foster a conversation that would at least begin to identify gaps and give way to solutions. To us, this was an opportunity to bring together experts from across the world, with different backgrounds and experiences, who could tell the story of their region and, at the same time, be part of a single conversation about expanding the impact of the decision to places beyond Colombia. As Dickens indicated, the Constitutional Court has not only "*clarified the law*" on conscientious objection and abortion in Colombia, but it has also "*transcend[ed] that single country and its particular constitutional provisions*."

The Colombian decision is helping the global debate on conscientious objection and abortion evolve, offering clearer and more convincing arguments on who can invoke the right to conscientious objection to abortion. For example, in the United States, hospitals and, in some states, healthcare companies have been recognized as rightful holders of the right to conscientious objection.[2] Most recently, as discussed by Melling and Lee, the U.S. Supreme Court recognized in *Burwell v. Hobby Lobby* the right of for-profit corporations to use religious liberty claims to bypass federal law requiring that insurance plans cover contraception.[3] On the other hand, countries like Norway[4] and Zambia[5] have passed laws limiting this right to only medical doctors and nurses who directly participate in the abortion procedure. In certain countries, such as Sweden, no one can conscientiously object to facilitate or provide the abortion.[6] At the other end of the spectrum, there are countries that have not developed any standards.[7] It is for this reason that the conclusiveness and clarity of the Colombian decision has been well received by those seeking guidance on the issue.

Now that the Colombian Court has offered clearer guidance on the issue, we reflect on the way forward. We fully understand that there is a need for these standards to be implemented and enforced in many countries

that need them. And as Barroso indicated, we know that there are still certain aspects of the debate that require further elaboration and clarification, such as what constitutes "*conscience*" and how we can better apply the notion of conscience in the provision of abortion services. But how can all this be accomplished? Cavallo and Ramón Michel present a set of proposals geared at fostering greater dialogue and understanding among actors. Essentially, there is a need to elevate the abortion discussion to a public and (we would add) global debate, where issues like conscientious objection, moral pluralism, and the criminalization of abortion can be addressed openly and where socially conscious solutions can be attained.

To respond to this need, the domestic needs to be translated to the international and then back to the domestic—a process that we hope to fuel with this publication. Ultimately, it is about learning across regions and potentially finding solutions in a more coordinated and coherent manner. While countries and regions may differ historically, politically, and economically, the issue of unsafe abortion (along with its causes) is nevertheless a shared and global problem—another point that is illustrated by this publication. In the United States, the use of conscientious objection has not been limited to abortion and can extend to the provision of contraception (as seen in *Hobby Lobby*) and treatments expenditures.[8] Meanwhile, the Colombian Constitutional Court and the Maputo Protocol have recognized the right to safe abortion.[9] Evidently, the North has much to learn from the South—Melling and Lee made this point clearly.

Decision T-388/09 also creates South-South learning opportunities. In the case of Africa, Ngwena has shown that the region's post-independence era has witnessed a changing legal landscape with the advent of "*constitutionalization*" of human rights. Africa has undergone abortion law reforms at the domestic as well as regional levels, and these developments call for clarification and (equally significant) implementation of individual rights and professional responsibilities concerning the regulation of abortion in Africa in a manner that could not have been remotely conceived at the time that abortion laws first made their entry into the region. Considering the lack of precedents on the right of conscientious objection and the existing "*obligations to interpret and apply laws that recognize the right to abortion in certain circumstances*," Ngwena views the Colombian decision as "*potentially instructive for African domestic courts and regional treaty bodies*."

1. A RIGHT TO HEALTH DISCOURSE

There is also another important characteristic to highlight about decision T-388/09 that can significantly influence how the issue of conscientious objection and abortion can be effectively addressed. With new avenues for dialogue being created around the issue of conscientious objection, women's health-centered human rights are likely to take center stage, as in the case of decision T-388/09. First, Ngwena pointed out that the decision is an important contribution to abortion jurisprudence that situates the right to conscientious objection within a framework grounded not just in constitutionalism, but also in human rights. Second, in defining conscientious objection, Cavallo and Ramón Michel distinctly pointed out that the legality of conscientiously objecting to perform an act directly depends on the harm that others will incur from this abstention. The Court held that the right to conscientious objection must be balanced with the rights to life, sexual and reproductive health, personal integrity and human dignity of the woman—hence the concern for ensuring that another healthcare professional is available to perform the service.[10]

The Constitutional Court's explicit recognition of women's fundamental right to health is important because it represents an approach that could yield practical results in guaranteeing safe abortions to women. An emphasis on the right to health may constitute a departure from the traditional approach of focusing on the woman's rights to self-determination and privacy, but framing it around the right to health presents it as a public health issue—language that governments may be more willing to embrace and more comfortable in using to justify setting limits to conscientious objection in the context of abortion. Much like conscientious objection has been innovatively re-conceptualized in Spain to provide healthcare to undocumented immigrants, by altering the discourse to embrace a right to health-based approach, advocates might come across doors not open to them before. For example, some have identified an opportunity in bringing greater awareness about the use of positive claims of conscience by healthcare providers who perform abortions "*for reasons of conscience*" and not for political beliefs.[11] This would help break down the favorable association that has been created overtime between conscience and opposition to provide abortion services.

Furthermore, the impact that the use of conscientious objection to abortion can have on women's health has also been recognized by the international human rights community. A number of international human rights bodies have supported the development of standards on the use of conscientious objection to abortion. In his 2011 report, the U.N. Special Rapporteur on the Right to the Highest Attainable Standard of Health (Special Rapporteur on the right to health) emphasized the link between restrictive abortion laws and poor health outcomes for women and explained that such laws "*may amount to violations of the obligations of states to respect, protect and fulfil the right to health*."[12] Recognizing that states bear the obligation to remove all barriers that interfere with the woman's ability to access safe and legal abortion, he ultimately called on states to "*[e]nsure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider*."[13]

Human rights treaty-monitoring bodies have also expressed concern over the negative impact of conscientious objection to abortion on women's health. In 2010, the Human Rights Committee (the body in charge of monitoring compliance with the International Covenant on Civil and Political Rights [ICCPR]) voiced concern over Colombian healthcare providers refusal to perform legal abortions despite the constitutional decision C-355/2006, which (as explained in previous sections) decriminalized abortion under specific circumstances.[14] Accordingly, the Committee observed that the state "*must ensure that health providers and medical professionals act in conformity with the ruling of the Court and do not refuse to perform legal abortions*." Likewise, the Committee responsible for overseeing compliance with the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (CEDAW Committee) has stressed that "*[i]t is discriminatory […] to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers*."[15] The CEDAW Committee has also criticized Mexico for the number of women denied access to legal abortion and that have been reported by heath care providers to judicial authorities.[16] The Committee underscored the duty of the state to ensure that healthcare providers understand their responsibilities.[17]

The Committee on Economic, Social and Cultural Rights (CESCR) similarly expressed concern over the number of women in Poland who are refused abortions based on healthcare professionals' conscientious objection claims and are forced to resort to clandestine procedures. The CESCR called on the government of Poland to "*take all effective measures to ensure that women enjoy their right to sexual and reproductive health, including by enforcing the legislation on abortion and implementing a mechanism of timely and systematic referral in the event of conscientious objection*."[18]

At the regional level, the European Committee of Social Rights recently ruled in the case *IPPF-EN v. Italy* and found Italy in violation of the right to health (article 11) and the principle of non-discrimination (article E) under the European Social Charter for failing to ensure the availability of non-objecting healthcare providers to perform abortions. The Committee concluded that while abortion may be covered under the public healthcare system (National Health Service), healthcare providers' refusal to provide the service created significant obstacles to actually accessing safe and legal abortion. The Committee explicitly noted that:

> "*As a result of the lack of non-objecting medical practitioners and other health personnel in a number of health facilities in Italy, women are forced in some cases to move from one hospital to another within the country or to travel abroad […]; in some cases, this is detrimental to the health of the women concerned. Therefore, the Committee holds that the women concerned are treated differently than other persons in the same situation with respect to access to healthcare, without justification*."

In *R.R. v. Poland*, the European Court of Human Rights stressed a state's obligation to manage conscience-based refusals to ensure patients access to services to which they are entitled under the law, including abortion.[19] It has produced jurisprudence[20] that seeks to define the relationship between article 9 (right to freedom of thought, conscience and religion) of the European Convention on Human Rights and conscientious objection to abortion. Fletcher indicates that both *P. and S. v. Poland* (2011) and *R.R. v. Poland* (2012) establish "*considerable limits*" on conscientious objection. She especially explains that

the European Court has not interpreted article 9 as prohibiting restrictions on the use of conscientious objection. Rather, according to Fletcher, only "*those beliefs to which the individual is personally and intimately committed and which put the individual in conflict with legal obligations*" are considered justified.

2. THE IMPORTANCE OF EFFECTIVE IMPLEMENTATION

These developments reveal that there are opportunities available to foster a health-centered debate. However, they also demonstrate that the debate on conscientious objection to abortion has extended and developed well beyond the domestic level and is clearly present in the international human rights space. Particularly in countries where international human rights instruments have been incorporated into domestic law, or even more, are held at the same legal authority as the country's Constitution, this type of observations made by international human rights bodies can help guide countries on determining the relationship between the right to conscientious objection and sexual and reproductive rights. With the Colombian decision being promoted outside of Colombia, the international human rights community can also encourage countries to develop more concrete standards and guidelines on when the right to conscientious objection may be invoked and by whom within the context of abortion. For example, integrating the decision's standards into the international human rights discourse could potentially strengthen advocacy efforts in countries where important cases like *Doogan and Wood v. Greater Glasgow and Clyde Health Board*[21] (2013) are pending. The critical step to translating this domestic decision into international human rights law is for these bodies to actively begin incorporating the decision's standards into their observations and recommendations and essentially serve as a source for the promulgation of progressive and sensible standards.

Nevertheless, echoing the CEDAW Committee's observations to Mexico mentioned above, effective implementation of advances made in the area of sexual and reproductive rights is required—without it, court rulings and legislation become meaningless. For example, considering the Colombian Court's holding that only individuals, and not institutions, are capable of invoking the right to conscientious objection, there is ample room for non-compliance with the decision unless the Colombian government takes the necessary steps to regulate relevant institutions.

With this in mind, we recall the multi-dimensional approach to implementation proposed by Cavallo and Ramón Michel, particularly the measures that the state can undertake and those that should be assumed within the health sector. They propose as one of the measures the decriminalization of abortion. This is essential as decriminalization promotes transparency on the issue and welcomes effective regulation that can have positive public health results, including the reduction in the country's maternal mortality. In fact, it has been observed that conscience-based refusal to abortion will have less of an impact on the population's health where abortion is safe and legal. Conversely, the detrimental effects on health at the population level are felt to a greater extent where abortion laws are more restrictive.[22] The decriminalization of abortion also removes the moral environment of fear, stigma and shame for healthcare providers where abortion is criminalized. In places with restrictive abortion laws, the role of healthcare providers shifts and is wrought with ambiguities (e.g., refuse to provide abortion as a right or provide healthcare as a duty)—they are ultimately forced to pass judgment on their patient, rather than listen to her as they normally would with any other patient.[23]

Cavallo and Ramón Michel make additional propositions that support a right to health-based argument that could help address the abuse of conscientious objection claims. They propose that the state actively incentivize healthcare professionals to perform legal abortions and undertake a mapping exercise of the issue to fully understand the factors that determine the availability of healthcare professionals for the provision of abortion services. It also should find ways of using already established institutional mechanisms intended for health policy coordination and development to allow better coordination among multiple government sectors in identifying problems and solutions. They also propose improving access to misoprostol and mifepristone, framing abortion as a healthcare service, and integrating it into the training of healthcare professional. And the creation of an information campaign to inform women about accessing information and legal abortion services are essential.[24] However, on this point we would add that a campaign to inform healthcare professionals about their rights and obligations with respect to abortion is likewise essential.

While state seeks to undertake these and other measures, the health sector bears similar responsibilities without which effective implementation would not be possible. A number of the proposals made by Cavallo

and Ramón Michel center around facilitating greater debate on the issue, especially in spaces that are seen as traditionally hostile to the idea of abortion. They particularly mention capacity-building activities on the legal and scientific aspects of the issue. They explain that the exchange of views leads to greater empathy, shared experiences, and identification of areas for collaboration. Equally, they express the importance of encouraging an exchange between healthcare professionals who are *friendly* to the provision of abortion services.

3. CONCLUDING WORDS

Ngwena reminded us that *unfettered* use of conscientious objection can lead to increased stigmatization of abortion, which, in turn, can further deter women from seeking abortion services within the formal health sector. In other words, where conscientious objection is not adequately restricted, women are compelled to seek unsafe abortion procedures. However, Ngwena also made clear that striking the balance between a healthcare provider's freedom of conscience and women's sexual and reproductive rights does not mean an absolute ban on the exercise of conscientious objection, but rather allowing the exercise of this right in a way that equally respects and protects the fundamental rights of women seeking abortion services. After all, as Fletcher points out, a healthcare provider should not be forced to engage in acts that violate her most intimate convictions. It is exactly this approach to finding a fair balance between this competing right that makes decision T-388/09 valuable to the debate and that can drive countries closer to addressing the problem effectively at home. The emphasis on ensuring the availability of a willing and available healthcare professional to perform the service is fundamental to the standards set by the decision. It represents the understanding that unsafe abortion can have detrimental effects on the health of women and girls and that the harm that can come to the woman from unsafe abortion can be easily prevented. With this publication, we hope that this socially conscious approach to addressing conscientious objection and abortion developed by the Colombian Constitutional Court will begin to reach the ears of decision makers, authorities in the health sector, and civil society across the globe.

NOTES

[1] Wendy Chavkina, Liddy Leitmana and Kate Polin, "Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences, and Policy Responses," *International Journal of Gynecology & Obstetrics* 123(3) (2013): 41-56. Anne O'Rourke, Lachlan de Crespigny and Amanda Pyman, "Abortion and Conscientious Objection: The New Battleground," *Monash University Law Review* 38(3) (2012): 87-119.

[2] *See* R. Alta Charo, "Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience," *American Constitution Society for Law and Policy* 7 (2007).

[3] *Burwell v. Hobby Lobby Stores, Inc.*, Nos. 13-354, 13-356, 2014 WL 2921709 (2014).

[4] An abortion performed after 12 weeks of pregnancy must be performed in a hospital; before that point in pregnancy, an abortion can be performed in other approved institutions. A legal abortion must be performed by a physician. Healthcare personnel who, on grounds of conscience, do not wish to assist with an abortion, must express this fact in writing, along with substantiating details, to the administrative director of the institution. The right to refuse in assisting in an abortion is only granted to personnel who perform or assist in the actual procedure and not to those providing services, care and treatment to the woman before or after the procedure. The right of healthcare personnel to refuse to assist in an abortion has not been a major problem in Norway. Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

[5] *See* Termination of Pregnancy Act of 1972 Cap. 304, Laws of Rep. of Zambia (1972).

[6] Sweden was the only country in Europe to object the resolution titled *The Right to Conscientious Objection in Lawful Medical Care Resolution* of the European Council, alleging that: "*Sweden is one of few countries who are central in the international work focusing on sexual and reproductive health and rights. The Swedish policy on Sexual and Reproductive Health and Rights remains stable. The standing committee notices that the issue of abortion is not covered by the EU treaty. The standing committee remain negative to the content of Resolution 1763 (2010) and consider the [Swedish] delegation to take more action to accomplish a change of this resolution*." *See* Eur. Par. Ass., *The Right to Conscientious Objection in Lawful Medical Care*, Res. 1763 (2010), *available at*: http://assembly.coe.int/ASP/XRef/X2H-DW-XSL.asp?fileid=17909&lang=EN.

[7] For example, Poland. The Human Rights Committee expressed "*deep concern about restrictive abortion laws in Poland, which may incite women to seek unsafe, illegal abortions, with attendant risks to their life and health. It is also con-*

cerned at the unavailability of abortion in practice even when the law permits it, for example in cases of pregnancy resulting from rape, and by the lack of information on the use of the conscientious objection clause by medical practitioners who refuse to carry out legal abortions." U.N., Human Rights Committee, Report on Human Rights Committee, 6th Sess., Supplement No. 40, para. 8, U.N. Doc. A/60/40 (vol. I) (November, 2005), http://ccprcentre.org/doc/ICCPR/AR/-A_61_40_vol.I_E.pdf (accessed July 29, 2014).

8 *See* Christina Zampas, "Legal and Ethical Standards for Protecting Women's Human Rights and the Practice of Conscientious Objection in Reproductive Healthcare Settings," *International Journal of Gynecology & Obstetrics* 123(3) 2013: S63-S65: "*The practice of conscientious objection by healthcare workers growing across the globe. It is most common in re-productive healthcare settings because of the religious or moral values placed on beliefs as to when life begins. It is often invoked in the context of abortion and contraceptive services, including the provision of information related to such services. In some cases, legislation protects pharmacists from tort liability when they refuse to sell products based on religious or ethical grounds. A law passed in Mississippi in 2004 is a good example of the expansive new breed of refusal clause. It allows almost anyone connected with the healthcare industry—from doctors, nurses and pharmacists to the clerical staff of hospitals, nursing homes and drug stores—to refuse to participate or assist in any type of healthcare service, including referral and counseling, without any tort liability or consequence*." *See supra* note 2, at p. 119-135.

9 Constitutional Court [C.C.] May 10, 2006, Decision C-355/06, Gaceta de la Corte Constitucional [G.C.C.] (Colom.), http://www.corteconstitucional.gov.co/relatoria/2012/t-355-12.htm (accessed July 28, 2014).

10 Constitutional Court [C.C.], May 28, 2009, Decision T-388/09, Gaceta de la Corte Constitucional [G.C.C.] n.p. (Colom.), sec. 4.2, *available at*: http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm (accessed July 28, 2014). "*[H]ealth care professionals can object to terminating a pregnancy for reasons of conscience if and only if there is a guarantee that the pregnant woman will have access to the procedure in conditions of quality and safety, that she will face no additional barriers that interfere with her ability to access necessary healthcare services and that her fundamental constitutional rights to life, sexual and reproductive health, personal integrity and human dignity will be respected*."

11 Lisa H. Harris, "Recognizing Conscience in Abortion Provision," *The New England Journal of Medicine* 367 (2012): 982. *See* Bernard M. Dickens and Rebecca J. Cook, "Conscientious Commitment to Women's Health," *Int. J. Gynecol. Obstet.* 113(2) (2011): 163-6.

12 U.N. General Assembly, *Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, para. 21, U.N. Doc. A/66/254 (August 3, 2011). *See Ibid.*, at ¶ 16.

13 *Ibid.*, at ¶ 16.

[14] ICCPR Committee, *Examen de los informes presentados por los Estados partes en virtud del artículo 40 del Pacto. Observaciones finales del Comité de Derechos Humanos*, para. 19, U.N. Doc. CCPR/C/COL/CO/6 (August 3, 2011).

[15] CEDAW Committee, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, para. 11., U.N. Doc. A/54/38/Rev.1 ¶ 31 (1999).

[16] CEDAW Committee, *Observaciones finales del Comité para la Eliminación de la Discriminación contra la Mujer: México*, para. 32, U.N. Doc. CEDAW/C/MEX/CO/7-8 (August 7, 2012).

[17] *Ibid.*, at ¶ 33.

[18] CESCR Committee, *Consideration of Reports Submitted by States Parties under Articles 16 and 17 of the Covenant, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Poland*, para. 28, UN Doc. E/C.12/POL/CO/5 (December 2, 2009).

19 *R.R. v. Poland*, No. 27617/04, Eur. Ct. H.R. (2011), para. 206, *available at*: http://hudoc.echr.coe.int/sites/eng-/pages/search.aspx?i=001-104911.

[20] *Ibid. See P. and S. v. Poland*, No. 57375/08, Eu. Ct. H.R. (2012), *available at*: http://hudoc.echr.coe.int/sites/fra/-pages/search.aspx?i=001-114098; *Pichon and Sajous v. France*, No. 49853/99, Eur. Ct. H.R. (2001), *available at*: http://hudoc.echr.coe.int/sites/eng/pages/search.aspx?i=001-22644.

[21] *Doogan and Wood v Greater Glasgow and Clyde Health Board* [2013] CSIH 36, *available at*: http://www.scotcourts.-gov.uk/opinions/2013CSIH36.html, para. 37.

[22] Chavkin, Leitman and Polin, "Conscientious Objection and Refusal to Provide Reproductive Healthcare: A White Paper Examining Prevalence, Health Consequences, and Policy Responses": 45.

[23] Debora Diniz, Alberto Madeiro and Cristião Rosas, "Conscientious Objection, Barriers, and Abortion in the Case of Rape: A Study Among Physicians in Brazil," *Reproductive Health Matters* 22(43) (2014): 146.

[24] Mercedes Cavallo and Agustina Ramón Michel, "Conscientious Objection to Legal Abortion (or the Reaction to the *Problem* of Legal Abortion)" *in this book*, 87-109.

You can find more information about the liberalization of abortion in Colombia
and our other projects on Women's Link Worldwide's web page:
www.womenslinkworldwide.org