



Unconscionable

WHEN PROVIDERS DENY ABORTION CARE

The International Women's Health Coalition

advances the sexual and reproductive health and rights of women and young people, particularly adolescent girls, in Africa, Asia, Eastern Europe, Latin America, and the Middle East. IWHC furthers this agenda by supporting and strengthening leaders and organizations working at the community, national, regional, and global levels, and by advocating for international and U.S. policies, programs, and funding.

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Women and Health in Uruguay (Mujer y Salud en Uruguay, MYSU)

is a non-governmental, feminist organization whose mission is to promote and defend sexual and reproductive health and rights from a gender perspective. It has a staff and a network of professionals and associated researchers at a national and regional level. MYSU carries out four main lines of work: advocacy, research, communications, and training and technical assistance.

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Executive Summary

The global women's movement has fought for many years to affirm safe and legal abortion as a fundamental right, and the global trend has been the liberalization of abortion laws. Progress is not linear, however, and persistent barriers prevent these laws and policies from increasing women's access to services. One such obstacle is the growing use of conscience claims to justify refusal of abortion care.

Often called "conscientious objection," a concept historically associated with the right to refuse to take part in the military or in warfare on religious or moral grounds, the term has recently been co-opted by anti-choice movements. Indeed, accommodations for health care providers to refuse to provide care are often deliberately inserted into policies with the aim of negating the hard-fought right to abortion care.

Existing evidence reveals a worrisome and growing global trend of health care providers who are refusing to deliver abortion and other sexual and reproductive health care. This phenomenon violates the ethical principle of "do no harm," and has grave consequences for women, especially those who are already more vulnerable and marginalized. A woman denied an abortion might have no choice but to continue an unintended pregnancy. She may resort to a clandestine, unsafe abortion, with severe consequences for her health or risk of death. She might be forced to seek out another provider, which can be costly in time and expense. All of these scenarios can lead to health problems, mental anguish, and economic hardship.

International human rights standards to date do not require states to guarantee a right to "conscientious objection" for health care providers. On the contrary, human rights treaty monitoring bodies have called for limitations on the exercise of conscience claims when states do allow them, in order to ensure that providers do not hinder access to 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 patient access to services.

Noting the increase in the use of conscience claims by health care providers to deny abortion to those who seek them, with dire consequences for women, the International Women's Health Coalition (IWHC) and *Mujer y Salud en Uruguay (MYSU)* co-organized the *Convening on Conscientious Objection: Strategies to Counter the Effects*, in August 2017. The convening brought together 45 participants from 22 countries, including activists and advocates, health and legal professionals, researchers, academics, and policy-makers. Over three days, 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.

Participants at the IWHC- and MYSU-led convening agreed that, while health care professionals are entitled to their religious beliefs, they must not prioritize these beliefs over their duty to provide services. Patients' health and rights should never be subordinate to providers' individual concerns. Health care providers who put their personal beliefs over their professional obligations toward their patients threaten the health care profession's integrity and its objectives. Nothing would stop such individuals from joining the health care profession, but they ought to specialize in fields in which their abilities to provide comprehensive services is not undermined by their personal beliefs.

Existing evidence reveals a worrisome and growing global trend of health care providers who are refusing to deliver abortion and other sexual and reproductive health care. This phenomenon violates the ethical principle of “do no harm,” and has grave consequences for women, especially those who are already more vulnerable and marginalized.

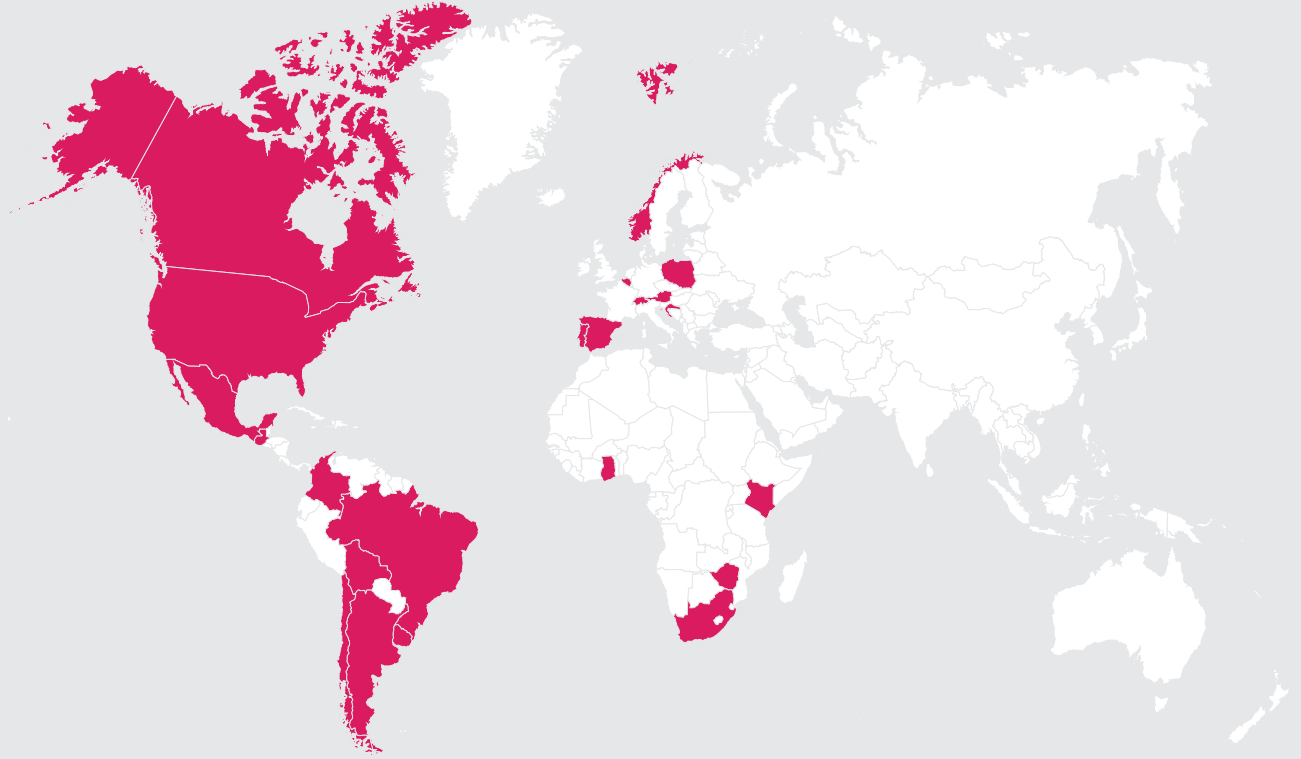
Joining the health care profession is voluntary, unlike conscripted military service. The military objector pays a price, often undergoing a government vetting process, carrying out obligatory alternative service, and frequently facing stigma and discrimination. In the case of the refusal of health care based on conscience claims, the providers do not pay a price, while others do. The most severely affected, of course, is the person denied care. Providers who refuse to deliver a service also increase the workloads of their peers who choose to uphold their professional obligations to provide comprehensive care. Finally, accommodating providers who refuse to perform essential aspects of their jobs can cause costly disruptions and inefficiencies in the health care system and divert precious resources away from service provision.

Currently, more than 70 jurisdictions have provisions that allow so-called “conscientious objection” in health care, according to analysis of preliminary data from the World Health Organization’s Global Abortion Policies Database. Many national laws stipulate that health care providers are required to carry out an abortion in case of an emergency, or if no one else is available. Evidence clearly shows, however, that even where regulations are in place, they are extremely difficult—and costly—to enforce. Despite the difficulty of regulating conscience claims, participants agreed that governments should enforce regulations and ensure that all women are able to access affordable, comprehensive health care.

Most convening participants agreed that health care policies should not allow for the refusal to provide services based on conscience claims. Where policy-makers are revising abortion laws or policies, they should not make references to conscience claims. Enshrining into law the notion that providers’ personal beliefs can determine the provision of health care opens up the door to abuses and legitimizes conscience claims.

Finally, the convening 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.” They agreed to bring the agreements from the convening, and the recommendations captured at the end of this report, to their own work, so that no one is denied their right to health care.

The convening brought together...



45 participants from **22** countries



ACTIVIST/ADVOCATE—17



HEALTH PROFESSIONAL—12



LAWYER/LEGAL PROFESSIONAL—10



RESEARCHER/ACADEMIC—9



OTHER/POLICY MAKER—1

with **diverse** professional backgrounds.*

* Data regarding participants' professional background was drawn from the participant feedback survey. Some participants chose more than one response (and are counted twice here). Response rate was 34/45 (76%).

I. Background

The International Women’s Health Coalition (IWHC) and Mujer y Salud en Uruguay (MYSU) co-organized a global Convening on Conscientious Objection: Strategies to Counter the Effects, in August 2017. This meeting, designed to analyze and address the phenomenon of health care providers refusing to provide abortion care by using personal belief as a justification, grew out of an IWHC-MYSU study of the factors that led to the liberalization of Uruguay’s abortion law in 2012.¹ Examining the outcomes of the reform process in that country underlined the urgent need to address the growing claims of “conscientious objection” by health care professionals in order to refuse to provide abortion services.

Called to action by the global expansion of this barrier to abortion access and the experiences of women who were denied their right to an essential service, IWHC and MYSU brought together diverse actors from countries worldwide. Forty-five participants from 22 countries² convened in Montevideo, Uruguay, where MYSU is based. Participants included activists and advocates, health care and legal professionals, researchers, academics, and policy-makers (appendix A). The convening catalyzed an agreement that proponents of women’s rights should challenge the use of conscience claims to deny access to abortion care. The participants also identified strategies to counter the adverse effects that the refusal to provide care can have on the health and rights of those needing services.

Throughout three days of presentations and working groups (appendix B), participants shared their experiences and expertise on policies and legal frameworks, ethics, health care training and provision, activism, research, and communications. The result: recommendations that advocates can use to tackle the growing trend of health providers using claims of “conscientious objection” to deny abortion services. In this report, we present the key points and strategies discussed at the convening, with practical recommendations at the end of each section, and a summary of takeaways in the conclusion.

II. Defining “Conscientious Objection” in Health Care and Understanding Its Scope and Consequences

The global women’s movement has fought hard to increase access to safe and legal abortion. These efforts have contributed to the growing recognition of abortion access as a fundamental right, with countries around the world liberalizing their abortion laws.³ In many instances, however, persistent barriers prevent full implementation of these laws and policies. One component of this backlash to progress is the increasing use of what is known as “conscientious objection” in the context of reproductive health care, which results in the denial of abortion services to those who need and want them.

The prevalence of denial of abortion based on conscience claims is a growing trend. Unfortunately, the scope of the problem is not well documented. While researchers and advocates continue to gather more data, existing evidence reveals that “conscientious objection” is a global phenomenon with grave consequences for women, especially those most vulnerable. Indeed, research into the experiences of women who face denial of abortion shows that despite their resilience, they are more likely to face harm to their physical and psychological health, socioeconomic outcomes, and life trajectories.⁴

Invoking so-called “conscientious objection” in health care represents a significant departure from the historical roots of this practice. “Conscientious objection” initially emerged primarily in Europe and North America in response to conscripted military service, where civilians—based on their religious or moral beliefs—could opt out of mandatory combat and instead participate in alternative service. Military conscientious objectors, unlike objectors in health care, have been vigorously vetted by government authorities and often have faced stigma, discrimination and even punishment for their anti-war position.⁵ (For more on this distinction, see section IV.)

In the context of health care, providers are now invoking “conscientious objection” to deny delivery of a service they oppose, claiming that the service is against their religious, ethical, or other beliefs. While this convening focused on abortion care, conscience claims are also used by health care providers and pharmacists to refuse other services, such as emergency contraception and other forms of contraception, health services for transgender people, and sterilization and infertility treatments. This practice is increasingly encouraged by some religious groups, especially in countries with a strong Christian tradition. Conscience claims are most prevalent in reproductive health care, in particular to refuse provision of abortion services.⁶ In some cases, it is not only the direct providers such as doctors and nurses who make these claims, but also those who are indirectly involved, such as administrators, managers, and even judges, who refuse to hear cases regarding the denial of legal abortion.⁷ In addition, many institutions invoke “conscientious objection,” when department heads, hospital managers, or political decision-makers invoke their personal beliefs on behalf of those who work at that institution.

Freedom of conscience is enshrined in domestic legislation in many countries, and internationally in instruments such as the Universal Declaration of Human Rights⁸ and the International Covenant on Civil and Political Rights (ICCPR).⁹ However, no international human rights standard recognizes a right to “conscientious objection” in the context of health care. Religious anti-choice groups have appropriated the term and extended it to the realm of health care.¹⁰ In doing so, they distort the historical use of the term, and contribute to obstructing sexual and reproductive health care access. Particularly in the case of abortion, they demonize a routine health procedure and those who provide or seek it. Claims of “conscientious objection” to abortion place the preferences of providers ahead of the rights of patients. Providers and institutions claiming personal or religious beliefs to justify the refusal to provide services undermine the objectives of their profession, which is to provide health care to those who need it.

Medical ethics guidelines require providers to prioritize patient care over conscience claims.¹¹ Current guidelines by the International Federation of Gynecology and Obstetrics (FIGO) state that a doctor objecting to abortion based on conscience “has an obligation to refer the woman to a colleague who is not in principle opposed to termination.”¹² 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.¹³ (For more on the discussion of health care ethics from the convening, see section IV.)

Countries follow the non-binding FIGO and WHO recommendations and interpret human rights laws to varying degrees, which has led to an array of policies on the use of conscience claims in health care. Currently, at least 70 jurisdictions (national and subnational) have provisions that allow refusal to treat in the context of unwanted pregnancies under so-called “conscientious objection,” according to preliminary data analysis from the newly launched WHO Global Abortion Policies Database.¹⁴ Most Global North countries allow individual health care professionals—and, in a few cases, institutions—to exercise “conscientious objection” to some extent through “refusal clauses” or “conscience clauses.” In the European Union, 21 countries grant the right to “conscientious objection.”¹⁵ In other regions, the policy responses are less systematically documented.¹⁶ Difficulty with enforcing the regulations is widespread, as discussed below in section III.

No international human rights standard recognizes a right to ‘conscientious objection’ in the context of health care. Religious anti-choice groups have appropriated the term and extended it to the realm of health care. In doing so, they distort the historical use of the term, and contribute to obstructing sexual and reproductive health care access. [...] Providers and institutions claiming personal or religious beliefs to justify the refusal to provide services undermine the objectives of their profession, which is to provide health care to those who need it.

The best estimates of the prevalence of the exercise of “conscientious objection” in health care comes from the few places, mostly in Europe, where those denying services are required to register or provide written notification of their status as “objectors.” In Italy, for example, 70 percent of obstetrician-gynecologists have registered with the Italian Ministry of Health as objectors to abortion. Survey data generate estimates in other countries. In the United Kingdom, a random sample of those training to become obstetrician-gynecologists showed about a third objected to abortion, and in Hong Kong, 14 percent of physicians surveyed reported their objection.¹⁷ (For more on the discussion of the use of conscience claims to deny services on the national level, see section III.)

Convening participants shared data from their home countries, adding to the picture of how the refusal to provide abortion predicated on personal beliefs is mounting worldwide.



Lilián Abracinkas, MYSU Executive Director, presents at the Convening on Conscientious Objection, August 2017 © IWHC

GHANA

Refusal to provide abortion care based on religious or moral beliefs is widespread in Ghana. Global Doctors for Choice (GDC) Ghana conducted the first ever study on the use of “conscientious objection” in the northern regions of Ghana from June 2015 to 2016. Barriers to accessing and improving health care quality acutely affect these areas, which have the lowest ratios of health care workers to population in the country. The study found that the overall prevalence of “conscientious objection” among health service providers—including doctors, midwives, and other mid-level professionals trained to provide abortion services—was 37.9 percent.¹⁸ GDC is preparing to conduct a similar study in the southern part of Ghana to get a picture of the prevalence at the national level.

SPAIN

Data on the prevalence of the use of “conscientious objection” in Spain is difficult to obtain. Media outlets indicate that the prevalence of medical professionals who have formally declared themselves to be objectors, a step that is legally required, is quite low, at about 1 percent. However, political leaders in some regions inflate the figures and report—without providing supporting data—a prevalence of up to 100 percent, in order to deny abortion services. In cities such as Galicia and Murcia, for example, some health care facilities claim that all of their doctors are conscientious objectors in order to justify referring pregnant women to clinics in other regions of the country.

URUGUAY

Since the enactment of Uruguay’s 2012 law allowing the voluntary termination of pregnancies, studies from MYSU have shown a high prevalence of “conscientious objection” claims, creating delays and other complications for women seeking abortion. In the more remote areas of western and northern Uruguay, between 60 to 80 percent of health care professionals working in gynecology refuse to perform abortion, with levels in the south estimated to be below 30 percent. Prevalence of “conscientious objection” also varies based on the type of facility. For example, in Montevideo, 53% of these professionals who work for public primary health care centers refuse to perform abortion; at Médica Uruguaya, a private facility, 27% refuse to do so; and at the specialized Women’s Hospital, 15% refuse.

Behind the numbers, there is a grim reality for those whose rights are violated as a result of providers claiming “conscientious objection.”¹⁹ A provider’s refusal to perform abortion services compounds the effects of the many barriers women face in health care: discrimination, stigma, financial burdens, lack of information, transportation difficulties, and limited autonomy to make decisions about their own bodies.²⁰ Despite the widespread recognition of the legal right to abortion, at least under some circumstances, the substantive right of access remains elusive because of these barriers, affecting poor and otherwise vulnerable people the most.

Convening participants who work at the community level shared experiences of women who have suffered due to their health care providers refusing to provide abortion services on the basis of their personal beliefs.

SPAIN

A woman in Spain learned late in her pregnancy that the fetus had a lethal anomaly. She was unable to find anyone in her area who would terminate the pregnancy. The local public health authority declared that “in order to respect the professionals’ right to objection on moral grounds,” she would have to travel to Madrid. By the time she arrived at the clinic there, she was bleeding heavily and had to go to a hospital for an emergency cesarean section to remove the fetus, which died soon after. They removed her uterus to stop the bleeding, which nearly killed her. She is now unable to have any more children.²¹

BRAZIL

In 2015, a young woman who was pregnant resulting from rape sought an abortion. She went to a specialized center for victims of violence at the Pernambuco State University Hospital. The hospital provided the young woman with a prescription for misoprostol to induce the termination of her pregnancy, which was less than ten weeks along, in accordance with Brazilian law. When she arrived, however, she heard from staff members: “These women take no care when they have sex and then come here to abort.” This carried on for several days—doctors, nurses, technicians, pharmacists, and others—continued to postpone the induction. She was anxious to receive services and for the ordeal to be over. Providers would say, “Have you thought about it more? Are you sure?” but then did not listen to her answers. Nevertheless, she was adamant in her desire to end the pregnancy and stayed. She did not receive treatment until five days later, when a resident physician recognized her from the previous shift and finished the process by manual vacuum aspiration.

KENYA

Atieno is 21 years old and the eldest daughter in her family. The pride and joy of her family and community in western Kenya, Atieno won a scholarship to attend university. After graduation, she found work and sent money home, becoming the breadwinner for her extended family.

Atieno fell in love with Andrew, a colleague at work. At first, Andrew was gentle and loving, but gradually he became distant and unkind. Atieno discovered that he had another girlfriend and tried to end the relationship. Andrew became very angry and forced her to have sex. Two months later, Atieno was shocked to discover that she was pregnant. Determined not to carry that pregnancy or go back to Andrew, she inquired at a clinic about terminating the pregnancy. The staff would not even discuss it because of their religious beliefs.

Another clinic also turned her away and even told her not to kill the “innocent baby.” Atieno was afraid and too ashamed to tell anyone about the rape and pregnancy. She became desperate and tried drinking toxic household chemicals that she had heard would terminate a pregnancy. When that failed, she inserted sticks into her cervix. She became terribly sick and developed a painful infection, but was still pregnant. She called her best friend who rushed her to a midwife trained in comprehensive abortion care. The midwife performed the abortion immediately and saved Atieno’s life.

As these stories illustrate, providers being allowed to prioritize their beliefs over their patients’ rights and needs—whether formally declared “conscientious objection” or not—hurts women.



Recommendations for Documenting and Exposing the Scope and Consequences of “Conscientious Objection” in Health Care:

- **Collect more data on the prevalence and consequences of “conscientious objection” claims in reproductive health care, specifically regarding abortion.** While the existing evidence suggests widespread use of conscience claims in health care, the data are not sufficient to capture the breadth and depth of this phenomenon, especially in countries with significant data gaps. A key recommendation for advocates and researchers is to continue developing methodologies to measure prevalence in a variety of contexts, as well as linking studies of prevalence to studies of impact to determine the consequences of conscience claims that deny the provision of abortion services.
- **In research and analysis, focus on those who are most affected in order to understand the consequences of the use of conscience claims to deny health care.** In investigating and exposing the consequences of conscience claims, research methods, data collection, and analysis should focus on the experiences of those who are denied access to abortion (or other health services). Centering on the perspectives and realities of those affected, especially the most vulnerable, exposes the power imbalance inherent in this situation, in which the health care providers’ personal views and beliefs are used to deny patients the services that they need. This shift in perspective can directly link to advocacy, litigation, and other strategies to mitigate and eventually eliminate the harms produced by the use of “conscientious objection” in health care.

Behind the numbers, there is a grim reality for those whose rights are violated as a result of providers claiming “conscientious objection.” A provider’s refusal to perform abortion services compounds the effects of the many barriers women face in health care.

III. Perspectives from International, Regional, and National Laws and Policies

International Human Rights Law and Agreements

International human rights treaties include the right to freedom of conscience, thought, and religion, and the right to the enjoyment of the highest attainable standard of health as fundamental human rights. The majority of countries in the world have ratified these treaties, which include the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).²² Treaty monitoring bodies provide guidance for interpretation of these rights through adopted documents, such as general comments or recommendations and concluding observations.

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.²³

Following are a few examples of the evolving human rights standards for state obligations to address the barrier that “conscientious objection” poses to accessing abortion services.

- **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 abortion 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
- **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

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- 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
-
- **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
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- **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
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- 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
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Legal experts at the convening pointed to the fact that international treaty monitoring bodies often ask questions about unsafe abortion linked to increased maternal mortality and morbidity. They do not consistently ask, however, about all the barriers to access safe abortion. The legal experts stressed the importance of utilizing treaty bodies and other country reviews of international agreements, including the Universal Periodic Review, to comment on the exercise of “conscientious objection” and its effects. Civil society advocates can raise concerns in shadow reports or letters to such monitoring bodies, showing how the use of refusals based on “conscientious objection” denies services, hinders access to care, and contributes to the incidence of unsafe abortion and other harms, often compounding other barriers that adversely affect poor and vulnerable women the most. The United Nations and other international agencies such as the World Health Organization should also raise the issue when addressing barriers to care and links to maternal death.

In addition to international human rights law and mechanisms, convening participants reviewed noteworthy cases from the European and Latin American human rights systems. These have also established that the use of “conscientious objection” cannot obstruct the rights of individuals to health care services they are lawfully entitled to receive, and that to do so amounts to a violation of the right to privacy and other human rights.

European Human Rights Law and Jurisprudence

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.

In the 2011 case of *R.R. v. Poland*, a woman was denied access to timely prenatal genetic examinations, in part due to conscience-based refusal, after potentially severe fetal abnormalities were discovered during a sonogram. The additional examination results would have informed her decision on whether to terminate her pregnancy, to which she was legally entitled under Polish law, yet doctors and hospital administrators repeatedly denied her these diagnostic tests until the pregnancy was too advanced for abortion to be a legal option.³²

In the 2012 case of *P. and S. v. Poland*, a 14-year-old became pregnant as a result of rape, but encountered numerous barriers to obtaining an abortion to which she was legally entitled to receive, in part due to the use of “conscientious objection.” She was subjected to coercive and biased counseling by a priest and was removed from the custody of her mother, who supported her decision to have an abortion. She also discovered that confidential information about her pregnancy had been divulged to the press. Eventually, she was able to have the abortion, but did so clandestinely, far from her home, and without proper post-abortion care.³³

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.³⁵

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

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.



European Court of Human Rights. © David Betzinger, Council of Europe

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

Legal Decisions in the Human Rights System in Latin America

The Inter-American Court of Human Rights (IACHR), together with the Inter-American Commission on Human Rights, are the systems that serve to uphold basic rights and freedoms for the Organization of American States.⁴³ Unlike the European Court of Human Rights, the IACHR has not yet had the opportunity to rule on “conscientious objection” in health care contexts.⁴⁴ Given the lack of rulings on the issue in the Inter-American system to date, the Inter-American Commission on Human Rights uses the standards established by the decisions from the Colombian Constitutional Court, which constrained the use of conscience claims to refuse abortion services.⁴⁵

In 2006, the Colombian Constitutional Court partially decriminalized abortion. In 2008, the Court clarified the law with a ruling on the case of a 13-year-old girl who was refused an abortion by a health facility and subsequently was forced to carry out her pregnancy resulting from rape. The Court established more stringent limitations on the use of “conscientious objection,” notably stating that the law does not permit institutional objection to abortion, and that only individuals, not institutions, have the right to refuse to provide abortion services based on conscience. They also restricted the ability to make conscience claims to the individuals directly involved with the abortion procedures, which would not include administrative staff, and required the health care provider

Given the lack of rulings on the issue in the Inter-American system to date, the Inter-American Commission on Human Rights uses the standards established by the decisions from the Colombian Constitutional Court, which constrained the use of conscience claims to refuse abortion services.

refusing to offer care to make a written statement. Notably, the Court fined the health facility that denied this girl an abortion, also mandating that it financially compensate her.⁴⁶

While not pertaining directly to abortion, the IACHR passed landmark jurisprudence on women's human rights in 2012, in the case of *Artavia Murillo et al. v Costa Rica*. Artavia Murillo brought a case to the IACHR on behalf of nine infertile couples, challenging Costa Rica's stance that deemed in vitro fertilization (IVF) unconstitutional. Murillo successfully argued that barring the couples from IVF violated their rights to privacy, to family life, and to non-discrimination. The IACHR's decision sets an important precedent, as it establishes states' responsibilities to protect citizens' reproductive autonomy and their access to reproductive health services, creating links between the rights to privacy, family life, and personal integrity and the access to health care. This provided grounds to challenge laws that criminalize women's access to safe and legal abortion, including situations in which "conscientious objection" is used to prevent their access to abortion services.⁴⁷

Abortion as a Human Right in Africa

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."⁵⁰

The Maputo Protocol and the General Comment no. 2 on article 14 declare that access to safe abortion is a human right. Those who oppose the recognition of this right, however, claim that Western countries have imposed this position. By claiming the "un-African-ness" of abortion, its opponents are discrediting the efforts to liberalize abortion laws. "Culture" is pitted against "rights," with "rights" treated as if they are "invaders." Those who argue for "conscientious objection" take advantage of this conflict to justify their arguments.⁵¹

Only relatively recently have international human rights bodies begun to criticize and advise states on the use of conscience claims to refuse to provide abortion care. They have not yet addressed the issue comprehensively, and the development of international human rights standards in this area is still in a relatively nascent stage. This means that reproductive health advocates have a meaningful opportunity to shape human rights obligations in order to ensure that they protect women's dignity and rights when they are seeking the health care they need and want. It is also worth noting that some national governments have not carried out the recommendations of international human rights bodies, creating an opportunity for advocates to hold governments accountable to these standards.

National Laws and Policies

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. 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.

Countries in which the law allows abortion under certain conditions address conscience claims made by health care providers in different ways. Some laws define who can use personal beliefs or religion to justify their refusal to provide—or even participate in—abortion services. For example, laws may specify that they apply to the direct provider only, or they may also apply to auxiliary health care workers or administrative staff. The laws of only two countries, France and Uruguay, specify that private facilities can accommodate refusals of abortion care based on conscience claims.

A few countries ban refusals by health care providers outright.⁵³ Many more regulate the use of so-called “conscientious objection,” requiring those refusing to provide abortion services to adhere to certain conditions; for example, 31 jurisdictions require objecting health care providers to refer women to other facilities to receive services.⁵⁴ Other regulations include the requirement that objectors register with the government, provide written confirmation of their position to their employer, and/or inform their patients. Many national laws stipulate that providers must carry out an abortion in the case of an emergency, or if no one else is available. Evidence clearly shows, however, that even where regulations are in place, they are extremely difficult—and costly—to enforce. Indeed, many providers who object to abortion care also refuse to refer or to provide emergency care, claiming that those actions would make them complicit in the provision of abortion.

Convening participants shared experiences from their countries, examining the way policies on “conscientious objection” to abortion play out in various contexts. Their examples indicate that regulations surrounding conscience claims rarely guarantee access to abortion services.

More robust research on the impact of “conscientious objection” in South Africa is needed, but the evidence is sufficient to show that current regulations are not effective and that the refusal to provide care is a significant barrier to access.

SOUTH AFRICA

Where regulations are not working



Taking effect in 1997, the Choice on Termination of Pregnancy (CTOP) Act of South Africa is the most liberal abortion law in Africa. It legalizes voluntary abortion through 12 weeks of pregnancy, and without time limits in the cases when pregnancy is a result of rape; when the fetus is unlikely to survive; or when there is a risk to the woman’s life, mental, or physical health. The CTOP Act has not resulted in the consistent availability of abortion services; currently, fewer than 50 percent of licensed facilities are providing abortion services to their communities.⁵⁵ Medical abortion is not well implemented, and mifepristone, though legal, is not on South Africa’s essential drug list and often is unavailable.

The CTOP Act does not specifically mention a right to “conscientious objection” for health care providers, but the Act is clear on providers’ professional obligations. Refusal to provide abortion applies only to the actual procedure, meaning that those not directly involved do not have the right to refuse. Health care professionals are under legal and ethical obligations to provide care for any patients with complications from abortion. Unfortunately, the implementation of these regulations is not monitored or enforced.

Managers, professional staff, and administrators often do not have clear understanding of the obligations stated in the CTOP Act. Providers do not receive training on the content of the law, or on the limits on the exercise of “conscientious objection.” Medical school training is often inadequate and, in some instances, lawyers deliver lectures to students about how to “get out of doing abortion,” rather than teaching them about their ethical and professional obligations under the CTOP Act. Some medical students have objected to learning how to care for women who present with incomplete abortion and thus need emergency care, clearly a violation of the CTOP Act.

More robust research on the impact of “conscientious objection” in South Africa is needed, but the evidence is sufficient to show that current regulations are not effective and that the refusal to provide care is a significant barrier to access. When health care providers turn women away, the experience is often traumatic for women, who have nowhere to report this misconduct and who may not question the legality of denying abortion care.⁵⁶

CHILE

Where regulations in a newly liberalized law have yet to be tested



In August 2017, after more than 20 years of struggle, Chile decriminalized abortion in three cases: when the life and health of the woman is at risk, when there is a fetal abnormality which makes it unlikely to survive, and when a pregnancy results from sexual violence.

Reproductive rights advocates celebrated this legislative victory. But they remain cautious because Chile's law allows the use of "conscientious objection," both at the institutional level and from any employee who participates directly or indirectly in abortion procedures. The new law limits the scope of conscience claims by requiring objectors to refer patients to an alternative clinician who is willing to provide the abortion.⁵⁷ But advocates

recognize that it will be difficult to ensure that the regulations are implemented effectively, and that it will be hard to track what happens inside health care institutions, especially in faith-based facilities. Indeed, as of March 2018, seven institutions had invoked "conscientious objection" in order to refuse to provide abortion. Reports show that these institutions have not gone through the required process of declaring their objection to the government, even though they are obligated to formally register with authorities.⁵⁸

Given that Chilean law allows "conscientious objection," reproductive health advocates believe that a state entity such as the Ministry of Health should be responsible for protecting and guaranteeing access to abortion, and that the government should establish an impartial body to monitor abortion service delivery within both public and private institutions.

Where the use of "conscientious objection" in health care is not allowed, the explicit expectations of providers and the mechanisms for holding them accountable to their professional obligations facilitates access to high quality and evidence-based reproductive health care.

PORTUGAL

Where the obligation of hospitals to perform abortion limits the negative impact of “conscientious objection” on women



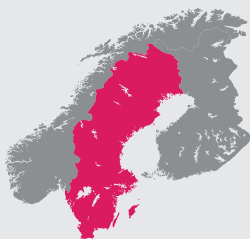
Until 2007, Portugal only allowed abortion in cases that would save a woman’s life, when a fetus has severe abnormalities, or for pregnancies resulting from rape. In July of that year, protests led to an expansion of the law, allowing women to have voluntary abortion for up to 10 weeks of pregnancy. The 2007 law defines and regulates the use of “conscientious objection:” only those directly involved in providing abortion care are allowed to refuse based on personal beliefs. Furthermore, the provider who refuses must submit a written statement to their hospital director clarifying why they object and confirming their agreement to provide an abortion if necessary to save the woman’s life. They also must inform the patient, refer the patient to

a non-objecting abortion provider, and cannot participate in counseling. Research shows, however, that health care providers often do not follow these requirements.

The national public health system in Portugal provides abortion services, and all gynecological departments must have at least one doctor willing to perform abortion. This legal obligation has made it possible for patients to access abortion services near their homes. The relatively small size of Portugal is another supporting factor for women to receive care without having to travel far. While prevalence of “conscientious objection” in Portugal is not well documented, it appears women are able to access abortion services.⁵⁹

SWEDEN

Where “conscientious objection” in health care is not allowed



Sweden, along with Iceland and Finland, prohibits under any circumstances the refusal to treat patients, including the use of “conscientious objection” in reproductive health care. Sweden’s Abortion Act of 1975 gives women the right to safe, voluntary abortion without delay. Because it is a rights-based law, abortion is not included in the criminal code. Women are not required to provide a reason up to 18 weeks of pregnancy; after 18 weeks, women must give a reason, although there is no upper time limit or restriction on the reasons.

Because the Swedish Abortion Act does not allow “conscientious objection,” medical authorities have established abortion care as a professional obligation for obstetricians-gynecologists and midwives, and all hospital obstetrics-gynecology departments are required to perform them. Health care providers receive mandatory abortion training as part of their medical education, and schools dissuade most anti-choice students from entering the obstetrics-gynecology or midwifery specializations. Furthermore, as in Norway, heads of hospitals or clinics in Sweden can refuse to hire a provider who objects to abortion or to contraception counseling.

In this legal environment, where the use of “conscientious objection” in health care is not allowed, the explicit expectations of providers and the mechanisms for holding them accountable to their professional obligations facilitates access to high quality and evidence-based reproductive health care.⁶⁰

THE UNITED STATES OF AMERICA

Where federal and state laws protect refusal of care



The United States has a patchwork of laws at the federal and state levels, which grant accommodations and exemptions allowing both institutions and individuals to refuse to provide reproductive health care, particularly abortion and abortion-related services. At the federal level, these began shortly after the US Supreme Court's 1973 decision in *Roe v. Wade*, which affirmed a woman's constitutional right to abortion. These accommodations and exemptions are legislated by the Church Amendment (1973), the Coats Amendment (1996), and the Weldon Amendment, the latter of which has been tied to the annual appropriations bill that funds the Departments of Labor and of Health and Human Services every year since it was passed in

2004. State laws have also passed throughout the US and now exist in almost all 50 states. In 45 states, for example, laws allow refusals to provide abortion-related services, with 43 states permitting institutions—not just individuals—that provide health care services to do so. There are laws in 18 states allowing refusals to provide sterilization services and 12 allowing refusals to provide contraception.⁶¹

In January 2018, the Trump Administration proposed a new rule intended to dramatically expand the right to refuse to provide patients reproductive and other health care, and announced the creation of a new Conscience and Religious Freedom Division within the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) to enforce it.⁶² Preliminary government estimates indicate that establishing mechanisms to conform to this new rule will cost the health care system more than \$300 million.⁶³ By prioritizing health care providers' beliefs over patients' health and rights, it is clear that the administration's goal is to enable sweeping discrimination against women, transgender people, and others seeking health care.

Existing policies allowing refusal to provide medical services, which the administration seeks to expand with its proposed rule, already affect many people in a system dominated by private health care service providers. Today, one in six hospital beds in the United States is in a Catholic hospital, either owned by or affiliated with a Catholic health system. Those hospitals are governed by a set of ideologically driven policies, or "Ethical and Religious Directives," which are issued by the US Conference of Catholic Bishops (USCCB) rather than by medical professionals. The Directives prohibit a range of reproductive health services, including contraception, sterilization, many infertility treatments, and abortion, even when a woman's health or life is jeopardized by a pregnancy. As a result, individual health care providers in these hospitals are prevented from providing medically appropriate care to patients, endangering patients' health and lives. Furthermore, these institutional rules may conflict with patients' rights to make medical decisions according to their own religious or moral beliefs, and can exacerbate existing inequalities in accessing health care.⁶⁴ A 2018 report reveals that women of color are more likely to access Catholic hospitals, and thus disproportionately rely on religiously restricted reproductive health care in many US states. This finding is alarming given that women of color face other health disparities that increase their need for comprehensive reproductive health care.⁶⁵

By sharing these and other countries' experiences and drawing on participants' expertise in international, regional, and national law, the convening discussion illuminated ways that advocates can use the law, legal systems, and the courts to continue to protect and expand abortion rights by challenging the use of conscience claims to deny abortion services. Taking into consideration that contexts are different and one approach won't fit all, convening participants discussed recommendations for ways to address the use of "conscientious objection" to abortion through laws and policies. They pointed out that the majority of attempts to regulate denials to provide services based on conscience claims are patchy and often ineffective at guaranteeing access to abortion services. They recognized that abortion opponents have turned "conscientious objection" into a bargaining chip by insisting it be included in the law at a national or sub-national level and then using it to limit access.

While convening participants did not come to a consensus, the majority recommended that—given the difficulty of enforcing regulations—laws and policies ought to avoid any mention of "conscientious objection." For countries where abortion laws are under review or revision, advocates and allied stakeholders should strive to draw attention to the consequences of refusal to provide care, ensure that they do not use the term "conscientious objection," and do not allow exceptions for health care providers to refuse to provide care based on personal beliefs. Where laws already exist, provisions may need to be made for health care professionals already in service while preparing the next generation of providers to think differently about balancing personal beliefs with professional and ethical obligations. At the same time, advocates must hold governments accountable for the provision of high quality and widely available reproductive health services through the enforcement of regulations on conscience claims.



Jorge Basso, Minister of Health of Uruguay, speaks to reporters at the Convening on Conscientious Objection, August 2017 © IWHC



Recommendations for Advocating and Developing Laws and Policies:

- **Utilize international and regional human rights mechanisms.** Advocates can help shape the application of international law on this issue by engaging with treaty monitoring bodies through shadow reports or letters, raising the use of so-called “conscientious objection” and the implications for women’s rights and health. International agencies such as the WHO and professional organizations such as FIGO can also influence international law, and hence, states, by documenting the consequences of the refusal to provide care and by developing clear standards for the obligations of health care professionals and states. Advocates should also work at the national level to include the “conscientious objection” issue in official government reports to international and regional entities, such as Universal Periodic Review to the Human Rights Council. To this end, they should continue to seek opportunities, such as this convening, to generate strategies for engaging with international and regional bodies and for utilizing country reporting processes. In some instances, this requires skills and capacity building for advocates, as well as more information about making use of these strategic opportunities. To that end, it would be helpful to document all relevant existing international and regional human rights law and jurisprudence, to map the structures that have the ability to issue rulings and recommendations that can influence government actions, and to translate this information into multiple languages.
- **Shape the development of national laws and policies.** As discussed above, the majority of the participants concluded that abortion laws should not include “conscientious objection,” and should not allow for exceptions for reproductive health specialists—such as obstetrician-gynecologists and midwives—to refuse to provide services on the basis of personal beliefs. The law should be clear that health care providers are required to uphold professional obligations in the context of unintended pregnancies.
- **Hold governments accountable for enforcing regulations.** In instances where the law already allows for such denial of services, governments should strictly limit and regulate the use of conscience claims. The relevant authorities must make these regulations widely known in the health and legal sectors, as well as within civil society. They also need to establish mechanisms to enforce and monitor compliance with the regulations and to sanction their misuse or abuse. At the same time, advocates should hold governments accountable for ensuring that health care professionals refusing to provide care do not hinder access to abortion. In specific instances, litigation might be an effective tool. In others, the emphasis would be on advocacy around changing the law, strengthening regulations, and enforcing compliance.

IV. Perspectives from the Health Care Sector

Ethical perspectives

At the heart of the health care profession is a provider's promise that the patient's well-being comes first.⁶⁶ Claims of "conscientious objection" to refuse abortion services violate this promise to do no harm and to serve patients. The decisions of "conscientious objectors" are by necessity not driven by professional judgments, but by personal convictions. The accommodation of such decisions is in conflict with the stated justification for the existence of the profession.

Bioethicists, health care providers, activists, and others at the convening agreed that denial of abortion services based on conscience claims directly violates health care providers' obligations to serve the public good and to put their patients' health first, and in fact causes harm. It is unethical to allow one's personal, idiosyncratic beliefs to undermine the rightful claim of patients to access essential health services. This ultimately undermines the equal rights of the patient.⁶⁷ It also reinforces an existing power imbalance between provider and patient, which feminists have long identified as a significant obstacle to realizing sexual and reproductive rights. Patients are the weaker party in this situation, and providers prioritizing their own beliefs over the needs and rights of those they are supposed to serve shifts even more power into their hands, often exacerbating gender inequality, as well.

Convening participants unpacked this reasoning and considered the costs of accommodating "objectors" in health care. Doing so creates a conflict between a patient's right to receive professional care and the conscience claims of a health care professional. As a result, patients often experience significant inconvenience and frequently are unable to obtain the health care services they wish to access and are entitled to receive. Service delivery becomes unpredictable and substandard. Furthermore, accommodating those who refuse to treat causes disruption in the health care system. It can create costly inefficiencies and inequitable workloads, overburdening those health care workers who honor and uphold their professional obligations and distorting resource allocation in health care systems that often are already strained.⁶⁸

The convening participants recognized that patients typically end up bearing the burden of the refusal to provide services. Meanwhile, health care providers who refuse to treat rarely face any consequences for their actions in a field that they entered voluntarily and where they are the monopoly provider of the services. This is a key distinction from "conscientious objection" to conscripted military service. Military objectors have to substantiate the reasons for their refusal and undergo a rigorous review process. Oftentimes, they have to do alternative, non-combatative service, pay a fine, or face heavy punishment, from the stigma and discrimination associated with being a "draft dodger" to imprisonment, and even execution.⁶⁹ When providers refuse to carry out abortion services, it is the women who pay the price—facing additional costs, increased stigma, and sometimes the loss of life.⁷⁰

Requiring health care providers to fulfill the core competencies and obligations of their specific line of work does not lead to unjust discrimination in hiring, unfair limitations on the equality of opportunities, or reduced diversity of the field. Limitations on equal opportunity arise in many contexts and for many reasons. For example, visual impairment might make an individual unsuited to becoming a pilot, and a hand tremor would make dentistry an inappropriate choice. These limitations are tied to the requirements of the profession and do not deny anyone the right to hold personal, private religious or moral beliefs, so long as they do not use them to deny others their rights.⁷¹

In Sweden, Finland, and Iceland, this ethical perspective has shaped health care law practice. These three countries do not permit public health care providers to refuse to perform legal medical services for reasons related to personal beliefs when the service is a part of their professional duties. Because abortion is a duty of obstetrician-gynecologists and midwives in Sweden, employers list it as a job requirement, and can decide not to hire an anti-abortion provider. Mandatory training in abortion care for these specializations bolsters this approach.⁷²

Convening participants shared insights from their own experiences to enrich the discussion of professional ethics and the duties of health providers. Said one provider from South Africa: "Health workers should be servants to the patients.... There should be no place for health workers to refuse abortion." He further described the complicated medical environment he has seen firsthand, and the way that "conscientious objection" interacts with other barriers such as limited abortion care skills due to inadequate training for providers, weak health systems infrastructure, and stigma for both abortion providers and the women seeking abortion.⁷³

NURSES IN SOUTH AFRICA

Sam is a nurse who provides abortion care at a public hospital in Eastern Cape, South Africa. She has been doing so for four years, and is the only one who provides abortion care in the women's clinic of the hospital where she works. However, Sam is not entirely comfortable with abortion. When approached by management, she agreed to be involved with abortion care because she realized that many women die from unsafe procedures, and because if she did not get involved, women would continue to die. Like other nurses and other providers who perform abortion, she feels isolated and neglected. Sam remembers that, when she first started at the women's clinic, the department of health would organize sessions where abortion providers from different hospitals would get together and discuss their experiences. She wishes those sessions or something similar could be reinstated, so that she and others like her could have access to support. At some point, Sam will retire from abortion care due to burn out. Who will replace her?

Who pays the costs for the refusal of abortion care?



Calculating the costs and who pays them

Convening participants talked about health care providers in their communities who work in both the public and private sectors. In some cases, health care professionals refuse to provide services, claiming “conscientious objection” during their shifts in a public facility, but offering abortion care in their private offices. This duplicity has several causes and implications. First, where policies allow claims of “conscientious objection,” providers often abuse these accommodations by “objecting” in some cases and not in others.⁷⁴ Second, this illustrates the difficulty—and some argue, the futility—of attempting to regulate refusal to treat on the basis of conscience. Third, it indicates there are incentives and disincentives driving the behavior of health care providers who invoke “conscientious objection,” which go beyond their faith or conscience claims.

An analysis of “conscientious objection” to abortion from an economic perspective showed that access to abortion entails an unequal and inefficient distribution of resources. Health care providers represent a monopoly because they offer a sought-after, specialized, and finite service. In this context, the stigma attached to abortion provision operates as a disincentive to providers in two ways. It manifests as a disincentive materially because providers perceive that stigma causes patients and other health care providers to shun them, which may hinder them from providing other more lucrative and “acceptable” services. It also manifests itself socially, because of discrimination, isolation, and lack of respect from their colleagues and communities more broadly. In other words, providers experience incentives to refuse to treat, claiming “conscientious objection,” in order to maintain their reputations, align themselves with the status quo, and to avoid the stigma and inconvenience of providing abortion services. At the same time, providing abortion exclusively in the private sector offers some doctors an opportunity to earn an income outside the public sector. Thus, providers who use conscience claims to refuse services may view it as a rational decision, favorable for them as individuals both materially and socially. Given that reproductive health care providers represent a state-sanctioned monopoly on service provision, this cost calculation exacerbates the power imbalance between providers and patients.⁷⁵ The providers make a decision that benefits them in multiple ways, while their patients incur the significant costs of risks to health and well-being, and of having to search for a willing abortion provider.⁷⁶

Strategies to alter these incentives and disincentives should exact a cost for health care providers who deny abortion services, and offer benefits to those who provide them. Participants discussed proposals similar to the measures required of conscientious objectors to military service, such as undergoing a review process to substantiate their claims, and fulfilling an alternative service. They also deliberated, but did not come to agreement, on the strategy of creating a public registry of “objectors.” Participants discussed how this approach could be a step toward accountability and transparency. At the same time, in contexts where abortion is highly stigmatized, a public registry of “objectors” could make those who do not sign it more vulnerable by revealing their identities. It could also provide an incentive to register as a way of disassociating from abortion. Comprehensive measures that ensure women can access legal abortion services must accompany an approach such as a public registry, which by itself would be insufficient. Strategies focused on tipping the scales of incentives and disincentives in favor of patients’ rights would require the participation and leadership of the health sector and policy-makers.



Recommendations for Clarifying the Costs and Consequences of Health Care Providers' Actions:

- Reframe and rename.** Reframe the debate to clarify and emphasize that “conscientious objection” is a misnomer and a co-optation of an ethical practice used by people subjected to mandatory military service. In health care, it subverts the professional obligations and standards of people who joined their profession voluntarily. While convening participants did not come to consensus on what terminology to use, they considered such terms as “refusal to provide services,” “denial of services,” and “dishonorable disobedience,” which has been suggested previously.⁷⁷
- Reclaim the concept of conscience.** Do not cede the term “conscience” to those that privilege individual belief over professional conduct and the right to access or provide health care. Shine a light on the harmful consequences that the accommodation of conscience claims produces in the context of the provision of abortion. Emphasize the “conscientious commitment” and professional conduct of providers who prioritize patients’ rights.⁷⁸ Highlight that professional conduct and professional judgment require the provision of abortion services as an essential aspect of women’s health.⁷⁹
- Quantify the costs incurred by health systems due to claims of “conscientious objection” to abortion.** Managing conscience claims can be costly and can create inefficiencies in the allocation of scarce health care resources. Quantifying those costs would fill a gap in our understanding of the consequences of refusal of abortion care due to conscience claims.

Given that reproductive health care providers represent a state-sanctioned monopoly on service provision, this cost calculation exacerbates the power imbalance between providers and patients. The providers make a decision that benefits them in multiple ways, while their patients incur the significant costs of risks to health and wellbeing.

Training and supporting providers

The pervasiveness of “conscientious objection” to abortion not only affects patients seeking services, but also health care professionals who choose to provide them. Those who conscientiously serve women seeking abortion often face stigma and discrimination from their colleagues, exacerbating other obstacles that complicate their work.

Health care providers at the convening underscored the importance of comprehensive training and support for those who work in abortion care. They stressed the demands of the job and the physical, mental, and emotional toll it can take, especially for those who work in legally restrictive contexts or where abortion is highly stigmatized.

Convening participants also acknowledged that health care providers are at different points along a spectrum of views, including on the recognition of abortion as a human right. They emphasized the necessity of initially meeting providers in their comfort zone, while offering ongoing education and support to prevent stress, burnout, stigma, and trauma, and to move them toward becoming guarantors of the right to abortion.

Other health and social service professionals such as clinic managers, counselors, or social workers can also benefit from this type of education and support in order to gain the knowledge and confidence to refer clients for abortion as needed. Evaluation of programs that deliver training and technical assistance to these professionals have shown that they can be very effective at increasing their knowledge, skills, and intention to be responsive to women’s needs and their willingness to refer clients for abortion.⁸⁰

In order to maintain a pipeline of pro-choice providers, it is essential to establish a solid foundation of skills training, grounded in ethics and human rights. Professional organizations can play a leadership role in setting expectations and defining standards. Medical education, including both pre-service and in-service training, can be structured to provide sustained professional and psychosocial support to providers, and can advocate within the field of reproductive health care for those who are providing abortion services.

Those who conscientiously serve women seeking abortion often face stigma and discrimination from their colleagues, exacerbating other obstacles that complicate their work. Health care providers at the convening underscored the importance of comprehensive training and support for those who work in abortion care.

REPRODUCTIVE HEALTH CARE EDUCATION IN THE UNITED STATES: THE RYAN RESIDENCY PROGRAM AND THE FAMILY PLANNING FELLOWSHIP

MEDICAL EDUCATION IN ABORTION IN CONTEXTS WHERE OBJECTION IS ALLOWED

In the early 1990s, more than 20 years after the legalization of abortion in the United States, only 12 percent of obstetrics-gynecology (ob-gyn) residency programs had integrated routine abortion training. As a response, the Accreditation Council for Graduate Medical Education issued a mandate requiring ob-gyn residency programs to offer abortion training, but also allowing residents with a religious or moral objection to opt out. (All residents must have training and experience in managing complications of abortion and in providing all forms of contraception.)

The Kenneth J. Ryan Residency Training Program in Abortion and Family Planning was founded at the University of California, San Francisco (UCSF) in 1999 to help departments of obstetrics and gynecology integrate abortion training through an “opt out” rotation that encourages residents to clarify their values. It has expanded to 90 programs in the US, including in the conservative southern states.

All residents, even those who opt out, are expected to participate in values clarification exercises and in training along a continuum that includes: accompanying a woman through her abortion, observing abortion, participating in some aspects of an abortion, performing some indicated abortion, and providing post-abortion contraception. After this initial training, residents who continue to object to performing certain procedures on the basis of their beliefs will nonetheless provide a range of related services, including counseling, postoperative care, and the management of abortion complications.

Survey data from a review of the first ten years of the Ryan Program showed that residents, including those who participated only partially, gained significant exposure to all methods of first- and second-trimester abortion and contraception care. Nearly half of previously undecided residents became more likely to include abortion in their practice. Ninety-seven percent of residency program directors reported that training improved resident competence in abortion and contraception care.⁸¹

DEVELOPING LEADERS AND SUPPORTING PROVIDERS: THE FELLOWSHIP IN FAMILY PLANNING

The Fellowship in Family Planning, also originating at UCSF, is devoted to developing reproductive health leaders. During the two-year fellowship program, fellows work with leaders in the field to hone clinical and research skills to advance scientific evidence, become advocates, and learn about reproductive health in a global context. As part of a network of peer experts, they have opportunities to present research, establish a Ryan Residency Program to further integrate medical education, and connect with domestic and international leaders.

Where the law has recently changed to expand access—such as Uruguay in 2012 and Chile in 2017—there will be adjustments in the health care sector and beyond to accommodate policy progress. Convening participants recognized that any profession requires its members to adjust and adapt to keep up with developments in their field, including changes in law. They acknowledged that, in these evolving contexts, a transition period would be necessary to usher in meaningful changes in policies and practices. Programs like those described above can help prepare providers for the transition, and can also champion providers who take the lead on offering abortion services.

The convening participants discussed that there should not be any accommodations for “conscientious objection” claims in health care laws and policies. (See section III for policy recommendations.) They also developed recommendations and strategies for the health sector.



A member of the Sexual and Reproductive Justice Coalition in South Africa demonstrates the surgical abortion method at a panel on safe abortion, September 2017 © SRJC



Recommendations on Training and Supporting Health Care Providers:

- **Educate current and potential providers.** Integrate reproductive health and rights across education and training in health professions by creating training mandates. This includes ensuring that all who enter the health care field have knowledge of the public health consequences of illegal and legal abortion and of all methods of contraception and comprehensive abortion care, reserving in-depth technical knowledge for those who specialize in reproductive health. It also entails focusing on bioethics and human rights education, including values clarification on abortion, and the definition of professionalism in pre-professional studies as early as undergraduate education.
- **Elevate professional skills and commitments.** Encourage and support health care providers to pursue continuing professional development, to deepen their knowledge and skills on abortion care, to learn about ethics and human rights, and to clarify their values. For those providers who are ambivalent, help them to move along a continuum towards understanding abortion as a human right. Professional organizations and medical societies, medical and nursing schools, government agencies, and nongovernmental organizations can collaborate to ensure that abortion care is seen as a human right and a professional obligation of all those in reproductive health care.
- **Motivate those who provide care.** Create and institutionalize systems of accessible support networks for providers to combat stigma, isolation, stress, and burnout, and to enable them to sustain their practice. Develop ways to recognize and celebrate the hard, passionate work of providers through awards for leaders in the field, days of community and international solidarity, and the support to attend, network, and present at high-level regional and global meetings. Health care professional organizations or medical societies can play a leading role in motivating, recharging, and advancing the field.
- **Reach out to those who claim “conscientious objection” and hold them accountable to their professional duties.** In situations where “conscientious objection” is already codified, create educational programs for providers to learn all about clinical, psychosocial, and public health aspects of abortion. For those who continue to object, create obligations, for example, requiring them to justify their positions and to perform an alternative service. Similarly, they should assume responsibility for the burdens caused by their refusal to provide services for their patients, their peers, and the health care system by providing adequate and timely information and referrals to women, and by performing extra duties to relieve their non-objecting colleagues.
- **Foster leadership.** Providers who feel able to do so should be encouraged to embrace an advocacy role within their institutions and professional communities and among policy-makers. They should be supported to talk about their work and the women they serve, the evidence on safe abortion care, and the burden and consequences of “conscientious objection” for women and other providers.

V. The Role of Civil Society

Convening participants agreed that women's rights advocates have a significant role to play in challenging the use of "conscientious objection" to deny health care. Indeed, feminist movements have been the key to bringing about progressive social and political change, according to recent research. Women's rights organizing articulates the needs of marginalized groups, pressures policy-makers, brings global agreements to the local level, and influences public opinion.⁸²

As discussed above in section III, advocates can influence the development of new laws and policies. The following example illustrates that advocacy on the issue of conscience claims in health care requires careful preparation, relationships with decision-makers willing to lead, and an understanding of the political moment.

LESSONS LEARNED FROM WORKING WITH POLICY-MAKERS

A convening participant representing the European Parliamentary Forum on Population and Development (EPF) shared lessons learned in working with parliamentarians. In 2008, EPF attempted to introduce recommendations to counter unrestricted claims of "conscientious objection" to abortion in Europe at the Parliamentary Assembly of the Council of Europe. As a response, the rapporteur parliamentarian became a target of anti-choice opposition, which had mobilized quickly to counter the proposed recommendations. Meanwhile, supportive parliamentarians from Scandinavia and France were absent during the final vote. The rapporteur, with retirement around the corner, took a risk and moved to a vote. The proposed recommendations to restrict "conscientious objection" failed to pass by a slim margin. With this experience, EPF illustrated the risks of pushing the debate on "conscientious objection" without astute political maneuvering in cases when there is no strong majority voting for the issue and the opposition is mobilized. While they stressed the significance of working with parliamentarians, they emphasized the importance of building cross-party alliances to ensure continuity and broad support, the necessity of thoroughly understanding the political context, and the importance of timing.

While this example is drawn from an experience with a regional policy-making body, advocates at the national level also need to gauge the political opportunities and risks. If at all feasible, they should press for no allowance for "conscientious objection" in laws and policies on abortion and other health care. If laws do allow for exemptions on the basis of conscience, advocates should call for strict limitations on the use of those exemptions, and should demand that those who refuse to deliver services share some of the cost of the consequences. Advocates should hold governments accountable for implementing regulations on conscience claims, and for ensuring access to abortion without obstructions caused by the denial of services. Advocates can help shape the application of international law on this issue by engaging with treaty monitoring bodies, raising questions about the use of conscience claims and their consequences for women's rights and health. Finally, convening participants agreed that it would be helpful to document and disseminate information about relevant existing international and regional human rights law and jurisprudence, as well as national laws and regulations. (See section III for detailed recommendations for advocacy on laws and policies.)



At the March for Safe Abortion in Brussels on September 28, 2017, International Safe Abortion Day © IWHC

Reproductive justice is a useful organizing framework for developing a strategic response to the negative effects of conscience claims by health care providers. Coined by a women of color organization in the US,⁸³ reproductive justice is defined as the human right to maintain personal bodily autonomy, have children, not have children, and parent one's children in safe and sustainable communities.

South Africa, for example, has a constitution that is celebrated for its right-based framework for sexual and reproductive health. The realization of these rights, however, remains inequitable. In working to hold the government accountable, activists and advocates use reproductive justice to highlight intersecting barriers to human rights. Supporting this commitment, the Ministry of Social Development recognized the concept of reproductive justice as being achieved "when all people have the social, political, and economic power and resources to make healthy decisions about their gender, bodies, and sexualities." In 2014, the Minister stated that "the right of women to have an abortion should always be fully located and discussed as part of the rights—and the transformation of society—that enable the complete emancipation of women."⁸⁴

Using a reproductive justice perspective requires examining and deconstructing systems of power, addressing oppressions that intersect, focusing on the most vulnerable, and working together across issues and identities. This allows for an analysis that not only reveals the power imbalance inherent in a situation in which the personal beliefs of the more privileged trump the rights and needs of those with

less privilege and access, but also illuminates who is most affected. It also points to the importance of alliance-building. Refusals to provide care based on conscience claims go beyond abortion and apply to other aspects of sexual and reproductive health care, including contraception, sterilization, infertility treatments, and health care for lesbian, gay, bisexual, transgender, and queer (LGBTQ) people. Advocates for abortion access can build alliances with others affected by conscience-based denial of care and expose how these claims often harm the more vulnerable.

Advocates can also build alliances with organizations who share concerns about the effects of conscience claims, such as human rights and patients' rights groups. As in other struggles for reproductive justice, abortion rights advocates can look to generating support from organizations such as trade unions, university students, and lawyers' organizations.⁶⁵ In their efforts to build collective power, advocates should be aware of deliberate right-wing strategies that exploit existing tensions between groups, with the intention of fracturing alliances. For example, they aim to sow discord among people of faith on the issue of abortion, or to pit disability rights groups against abortion rights groups. In recognizing how the right wing seeks to exacerbate fault lines, advocates can strategize against these tactics to unite against shared opposition. Strategic spaces such as the convening are essential opportunities for advocates to build alliances across sectors and issues and to develop the best strategies for working together.

Finally, advocates using a reproductive justice lens can shape the narrative about the role of conscience claims in abortion provision and access. They can shine a light on the consequences for women's lives and on those who are most affected. Reclaiming the concept of conscience from those who are anti-choice is essential for protecting the right of health care professionals to provide abortion, affirming abortion as a human right, and ensuring that the health and legal sectors make this right a reality for women.



Refusals to provide care based on conscience claims go beyond abortion and apply to other aspects of sexual and reproductive health care



Recommendations for Civil Society Activism:

In addition to the strategies for the legal and health sectors (see recommendations from section III and IV), advocates should:

- **Show how refusal of services exacerbates other inequalities.** Highlight the effects of the refusal to provide services, particularly on those most marginalized, and make the case for limiting and eventually eliminating the option for health care providers to refuse. Using a reproductive justice framework to guide community organizing and advocacy focuses on the most vulnerable, examines and seeks to deconstruct power imbalances, and reveals intersecting causes of discrimination and inequality.

- **Build alliances across movements to share expertise and develop strategies to combat the use of conscience claims to deny services.** Women's rights activists should build alliances with other movements and affected communities to combat the effects of refusal to provide care.

Advocates for abortion access can build alliances with others affected by conscience-based denial of care and expose how these claims often harm the more vulnerable.

VI. SUMMARY OF RECOMMENDATIONS



Documenting and Exposing the Scope and Consequences:

- Collect more data on the prevalence and consequences of conscience claims regarding abortion.** Advocates and researchers should continue developing methodologies to measure prevalence in a variety of contexts, especially in countries with significant data gaps. Link studies of prevalence to studies of impact to determine the consequences of the denial of abortion services due to conscience claims.
- In research and analysis, focus on those who are most affected in order to understand the consequences of the use of conscience claims.** Research methods, data collection, and analysis should focus on the experiences of those who are denied access to abortion (or other health services), especially those who are the most vulnerable to the adverse effects.



Advocating and Developing Laws and Policies:

- Utilize international legal and regional human rights mechanisms.** Advocates can help shape the application and development of international law by engaging with treaty monitoring bodies, raising questions about the use of so-called “conscientious objection” and its implications for women’s rights and health. International agencies and professional organizations can also help influence international human rights standards by documenting the consequences of the refusal to provide care and developing clear standards for health professionals’ obligations. At the national level, advocates should work to include the issue in government and shadow reports to international and regional processes and entities.
- Shape the development of national laws and policies.** The majority of the participants concluded that abortion laws should not include conscience claims, and should not allow for exceptions for reproductive health specialists such as obstetrician-gynecologists and midwives to refuse to provide services based on personal beliefs.
- Hold governments accountable for enforcing regulations.** Where the law already allows for conscience claims to deny services, governments should strictly limit and regulate their use, e.g. requiring written notification, a referral to other health care providers, and the provision of care in cases of emergency or the inaccessibility of another provider. Conscience claims should never be allowed by institutions or individuals not directly involved in abortion procedures. Governments must make these regulations widely known, establish mechanisms to enforce and monitor compliance, and sanction their misuse or abuse. Advocates should hold governments accountable for strengthening and enforcing regulations and ensuring that everyone can access services without hindrance.



Clarifying the Costs and Consequences of Providers' Actions:

- **Reframe and rename.** Reframe the debate to clarify and emphasize that “conscientious objection” is a misnomer that subverts the ethics, obligations, and standards of the health care profession.
- **Reclaim the concept of conscience.** Do not cede the term “conscience” to those who prioritize individual beliefs over professional conduct and the right to access or provide health care. Shine a light on the harmful health consequences of conscience claims in the context of abortion care. Emphasize the “conscientious commitment” and professional conduct of health care providers who prioritize patients' rights.
- **Quantify the costs incurred by health systems due to claims of “conscientious objection” to abortion.** Managing conscience claims can be costly and can create inefficiencies in the allocation of scarce health care resources. Quantifying the costs would fill a gap in our understanding of the consequences of refusal to provide abortion care due to conscience claims.



Training and Supporting Health Care Providers:

- **Educate current and potential providers.** Integrate reproductive health and rights across education and training in the health professions by creating training mandates. Focus on bioethics and human rights education—including the values clarification on abortion—in pre-professional studies as early as undergraduate education.
- **Elevate professional skills and commitments.** Encourage and support healthcare providers to pursue continuing professional development in order to deepen their knowledge and skills on abortion care, learn about ethics and human rights, and clarify their values. Professional organizations and medical societies, medical and nursing schools, government agencies, and nongovernmental organizations can collaborate on this.
- **Motivate those who provide care.** Create and institutionalize systems of accessible support networks for health care providers to combat stigma, isolation, stress, and burnout. Develop ways to recognize and celebrate the hard, passionate work of health care providers. Health-related professional organizations and medical societies can play a leading role in motivating, recharging, and advancing the field.
- **Reach out to those who claim “conscientious objection” and hold them accountable to their professional duties.** In situations where “conscientious objection” is already codified, create educational programs for health care providers to learn about all aspects of abortion. For those who continue to object, create obligations; for example, require them to justify their positions and to perform an alternative service. They should assume responsibility for the burdens caused by their refusal to provide services.
- **Foster leadership.** Health care providers who feel able to do so should be encouraged to embrace an advocacy role within their institutions, professional communities, and among policy-makers to talk about their work, the women they serve, the evidence on safe abortion care, and the burden and consequences of “conscientious objection” for women and other providers.



Civil Society Activism:

- **Show how refusal to provide services exacerbates other inequalities.** Show the effects of the refusal to provide services on those needing them. Use a reproductive justice framework to focus on the most vulnerable people, deconstruct power imbalances, and reveal intersecting causes of discrimination and inequality.
- **Build alliances across movements to share expertise and develop strategies to combat the use of conscience claims to deny services.** Women's rights activists should build alliances with other movements and affected communities to combat the effects of the refusal to provide care.

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Appendix 1

LATIN AMERICA		
Country	Name	Organization
Argentina	Soledad Deza	Católicas por el Derecho a Decidir –Argentina
Argentina	Martin Hevia	Universidad Torcuato Di Tella
Argentina	Ruth Zurbriggen	Feminist activist and professor
Argentina	Daniel Teppaz	Secretaría de Salud Pública, Rosario, Argentina
Bolivia	Gretzel Brozovich	IPAS Bolivia
Brazil	Vanessa Dios	ANIS - Institute of Bioethics, Human Rights and Gender
Brazil	Bia Galli	IPAS Brazil
Brazil	Paula Viana	Grupo Curumim
Chile	Adela Montero	Facultad Medicina de la Universidad de Chile
Chile	Dominique Truan Kaplan	Miles
Colombia	Cristina Rosero	Women's Link Worldwide
Colombia	Isaac de Leon Beltran	Director of Research, Profamilia Colombia, IPPF/WHR
Guatemala	Rossana Cifuentes	Feminist doctor
México	Oriana López Uribe	Balance, Fondo Maria
México	Fernanda Díaz de León	Ipas Mexico
Uruguay	Lilián Abracinskaskas	MYSU (co-convener)
Uruguay	Patricia Campos	MYSU (co-convener)
Uruguay	Romina Napiloti	MYSU (co-convener)
Uruguay	Alejandra Lopez	University Faculty of Psychology
Uruguay	Martín Couto	Instituto de Psicología de la Salud
Uruguay	Constanza Moreira	Feminist senator
Uruguay	Hugo Rodriguez	Facultad de Medicina de la Universidad de la República
Uruguay	Alicia Castro	Tribunal
Uruguay	Leonel Briozzo	Facultad de Medicina, Universidad de la República

SUB-SAHARAN AFRICA		
Country	Name	Organization
Ghana	John Koku Awoonor-Williams	Global Doctors for Choice-Ghana and GDC Steering Committee
Ghana	Grace Gyimah Boateng	President, Curious Minds
Kenya	Monica Oguttu	Kisumu Medical & Education Trust (KMET), Executive Director
Kenya	Jade Maina	Trust for Indigenous Culture And Health (TICAH), Deputy Director
South Africa	Eddie Mhlanga	Department of Health and Global Doctors for Choice
South Africa	Tlaleng Mofokeng	Sexual and Reproductive Justice Coalition (SRJC)
South Africa	Marion Stevens	SRJC and Women in Sexual and Reproductive Rights and Health (WISH) Associates
South Africa	Jabulile Mavuso	Rhodes University
South Africa/ Zimbabwe	Malvern Chiweshe	Rhodes University

EUROPE/NORTH AMERICA AND INGOS		
Country	Name	Organization
Austria	Christian Fiala	International Federation of Professional Abortion & Contraception Associates (FIAPAC)
Belgium	Marina Davidashvili	Senior Policy Officer at European Parliamentary Forum on Population and Development
Canada	Udo Schuklenk	Department of Philosophy, Queens University
Canada/ Switzerland	Christina Zampas	Reproductive and Sexual Health Law Fellow, University of Toronto
Croatia	Jasna Karacic	President of the Croatian Association for the Promotion Patients' Rights
Croatia	Sanja Cesar	Center for Education, Counseling and Research (CESI)
Norway	Charlotte Andersen	Senior Advisor on SRHR at Sex og Politikk (IPPF Norway)
Norway	Tor-Hugne Olsen	Executive Director Sex og Politikk (IPPF Norway)
Poland	Krystyna Kacpura	Executive Director of the Federation for Women and Family Planning
Poland	Kamila Ferenc	Coordinator of the Federation For Women and Family Planning's Network of Lawyers
Portugal	Teresa Bombas	Portuguese Society of Contraception
Spain	Francisca Fernández Guillén	Lawyer
Switzerland/ Global	Ronnie Johnson	World Health Organization
United States	Uta Landy	University of California, San Francisco: Bixby Center
United States	Georgeanne Usova	Legislative counsel for the American Civil Liberties Union in Washington D.C.
United States	Cynthia Romero	Director of Communications, Catholics for Choice
United States	Susan Wood	Director of Program Learning & Evaluation, IWHC
United States	Michelle Truong	Program Assistant for Learning, Monitoring & Evaluation, IWHC
United States	Shena Cavallo	Program Officer for Strengthening International Partnerships, IWHC
United States	Vanessa Rios	Program Officer for Learning, Monitoring & Evaluation, IWHC
United States	Nina Besser	Senior Program Officer for U.S. Foreign Policy, IWHC
United States	Gypsy Guillén Kaiser	Director of Communications, IWHC

Appendix 2

DAY 1: 1ST AUGUST 2017			
Time	Session	Description	Responsible
9:00 – 10:00	Session 1: Welcome, Introductions, and convening objectives	Why this convening, what do we aim to achieve and who are we? 9:00 – 9:25 Opening and presentation of objectives from convening organizers 9:25 – 9:55 Round Table: Participants say their name, country, organization and one word that describes what conscientious objection means to them 9:55 - 10:00 Review of agenda and questions to keep in mind for the day	Representatives of MYSU & IWHC Participants
10:00 – 12:00	Session 2: Legal and human rights frameworks for conscientious objection (CO)	What do international & regional legal frameworks & courts tell us about CO and health service provision? 10:00 – 10:20 Basis for CO in international law 10:20 – 11:30 Status of legal frameworks based on international and regional treaties and frameworks (e.g. ICCPR, CEDAW, regional European, IAHR system), as well as relevant court cases: Latin American and the Caribbean and Europe 11:30 – 12:00 Q&A	Moderator: Ronnie Johnson Cristina Rosero, Martín Hevia, Christina Zampas
12:00 – 13:30	Lunch provided by the Convening		
13:30 – 15:30	Session 3: National experiences with laws and policies	What can we learn from experiences at the national level about strategies to use law and policy to limit CO in case of abortion? 13:30 – 14:00 Part 1: Norway, Uruguay, Ghana 14:00 – 14:30 Q&A 14:30 – 15:00 Part 2: South Africa, Poland, Mexico 15:00 – 15:30 Q&A	Moderators: Teresa Bombas & Monica Oguttu Part 1: Charlotte Andersen, Alicia Castro John Koku Awoonor-Williams Part 2: Edgar Mhlanga, Krystyna Kacpura Fernanda Díaz de León
15:30 – 16:00	Coffee break		
16:00 – 17:15	Small group discussion of laws, regulation and implementation	Questions to small groups: 1) If your country were developing a new abortion law or policy, how would you approach conscientious objection? 2) If your country already has laws on abortion that include conscientious objection, what are ways to enforce regulations?	Participants
17:15 – 17:45	Plenary	Groups present their main conclusions and recommendations	Small group representatives
17:45 – 18:00	Wrap up	How did the day go? Recommendations for the next day, Logistics for evening and next day	IWHC and MYSU
Dinner on your own			
DAY 2: 2ND AUGUST 2017			
9:00 – 12:00	Public Event	Event with government authorities, public health officials and providers, advocates, researchers and the press in Uruguay, with the international participants, to discuss conscientious objection in Uruguay	
12:00 – 13:30	Lunch provided by the Convening		
13:30 – 16:00	Session 4: Challenges for the health sector with the implementation of abortion services: Ethical considerations	What is the ethical obligation of individual providers and of the state to those seeking abortions? Opening presentation on ethical considerations in health care and the place of conscientious objection in health care practice. Round table discussion on obligations of health care providers and women's right to health	Moderator: Vanessa Dios Udo Schuklenk, Tlaleng Mofokeng Isaac de León Beltrán, Hugo Rodríguez
16:00 – 16:30	Coffee break		
16:30 – 18:00	Session 5: Professional training, values clarification, and setting standards for providers	What are best approaches to changing objectors' minds and actions? Training of health professionals as part of medical education, Role of normative bodies and professional associations in addressing ethical questions, Experiences of values clarification for health care providers	Moderator: Leonel Briozzo (TBC) Uta Landy, Christian Fiala, Daniel Teppaz
18:00 – 18:15	Wrap up	Review of the day, Recommendations for the next day	IWHC and MYSU
20:00	Dinner outside the hotel provided by the Convening		
DAY 3: 3RD AUGUST 2017			
9:00 – 12:00 (with a coffee break)	Session 6: Changing social norms and public opinion: The role of different actors	What is the role of research, advocacy and the media in changing policies and social norms regarding CO? The role of research in generating evidence on the use and misuse of CO and consequences on women's rights and health, Working with policy-makers to develop and strengthen laws and regulations, The role of civil society in bringing about cultural and social norm change, Responding to right-wing backlash, Working directly with women, The role of media and communications	Moderator: Lilián Abracinskas Round table on different strategies and approaches
12:00 – 13:30	Lunch provided by the Convening		
13:30 – 13:45	Session 7: Develop recommendations	IWHC and MYSU present main points emerging from the debates so far, to inform small group formulation of recommendations	IWHC and MYSU
13:45 – 14:45	Small groups to develop recommendations	What can be done in the following areas to counter the effects of CO? Legal: Formulation and implementation of laws and regulations and the use of the courts Service provision: Implementation of services and capacity building of providers Priorities for research: Increasing knowledge about the consequences of conscientious objection on women's health and rights and the health care system Advocacy: Approaches to reduce the mis-use of CO and to increase public support for the right to abortion services	Participants
14:45 – 15:00	Coffee Break		
15:00 – 16:15	Plenary and synthesis of recommendations	Groups present recommendations Meeting evaluation Conclusions and next steps	
16:15 – 16:30	Closing and departures		



In October 2017, more than 70,000 women from across Argentina convened for the Encuentro Nacional de Mujeres or "National Women's Gathering" to mobilize on a range of women's issues and march through the streets. © IWHC



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