

What International Human Rights Groups and Agreements, and Global Health Orgs, Say About “Conscientious Objection” in Healthcare

This document is a compilation of everything relevant to “conscientious objection” in reproductive healthcare, as contained in international human rights agreements, and guidelines/reports by global health and human rights groups and governing bodies that have weighed in on the topic. The excerpts are contextualized by the view that “CO” in healthcare is inappropriate, unworkable, and not a right.

Compiled by Joyce Arthur, Initiative for Reproductive Health Information (IRHI), joyce@joycearthur.com

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Definition of “Conscientious Objection” in Reproductive Healthcare: The refusal by a health care professional to provide a legal, patient-requested medical service or treatment for which they would normally be responsible, based on their objection to the treatment for personal or religious reasons.

Colour coding in this document:

Green – Quotes from the Uruguay report.

Purple – Excerpts from international agreements, and documents by health and human rights organizations or governing bodies.

Many international human rights agreements exist; most are not included here.¹ Some recognize the right to conscience as a basic individual right, but this does not equate to a right to “conscientious objection” (“CO”) in healthcare, as has been made clear by international human rights bodies and expert groups that have examined the issue. *“CO” in healthcare has never been designated as a right by any international human rights body.*

Military Service: The right to conscientious objection to military service is based on article 18 of the International Covenant on Civil and Political Rights, which guarantees the right to freedom of thought, conscience and religion or belief. The Covenant does not explicitly refer to a right to conscientious objection to military service. This [specific right has been derived from article 18](#), as per general comment No. 22 (1993) by the Human Rights Committee.

Uruguay Report: “Unconscionable – When Providers Deny Abortion Care”

The “Uruguay Report”: https://issuu.com/mujerysaludenuruguay/docs/iwhc_co_report-web_single_pg

This report summarizes the proceedings from a meeting of 45 participants from 22 countries, that took place in Montevideo Uruguay in August 2017, organized by International Women’s Health Coalition and Women and Health in Uruguay (Mujer y Salud en Uruguay, MYSU).

Participants discussed the consequences of the refusal of care by health care providers claiming a moral or religious objection, possible legal and policy responses to arrest this trend, and the need to reframe the way so-called “conscientious objection” is understood in the context of healthcare:

Most convening participants agreed that health care policies should not allow for the refusal to provide services based on conscience claims. The participants resoundingly agreed that health care providers and women’s rights advocates must not cede the term “conscience” to those who misapply it to deny others health care, which should more appropriately be called “refusal to provide services” or “denial of services based on conscience claims.”

Pg 14-20: Summary of international groups, rulings, and laws around “CO”:

¹ This Wiki page lists several dozen human rights agreements:
https://en.wikipedia.org/wiki/International_human_rights_instruments

Participants at the convening on “conscientious objection” underscored that international human rights standards to date do not require states to guarantee a right to “conscientious objection” in the provision of health care services. On the contrary, human rights treaty monitoring bodies have called for limitations on the exercise of conscience claims, when states allow for such claims, in order to ensure that health care providers do not hinder access to reproductive health services and thus infringe on the rights of patients. They call out states’ insufficient regulation of the use of “conscientious objection,” and direct states to take steps to guarantee access to services. They also affirm that claims of “conscientious objection” cannot be exercised by institutions.

The rest of this document often quotes from the Uruguay report. (The report’s reference numbers are provided, but [go to the source](#) to access the citation itself.)

National Laws

This document does not cover national laws at the country level because they are often politically motivated. Countries that restrict abortion are in effect imposing societal “CO” by law. Countries that allow abortion on request often have a law or policy allowing “CO” against abortion or other healthcare, but in a way that may violate international human rights codes or agreements (such as in the [United States](#)). Where limits on “CO” are imposed to protect access to healthcare, such as requiring referrals or emergency care, they are virtually never enforced.

“CO” does not become a right just because some countries claim it is, or allow it by law or policy.

From the Uruguay report:

At the national level, laws, policies, and norms vary from country to country, with diverse implications for implementing human rights protections. Most countries do not tolerate health care providers refusing patients for personal reasons and sanction such behavior as discriminatory. [e.g., *denying care to ethnic minorities, LGBT people, etc.*] Currently, however, at least 70 jurisdictions allow health care providers to refuse treating a patient in the context of terminating an unwanted pregnancy, invoking “conscientious objection,” according to preliminary data from the newly launched Global Abortion Policies Database. 52 The extent to which protections for conscience claims are addressed in the law and exercised in practice varies by context. In countries that prohibit or highly restrict abortion, providers do not use claims of “conscientious objection,” because abortion is not permissible or accessible.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

An international bill of rights for women adopted by the United Nations General Assembly in 1979.

CEDAW does not mention conscience specifically, but says the refusal to provide legal reproductive health services for women is discriminatory and that “measures should be introduced to ensure that women are referred to alternative health providers”. There are many clauses against discrimination

against women, including in relation to reproductive rights and health – in particular: “rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”

General info: <http://www.un.org/womenwatch/daw/cedaw/>

Text of bill of rights: <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>

General recommendation No. 24: Article 12 of the Convention (women and health) (1999):
<https://www.escr-net.org/node/387809>

Article 1: For the purposes of the present Convention, the term "discrimination against women" shall mean any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

Article 2: States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women.

[list of actions to take omitted]

Article 12:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 12(1): 11. 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 introduced to ensure that women are referred to alternative health providers.

Article 16: 1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: ... (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

From the Uruguay report:

As far back as 1999, the Committee on the Elimination of all Forms of Discrimination Against Women, which monitors compliance with the CEDAW, issued general recommendation number 24, article 12 on women and health, which clarifies that it is discriminatory for states to refuse to provide certain

reproductive health care services for women. It also says that where providers are permitted to refuse to provide services, the state must take steps to guarantee access to services. 26

International Covenant on Civil and Political Rights (ICCPR)

A multilateral treaty adopted by the UN General Assembly on 16 December 1966. Includes the right to life, freedom of religion, freedom of speech, freedom of assembly, electoral rights and rights to due process and a fair trial.

<https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>

The Covenant recognizes the general right to conscience, but freedom to manifest beliefs can be limited to protect the rights of others. There is no recognition of “CO.”

Article 18

1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.
2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.
3. 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.
4. The States Parties to the present Covenant undertake to have respect for the liberty of parents and, when applicable, legal guardians to ensure the religious and moral education of their children in conformity with their own convictions.

Article 26: All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

From the Uruguay report:

The Human Rights Committee is the body that monitors state compliance with the International Covenant on Civil and Political Rights (ICCPR). The Human Rights Committee has issued numerous comments to national governments, admonishing them to take steps to ensure providers do not hinder women's access to abortion services by using a conscience or religious argument. For example, after reviewing Italy's compliance with the rights guaranteed in the ICCPR in 2017, the Human Rights Committee expressed “concern about the reported difficulty in accessing abortion owing to the high number of physicians who refuse to perform abortion for reasons of conscience and the distribution of such physicians across the country. It is also concerned that this results in a significant number of clandestine abortions being carried out.” It set forth recommendations for the state to take “measures

necessary to guarantee unimpeded and timely access to legal abortion services in its territory, including by establishing an effective referral system for women seeking such services.” The observation is significant for its articulation of the use of “conscientious objection” as a barrier to access to services women are entitled to receive.²⁴

General Comment #36 on Article 6

Human Rights Committee’s General Comment No. 36 (2018) on article 6 of the International Covenant on Civil and Political Rights, on the right to life.

Article 6 recognizes and protects the right to life of all human beings. The language of Comment #36 affirms that abortion is a human right, that preventable maternal deaths are a violation of the right to life, and that the right to life begins at birth. Further, states must remove barriers to abortion access, including those caused by the exercise of conscientious objection by individual medical providers.

8. Although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy. States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, and where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable. [8]

In addition, States parties may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, and they should revise their abortion laws accordingly. [9] For example, they should not take measures such as criminalizing pregnancies by unmarried women or apply criminal sanctions against women and girls undergoing abortion [10] or against medical service providers assisting them in doing so, since taking such measures compel women and girls to resort to unsafe abortion. States parties should not introduce new barriers and should remove existing barriers [11] that deny effective access by women and girls to safe and legal abortion [12], including barriers caused as a result of the exercise of conscientious objection by individual medical providers. [13]

States parties should also effectively protect the lives of women and girls against the mental and physical health risks associated with unsafe abortions. In particular, they should ensure access for women and men, and, especially, girls and boys, [14] to quality and evidence-based information and education about sexual and reproductive health [15] and to a wide range of affordable contraceptive methods, [16] and prevent the stigmatization of women and girls seeking abortion.[17] States parties should ensure the availability of, and effective access to, quality prenatal and post-abortion health care for women and girls, [18] in all circumstances, and on a confidential basis. [19]

International Covenant on Economic, Social and Cultural Rights (ICESCR)

A multilateral treaty adopted by the UN General Assembly in 1966. It commits its parties to work toward the granting of economic, social, and cultural rights, including labour rights and the right to health, the right to education, and the right to an adequate standard of living.

United Nations, OHCHR (Office of High Commissioner of Human Rights):

<https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx>

The covenant has nothing about conscience but has two anti-discrimination clauses that would mitigate against “CO”.

Article 2: (2) The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

Article 3: The States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant.

General Comment #22 on Article 12

General Comment No. 22 (2016) on the Right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)

Author: Committee on Economic, Social and Cultural Rights (ESCR):

<https://www.escr-net.org/resources/general-comment-no-22-2016-right-sexual-and-reproductive-health>

From the Uruguay report:

The Committee on Economic, Social and Cultural Rights, which monitors the implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR), issued an important general comment in 2016 recommending that all countries must establish norms to guarantee access to sexual and reproductive health care services. This comment elaborates on a recommendation issued in 2000, declaring that states have the obligation to respect, protect, and fulfill the right to health. The obligation to protect the right to health requires the state to take measures to prevent private actors from imposing barriers to services, which include conscience claims to refuse to provide abortion. 25.

The ESCR Committee does not recognize “CO” as a right and in fact refers to it as an “ideologically-based policy or practice” that must not be a barrier to health services. Where the practice is allowed, the Committee says that states must regulate it to ensure access to healthcare.

14. Unavailability of goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services; an

adequate number of health care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach.[18]

43. States must prohibit and prevent private actors from imposing practical or procedural barriers to health services, such as physical obstruction from facilities, dissemination of misinformation, informal fees and third-party authorization requirements. Where health care providers are allowed to invoke conscientious objection, States must appropriately regulate this practice to ensure that it does not inhibit anyone's access to sexual and reproductive health care, including by requiring referrals to an accessible provider capable of and willing to provide the services being sought, and the performance of services in urgent or emergency situations.[38]

United Nations (other)

Nothing else from the UN provides for the right to "CO" in healthcare. Instead, the following characterize its use as "torture or ill-treatment", protect the right of children to safe abortion, and blame "CO" for barriers to access, calling for it to be limited and requiring referrals and alternative services.

Committee Against Torture

From the Uruguay report:

The Committee Against Torture has also expressed concern about the use of "conscientious objection" as torture or ill-treatment. For example, in its 2013 review of Poland, the Committee Against Torture stated in its concluding observations that the use of "conscientious objection" may lead women to seek unsafe, clandestine abortion that pose risks to health and life. They recommended states follow the WHO guidance on abortion and ensure that "conscientious objection" does not block access. 27

Also in 2013, they expressed concern over a law in Bolivia requiring women victims of rape to obtain judicial authorization for abortion, stating that some judiciary members' invocation of "conscientious objection" makes access to lawful abortion impossible, and may lead to women to seek unsafe, clandestine abortion. The Committee recommended that the Bolivian government ensure access to abortion for women victims of rape without unnecessary hurdles. 28

Committee website: <https://www.ohchr.org/en/hrbodies/cat/pages/catindex.aspx>

Convention on the Rights of the Child

From the Uruguay report:

The Convention on the Rights of the Child protects children's rights to equality, non-discrimination, and access to sexual and reproductive health services, including access to safe abortion and post-abortion services, regardless of whether abortion is legal. 29

Convention text: <https://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

Report from Special Rapporteur on the Right to Health

From the Uruguay report:

Finally, the **United Nations Special Rapporteur on the Right to Health** issued a watershed report in 2011 that highlighted the negative impact of abortion criminalization on the health and lives of women, especially those who are poor and displaced. The special rapporteur's report noted explicitly that states must remove barriers that impede access to health services and autonomous decision-making, including laws and practices that enable so-called "conscientious objection." The report noted that this barrier makes abortion unavailable, unsafe, and reinforces it as a stigmatized and "objectionable" practice. It reiterated that where there is the use of "conscientious objection" to abortion, states must clearly define its scope, regulate its use, and ensure that referrals and alternative services are readily available to guarantee access. 30

Special Rapporteur's 2011 Report: "Right of everyone to the enjoyment of the highest attainable standard of physical and mental health" by Anand Grover:

<https://digitallibrary.un.org/record/706246?ln=en>

24. Other legal restrictions also contribute to making legal abortions inaccessible. Conscientious objection laws create barriers to access by permitting health-care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures and referrals to alternative facilities and providers. 13

V. 5 Recommendations: (m) Ensure 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;

European Human Rights

European Convention on Human Rights (ECHR)

An international convention to protect human rights and political freedoms in Europe. Drafted by the Council of Europe, it came into force in 1953.

The convention recognizes the general right to conscience, but freedom to manifest beliefs can be limited to protect the rights of others. There is no recognition of "CO" in healthcare. The right to respect for private and family life, and prohibition of discrimination, mitigate against it.

https://www.echr.coe.int/Documents/Convention_ENG.pdf

ARTICLE 9: Freedom of thought, conscience and religion

1. Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance.

2. Freedom to manifest one's religion or beliefs shall be subject only to such limitations as are prescribed by law and are necessary in a democratic society in the interests of public safety, for the protection of public order, health or morals, or for the protection of the rights and freedoms of others.

ARTICLE 8: Right to respect for private and family life

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

ARTICLE 14: Prohibition of discrimination

The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.

From the Uruguay report:

Like the United Nations system, the European human rights system has never stated that health care providers are entitled to refuse to provide reproductive health care based on their conscience. They have, however, stated that if domestic law allows providers to refuse to provide legal reproductive health services through the use of conscience claims, states must ensure that they do not hinder access to care, and must put mechanisms in place to guarantee access to lawful health care services. Two bodies of the European human rights system have each heard three cases related to the exercise of "conscientious objection" and neither has recognized it as right in the case of health care. 31

One of these bodies is the **European Court of Human Rights** ("the Court"), which was established under the European Convention on Human Rights, an international treaty that protects human rights and fundamental freedoms in Europe. The following two groundbreaking cases against Poland illustrate important precedents set by the Court.

[details on RR v Poland, and P and S v Poland omitted]

In both cases, the Court found the unregulated practice of conscientious refusal to be in violation of the European Convention on Human Rights. 34 It determined that Poland—by obstructing access to lawful reproductive health care information and services—had violated the individuals' right to be free from inhuman and degrading treatment, as well as the right to privacy. Furthermore, for the first time, the Court recognized that states have an obligation under the Convention to regulate the exercise of "conscientious objection," in order to guarantee patients access to lawful reproductive health care services. The enumerated rights protect the right to "freedom of thought, conscience and religion" but not "CO" in healthcare. Even general conscience rights are subject to limitations to protect the rights of others.

The case of *R.R. v. Poland* is also important because the Court supported its decision by directly referring to ethical guidelines on “conscientious objection” from the International Federation of Gynecology and Obstetrics (FIGO).³⁶ FIGO submitted an amicus brief in this case, incorporating its resolution and ethical guidelines on “conscientious objection,” which the Court cited as a source of relevant law and practice.³⁷

Thus, FIGO’s ethical guidelines and resolution directly influenced the emerging human rights standards on this subject. This offers an excellent example of how ethical standards set by professional associations, such as FIGO, or international agencies, such as the WHO, can shape the development of international human rights law and play a critical role in protecting and promoting human rights.³⁸

In the 2001 *Pichon and Sajous v. France* case involving two French pharmacists who refused to sell contraceptives, the Court decided that the right to freedom of religion does not entitle people to apply their individual beliefs in the public sphere, especially in such a situation in which a product cannot be purchased anywhere other than in a pharmacy.³⁹

European Social Charter (ESC)

A treaty guaranteeing social and economic rights.

There is nothing specifically about conscience in the ESC, but the European Committee on Social Rights has ruled on the issue, saying that the Charter’s right to health does not allow the refusal to provide health services.

<https://www.coe.int/en/web/turin-european-social-charter>

The European Social Charter is a Council of Europe treaty that guarantees fundamental social and economic rights as a counterpart to the European Convention on Human Rights, which refers to civil and political rights. It guarantees a broad range of everyday human rights related to employment, housing, health, education, social protection and welfare.

The Charter lays specific emphasis on the protection of vulnerable persons such as elderly people, children, people with disabilities and migrants. It requires that enjoyment of the abovementioned rights be guaranteed without discrimination.

European Social Charter, Collected texts (7th edition, January 2015):

<https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168048b059>

From the Uruguay Report:

The **European Committee on Social Rights** (“the Committee”), also part of the European human rights system, hears collective complaints and monitors compliance with the **European Social Charter**, which is a treaty guaranteeing social and economic rights. Regarding the use of “conscientious objection,” the Committee noted that international human rights obligations—specifically the right to health, which the Charter guarantees—do not give rise to an entitlement to refuse to provide health services.

In a collective complaint case, *FAFCE v. Sweden*, the Federation of Catholic Families in Europe (FAFCE) argued that Sweden had failed to protect the right to health, asserting that the guarantee to claim “conscientious objection” is necessary to promote the health of health care workers. They also argued that Sweden was violating health care workers’ right to non-discrimination, because the government had not established a regulatory framework allowing them to refuse to provide abortion services by using conscience claims. Under Swedish law, health care providers have a duty to provide abortion; although health care institutions may choose to exempt an employee from performing abortion, exemption is not an entitlement.

The Committee found that under the Charter, neither the right to health nor the right to non-discrimination entitles health care professionals to refuse to perform abortion services on grounds of personal conscience. The Committee stated that the purpose of the right to health is to guarantee individuals’ access to adequate health care, not to protect the interests of health care providers. When it comes to reproductive health care in cases of maternity, the Committee said that the primary rights holders under the Charter are pregnant women, not their doctors.

Importantly, the Committee also went on to underscore that the Charter “does not impose on states a positive obligation to provide a right to “conscientious objection” for health care workers.” This is the most explicit finding yet that international human rights standards do not allow for an entitlement to refuse health services based on conscience claims.⁴⁰

In an important 2014 case, *IPPF EN v. Italy*, the Committee determined that the government of Italy was violating the rights to health and to non-discrimination of women by not properly regulating refusals of abortion care. The shortage of health care providers due to refusals based on conscience claims forced women to wait long periods or travel long distances to obtain abortion, placing an undue burden on them, especially on those with fewer resources.⁴¹ The Committee upheld this judgment in another case in 2016, finding that the government of Italy had failed to rectify this situation.⁴²

Council of Europe (CoE)

The aim of the Council of Europe is to uphold human rights, democracy and the rule of law in Europe. It is distinct from the European Union and cannot make binding laws but has the power to enforce select international agreements reached by European states. The best known body of the Council of Europe is the European Court of Human Rights, which enforces the European Convention on Human Rights.

The Council of Europe’s Resolution 1763 guarantees “CO” as a right. However, such Parliamentary Assembly resolutions are non-binding and the process by which the Resolution passed was highly politicized, rendering the Resolution non-representative and illegitimate:

- On Oct 7, 2010, the CoE held a debate and vote on both a **Resolution** and a **Recommendation**² for the report: “Women’s access to lawful medical care: the problem of unregulated use of

² A **Resolution** “embod[ies] a decision by the Assembly on a question of substance which it is empowered to put into effect, or an expression of a view for which it alone is responsible”. A **Recommendation** constitutes “a proposal by the Assembly addressed to the Committee of Ministers, the implementation of which is beyond the competence of the Assembly, but within that of governments.”

conscientious objection.” The report called for strict limits on the exercise of “CO” to protect women’s access to healthcare.

- The report became the subject of an aggressive anti-choice campaign, including a large number of letters urging politicians to vote against the report, an anti-choice event at the Assembly involving conservative MPs, and a flood of amendments submitted just before the deadline that prevented a thorough preparation by the Rapporteur for the debate next morning. These amendments largely passed, subverting and sabotaging the entire intent of the report.
- The vote was scheduled for an unfavourable slot that conflicted with elections in several progressive countries, including Sweden and the Netherlands, which prevented attendance by their full delegations. Only 111 Parliamentarians were present at the vote out of 318 CoE members. Postponing the vote till the Jan 2011 Assembly meeting could have led to the adoption of the original Resolution and Recommendation.
- Because the Resolution and Recommendation were significantly amended by anti-choice members to enshrine “CO” as a right (including for institutions), its original supporters were forced to vote against them. However, while the Resolution was adopted via 56 to 51 votes, the far more important Recommendation was **rejected** by a vote of 56 to 51. This meant that possible advances for SRHR were not accomplished, but the current legal status quo remained unchanged.

In other words, the Resolution has no force and effect, especially since it directly conflicts with other European human rights agreements and jurisprudence. It should also be noted that clause 3 of the Resolution is demonstrably false, as most countries do not monitor or enforce “CO” regulations meant to ensure patients’ right to healthcare.

Source: [https://www.secularism.org.uk/uploads/epf-analysis-on-the-vote-on-the-resolution-1763-\(2010\)-and-recommendation-on-womens-access-to-lawful-medical-care-the-problem-of-unregulated-use-of-conscientious-objection.pdf](https://www.secularism.org.uk/uploads/epf-analysis-on-the-vote-on-the-resolution-1763-(2010)-and-recommendation-on-womens-access-to-lawful-medical-care-the-problem-of-unregulated-use-of-conscientious-objection.pdf)

Resolution 1763 (2010) Final version: The right to conscientious objection in lawful medical care

<http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17909>

Origin - Assembly debate on 7 October 2010 (35th Sitting) (see Doc. 12347, report of the Social, Health and Family Affairs Committee, rapporteur: Mrs McCafferty; and Doc. 12389, opinion of the Committee on Equal Opportunities for Women and Men, rapporteur: Mrs Circene). Text adopted by the Assembly on 7 October 2010 (35th Sitting).

1. No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion, the performance of a human miscarriage, or euthanasia or any act which could cause the death of a human foetus or embryo, for any reason.
2. The Parliamentary Assembly emphasises the need to affirm the right of conscientious objection together with the responsibility of the state to ensure that patients are able to access lawful medical care in a timely manner. The Assembly is concerned that the unregulated use of

conscientious objection may disproportionately affect women, notably those with low incomes or living in rural areas.

3. In the vast majority of Council of Europe member states, the practice of conscientious objection is adequately regulated. There is a comprehensive and clear legal and policy framework governing the practice of conscientious objection by health-care providers ensuring that the interests and rights of individuals seeking legal medical services are respected, protected and fulfilled.
4. In view of member states' obligation to ensure access to lawful medical care and to protect the right to health, as well as the obligation to ensure respect for the right of freedom of thought, conscience and religion of health-care providers, the Assembly invites Council of Europe member states to develop comprehensive and clear regulations that define and regulate conscientious objection with regard to health and medical services, and which:
 - 4.1. guarantee the right to conscientious objection in relation to participation in the medical procedure in question;
 - 4.2. ensure that patients are informed of any conscientious objection in a timely manner and referred to another health-care provider;
 - 4.3. ensure that patients receive appropriate treatment, in particular in cases of emergency.

European Parliament (EP)

The European Parliament is an important forum for political debate and decision-making at the EU level. The Members of the EP are directly elected by voters in all Member States to represent people's interests with regard to EU law-making and to make sure other EU institutions are working democratically. The Parliament acts as a co-legislator, sharing with the Council the power to adopt and amend legislative proposals and to decide on the EU budget. It also supervises the work of the Commission and other EU bodies and cooperates with national parliaments of EU countries to get their input.

Sexual and reproductive health and rights in the EU, in the frame of women's health

https://www.europarl.europa.eu/doceo/document/TA-9-2021-0314_EN.pdf

On June 24, 2021, the [European Parliament voted in favour of a landmark resolution](#) presented by Croatian MEP Predrag Fred Matić, which addresses the full range of SRHR and highlights the importance of accessing all essential SRH services, including comprehensive sexuality education, contraception, abortion, maternal health and fertility services; and of preventing and addressing sexual and gender-based violence.

Although non-binding, the report is notable for its strong language against so-called “conscience clauses.” While it recognizes that individuals may invoke their conscience for personal reasons, it warns that this must not interfere in any way with patients’ access to healthcare. The report “regrets” that Member States commonly allow so-called “conscience”-based treatment refusals for medical practitioners, as this leads to the denial of abortion care and endangers women’s lives and rights.

Page 17/18:

- 32 Recalls that Member States and public authorities have a responsibility to provide evidence-based, accurate information about contraception and to establish strategies to tackle and dispel barriers,

myths, stigma and misconceptions; calls on the Member States to establish awareness-raising programmes and campaigns on modern contraceptive choices and the full range of contraceptives, and to provide high-quality modern contraceptive service delivery and counselling by healthcare professionals, including emergency contraception without prescription, in line with WHO standards, **which is often denied in certain countries by doctors on the grounds of personal beliefs;**

36. Recognises that for personal reasons, individual medical practitioners may invoke a conscience clause; stresses, however, that an individual's conscience clause may not interfere with a patient's right to full access to healthcare and services; calls on the Member States and healthcare providers to take such circumstances into account in their geographical provision of healthcare services;
37. Regrets that sometimes common practice in Member States allows for medical practitioners, and on some occasions entire medical institutions, to refuse to provide health services on the basis of the so-called conscience clause, which leads to the denial of abortion care on grounds of religion or conscience, and which endangers women's lives and rights; notes that this clause is also often used in situations where any delay could endanger the patient's life or health;
38. Notes that this conscience clause also hinders access to prenatal screening, which is not only a violation of women's right to information on the condition of the foetus, but also in many cases obstructs the successful treatment during pregnancy or immediately afterwards; calls on the Member States to implement effective regulatory and enforcement measures that ensure that the 'conscience' clause does not put women's timely access to SRH care at risk;

[Section U, page 10] whereas abortion laws are based on national legislation; whereas even when abortion is legally available, there are often a range of legal, quasi-legal and informal barriers to accessing it, including limited time periods and the grounds on which to access abortion; medically unwarranted waiting periods; a lack of trained and willing healthcare professionals; **and the denial of medical care based on personal beliefs,** biased and mandatory counselling, deliberate misinformation or third-party authorisation, medically unnecessary tests, distress requirements, the costs involved and the lack of their reimbursement;

[Section I, page 7/8] whereas SRHR challenges and obstacles can include, among other things, obstacles of a legal, financial, cultural and information-related nature, such as a lack of access to universal, high-quality and accessible SRHR services; a lack of comprehensive, age-appropriate and evidence-based sexuality education, especially in the light of the fact that the enjoyment of SRHR for LGBTI persons may be severely hindered owing to the omission from sex education curricula of the diversity of sexual orientation; gender identity, expression and sex characteristics; a lack of available modern contraception methods; **the denial of medical care based on personal beliefs;** legal restrictions and practical barriers in accessing abortion services; the denial of abortion care; forced abortion; gender-based violence; gynaecological and obstetric violence; forced sterilisation, including in the context of legal gender recognition; intimidation, cruel and degrading treatment; disparities and gaps in maternal mortality rates and mental health support; increasing Caesarean section rates; a lack of access to treatment for cervical cancer; limited access to medically assisted reproduction and fertility treatments; difficulties in accessing the goods necessary for SRHR; high rates of STIs and HIV; high adolescent pregnancy rates; harmful gender stereotypes and practices such as female and intersex genital mutilation; child, early and forced marriages (CEFM) and honour killings, and so-called 'conversion therapy' practices which can take the form of sexual violence such as 'corrective rape' perpetrated

against lesbian and bisexual women and girls, as well as transgender persons; and outdated or ideologically driven legal provisions limiting SRHR;

Sexual and reproductive health rights and the implication of conscientious objection

[http://www.europarl.europa.eu/RegData/etudes/STUD/2018/604969/IPOL_STU\(2018\)604969_EN.pdf](http://www.europarl.europa.eu/RegData/etudes/STUD/2018/604969/IPOL_STU(2018)604969_EN.pdf)

Oct 2018, 128 pages with a 17-page section on conscientious objection (starting page 90).

(Note: The above June 2021 resolution is a superior document in relation to the harms and rights violations of “conscientious objection.”)

This 2018 European Parliament report recognizes “CO” as a right and entirely conflates it with military CO, based on UN instruments and the ECHR. However, both the ECHR and UN instruments only recognize the general right of conscience as well as military CO. Neither body recognizes “CO” in healthcare itself as a right, and UN instruments call for limits on the exercise of “CO” to minimize harms to patients.

Despite mistakenly recognizing “CO” as a right, the European Parliament’s report starkly highlights the many systemic harms and problems with “CO”, and the last paragraph of its Key Findings section (pg 91; reproduced below) ironically shows that the refusal to treat in healthcare has little to do with true CO. Instead, it is politically motivated and organized, and driven by abortion stigma and misogyny.

The References section for the chapter on “CO” consists only of UN documents, EU reports, court decisions, and government reports. Nothing is cited from research studies, academic papers on the ongoing “CO” debate, or the Uruguay report. This deficiency of sources and the mistaken assumption that international agreements recognize a right to “CO” in healthcare reduces the report’s credibility on this topic.

The Conclusion and Recommendations section calls for a “balancing of the rights of health providers to express their beliefs with states’ responsibility to ensure people’s access to their SRHR”. However, the report shows that such a balance does not exist in practice and when attempted in any fashion, inevitably violates the right to healthcare, in particular women’s right to access abortion care. Many or most objectors will refuse to obey rules requiring them to refer, impart accurate information, or provide emergency services. Further, many hospitals enforce institutional-level “CO”, prohibiting any healthcare worker from providing or assisting in an abortion. Regulations that purport to “balance” rights of providers with patients are rarely enforced and patients end up on the losing end.

Key Findings

- Conscientious objection is recognised internationally mainly via UN instruments and the ECHR. It is widely recognised by UN treaty bodies that the right to conscientious objection is not absolute and can be restricted in key circumstances.
- The ICESCR held that the exercise of conscientious objection must not be a barrier to accessing SRH services and the CEDAW Committee called upon State Parties to establish an effective mechanism of referral if health service providers refuse to perform reproductive health services for women based on conscientious objection.

- Under the ECHR, conscientious objection is guaranteed under the right to freedom of thought, conscience and religion, but must be balanced against respect for privacy and family life (which serves as the basis for many SRH rights). Both rights can be limited to protect ‘health and morals’ or the rights of others.
- Relevant ECtHR rulings established that applicants cannot use their religious beliefs to justify refusing to sell contraceptive methods to certain individuals, and that governments are obliged to ensure that the exercise of freedom of conscience does not block patients from accessing services to which they are legally entitled.
- There is no clear competence under the EU mandate to regulate the harmonisation of the right to conscientious objection in access to SRH goods and services.
- The EU’s Employment Equality Directive (Directive 2000/78/EC) protects healthcare employees from discrimination due to their religion or beliefs in relation to employment conditions. However, a restriction could be applied on the freedom of religion or belief when it results from a genuine occupational requirement, the objective is legitimate, and the requirement is proportionate.
- 22 of the 28 Member States provide for a right to conscientious objection in relation to the provision of abortion (281). In the six Member States in this study, all but Sweden have a conscientious objection clause in their legislation. Croatia, the Czech Republic and Poland have broad provisions that do not explicitly cover SRH services and goods. Italy and Portugal have specific conscientious objection clauses in relation to the provision of SRH services and, in particular, abortions and related procedures. Czech Republic, Italy, Poland and Portugal establish some limitations to the application of conscientious objection. Most commonly, these prevent conscientious objection from being invoked where it will cause a serious danger to a patient’s life.
- There are key gaps in the legislation on conscientious objection, for example limited right of appeal, a lack of obligation to refer to other medical practitioners and a failure to pay specific attention to vulnerable groups.
- There is a lack of data on the extent of conscientious objection in the six Member States. The impact of conscientious objection on access to SRH goods and services has not been effectively monitored and measured. However, it appears that to constitute an additional barrier for women in accessing healthcare and SRHR specifically.
- The driving factors behind the exercise of conscientious objection and the resulting limited access to SRH services are: a strong religious background and culture has affected the understanding of services such as abortion; anti-choice movements, as well as movements with a specific interest in subverting advancements in gender equality, have grown across Europe in the past 10 years; work-place culture, which encourages the practice of conscientious objection and often actively discourages the provision of abortion services; the stigma of abortion; lack of information and sufficient training.

From “Conclusions and Recommendations”, page 108-109:

In the specific context of conscientious objection, 22 Member States recognise a right to conscientious objection, in particular in relation to the provision of abortion (354). The right to conscientious objection, requires a balancing of the rights of health providers to express their beliefs with states' responsibility to ensure people's access to their SRHR, specifically access to related services and goods (355). Investigation in the countries at the core of this study showed that, where health providers have the possibility to exercise their right to object, this balance is most often not attained. In this context, a number of gaps were identified, such as the lack of monitoring and evaluation mechanisms that could ensure that this balance is respected. Other key gaps are limited right of appeal, a lack of obligation to refer to other medical practitioners and a failure to pay specific attention to vulnerable groups. Moreover, there is an evident lack of data on the extent of conscientious objection in the six Member States.

Maputo Protocol

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa:
<https://au.int/en/treaties/protocol-african-charter-human-and-peoples-rights-rights-women-africa>

An agreement that guarantees comprehensive rights to women including the right to take part in the political process, to social and political equality with men, improved autonomy in their reproductive health decisions, and an end to female genital mutilation.

The clauses supporting women's rights to determine whether to have children, the number of children and the spacing of children; and authorizing abortion in certain circumstances, mitigate against any right to "CO."

Article 14: Health and Reproductive Rights

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

- a) the right to control their fertility;
- b) the right to decide whether to have children, the number of children and the spacing of children;
- c) the right to choose any method of contraception;
- d) the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;
- e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
- f) the right to have family planning education.

2. States Parties shall take all appropriate measures to:

- a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;

b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;

c) protect the reproductive rights of women by authorising medical abortion 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.

From the Uruguay report:

Africa's main legal instrument for the protection of women's rights, known as the Maputo Protocol, is unique for its explicit recognition of abortion as a human right under limited circumstances (article 14.2 (c)).⁴⁸ Yet, even where abortion has been legalized as mandated by the Maputo Protocol, gaps in implementation remain due to the stigmatization of abortion, the lack of availability of abortion services and of resources for health care, and other barriers, including "conscientious objection." However, 37 out of the 54 member states of the African Union have ratified the Maputo Protocol, with Sierra Leone being the latest one to do so in 2015. ⁴⁹

In 2014, the African Commission on Human and Peoples' Rights ("the African Commission"), charged with protecting and promoting the Maputo Protocol, recognized these weaknesses in General Comment no. 2, article 14. The General Comment helps guide state monitoring of legislation and other measures to promote and protect sexual and reproductive rights of women and girls—including access to safe abortion—in accordance with the Maputo Protocol. It includes specific attention to "conscientious objection," stating that "state parties should particularly ensure that health services and health care providers do not deny women access to contraception/family planning and safe abortion information and services because of, for example, requirements of third parties or for reasons of conscientious objection."

World Health Organization (WHO)

A specialized agency of the UN. The WHO acts as a directing and coordinating authority on international health work. The objective is the attainment by all peoples of the highest possible level of health.

The WHO never claims that "CO" is a right. It recognizes the general right to conscience but says that claims to conscience in healthcare may jeopardize patients' access to healthcare and must be subject to limitations.

Clinical Practice Handbook for Quality Abortion Care

<https://www.who.int/publications/i/item/9789240075207>

Pg 2: **1.1.1 Provide information**

Accurate, high-quality, evidence-based information on abortion must be available to individuals and provided in a way that respects privacy and confidentiality. Information should be presented in a way that is non-coercive, nondiscriminatory, can be understood and is acceptable and accessible to the individual...

Pg 10: **1.1.2 Offer counselling**

Counselling is a focused, interactive process through which a person voluntarily receives support, additional information and nondirective guidance from a trained person, in an environment that is conducive to openly sharing thoughts, feelings and perceptions and personal experiences. When offering and providing counselling, remember to apply the following principles.

- Only provide counselling if the individual has requested or agreed to it – counselling is not required.
- Ensure that there is privacy and maintain confidentiality.
- Ask the individual what they want or need, what their concerns are, give them the time they need to respond, and actively listen to their expressed needs and preferences.
- Present all the options that are suitable for the individual, **while avoiding imposing your personal values and beliefs onto them.**
- Highlight relevant information during the counselling session (such as the information provided in section 1.1.1).
- Communicate information clearly, respectfully and non-judgementally, and in a manner and language that is understandable to the individual.
- Support the individual's needs and ensure that you give adequate responses to their questions and that they understand the information provided.
- Use shared decision-making to determine which services are needed, while at the same time being sure to support the woman's autonomy in decisionmaking.

Safe abortion: technical and policy guidance for health systems

Second edition, 2012: <https://apps.who.int/iris/handle/10665/70914>

Evidence brief: https://apps.who.int/iris/bitstream/handle/10665/173586/WHO_RHR_15.04_eng.pdf

From the Uruguay report:

The current World Health Organization (WHO) safe abortion guidance further stipulates that the referral must be to someone in the same or another easily accessible health care facility. If a referral is not possible, the objecting provider is obligated to provide a safe abortion to preserve the woman's life and to prevent risks to her health. Any woman who presents with complications due to abortion must receive professional care with urgency and respect, as with any other emergency case.

From the WHO guidance:

Pg 72: In addition to skills training, participating in values-clarification exercises can help providers differentiate their own personal beliefs and attitudes from the needs of women seeking abortion services (27). Values clarification is an exercise in articulating how personal values influence the way in which providers interact with women seeking abortion. Despite providers' attempts at objectivity, negative and pre-defined beliefs about abortion, and the women who have them, often influence professional judgement and the quality of care (28, 29).

Pg 96: **4.2.2.5 Conscientious objection**

Health-care professionals sometimes exempt themselves from abortion care on the basis of conscientious objection to the procedure, while not referring the woman to an abortion provider. In the absence of a readily available abortion-care provider, this practice can delay care for women in need of safe abortion, which increases risks to their health and life. While the right to freedom of thought, conscience, and religion is protected by international human rights law, international human rights law also stipulates that freedom to manifest one's religion or beliefs might be subject to limitations necessary to protect the fundamental human rights of others (61).

Therefore laws and regulations should not entitle providers and institutions to impede women's access to lawful health services (62).

- Health-care professionals who claim conscientious objection must refer the woman to another willing and trained provider in the same, or another easily accessible health-care facility, in accordance with national law. Where referral is not possible, the health-care professional who objects must provide abortion to save the woman's life or to prevent damage to her health. Health services should be organized 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.

Framework for ensuring human rights in provision of contraceptive information and services

<https://apps.who.int/iris/bitstream/handle/10665/133327/?sequence=1>

Pg 5: Women's access to contraceptive information and services may be jeopardized by health-care providers' refusal to provide services due to conscientious objection. In the context of contraceptive services, this is usually manifested in a provider's refusal to issue a prescription for contraceptives, or a pharmacist's refusal to dispense or sell contraceptives, especially emergency contraceptives. While international human rights law protects the right to freedom of thought, conscience and religion, it also stipulates that the freedom to manifest one's beliefs in the professional sphere is not absolute and might be subject to limitations that are necessary to protect the rights of others, including the right to access reproductive health care (40, Article 18; 41).

Human rights bodies have consistently called on states to regulate the practice of conscientious objection in the context of health care, to ensure that patients' health and rights are not in jeopardy (3, 42). Some human rights bodies have explicitly addressed conscientious objection in the context of contraceptive service provision, stating that where women can only obtain contraceptives from a pharmacy, pharmacists cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products (41).

International Federation of Gynecology and Obstetrics (FIGO)

An organisation that brings together professional societies of obstetricians and gynecologists on a global basis. FIGO's vision is for women of the world to achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives.

FIGO's position on "conscientious objection" has evolved considerably since 2006. At that time, FIGO called it a "right" in an *IJGO* journal article and implied as much in their 2006 Resolution on "Conscientious Objection". This resolution was taken offline in 2020 and upon inquiry, FIGO informed us that they were preparing a new statement to replace it. While the new policy was issued in October 2021, the 2006 resolution was found online again in March 2021. References to "CO" also appear in its 2019 statement about post-abortion care, which seems to tacitly accept an individual "right" to "CO" even though Recommendation 8 in the same statement conflicts with this.

FIGO also held an online roundtable discussion on June 24, 2021, hosted by FIGO's Advocating for Safe Abortion Project (ASAP) and Committee on Safe Abortion. The discussion explored "conscientious objection" and its impact on the availability of and access to legal and safe abortion services.

Conscientious Objection: A Barrier to Care

Oct 2021: <https://www.figo.org/resources/figo-statements/conscientious-objection-barrier-care>

FIGO recommendations

FIGO urges its national member societies and other stakeholders to work towards sensitising health care providers to their ethical and legal duties, aiming to reduce use of conscientious objection globally. Health care providers should ensure that women and girls across the world have the right to make their own reproductive choices – ones they think will enable them to achieve the highest standards of health and wellbeing.^{5,6} In this regard, FIGO recommends that all member societies undertake activities to meet the following goals.

- Member societies must engage with health care professionals and key stakeholders to educate and sensitise them to recognise the rights of women and girls. Health system biases should not hinder access to services. Women and girls should be able to exercise their legally safeguarded human rights.
- Member societies must be supported to initiate advocacy with their governments in order to develop laws, policies or guidance that set clear standards on the regulation of conscientious objection. Conscientious objection should be regulated so that its exercise is only possible for health care providers – its extension to administrative or support personnel should not be allowed.^{7–11} Health care institutions must not invoke conscientious objection to systematically object to the provision of abortion care.
- Member societies should ensure that health systems strictly regulate conscientious objection and hold health care providers or others accountable for its misuse.
- Member societies must engage with health system administrators to establish a strong referral system to ensure that providers refusing to provide abortion care based on grounds of conscientious objection can refer their patients to another provider who is willing and qualified to perform the procedure.

- Member societies should inform providers that they must render emergency obstetric care, including post-abortion care that is within their means, to women and girls, without regard to whether as individuals they refuse to provide abortion.
- Member societies should train medical students to provide good quality care according to human rights standards and to not discriminate against women and girls when they seek abortion care.
- Member societies should advocate for and work with key stakeholders to prevent lack of access to accurate information and quality, safe reproductive health services, including safe abortion, post-abortion and contraceptive care.

Online Roundtable Discussion

June 24, 2021: *From ‘Conscientious Objection’ to ‘Conscientiously Committed’ – How OBGYNS can advocate for bodily autonomy in access to safe abortion:* <https://www.figo.org/news/conscientious-objection-conscientiously-committed-how-obgyns-can-advocate-bodily-autonomy>

FIGO has identified the following as key strategies to engage in and to promote engagement by member societies.

- Inclusion of sexual and reproductive health and rights including safe abortion, in pre and in-service training for health care practitioners.
- Lobby and advocate for stricter regulation and accountability of CO in facilities whereby it cannot be used to deny care in the care of emergency situations or for post-abortion care; also that it cannot be used by institutions or individuals other than those directly providing the abortion.
- Strive to end discrimination faced by patients who seek access to safe abortion services and those who provide these essential services and create a movement of health care providers ‘conscientiously committed’.
- Advocate for better regulation and monitoring of governments’ sexual reproductive health rights obligations eg on the implementation of access to abortion-related goods and service which includes access to information, and laws and standards that promote and protect women and girl's autonomy, privacy and informed consent central to all sexual reproductive health laws and policies.
- Integrate the recommendations from the UN Working Group on Discrimination Against Women reports, in addition to other expert UN groups, within their own advocacy calls.

Ethical Responsibilities in Post-abortion care: FIGO statement on the Ethics of Post-Abortion Care

Prepared by the FIGO Committee on Ethical and Professional Aspects of Human Reproduction and Women’s Health. April 11, 2019. <https://www.figo.org/ethical-responsibilities-post-abortion-care>.

Relevant aspects on “CO” are reproduced below. Problematic language highlighted indicates that FIGO has fallen into the trap of accepting the anti-choice frame that abortion is immoral or should be seen as a crime. Also note that Recommendation 8 conflicts with Background point 5.

Background

5. A care provider **who has a conscientious objection to participating in inducing abortion** cannot invoke such objection to decline rendering clinically indicated post-abortion care. As a provider of post-abortion care, a care-giver is not a participant nor **complicit in** another's prior acts causing the need of such care.

Recommendations

1. Practitioners should promptly render indicated post-abortion care to patients that is within their means without regard to whether as professionals they **conscientiously object** to participation in induced abortion.

5. Educational programs and professional certification in gynecology should require training and competence in post-abortion care, disallowing students' and candidates' non-compliance on grounds of **conscientious objection to participation or complicity in** induced abortion.

8. Human rights agencies, both national and international, characterize neglect or limitation of health services that only women need as violating obligations to eliminate all forms of discrimination against women. Practitioners and facility managers should ensure compliance with non-discrimination laws in provision of post-abortion care services.

Ethical guidelines on conscientious objection

International Journal of Gynecology and Obstetrics (2006) 92, 333—334

<https://obgyn.onlinelibrary.wiley.com/doi/abs/10.1016/j.ijgo.2005.12.020>

FIGO's 2006 Ethical Guidelines published in the *IJGO* are 13 years old and obsolete, but nevertheless still available in the journal. The Guidelines call "CO" a right, but without justifying this claim. They go on to impose many strict limitations on this supposed right, repeatedly emphasizing that patient care comes first. They say for example that doctors must not superimpose their personal beliefs onto a procedure instead of the profession's understanding of medical science, and that placing their personal "conscientious interests" before their patients' interests is "a conflict of interest". However, such statements preclude and contradict the idea of a "right" to object for personal reasons. Further, FIGO's requirements for disclosure, referral, and emergency care are generally unenforceable and unworkable since objectors often refuse to obey them.

FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health

Background

The primary commitment of obstetrician—gynecologists ("practitioners") is to serve women's reproductive health and well-being. Practitioners who find themselves unable to deliver medically indicated care to their patients for reasons of their personal conscience still bear ethical responsibilities to them. When practitioners feel obliged to place their personal conscientious interests before their patients' interests, they have a conflict of interest. Not all conflicts can be avoided, but when they cannot, they can be resolved by due disclosure; that is, practitioners must inform potential patients of the treatments in which they object to participate on grounds of their personal conscience.

Practitioners have duties to inform their patients of all medically indicated options for their care, including options in which the practitioners decline to participate. When patients select such an option,

practitioners are governed by the FIGO Ethical Framework for Gynecologic and Obstetric Care (1994), paragraph 4 of which provides that:

“If a physician is either unable or unwilling to provide a desired medical service for non-medical reasons, he or she should make every effort to achieve appropriate referral.” [1]

Practitioners have the right both to undertake and to object to undertaking medical procedures according to their personal conscience. As medically trained and licensed practitioners, they are bound to apply the profession’s understanding of medical and reproductive science, and not to superimpose different characterizations of procedures based on their personal beliefs.

When in an emergency, patients’ lives, or their physical or mental health, can be preserved only by procedures in which their practitioners usually object to participate, and practitioners cannot refer such patients to non-objecting practitioners in a timely way, the practitioners must give priority to their patients’ lives, health and well-being by performing or participating in the indicated procedures.

Ethical guidelines on conscientious objection

1. The primary conscientious duty of obstetrician—gynecologists (hereafter “practitioners”) is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty.
2. Provision of benefit and prevention of harm require that practitioners provide such patients with timely access to medical services, including giving information about the medically indicated options of procedures for their care and of any such procedures in which their practitioners object to participate on grounds of conscience.
3. Practitioners have a professional duty to abide by scientifically and professionally determined definitions of reproductive health services, and to exercise care and integrity not to misrepresent or mischaracterise them on the basis of personal beliefs.
4. Practitioners have a right to respect for their conscientious convictions in respect both of undertaking and not undertaking the delivery of lawful procedures, and not to suffer discrimination on the basis of their convictions.
5. Practitioners’ right to respect for their choices in the medical procedures in which they participate requires that they respect patients’ choices within the medically indicated options for their care.
6. Patients are entitled to be referred, in good faith, for procedures medically indicated for their care that their practitioners object to undertaking, to practitioners who do not object.
7. Referral for services does not constitute participation in any procedures agreed upon between patients and the practitioners to whom they are referred.
8. Practitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients’ health and well-being, such as by patients experiencing unwanted pregnancy (see the FIGO Definition of Pregnancy, Recommendations on Ethical Issues in Obstetrics and Gynecology, November 2003, page 43, that pregnancy commences with the implantation of the conceptus in a woman) [2]

9. In emergency situations, to preserve life or physical or mental health, practitioners must provide the medically indicated care of their patients' choice regardless of the practitioners' personal objections.

2006 FIGO Resolution on 'Conscientious Objection'

<https://www.figo.org/resolution-conscientious-objection-2006>

(Reviewed and approved by the FIGO Executive Board, September 2005, and adopted by the FIGO General Assembly on 7 November 2006)

- Recognizing that physicians have an ethical obligation, at all times, to provide benefit and prevent harm for every patient for whom they care.
- Recognizing further that providers are obligated to inform patients of all medically indicated options for their healthcare and respect their choice (autonomy).
- Recognizing patients' rights to timely access to medical services.
- Acknowledging that practitioners have a right to respect for their conscientious convictions both not to undertake and to undertake the delivery of lawful services; and
- Noting the duty of practitioners as professionals to abide by scientifically and professionally determined definitions of reproductive health services and not to mischaracterize them on the basis of personal beliefs.

FIGO affirms that to behave ethically, practitioners shall:

1. Provide public notice of professional services they decline to undertake on grounds of conscience;
2. Refer patients who request such services or for whose cares such services are medical options to other practitioners who do not object to the provision of such services;
3. Provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well-being; and
4. In emergency situations, provide care regardless of practitioners' personal objections.

Amnesty International

Amnesty International is a global movement of more than 7 million people in over 150 countries and territories who campaign to end abuses of human rights.

Amnesty International's Policy on Abortion

<https://www.amnesty.org/download/Documents/POL3028462020ENGLISH.pdf>

Amnesty's September 2020 policy supports the "full decriminalization of abortion and universal access to abortion, post-abortion care and evidence-based, non-biased abortion-related information, free of force, coercion, violence and discrimination."

The policy says that States must remove barriers to safe abortion services, including: "denial of care for lawful services (including based on conscience or beliefs)". **Nothing is said about regulating the practice or in any way allowing it with limits.** Further, the policy says that denial of post-abortion care on

grounds of conscience or beliefs should be prohibited. The policy also supports the conscience rights of women needing abortion (not healthcare professionals to deny abortion). These positions follow from Amnesty's general approach to abortion as "principle-based and derived from international human rights law and standards and long-standing human rights principles."

States must ensure ... Access to post-abortion care for people who are managing complications from a miscarriage or abortion, regardless of the legality of abortion, and regulate refusals of care for lawful services (including based on conscience), prohibit the denial of such care on any grounds, including based on conscience or beliefs. (pg 7)

States must remove barriers to safe abortion services. These include laws, policies and practices that impede pregnant people from accessing safe abortion services, such as financial, social, geographic, detention-related and disability-related barriers (for example, physical barriers, lack of access to evidence-based, non-biased information and discriminatory attitudes, substituted decision-making by a guardian, parent or doctor), the need for third-party consent, biased counselling, denial of care for lawful services (including based on conscience or beliefs) and mandatory waiting periods. (pg 7-8)

Legal, policy and regulatory frameworks around abortion should be assessed to ensure that they respect and protect the human rights of women, girls and all people who can become pregnant. The assessment should include the impact on the rights to life, health, privacy, education, access to evidence-based, accurate information and the benefits of scientific progress, freedom of conscience, freedom from torture and other ill-treatment, and to equality and non-discrimination. (pg 9)

Statement by Amnesty International and Human Rights Watch

Statement by Amnesty International and Human Rights Watch: comprehensive approach to regulating conscientious objection in the health care field needed.

https://www.hrw.org/sites/default/files/related_material/Statement%20by%20Amnesty%20International%20and%20Human%20Rights%20Watch%20-%20Comprehensive%20Approach%20to%20regulating%20conscientious%20objection.pdf

This is an undated statement (likely from 2011 or 2012) that summarizes the positions of human rights bodies and international agreements against unregulated "CO", noting how its exercise can pose a barrier to care and be discriminatory against women. The statement calls for a "comprehensive approach to regulating conscientious objection in the health care field". Although the statement does call "CO" a "right", this language has subsequently evolved, given that Amnesty's 2020 position is to prohibit "CO" and HRW is overwhelmingly negative in its statements about "CO" (see next section for Human Rights Watch).

In conclusion, a human rights-based approach to regulating conscientious objection must include:

- Regulations defining conscientious objection, the entitlements and duties of healthcare providers wishing to exercise their individual right to conscientious objection and patients' right to information, diagnostic care and decision-making on the full range of lawful medical treatments;
- Implementation and enforcement procedures in the form of oversight and monitoring mechanisms which allow patients to make complaints and access remedies.

Amnesty's Country Reports

Amnesty international has also published a statement on Chile and a country report on South Africa that support robust limits on “CO”, citing UN instruments.

Why the conscientious objection protocol should outrage everyone, by Ana Piquer. Directora Ejecutiva, Amnistía Internacional Chile, 4 April 2018. <https://www.amnesty.org/en/latest/news/2018/04/por-que-el-protocolo-de-objecion-de-conciencia-debiera-indignar-a-todo-el-mundo/>

The article explains that Chile’s new abortion law included a “conscientious objection” clause for individual providers, but that a clause was later amended to also protect institutions, due to anti-choice political pressure.

In the case of abortion, the *[original]* clause allows medical professionals to refuse to perform abortions if performing them violates their religious or moral beliefs. If they object, they must then refer the woman or girl to a medical professional who does not. Conscientious objection, then, is always personal. The idea of “institutional conscientious objection” instated in Chile is extremely questionable from a human rights perspective.

...we have a law that ... invents an institutional conscientious objection that has no precedent of any kind in international human rights law, and that ... stands without any kind of legal regulation...

Conscientious objection has been identified by various United Nations bodies as an obstacle to women’s and girls’ access to abortion. It is necessary to take all possible measures to keep conscientious objection from becoming an obstacle to legal abortion.

Barriers to Safe and Legal Abortion in South Africa (Briefing), Feb 1, 2017. <https://www.amnesty.org/en/documents/afr53/5423/2017/en/>

The unregulated refusal by health care professionals to provide abortion services is a major contributor to the shortage of health facilities providing abortion services.¹³ Such refusal is often referred to as ‘conscientious objection’, which means: ‘to object in principle to a legally required or permitted practice’.¹⁴

[Description of right of refusal clauses in CTOPA legislation omitted, but it applies only to the direct provision of services and not to pre- and post-abortion care, and does not apply in cases of risk to the woman’s life or an immediate risk to her health. The law also states that any person who prevents or obstructs access to legal abortion services is guilty of an offence, punishable by a fine or imprisonment.]

Despite the clarity of the law, there is an apparent lack of understanding among many health care providers and individuals working in health care facilities of the obligations the CTOPA imposes.¹⁹ The WHO warns that “allowing conscientious objection without referrals on the part of health-care providers and facilities” is one of the major barriers to access of safe abortion services in contexts where abortion is legal.²⁰

The lack of clear policy guidelines for all involved in health care provision creates a vacuum for conscientious objection to be applied in an “ad hoc, unregulated and at times incorrect” manner.²¹ Despite the development of a National Strategic Plan for the Implementation of the CTOPA by the National Department of Health²² and a Draft National Policy for Conscientious Objection in the

Implementation of the CTOPA(2007),²³ Amnesty International and the Women’s Health Research Unit (WHRU) have documented failures in the referral process.²⁴ Left unchecked, conscientious objection has been found to lead to fragmented care,²⁵ and risks being invoked opportunistically;²⁶ restricting women and girls’ access to lawful procedures.

An expert review of all maternal deaths in South Africa from 2011-2013 has recommended that: “Facility managers must ensure that all doctors and nurses are aware of their professional and ethical responsibilities when on-duty, and must hold them accountable when these responsibilities are neglected.

Under regional and international human rights standards, South Africa has a duty to ensure that conscientious objection does not impact on access to services and that a functioning referral process is in place to ensure that the person seeking care can be guaranteed timely and appropriate quality care.³⁰ Both the African Commission on Human and People’s Rights (ACHPR)³¹ and the United Nations Committee on Economic, Social and Cultural Rights (CESCR) are clear that States have an obligation to ensure that the practise of conscientious objection is not a barrier to accessing abortion services.³² Human rights standards also require that South Africa must ensure “an adequate number of health care providers willing and able to provide such services should be available at all times in both public and private facilities and within reasonable geographical reach.”³³

The UN Special Rapporteur on the right to health has warned of the dangers of inadequate regulation of conscientious objection as a barrier that contributes to making legal abortions inaccessible.³⁴ The Special Rapporteur has recommended that States “ensure 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.”³⁵ Evidence indicates that conscientious objection risks becoming a way of ‘gate-keeping’ access to services in South Africa.³⁶

The ACHPR further requires that States ensure accountability mechanisms are in place, along with the ‘development of implementation standards and guidelines; a monitoring and evaluation framework, and availing accessible, timely and efficient redress mechanisms for women whose sexual and reproductive rights have been violated.’³⁸

A woman’s right to life, health and dignity must always take precedence over the right of a health care professional to exercise conscientious objection to participation in an abortion procedure. This is not the reality in South Africa. The government’s failure to sufficiently regulate and monitor conscientious objection means that South Africa risks breaching its human rights obligations. Regulation and clear policy guidelines are urgently required to both respect the right of health care professionals and ensure that women and girls’ right to reproductive health care is uniformly fulfilled within the health system.

Human Rights Watch

Human Rights Watch investigates and reports on abuses happening in all corners of the world. We are roughly 450 people of 70-plus nationalities who are country experts, lawyers, journalists, and others who work to protect the most at risk, from vulnerable minorities and civilians in wartime, to refugees and children in need. We direct our advocacy towards governments, armed groups and businesses, pushing them to change or enforce their laws, policies and practices.

While HRW acknowledges that some countries allow the exercise of “CO,” it is overwhelmingly negative in its statements about the practice. The group brings attention to the human rights violations that can occur when “CO” is exercised, and calls for strict limitations on its use, citing CEDAW, UN instruments, and the UN Special Rapporteur on Health. It often makes submissions to the United Nations’ Universal Periodic Review Sessions.

Also see HRW’s joint Statement by Amnesty International and Human Rights Watch, discussed above.

Human Rights Watch has dozens of reports and statements referencing “CO” in healthcare in many different countries – all of them criticizing the abuse or unregulated use of “CO.” Rather than list them below, you may view them by entering the term “conscientious objection” (with quote marks) in the Search box. The Search Results page will display all articles, although some relate to military CO.

Search box: <https://www.hrw.org/sitesearch>

Results: <https://www.hrw.org/sitesearch?search=%22conscientious+objection%22>.

International Medical Advisory Panel

The International Medical Advisory Panel (IMAP) is a panel of leading experts in the field of sexual and reproductive health who provide medical and technical advice to the International Planned Parenthood Federation.

IMAP: <https://www.ippf.org/our-approach/high-standards-care/imap>

Statement on Conscientious Objection: <https://www.ippf.org/resource/imap-statement-conscientious-objection>

Relying on a consensus from cases involving conscientious objection in reproductive health, IMAP claims that physicians have the “right” to refuse to provide a requested service, but that this right is not “absolute” and that the personal belief must meet a certain standard. Of course, guidance from case law is limited since there is little to no enforcement of these mechanisms, and many objectors will ignore or oppose them:

- The right to conscientious objection to health services is derived from the right to freedom of conscience, but it is not an absolute right in that it may not be an obstacle for access to health services for others.
- Conscientious objection is a right that can only be held by individuals; it may not be held by businesses, legal entities or the state.
- Conscientious objection is an individual decision; it is not a collective or institutional one. It must be based on duly grounded conviction, and must be presented in writing and be exercised consistently.
- Conscientious objection only applies to direct providers and not to administrative or support personnel.
- A provider who asserts conscientious objection has an obligation to immediately refer the patient to another health care worker who can provide the requested medical service.

- Essentially, states are responsible for regulating and supervising the provision of health care services to ensure the effective protection of the rights to life and humane treatment. In this context, the use of conscientious objection cannot violate a person's right to life or to humane treatment.

Moreover, the European Court of Human Rights found that for conscientious objection to be protected under law, the belief must have sufficient force, seriousness, cohesiveness and importance.