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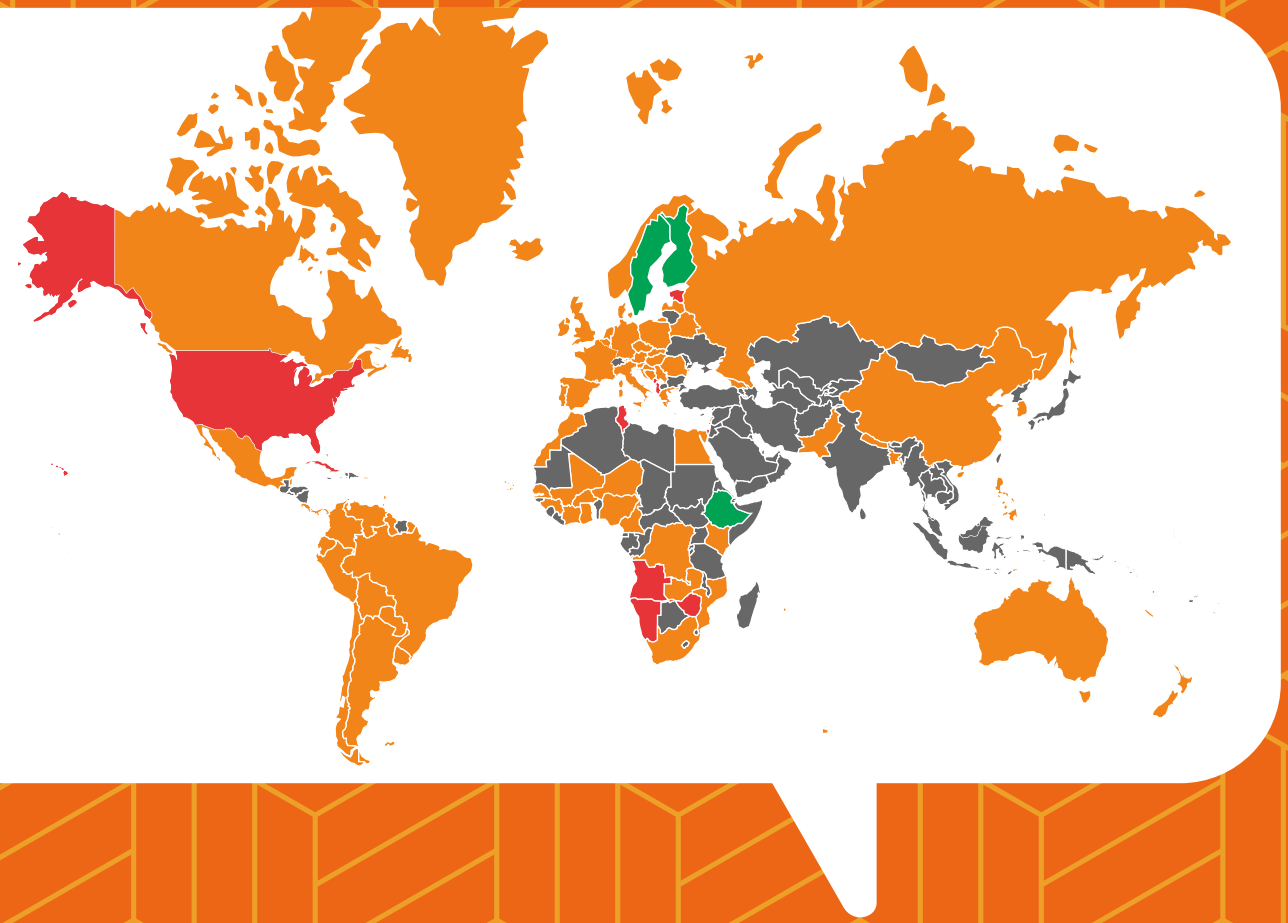

GLOBAL MAP OF **CONSCIENTIOUS OBJECTION** TO ABORTION

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2024 Update

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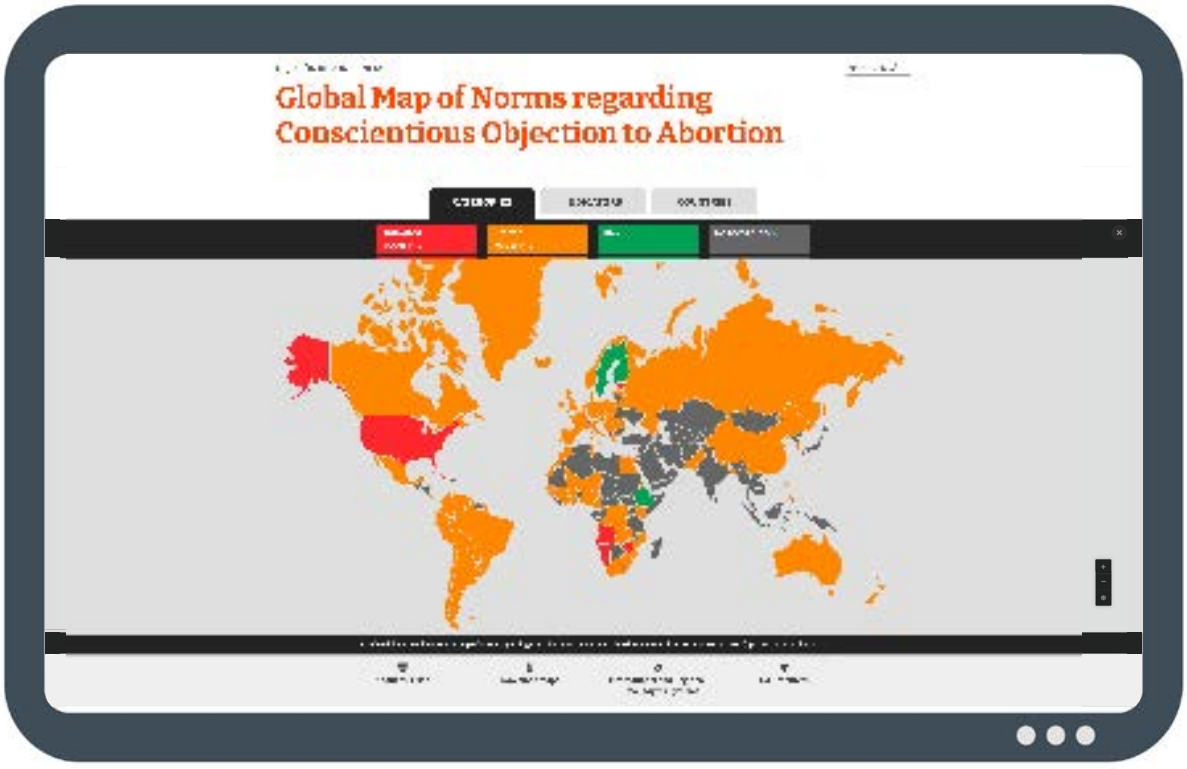
How do countries regulate healthcare professionals' conscientious objection (CO) in abortion care?

Conscientious Objection (CO) is both a persistent and a controversial topic in healthcare, particularly within the field of abortion. Until the launch of the Global Map of Norms regarding CO to abortion, there was no regulatory systematization on an international basis to provide an in-depth outlook of how CO is regulated across countries.
The Global Map has come to fill this void by introducing an interactive tool that allows users to access, compare, and analyze the various ways in which countries all over the world approach the dispute arising from CO. Actors involved in the CO dispute are healthcare professionals, women, teenagers, and girls, as well as the entire healthcare system.

This document deals with four key questions:

1. What are the main trends in CO regulations?
2. What kind of limits and duties must objectors comply with?
3. Who can object? and
4. What kind of information does the Interactive Global Map on OC provide?



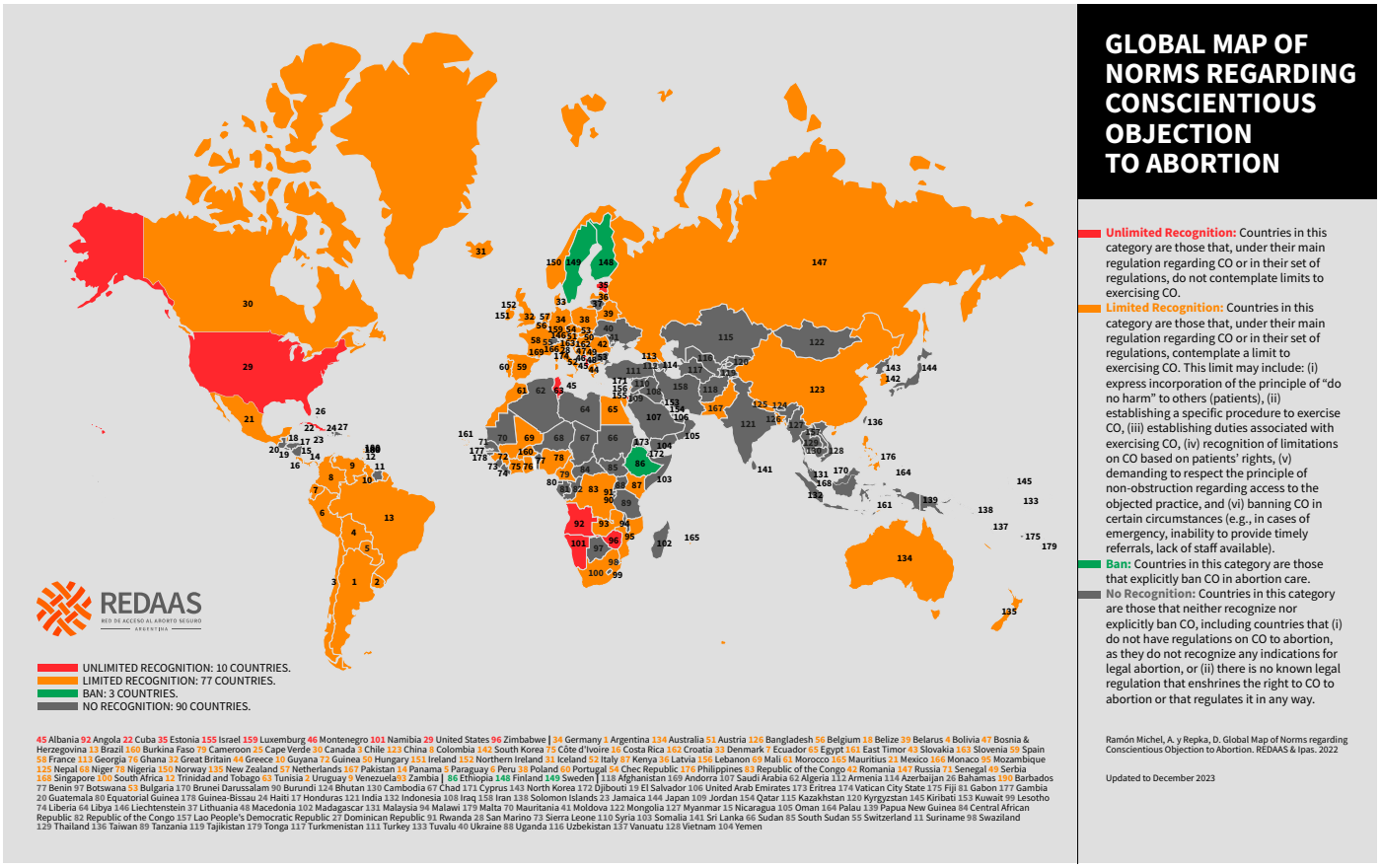
1

What are the trends on a global basis?

The global trend is to recognize CO

87 out of the **90** countries that have CO regulations allow it. This represents 97% of the total number of countries. Meanwhile, there are only three countries around the world that explicitly prohibit it: Ethiopia, Finland, and Sweden.

That is to say, the general rule is to authorize CO in healthcare.



GLOBAL MAP OF NORMS REGARDING CONSCIENTIOUS OBJECTION TO ABORTION

Unlimited Recognition: Countries in this category are those that, under their main regulation regarding CO or in their set of regulations, do not contemplate limits to exercising CO.

Limited Recognition: Countries in this category are those that, under their main regulation regarding CO or in their set of regulations, contemplate a limit to exercising CO. This limit may include: (i) express incorporation of the principle of "do no harm" to others (patients), (ii) establishing a specific procedure to exercise CO, (iii) establishing duties associated with exercising CO, (iv) recognition of limitations on CO based on patients' rights, (v) demanding to respect the principle of non-obstruction regarding access to the objected practice, and (vi) banning CO in certain circumstances (e.g., in cases of emergency, inability to provide timely referrals, lack of staff available).

Ban: Countries in this category are those that explicitly ban CO in abortion care.

No Recognition: Countries in this category are those that neither recognize nor explicitly ban CO, including countries that (i) do not have regulations on CO to abortion, as they do not recognize any indications for legal abortion, or (ii) there is no known legal regulation that enshrines the right to CO to abortion or that regulates it in any way.

Ramón Michel, A. y Repka, D. Global Map of Norms regarding Conscientious Objection to Abortion. REDAAS & Ipas. 2022

Updated to December 2023

Recognition of the right to CO is limited

Across the world, recognition of access to CO by healthcare professionals is not granted indiscriminately. In fact, it is very common for countries allowing CO to establish restrictions regarding its use.

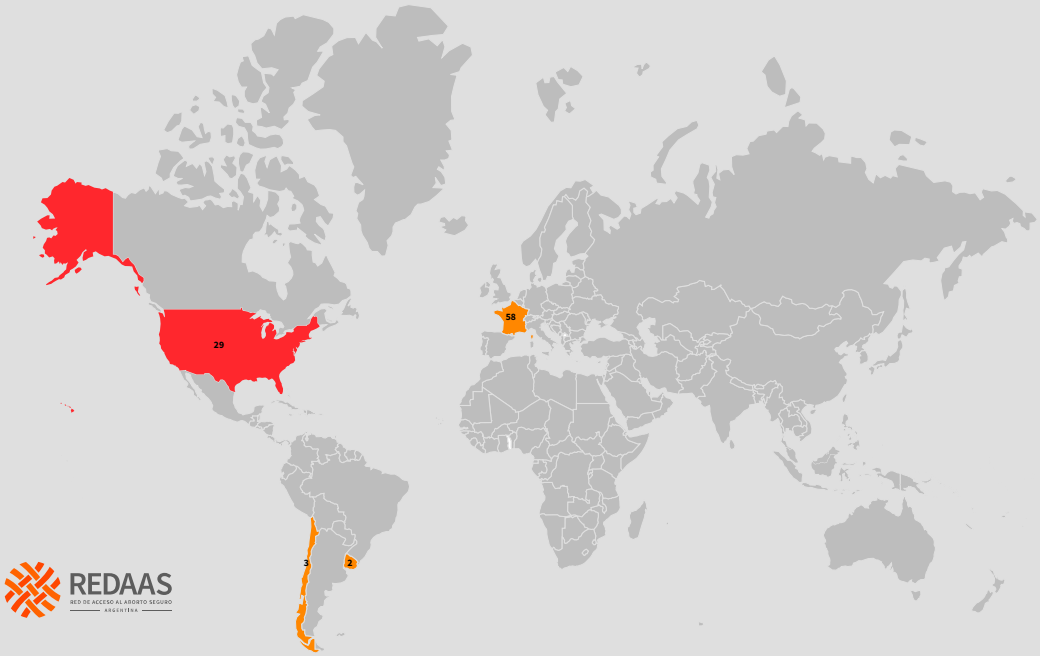
Out of the 87 countries accepting CO to abortion, the vast majority of them (74) impose limits and duties on objectors. In practice, this means that healthcare professionals cannot refuse to provide healthcare services solely based on their personal beliefs without any conditions.

Only 13 countries around the world do not have direct restrictions specified in their CO regulations. Nonetheless, this lack of limitations does not mean that healthcare professionals have full freedom to act on their personal beliefs without facing any consequences. In fact, their actions are still bound to professional duties and fundamental principles of law which are applicable to the exercise of any right whatsoever, such as the principle regarding the prohibition of abuse of rights.

Institutional or ideological CO is the exception

Limited recognition of CO is not just any type of limited recognition. This trend refers only to what is known as 'Individual CO'; i.e. that which can be legitimately invoked by a healthcare professional who refuses to take part in procedures that go against their personal values.
In contrast, the authorization of institutional or ideological CO—that which acknowledges institutions and healthcare teams or services as authorized subjects with permission to invoke it—is a clear exception: **only a handful of 4 out of the 87 countries that admit CO in abortion recognize it.**
3 out of **4** of these nations are located in the American continent (Chile, the United States, and Uruguay), while the other one (France) is located in Europe.

GLOBAL MAP OF NORMS REGARDING CONSCIENTIOUS OBJECTION



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UNLIMITED RECOGNITION
LIMITED RECOGNITION

RECOGNIZES INSTITUTIONAL CO

29 United States 3 Chile 58 France 2 Uruguay

Recognizes institutional CO or ideology objection: : This indicator was answered in the affirmative ("yes") in those countries whose regulations explicitly recognize the right to institutional CO or ideology objection.

Ramón Michel, A., Repka, D. y Ariza, S. Global Map of Norms regarding Conscientious Objection. REDAAS & Ipas. 2020.

Updated to December 2023.

2

What are the most common types of limits and duties imposed on professionals who object?

Most frequent limits and duties

Among the countries that allow CO, **3 common restrictions and obligations** have been identified:

Prohibition to invoke CO in cases of medical emergencies

The most common limitation globally is the prohibition of invoking CO in contexts of medical emergencies. In total, 57 countries acknowledge this restriction.

Section 9.3. of Costa Rica's Executive Decree N° 42113-S on the "Officialized Technical Norm for the Medical Procedure Linked to Section 121 of the Criminal Code" (2019)[1]

In cases of ***obstetric emergencies, CO cannot be invoked when there is only one available objecting healthcare professional*** *in the healthcare institution, since the paramount interest is that of protecting the life of the woman.* [Emphasis added].

- **Duty of the objecting professional to refer the patient**
  The second most common limit, which has been adopted in **33** countries, is the duty of the professional invoking CO to refer their patient to another duly trained professional.

Section 26 of Pakistan's National Service Delivery Standards and Guidelines for High-Quality Safe Uterine Evacuation / Post-Abortion Care (2018)[2]

Healthcare providers have a right to conscientious refusal to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women and girls, putting their health and life at risk. ***Where a healthcare provider refuses to provide uterine evacuation, they must refer the woman/girl to a willing and trained provider in their facility, or to another easily accessible healthcare facility***. [Emphasis added.]

- **Duty of the objecting professional to inform the patient**
  Finally, the third most usual duty is to inform the patient about the objection. This practice is acknowledged in **29** countries.

Section 7, sub-section 3 of New Zealand's Abortion Act N° 6 (2020)[3]

If a medical practitioner (...) has a conscientious objection (...), ***the medical practitioner must tell the complainant (...) of their conscientious objection at the earliest opportunity.*** [Emphasis added].

So... is that all?

Limits to CO stated by legislation tend to be, in general, 'individual' ones. That is, they become individual duties that objecting healthcare professionals must comply with.

However, as a result of the evidence posed by the multiple problems arising from these objections, as well as the difficulties they bring about in terms of women's access to abortion services, the tension within healthcare teams, and the need to maintain an organization of healthcare services that is both predictable and efficient, **some regulations have begun to introduce what are known as 'institutional safeguards.'**

> Institutional safeguards **are provisions imposed on countries and healthcare institutions** in order to guarantee that CO does not prevent users from having access to these services, as well as to minimize the negative effects of such objections on healthcare teams and healthcare systems.

The most usual examples of institutional safeguards are:

- Healthcare institutions must have mechanisms in place to refer women to other facilities in case a healthcare professional invokes CO and refuses to provide the service.
- Healthcare institutions must guarantee a number of healthcare professionals not claiming CO.
- Healthcare institutions must have an updated registry of healthcare professionals willing to offer abortion services.

Nonetheless, these mechanisms are still the exception. Only **23** countries (26% of the total number of countries admitting CO) include these guarantees in their CO clauses.[4] However, **in the last decade, an increasing trend towards its recognition has been observed in more and more countries.**

Section 11 of Argentina's Law N° 27.610 (2020)[5]

Those healthcare facilities in the private sub sector or social security that do not have professionals to carry out the interruption of pregnancy due to the exercise of the right to conscientious objection in accordance with the previous section, ***must provide for and order the referral to a health facility that actually performs the procedure and that is similar to the one originally chosen by the person requesting the service.*** *In all cases, the practice must be guaranteed in accordance with the provisions of this law.* ***The procedures and costs associated with the referral and transfer of the patient will be the responsibility of the facility making the referral.*** *All referrals contemplated in this section must be billed in accordance with the coverage in favor of the facility that performs the practice.* [Emphasis added.]

3 Who can object?

Regarding those who are entitled to object, the Map shows that the groups of subjects authorized to invoke CO varies considerably across countries. For this reason, these regulations have been categorized according to their source of legitimation: either the authorization derives from the healthcare personnel's profession / specialization field (subjective criterion), from the type of intervention that can be objected (objective criterion), or from a combination of the last two (mixed criterion).

Most countries (37 of them) have adopted the subjective criterion. The difference lies in the specializations and professions. The list comprises the following: 2 countries recognize CO only when invoked by an obstetrician-gynecologist (Cuba and Israel); 22 nations recognize CO when claimed by medical doctors (Albania, Angola, Bolivia, Burkina Faso, Cameroon, Ivory Coast, Croatia, Egypt, Georgia, Guinea, Latvia, Lebanon, Mali, Morocco, Nigeria, Poland, Democratic Republic of Congo, Romania, Russia, Senegal, Trinidad and Tobago, and Tunisia); and 13 countries recognize it when claimed by healthcare staff (Belgium, South Korea, Slovenia, Philippines, Island, Montenegro, Namibia, Niger, Paraguay, Peru, Czech Republic, Uruguay, and Venezuela). In many of these cases, the reason behind granting the right to invoke CO only to certain professionals within healthcare providers is that the abortion regulations themselves authorize only specific professionals to perform the procedure.

The second most widely adopted criterion (33 countries) is the objective criterion, despite the fact that there are some variations here as well: 6 countries implement a strict formula according to which only those performing the procedure are authorized to object (Bangladesh, Colombia, Ghana, Nepal, Panama, and Zambia). A similar, though more comprehensive case is that of 5 countries which establish that 'those directly participating in the procedures' have the right to invoke CO (Argentina, Bangladesh, Cape Verde, Ecuador, and Spain). Nevertheless, most countries (23 of them) have adopted the broadest formula, which grants the right to invoke CO to all of those who take part in abortion services (Germany, Barbados, Belize, Chile, Hong Kong, Costa Rica, Slovakia, the United States, Estonia, Great Britain, Guyana, Hungary, Northern Ireland, Kenya, Luxembourg, Maurice, Mozambique, The Netherlands, Pakistan, Portugal, Serbia, Singapore, and Timor-Leste.)

The remaining 16 countries opted for a mixed criterion to actively legitimate CO in their regulations, using the two criteria explained above.

4

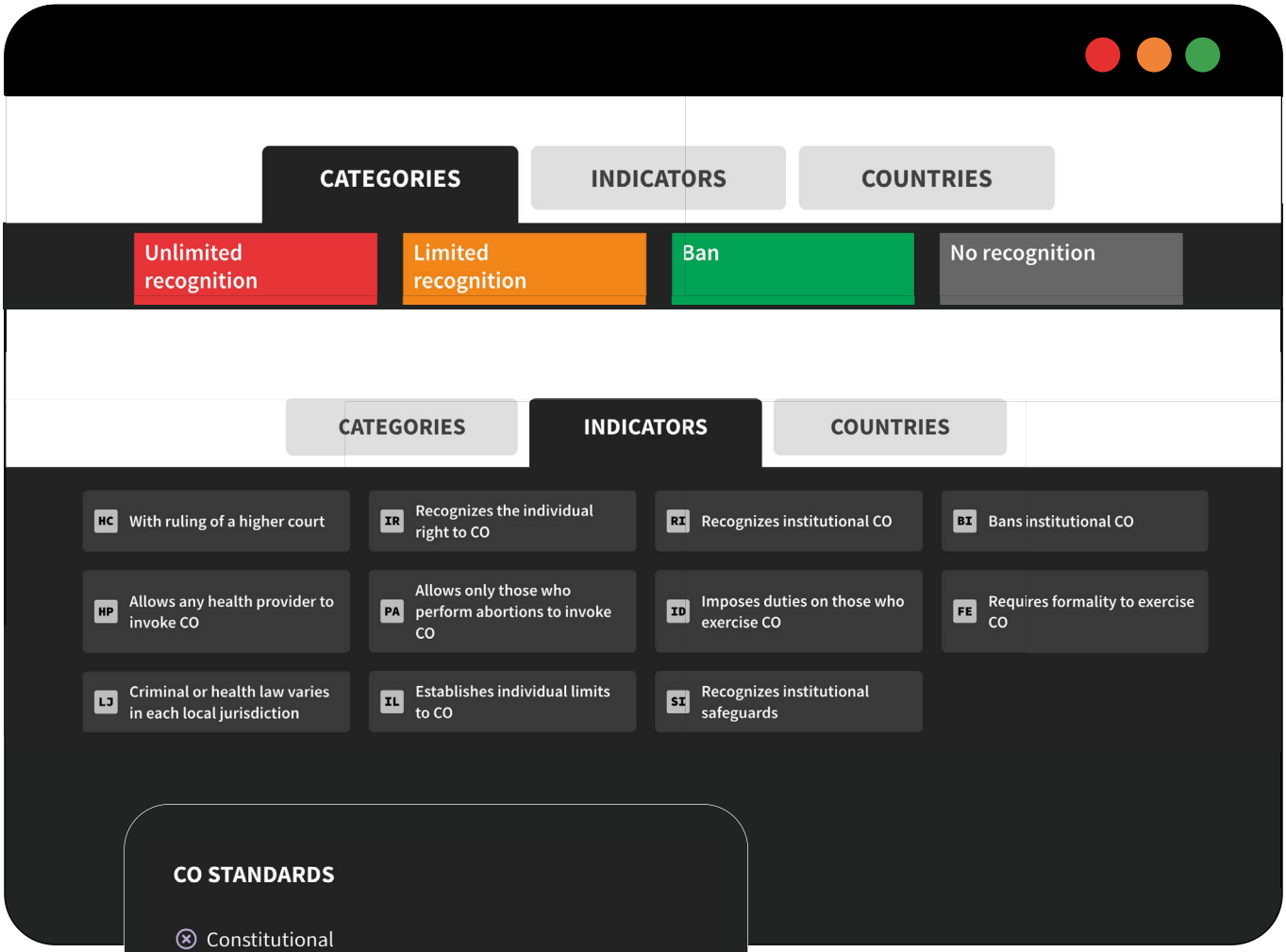
What is the Global Map of Norms regarding CO?

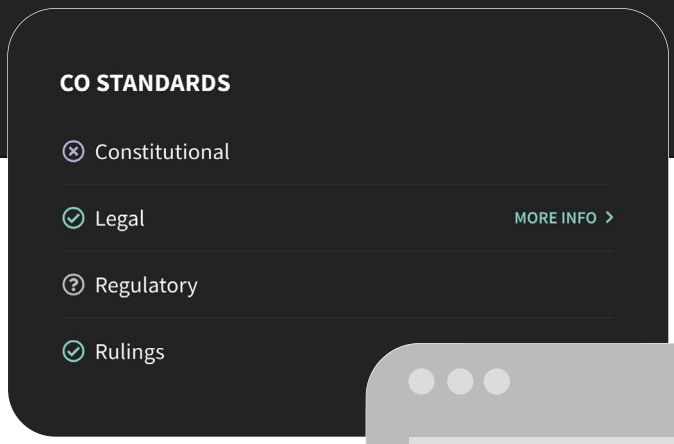
This online interactive map offers an unprecedented systematization of the current norms and regulations regarding CO to abortion across the world.[6]

Developed by Agustina Ramón Michel and Dana Repka from CEDES, with the support of REDAAS and IPAS, the map addresses a previously unfulfilled need, by providing a clear answer to two key questions: How do countries legally 'solve' CO conflicting issues? And, ultimately, what trends and differences can be identified across regulations when contrasting them?

The project, which started back in May 2020 and continues to be updated, collects, describes, and analyzes constitutional, legal, and regulatory norms as well, as ruling cases related to CO, in each of the 185 sovereign nations, 6 colonies and dependent territories included in code ISO 3166-1[7]. It also includes international and regional documents on human rights that are related to this topic.

Our interactive map is available both in Spanish and in English, and it also offers access to all legal documents in their original language. Additionally, the Map allows users to select 15 different filters to access a detailed analysis of CO policies in various countries, thus making it easier to study and compare global trends.





International and Regional Human Rights Systems

Conscientious Objection and Abortion in International and Regional Human Rights Systems [1]

Last updated March 1, 2021

Conscientious objection in the sexual and reproductive healthcare context in general, particularly in abortion care, has been recognized and has been limited, to a greater or lesser extent, both internationally within the framework of the Universal Human Rights System and in the context of Regional Human Rights SystemsBelow is a brief synthesis of the main regulatory and caselaw bodies belonging to the international human rights protection systems, with the purpose of identifying the current regulations regarding conscientious objection (hereinafter "CO").

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All systems set a trend of limited recognition of CO in the sexual and reproductive healthcare context, particularly in abortion care, which coincides with the trend in most

CONSICENTIOUS OBJECTION NORMS ACROSS THE WORLD | A SUMMARY

- The global trend is to recognize CO to abortion.
- Recognition of the right to CO is, in most parts of the world, limited.
- Institutional or ideological CO is the exception to the rule in CO recognition.
- The most frequent limits and duties are:
  - Prohibition to invoke CO in cases of emergency.
  - Duty of the objector to refer a patient.
  - Duty to inform.
- Institutional safeguards are less common than individual limits and duties. One of the most usual ones states that healthcare institutions are bound to have referral mechanisms in place.
- There are significant variations in the groups of subjects authorized to object depending on the country. Three criteria have been determined:
  - Objetive criterion
  - Subjective criterion
  - Mixed criterion

Notes

1 Costa Rica's Executive Decree N° 42113-S. on the 'Officialized Technical Norm for the Medical Procedure Linked to Section 121 of the Criminal Code'. 2019.
Source: https://abortion-policies.srhr.org/documents/countries/03-Costa-Rica-Norma-Tecnica-2019.pdf#page=15. [Emphasis added.]

2 Pakistan's National Service Delivery Standards and Guidelines For High-Quality Safe Uterine Evacuation/Post-Abortion Care.
Source: https://pphisindh.org/home/pic/technical%20resources/Maternal%20Health/Reference%20Material/MVA%20National%20SGs.pdf. [Emphasis added]

3 New Zealand's Act N° 6/2020. Abortion Legislation Act. 2020.
Source: https://www.legislation.govt.nz/act/public/2020/0006/latest/LMS237550.html [Emphasis added.]

4 It is the case of: Argentina, Bangladesh, Belarus, Bolivia, Brazil, Chile, Colombia, Costa Rica, Denmark, Ecuador, Slovenia, Spain, France, Ghana, Italy, Monaco, Nepal, Norway, Peru, Portugal, Serbia, South Africa, and Zambia.

5 Argentina's Law N°27.610 from 2020. Law of Access to Voluntary Interruption of Pregnancy. December 30, 2020.
Source: https://www.boletinoficial.gob.ar/detalleAviso/primera/239807/20210115

6 Ramón Michel A, Repka D. Global Map on Conscientious Objection Norms. Buenos Aires: REDAAS & Ipas. 2021 [December 2023 update].

7 It refers to the first section of international standard ISO 3166, published by the International Organization for Standardization (ISO), defining codes to names of countries and other dependent territories.

SUGGESTED QUOTE: Ramón Michel, A. y Repka, D. Global Map of Conscientious Objection to Abortion. REDAAS, Buenos Aires, May 2024.

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