



**CONSCIENTIOUS
OBJECTION:
PROTECTING
SEXUAL AND
REPRODUCTIVE
HEALTH RIGHTS**

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Photograph © 2005 Marilyn Keegan/COHSASA, courtesy of Photoshare. A medical intern checks medications at a hospital in South Africa.

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INTRODUCTION

Healthcare providers' conscientious objection to involvement in certain procedures is grounded in the right to freedom of religion, conscience and thought. However, such conscientious objection can have serious implications for the human rights of healthcare users, including their sexual and reproductive health rights.

This briefing paper examines the implications of conscientious objection, by healthcare providers, for the protection of sexual and reproductive health rights.

In many countries, debate on conscientious objection focuses to a great extent on national legal frameworks, as well as medical ethics. This publication is designed to demonstrate the bearing of international human rights law on conscientious objection. It gives examples of how the issue has already been addressed in the context of international law and provides information and makes recommendations on the relationship between conscientious objection and sexual and reproductive health rights, as well as States' obligations to uphold these rights.

Sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Conscientious objection is the objection to engaging in a particular procedure or activity because of its perceived incompatibility with the religious, moral or ethical dictates of an individual's conscience.

I. THE EMERGENCE OF CONSCIENTIOUS OBJECTION TO THE PROVISION OF SEXUAL AND REPRODUCTIVE HEALTHCARE

A. THE PRACTICE OF CONSCIENTIOUS OBJECTION

The last twenty years have witnessed increasing protection of sexual and reproductive health rights in international and domestic law. This, coupled with advances in medical technology and the expanding provision of healthcare in many countries, has led to the widening (but still grossly unequal) availability of sexual and reproductive healthcare on a global level.

As sexual and reproductive healthcare has become more widespread in many countries, so too has conscientious objection by healthcare providers, including direct providers such as doctors, as well as others indirectly involved in the provision of services, such as administrators and managers. Conscientious objection arises most frequently in the United States, Central and South America, and European countries where the Roman Catholic Church is influential. However, it also occurs in other countries too.¹ Conscientious objection has traditionally been used to excuse healthcare providers from direct participation in procedures they find

objectionable. However, some religious institutions and personnel opposed to certain procedures have tried to extend its application to entire institutions, such as hospitals or clinics.²

Conscientious objection is being claimed by an increasing range of personnel with more indirect involvement in medical procedures, such as pharmacists dispensing contraceptives, nurses and technicians providing pre- or post-abortion care or cleaning instruments that have been used in particular procedures, and administrators writing referral letters.³ The liberalisation of abortion laws in some countries has also led to judges invoking conscientious objection when they are required to hear appeals against the denial of legal abortion brought under constitutional guarantees.⁴

In practice, conscientious objection most frequently occurs with respect to the provision of legal abortion; elective sterilization; fertility treatment; pre-natal

examinations; and the prescription or dispensing of contraceptives, including emergency contraception. Some procedures may attract conscientious objection only in given situations. For example, the removal of a

man's testicles could be either a method of sterilisation, or a necessary life-saving measure in testicular cancer treatment: the former might give rise to objections, while the latter would not.

B. NATIONAL LEGAL PROTECTIONS OF CONSCIENTIOUS OBJECTION AROUND THE WORLD

National laws, and state laws in some federal countries, vary in terms of the permissible scope and limits of conscientious objection. The law in different countries and states sets out variations in terms of: who can object; which services can be objected to; whether or not conscientious objectors have a duty to refer patients to alternative providers; and the scope of exceptions to permissible conscientious objection (see Box 1).⁵

Experience shows that different policies on conscientious

objection invite many different interpretations. Many legal systems around the world include provisions – often in health or human rights laws – which allow health-care providers to opt out of supplying services to which they conscientiously object. However, healthcare providers sometimes invoke conscientious objection as grounds for denying services even in circumstances which are considered impermissible under domestic law in many countries, such as in emergency situations (see Box 2).

Box 1: Examples of varying domestic policies and laws on conscientious objection

The United States: an overview of state policies and laws on conscientious objection

"Almost every state in the country... has decades-old policies allowing individual health care providers to refuse to participate in abortion; many of these laws also apply to sterilization, and in 10 states, to contraception more broadly.... Only a handful of these laws specifically provide an exception to refusal rights in emergency circumstances; most do not require health care providers to notify their employers if they intend to opt out of certain services, and only three require any notice to patients; and about a dozen go so far as to allow providers to refuse to provide information, despite the broadly recognised obligations around obtaining patients' informed consent."

A. Sonfield, "Rights vs Responsibilities: Professional Standards and Provider Refusals," 7 *Guttmacher Report on Public Policy* 2005.

The British Abortion Act (1967)

The British Abortion Act (1967) allows doctors and

nurses to refuse to participate in terminations, although it obliges them to provide necessary treatment in an emergency where a woman's life is at threat. Barbara Janaway was a receptionist/secretary at Salford Health Authority. The authority terminated her employment on grounds of misconduct after she refused to type a letter of referral for an abortion. In the case of *Janaway v Salford Health Authority*, 1988, Janaway sought judicial review to quash the authority's decision, and to declare that her actions were justified on grounds of conscientious objection. The courts held that conscientious objection was only permissible in relation to actual administration of a treatment: merely typing a letter of referral did not constitute participation in procuring an abortion, and so the applicant's refusal to do so on grounds of conscientious objection was not justified. In other words, conscience could not justify a refusal to perform an indirect procedure surrounding the termination of a pregnancy.

Box 2: State laws in Mexico

An amendment to the Penal Code introduced in Mexico City in 2004 forbids health service providers from invoking conscientious objection in cases where an urgent termination of pregnancy is required, namely to safeguard the health or life of the woman.⁶

Had a similar provision been in place in the State of Baja California, it would have required doctors to

perform the abortion requested by 13-year old Paulina Ramirez, who in 1999 became pregnant as a result of rape. In this case, despite authorisation of the abortion given by the Attorney General's Office, doctors refused to provide a legal abortion on grounds of conscientious objection.

Information Group on Reproductive Choice, Paulina: 5 Years Later, 2005



Photograph © 2007
Rebecca Callahan/GHFP,
Courtesy of Photoshare.
A damaged copy of the
Do You Know Your Family
Planning Choices?
wallchart hangs outside a
clinic in Kenya

II. INTERNATIONAL HUMAN RIGHTS LAW: A FRAMEWORK FOR ADDRESSING CONSCIENTIOUS OBJECTION

International human rights provide a legal, moral and pragmatic framework for addressing the issue of conscientious objection. The majority of States have ratified international human rights treaties which include rights relevant to healthcare providers and users in the context of conscientious objection, such as: 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). These treaties outline key human rights freedoms and entitlements that relate to conscientious objection, such as the right to freedom of conscience, thought and religion and the right to the enjoyment of the highest attainable standard of physical and mental health ("right

to the highest attainable standard of health" or "right to health"). Guidance on the interpretation of these rights is provided by the documents adopted by the independent bodies of experts appointed to monitor the implementation of each treaty (treaty bodies), most importantly General Comments⁷ and Concluding Observations on States parties' periodic reports submitted under the treaties.

The following chapters highlight some of the key rights which arise in the context of conscientious objection: the right of freedom of thought, conscience and religion (a right of particular importance to healthcare providers) and sexual and reproductive health rights (a set of rights of particular importance to healthcare users); and how these rights can be balanced appropriately in practice.⁸

III. THE RIGHT OF HEALTHCARE PROVIDERS TO FREEDOM OF THOUGHT, CONSCIENCE AND RELIGION

Conscientious objection is grounded in the right of everyone to freedom of thought, conscience and religion. This right is protected in domestic legislation in many countries, and is also recognised in international human rights instruments, such as the Universal Declaration on Human Rights and the ICCPR (see Box 3).

The Human Rights Committee, the body that monitors the implementation of the ICCPR, has

underscored the importance of conscientious objection in the context of military service which, it concluded, can be derived from the right to freedom of thought, conscience and religion.⁹ The Committee has not, however, recognised a self-standing right to conscientious objection, nor has it defended conscientious objection to sexual and reproductive healthcare services.

Box 3: International Covenant on Civil and Political Rights: the protection of freedom of thought, conscience and religion

Article 18

1. Everyone shall have the right to freedom of thought, conscience and religion (...).
3. Freedom to manifest one's religion or beliefs may

be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.

Under international law, the right to freedom of thought, conscience and religion may not be limited. However, the freedom to *manifest* one's religion or beliefs can be limited for the protection of health and the protection of the morals or rights of others. As some human rights bodies have recognised, these limitations can be applicable in the context of conscientious objection to the provision of sexual and reproductive healthcare services (see Box 4).

The notion of balancing the right to freedom of

thought, conscience and religion with other human rights has not only been recognized by legal scholars but also by religious authorities. Pope John Paul II echoed ICCPR article 18(3) in stating: "freedom of conscience does not confer a right to indiscriminate conscientious objection. When an asserted freedom turns into license or becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses."¹⁰

Box 4: Limitations on the exercise of freedom of religion in the public sphere

The case of Pichon and Sajous v France

The European Court of Human Rights held that two pharmacists, who refused to sell contraceptives, were imposing their beliefs on the public. The Court's decision explained that religious beliefs can be manifested "in many ways outside the professional sphere," and that the right to freedom of religion, as a matter of individual conscience, does not always guarantee the right to behave in a manner

governed by that belief. The Court argued that "as long as the sale of contraceptives is legal and occurs on medical prescription nowhere other than in a pharmacy, the applicants cannot give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products"

Pichon and Sajous v France, European Court of Human Rights, Application No. 49853/99, admissibility decision of 2 October 2001.



IV. SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

A. THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

The right to the highest attainable standard of health is a fundamental human right. At the international level, it is recognised in several treaties, including ICESCR and CEDAW. It is also protected in regional treaties in the Americas, Africa and Europe. Around two-thirds of national constitutions worldwide recognise a duty of the State to guarantee health or healthcare.¹¹

The right to health is not a right to be healthy: it is a

right to a variety of services, facilities, goods and conditions that promote and protect the highest attainable standard of health. It encompasses both physical and mental health.

Sexual and reproductive health is recognized as an integral element of the right to health,¹² and international human rights law, and domestic law in many countries, includes protections of sexual and reproductive health rights.

B. DEFINING REPRODUCTIVE HEALTH RIGHTS

In 1994, States adopted by consensus the International Conference on Population and Development (ICPD) Programme of Action.¹³

Importantly, the document provides a definition of reproductive health and reproductive rights (see Box 5).

Box 5: The definition of reproductive health and reproductive rights from the International Conference on Population and Development (Cairo, 1994)

"Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in the last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth, and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of

life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (paragraph 7.2).

"Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning" (paragraph 7.3).¹⁴

The ICPD Programme of Action emphasises that the right to health is at the heart of reproductive rights. It also importantly recognises the right of all people to have the “freedom to decide if, when, and how often” to reproduce. This reflects the right of both women and men, on a basis of equality, to “decide

freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights”.¹⁵ This human right, recognised in CEDAW, is also highly relevant in the context of conscientious objection.

C. DEFINING SEXUAL HEALTH RIGHTS

The outcome document of the Fourth World Conference on Women includes an important affirmation of the right of women to have control over their sexuality, including their sexual health.¹⁶ Human rights bodies have taken important steps towards addressing this issue, confirming entitlements to the required health services, sexual freedom in relation to controlling one's health, and education and information on sexual health.¹⁷

The correct understanding of fundamental human rights principles (such as non-discrimination, the rights to equality, privacy and bodily integrity) as well as existing human rights norms, leads ineluctably to the recognition of sexual rights as human rights.¹⁸ The term “sexual rights” serves as a short hand for the bundle of specific norms that emerge when existing generic human rights are applied to sexuality. Sexual health rights are a crucial element of sexual rights. (see *Box 6*).

Box 6: Defining sexual rights (2004)

A working definition of sexual rights was developed in 2002 at a Technical Consultation on Sexual Health, co-organised by WHO and the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction. The definition states:

“Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;

- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.”¹⁹

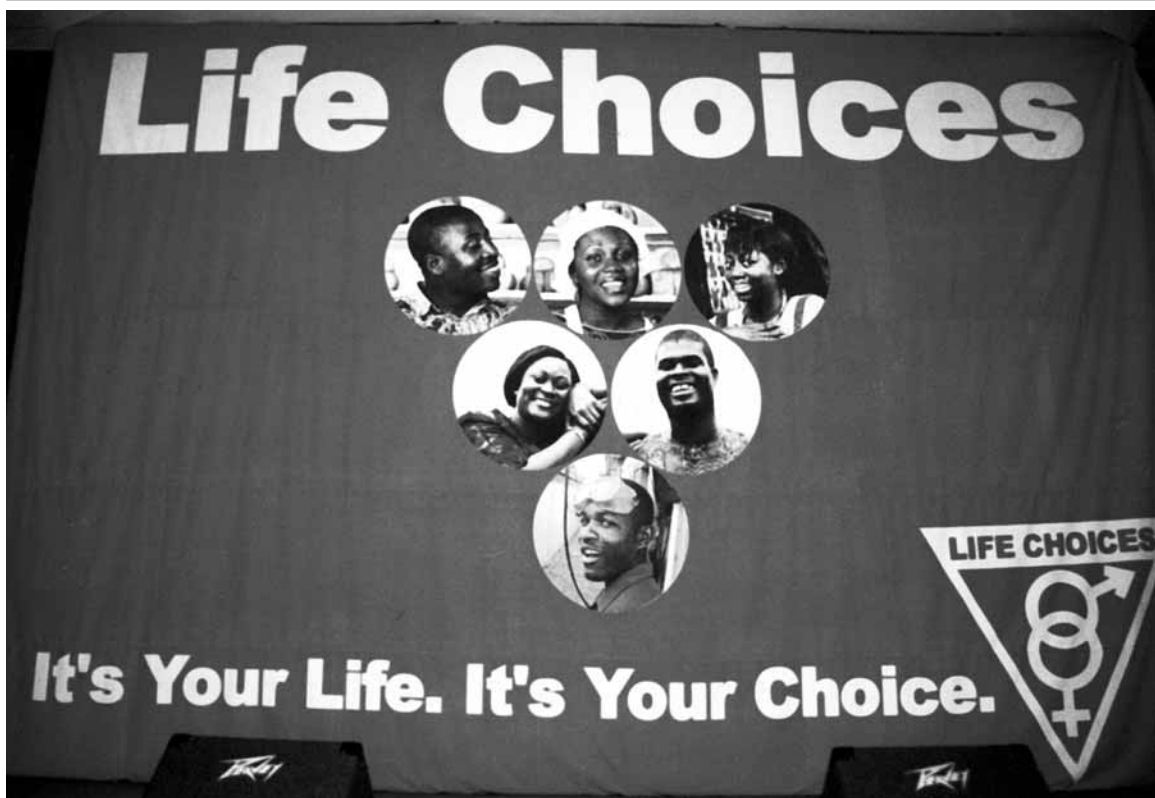
Source: WHO and Special Program of Research, Development and Research Training in Human Reproduction, Defining Sexual Health: Report of a Technical Consultation on Sexual Health, 28-31 January 2002, 2006. This definition does not represent a WHO position.

V. OBLIGATIONS ARISING FROM SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

A. FREEDOMS AND ENTITLEMENTS

The right to health includes a number of freedoms and entitlements that are relevant in the context of sexual and reproductive health, and which must be guaranteed regardless of whether conscientious objection is permissi-

ble. The following paragraphs outline these freedoms and entitlements, as well as other key aspects of the right to health which must be guaranteed in the context of conscientious objection.



Photograph © 2001 CCP, Courtesy of Photoshare. "Life Choices" family planning campaign banner featuring characters from promotional television spots.

> FREEDOMS

The right to health includes the freedom to control one's health and body. This means that the exercise of conscientious objection by a health worker should not give rise to a denial of access to healthcare services or goods that in turn denies women the freedom to control their health and bodies.

The right to health also includes the freedom not to be discriminated against. The failure by States to legally provide for the performance of certain reproductive health services for women – which may include emergency contraception and safe abortion services – is a form of discrimination (see Box 7).

Box 7: Conscientious objection and non-discrimination in the enjoyment of the right to the highest attainable standard of health

"It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious

objection, measures should be introduced to ensure that women are referred to alternative health providers."

CEDAW General Recommendation 24 on Women and Health, 1999, paragraph 11.

Equality and non-discrimination need to be approached not only from this gender perspective, but also in such a way that takes into account different groups of women, including those who are marginalised due to income, age or race. Patterns of discrimination in the context of abortion and other areas of sexual and reproductive healthcare are well documented, with marginalised

women having poorer access to the goods and services to which they are entitled.²⁰ Where geographical considerations lead to only one healthcare provider being accessible in a remote area, the exercise of conscientious objection by that individual would result in a disproportionate and discriminatory impact on these women who are already marginalised geographically.

> ENTITLEMENTS

The right to health includes an entitlement to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health.²¹ It includes specific entitlements to sexual and reproductive healthcare goods and services, including: family planning services; contraceptives; safe abortion where not against the law; and quality services for complications arising from abortion. These services must be available, accessible, acceptable and good quality:

a. Availability and accessibility

There must be an adequate number of financially and geographically accessible facilities, goods and services providing sexual and reproductive healthcare in a given country. This includes an adequate number of trained health providers to ensure that sexual and reproductive health care services that are lawfully provided are made available in a timely manner.

Conscientious objection may limit the availability and accessibility of service providers (see Box 8).²² If the necessary services or goods are denied on grounds of conscientious objection, and alternatives are neither within safe physical reach nor affordable, this may constitute a violation of the right to health. For example, the practical inaccessibility of abortion as a result of conscientious objection being exercised by local service providers may

lead to an increase in the incidence of clandestine and unsafe abortions.²³ This is a significant consequence in terms of the right to health as unsafe abortion contributes to the death of 68,000 women annually.

b. Acceptability

Sexual and reproductive healthcare must be sensitive to gender, respectful of medical ethics and designed to improve the health status of those concerned. Conscientious objection has often been addressed in the context of medical ethics. A range of international medical professional codes of conduct informed by medical ethics provide some useful guidance on the issue (see Box 9).

c. Quality

Healthcare services and goods must be of good medical quality. Healthcare users should receive healthcare and health-related information which is medically sound, and not predicated on the religious beliefs of the health provider.

The requirement of quality healthcare also has particular implications in the context of women who are denied abortions when these are not against the law. If women are forced to resort to unsafe abortion because conscientious objection means that no safe alternative is available, there can be serious consequences for their rights to life and health.

Box 8: Conscientious objection and availability and accessibility of legal abortion

Conscientious objection in Poland

The Committee on the Elimination of All Forms of Discrimination Against Women made the following comments about conscientious objection and access to legal abortion in relation to Poland's sixth period report:

"The Committee urges the State party to take concrete measures to enhance women's access to health care, in particular to sexual and reproductive health services, ... it also urges the State party to ensure that women seeking legal abortion have access to it, and that their access is not limited by the use of the conscientious objection clause."

Concluding Comments of the Committee on the Elimination of Discrimination Against Women on Poland's Sixth Periodic Report, UN doc. CEDAW/C/POL/CO/6, 2 February 2007, para. 25.

Italy's abortion law

"Italy's abortion law requires healthcare institutions to ensure that women have access to abortion. Specifically, regional healthcare bodies are required to supervise and ensure such access, which may include transfer of healthcare personnel to guarantee access to abortion. In accordance with this requirement, the law mandates healthcare personnel to submit a written declaration of their conscientious objection to abortion to the medical director of their employer healthcare institution and to the regional medical officer."

Written comments submitted by the Center for Reproductive Rights, 21 September 2005, in the case of Tysiac v Poland, European Court of Human Rights.

B. OTHER ESSENTIAL OBLIGATIONS

Access to information

Access to information on sexual and reproductive health is an important element of the right to the highest attainable standard of health. States are obliged to

provide all healthcare users with reliable and up-to-date information about all goods, facilities and services that should be available to them, and where they can obtain them. States must ensure that conscientious objection

does not limit access to essential information on sexual and reproductive health, necessary for individuals to take control of their own sexuality and related sexual health; access legal abortion; and understand procedures for referral.²⁴



Photograph © Don Hinrichsen/UNFP. Young people producing a weekly radio programme that educates its audience about reproductive health issues, including HIV and AIDS, broadcasting from Chisinau, Moldova.

Participation

Everyone has the right to participate in health-related decision-making processes that affect them.²⁵ This includes active and informed participation in health policy-making processes. States have the responsibility to ensure that all women are able to participate in policy and legislative processes relating to sexual and reproductive healthcare, including in relation to laws and policies on conscientious objection. Efforts should be made to ensure that marginalised groups are included.

Monitoring and accountability

Monitoring and accountability are vital to the realisation of the right to health. Information about the use and impact of conscientious objection by different health service providers can be limited, and this makes it difficult to monitor its effect on the right to the highest attainable standard of health and other human rights. This has been a concern of international human rights bodies, and some States have adopted monitoring procedures to regulate conscientious objection (see Box 10).

Box 9: Medical ethics: guidance on conscientious objection

Declaration on the Rights of the Patient (1981), World Medical Association

"The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care."

Declaration on Therapeutic Abortion (1970), World Medical Association

"If the physician considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of medical care by a qualified colleague."

Ethical Guidelines on Conscientious Objection, International Federation of Gynecology and Obstetrics (FIGO): (2005)

1. The primary conscientious duty of obstetrician-gynaecologists (hereafter "practitioners") is at all times to treat, or provide benefit and prevent harm to, the patients for whose care they are responsible. Any conscientious objection to treating a patient is secondary to this primary duty.
2. Provision of benefit and prevention of harm require that practitioners provide such patients with timely access to medical services, including giving information about the medically indicated options of procedures for their care and of any such procedures in which their practitioners object to participate on grounds of conscience.
3. Practitioners have a professional duty to abide

by scientifically and professionally determined definitions of reproductive health services, and to exercise care and integrity not to misrepresent or mischaracterise them on the basis of personal beliefs.

4. Practitioners have a right to respect for their conscientious convictions in respect both of undertaking and not undertaking the delivery of lawful procedures, and not to suffer discrimination on the basis of their convictions.
5. Practitioners' right to respect for their choices in the medical procedures in which they participate requires that they respect patients' choices within the medically indicated options for their care.
6. Patients are entitled to be referred in good faith, for procedures medically indicated for their care that their practitioners object to undertaking, to practitioners who do not object. Referral for services does not constitute participation in any procedures agreed upon between patients and the practitioners to whom they are referred.
7. Practitioners must provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardise patients' health and well-being, such as by patients experiencing unwanted pregnancy (...).
8. In emergency situations, to preserve life or physical or mental health, practitioners must provide the medically indicated care of their patients' choice regardless of the practitioners' personal objections.

Box 10: Monitoring conscientious objection**UN Human Rights Committee**

In 2004, the Human Rights Committee reviewed Poland's fifth periodic report under ICCPR. In its Concluding Observations, the Committee called for greater information on the use of the conscientious objection clause. The availability of such information would make it possible to monitor the effects of the clause being used:

"The Committee reiterates its deep concern about restrictive abortion laws in Poland, which may incite women to seek unsafe, illegal abortions, with attendant risks to their life and health. It is also concerned at the unavailability of abortion in practice even when the law permits it, for example in cases of pregnancy resulting from rape, and by the lack of information on the use of the conscientious objection clause by medical practitioners who refuse to carry out legal abortions".

Concluding Observations of the Human Rights Committee on Poland's 5th Periodic Report UN doc.CCPR/C/SR.2251, paragraph 8.

Norwegian Act concerning Termination of Pregnancy

This Act requires that health personnel give written notification with detailed explanation of their wish to perform or assist in pregnancy terminations. On a quarterly basis the administrative head of the hospital or institution must "notify the county municipality of the number of different categories of health personnel who are exempted on grounds of conscience. The report shall also include the numbers of each category of health personnel who are available at any time for pregnancy terminations."

Act dated 13 June 1975 no. 50 concerning Termination of Pregnancy, with amendments in the Act dated 15 June 1978 no. 4, Art. 20.

Accountability has an important role to play in ensuring access to lawful sexual and reproductive healthcare services. For example, where a woman is denied sexual and reproductive healthcare on grounds

of conscience, and an appropriate and timely referral does not take place, she should have access to an effective remedy, such as an appeals process before an impartial judge.

C. RESPECT, PROTECT, FULFIL

Under international human rights law, States have a three-fold obligation: to *respect*, *protect* and *fulfil* human rights. This framework sets out responsibilities that are relevant to all of the freedoms and entitlements set out above.

The following obligations, which have implications for the exercise of conscientious objection, must be upheld:

a. The duty to *respect* requires the State to refrain from



interfering with rights. This includes an obligation to abstain from enforcing discriminatory practices as a State policy, including practices relating to women's health status and needs. States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters.²⁶

- b. The obligation to *protect* is a responsibility to ensure that third parties do not interfere with the enjoyment of sexual and reproductive health rights. For example, States should ensure that the actions and beliefs of private healthcare providers do not limit people's access to health-related information and services.
- c. The obligation to *fulfil* requires States to give sufficient recognition to sexual and reproductive health rights in national political and legal systems. States must adopt and implement laws and policies that guarantee sexual and reproductive healthcare, including in rural areas. Policies and laws relating to conscientious objection should not compromise the fulfilment of sexual and reproductive health rights.

D. THE RESPONSIBILITIES OF HEALTHCARE PROVIDERS

The practice of healthcare providers has a significant impact on the enjoyment of sexual and reproductive health rights. Under international human rights law, States have primary responsibility for realising these rights and are ultimately accountable. However, numerous other national and international actors also have a responsibility in this respect. This includes healthcare providers.

States have a responsibility to create an environment in which healthcare providers can most effectively contribute towards the realisation of sexual and reproductive health rights. For example, they should ensure healthcare providers receive training on human rights. This is vital if healthcare providers are to promote sexual and reproductive health rights in their work.



Photograph © 2000 Rick Maiman/David and Lucile Packard Foundation, courtesy of Photoshare. Surgeons at a Tijuana clinic perform a new tubal ligation procedure. The 20 minute procedure is done under a local anaesthetic, allowing the patient to stay alert and walk out of the clinic shortly afterward. Currently in Mexico, the procedure is only performed in Tijuana.

VI. RECOMMENDATIONS FOR STATES' POLICIES AND LAWS

The following interdependent recommendations, drawing upon and interpreting international human rights standards and their corresponding obligations on States, are intended to guide States to guarantee sexual and reproductive health rights in the context of conscientious objection.

a. **The right to freedom of conscience and its limitations:** Healthcare providers have a right to respect for their freedom of thought, conscience and religion. They may conscientiously object to the provision of services provided this is in accordance with law, does not interfere with public health nor limit the enjoyment of human rights of healthcare users. States

should ensure that their laws and policies strike an appropriate balance between the exercise of conscientious objection and the protection of the enjoyment of the sexual and reproductive health rights of healthcare users.²⁷ Conscientious objection should not entail a limitation of sexual and reproductive health rights, in fact the exercise of conscientious objection should avoid interference with the enjoyment of these fundamental rights. Health systems should have procedures, such as referral procedures,²⁸ in place to ensure that in practice, legitimate conscientious objection does not obstruct the enjoyment by women and men of their sexual and reproductive health rights.

- b. **Access to healthcare:** Where conscientious objection is permissible, States have a responsibility to ensure that healthcare users have access to safe healthcare services. For example, States should establish and enforce protocols for the transfer – in the event of conscientious objection – of patients to other qualified service providers within reasonable physical reach. Referral of a patient to a second doctor does not constitute participation nor complicity in any subsequent procedure to which the first doctor may conscientiously object, and therefore falls outside the permissible scope for objection.
- c. **Access to information:** States must ensure that the availability of reliable and up-to-date information about sexual and reproductive health is not obstructed by the conscientious objection of individual healthcare providers. This should include information of particular relevance to groups marginalised because of their sexuality, ethnicity and educational background. States should proactively make available information about the legitimate use and scope of conscientious objection, and any limitations upon it set down by law. This information should be provided in a format that is appropriate to the needs of healthcare users.
- d. **Emergency healthcare:** In States which have conscientious objection clauses in national legislation or policies, there should be no allowance for conscientious objection where the right to life or health of an individual is immediately at stake if a procedure is denied, for example where pregnancy is threatening the life of a woman. Objective criteria to guide healthcare providers in determining such situations should be drafted in accordance with right to health standards.
- e. **Participation:** States should take steps to ensure that policies and laws relating to conscientious objection and sexual and reproductive health are formulated on the basis of views expressed in consultations with health system users, in particular groups who may be marginalised and particularly affected by conscientious objection, such as women living in rural areas and in poverty and who have limited access to health services, goods and facilities. The views of healthcare providers must also be sought during, and inform, relevant policy making processes.
- f. **Information and education on human rights:** States must ensure that healthcare providers are educated about human rights, including the rights of healthcare users as well as their own human rights relating to their professional practice. States must also ensure that healthcare users have access to information about their rights, including their sexual and reproductive health rights, and their rights in the context of conscientious objection of healthcare providers.
- g. **Respect for the autonomy and dignity of the individual:** Sexual and reproductive healthcare and information should respect and support the autonomy and dignity of healthcare users, as well as their right to control their health and bodies. It should help healthcare users make autonomous decisions about their healthcare, including decisions which relate to their right to decide freely and responsibly the number, spacing and timing of their children.
- h. **Monitoring and accountability;** States should ensure close monitoring of the practice of conscientious objection and its impact on the enjoyment of sexual and reproductive health rights. If monitoring reveals that conscientious objection operates in a way that discriminates against women, has a harmful impact on the rights to health or life, or infringes other rights, the State is responsible for taking action to remedy the situation. Accountability procedures must be in place to ensure that the exercise of conscientious objection does not lead to a denial of healthcare or health information. States must ensure that judicial mechanisms provide an effective remedy to challenge a decision in cases where conscientious objection leads to such a denial.²⁹

Some key obligations:

States have the responsibility to:

- ensure available, accessible, acceptable and quality health care which is not compromised by individual health care providers exercising their legitimate right to conscientious objection;
- ensure the functioning of administrative procedures that provide immediate alternatives to healthcare users when conscientious objection would otherwise lead to a denial of services, and effective remedies where necessary;

- monitor the exercise of conscientious objection with a view to ensuring that all services are available and accessible in practice.

Health service providers who conscientiously object to a procedure have the responsibility to:

- treat an individual whose life or health is immediately at stake; otherwise
- refer the patient to another provider.

ENDNOTES

- 1 See, for example, C. Ngwena, "Conscientious Objection and Legal Abortion in South Africa: Delineating the Parameters," 1 *Journal for Juridical Sciences*, 2003; Catholics for a Free Choice, *In Good Conscience: Respecting the Beliefs of Health-care Providers and the Needs of Patients*, 2007.
- 2 See French Constitutional Council, Decision 2001-446 DC of 27 June 2001 (Voluntary Interruption of Pregnancy (Abortion) and Contraception Act) on the removal of the possibility for a head of department of a public health establishment to oppose terminations of pregnancy being practised in his department.
- 3 See, for example, R. Alta Charo, *Health Care Provider Refusals to Treat, Prescribe, Refer or Inform: Professionalism and Conscience*, American Constitutional Society, 2007; *Janaway v. Salford Health Authority*, All Engl Law Rep. 1988 Dec 1; [1988] 3:1079-84.
- 4 See, for example, the *tutela* claim rejected by Judge José Yañez Moncada in *Yolanda Perez Ascanio v. Saludvida EPS*, Juzgado Décimo Civil Municipal de Cúcuta, Colombia. Quoted in Constitutional Court Judgement T-171/07, 9 March 2007, Bogota.
- 5 Many national laws recognise that conscientious objection is not permissible when the life or health of a woman is at risk, or where there is no possibility to refer a patient to another healthcare provider. However, some laws do not provide such exceptions.
- 6 "Decree reforming Articles 145 and 148 of the new Penal Code of Mexico City and adding Articles 16 bis 6 and 16 bis 7 to the Health Law of Mexico City," reported in *Official Gazette of Mexico City*, 14, no. 7, 24 January 2004, pp. 6-7.
- 7 Human Rights Committee (CCPR), General Comment 22: The right to freedom of thought, conscience and religion, CCPR/C/21/Rev.1/Add.4; Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14: The right to the highest attainable standard of health, E/C.12/2000/4.
- 8 Although achieving harmonisation between a coherent set of individual human rights is seen as an ideal, boundary lines can be drawn. Through "judicious partitioning and limitation of scope...and [the] assignment of competitive weight in zones of overlap", political agencies ought to be able to adjust rights to one another. Careful drafting allows a central core and protected area of each right to be identified, and therefore minimises the risk of conflict. However, where conflict between rights is intractable, a choice between the specific exercises of a given right in a particular occasion must be made on technical grounds. Rex Martin. *A System of Rights*. Oxford University Press, 1993. pp.109-123.
- 9 CCPR, General Comment 22; CCPR, Concluding Observations, Republic of Korea, 28 November 2006, CCPR/C/KOR/CO/3, para.17.
- 10 John Paul II Address, *If You Want Peace, Respect the Conscience of Every Person*, Vatican City 1991 Message for the 24th World Day of Peace 1991, para. 4.
- 11 E. Kinney, B. Clark, "Provisions for Health and Health Care in the Constitutions of the Countries of the World," 37 *Cornell International Law Journal*, 2004.
- 12 Commission on Human Rights resolution 2003/28 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, preamble and para. 8.
- 13 A/CONF.171/13.
- 14 Para. 7.3 continues with some important sentences which have not been reproduced here because of the shortage of space.
- 15 Convention on the Elimination of All Forms of Discrimination Against Women (1979), article 16(1)(e).
- 16 Beijing Platform for Action, adopted at the Fourth World Conference on Women, 4-15 September 1995, A/CONF.177/20, para. 96.
- 17 CESCR, General Comment 14.
- 18 Report to the Commission on Human Rights of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2004, E/CN.4/2004/49, para. 54.
- 19 This working definition does not represent an official WHO position.
- 20 R. Cook, S. Howard, "Accommodating Women's Differences under the Women's Anti-discrimination Convention," 56 *Emory Law Journal* 2007.
- 21 E/CN.4/2004/49, para. 28.
- 22 *Tysiac v Poland*, written comments submitted by the Center for Reproductive Rights, 21 September 2005.
- 23 European Union (EU) Network of Independent Experts on Fundamental Rights *Synthesis Report: Conclusions and Recommendations on the Situation of Fundamental Rights in the European Union and its Member States in 2004*, 2005, p. 51. See also EU Network of Independent Experts on Fundamental Rights, *Opinion No. 4-2005: The Right to Conscientious Objection and the Conclusion by EU Member States of Concordats with the Holy See*, 14 December 2005.
- 24 See ARTICLE 19, *Time for Change: Promoting and Protecting Access to Information and Reproductive and Sexual Health Rights in Peru*. London, ARTICLE 19, 2006. Chapter 2.
- 25 CESCR, General Comment 14, para. 54.
- 26 CESCR, General Comment 14, para. 34.
- 27 Rex Martin, see note viii.
- 28 Report to the Human Rights Council of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2008, A/HRC/7/11, para. 55.
- 29 See, for example, EU Network of Independent Experts on Fundamental Right, *supra* fn 23.



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