N° 17
April 2022
REDAAS Document
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GLOBAL DISCUSSION ON CONSCIENTIOUS OBJECTION TO ABORTION

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This document, elaborated by Agustina Ramón Michel and Dana Repka, summarizes the main ideas displayed at the presentation event for the Global Map of Norms on Conscientious Objection, available at: https://youtu.be/v2JXYi7An2A

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Suggested citation: Ramón Michel, A. y Repka, D. ID. Global discussion on conscientious objection to abortion. Buenos Aires. April 2022.

INTRODUCTION

The first English version **of the Global Map of Norms regarding Conscientious Objection** was released on April 7. This is an online map that systematizes legal sources on Conscientious Objection (CO) to abortion from more than 180 countries and other administrative agencies worldwide, a research carried out by Agustina Ramón Michel and Dana Repka (CEDES). Social science scholars, health providers, lawyers and activists from **Argentina, the United States, Italy, Mexico, South Africa, and FIGO** experts on CO came together to discuss the topic. Space for main ideas, data, and discussions.

Conscientious objection (CO) is one of the most persistent, disputed, and controversial issues within the field of health care, especially on the subject of abortion. However, until now, there was no systematization on a global scale that would allow comparing and analyzing how the different countries deal with the CO dispute that involves health care professionals, women, teenagers and girls, and the health system in general. The Global Map of Norms regarding Conscientious Objection -like its Spanish version, the **Mapa Global de Normas sobre Objeción de Conciencia,** launched in June 2021- aims to fill this gap and, in this way, gives an account of how countries "resolve" the CO dispute normatively.

> *CO is a legal concept present in the huge number of countries that regulate abortion in some way, but it has received little attention in terms of regulation and, for this reason, it has managed to infringe on rights. In this sense, this map is a breakthrough (Sonia Ariza, CEDES researcher).*

GLOBAL MAP OF NORMS REGARDING CONSCIENTIOUS OBJECTION - Agustina Ramón Michel y Dana Repka

The Global Map of Norms regarding CO provides a systematization of **current regulations regarding CO in abortion** around the world. It includes **419 regulations from 180 sovereign states,** along with six colonies and other administrative units. All this legal information has been put into an interactive online map available on the REDAAS website

Our decision to visualize this legal information by using an online map reflects our conviction that this information had to be communicatively accessible and that we want to encourage its wide use.

In a survey of these characteristics, with this dimension and on this global scale, we faced great

challenges. The first challenge was the **language barrier.** A second challenge was the **lack ofonline accessibility,** especially of low legal hierarchy regulations and lower instance rulings. And finally, the third challenge related to the systematization of the information was to **define the categories** to be exclusive and serf-explanatory.

The importance that we attach to detailing the methodology of the Map responds to the fact that we want to contribute transparency and knowledge to this exercise of comparative law.

The first finding is that **the worldwide trend is recognition of CO in abortion.** Whether we like it or not, in most places where there is legal abortion, there is recognition of CO. Of the countries that have CO regulations, 93% do so to allow CO. Only 6 countries expressly ban it.

The second finding is that, **in most parts of the world, recognition of the right to CO is limited.** In other words, CO is recognized, but these clauses also set out duties and obligations for objecting health professionals. 89% of the countries we surveyed have some precision about limits and duties:

- Most of the norms have written in different ways the limit that nobody can claim CO in a medical emergency.

- Then, another duty is the duty to refer: the objecting professional has the duty to refer and also has the duty to inform his CO.

- Far fewer countries impose what we call 'institutional guarantees'; that is, mechanisms by which the hospital itself, the institution, has to ensure that, regardless of the CO, the users have the right to access abortion.

If one looks at it in perspective and in relative terms, **it is a bit worrying how few regulations have the duty to refer,** when we know that it is one of the mechanisms that can guarantee the right to the users. So, although what I am saying here is that it is one of the most frequent limits, it is still not enough because only 28 countries out of 71 establish a duty to refer; and there are far fewer countries that have institutional guarantees to ensure that CO does not become a barrier.

We are always talking, it is worth clarifying, about how rules operate in-the-books. This is what we are analyzing in this map.

The third finding is that **even if individual CO does prevail and there is a trend towards its recognition, that is not the case of institutional CO, which recognition is an exception only:** a handful of countries recognize it. Two of them are in Latin America, Chile and Uruguay; and France and Moldova. In other words, 95% of the countries do not allow institutional CO.

To concluder:

- What we see is that CO is recognized as a right, but it is framed by limits and duties. In

addition, there is more emphasis on individual duties and limits, but not so on institutional duties.

- **Then there is this question: CO, in legal writings, is characterized by limits and obligations, but what happens in practice?**
    - The intention of the law is to frame the CO, to limit it. But does this happen -or not happen- in practice?
- The colleagues who will follow in this presentation will tell us a little about this and finally leave open the question of whether, with the advance of misoprostol, knowing how in reality CO is misused, we have to continue thinking in the same paradigm, in a form of a very liberal recognition of CO, which emphasizes above all the individual question, but does not commit itself at an institutional level to what the health system has to do to guarantee access to abortion.

UNITED STATES - Wendy Chavkin

CO, as a general concept, **poses the balancing act between individual's conscience and integrity and the protection of those and the society with other beliefs.** And it reflects bedrock values of the United States Constitution that we are supposed to be protecting the minority from the dictates of the majority. We acknowledge this derives from our separation of church and state that we acknowledge pluralism, that we have different beliefs and have to figure out how we can live together, how we can express our own beliefs without intruding on others.

In the United States, **there have been many examples of CO that we admire:** Resisting racially discriminatory laws, refusing to participate in the war in Vietnam, providing sanctuary to people seeking asylum. It is noteworthy that in all of these cases, the objectors accepted the social rules and the consequences: they went to jail, they paid fines or they performed alternative service.

In recent years, all of this has been turned on its head, and the mantle of CO **is now being used to defy political and socio-cultural norms with which objectors disagree and to reject social obligations and consequences.**

Some of us have therefore proposed **the CO be allowed only if it is not discriminatory, and if the harms can be mitigated.** When it comes to **medical care, there should be even further constraints on CO** because medical providers have the extra obligation: a fiduciary duty. Fiduciary duty recognizes that there are uneven power dynamics between certain categories of professionals, doctors, lawyers, financial advisors, and their clients. Therefore, these professionals are required to put the patient or the client's needs first ahead of their own.

The interactive map that you've created **is highly useful for those who are planning country-based strategies to limit CO** so as to ensure access to contested components of reproductive and other health care.

A core precept of Global Doctors For Choice is that we need to learn from one another, even as we understand that an approach cannot be imported wholesale from one country to another, as local context is specific, but we can certainly get ideas from one another.

- For example, we learned from the UK and Norway that one way to guarantee access to abortion, while permitting objection is to allow patients to skip the usually required first stop at primary care and go directly to the abortion provider.
- In Ireland, where the model is a different one, the basic model relies on the primary care provider, the government run my options telephone line for those who are seeking abortions, rout them directly to willing providers.
- Portugal, when it experiences a dearth of providers because of objection, pays for patients to travel to services and it pays for doctors to travel to provide services in those areas lacking them.
- The U.K., Portugal and Norway all allow willingness to provide abortion to be a condition of hiring.

Now, all of these require **governmental oversight and enforcement** to ensure that they are meaningful, and that access is indeed accomplished.

- In the UK, contracts to the local providers will not be renewed if the expected number of abortion procedures for a catchment area falls short of what is anticipated.

The concept underlying all of this is that the obligation to provide care is at the institutional level, the organizational level, not at the individual level. The individual objector can be accommodated if that care can be guaranteed and if nobody is harmed.

We have learned both from the U.S. and from other examples that we can anticipate that CO will continue to be an issue around the world.

MEXICO - Pauline Capdevielle

In Mexico, we have this giant gap between what the texts say and everyday practices.

CO is legally recognized for various health issues. But in practice, **CO is especially observed** in matters related to **sexual and reproductive** issues, in particular regarding the question of **abortion.**

The country is going through a significant transition, moving from a criminalization approach to jurisprudence recognizing the right to choose, with the additional complication that Mexico is a federal system and, therefore, the legislation on the matter is fragmented.

Another problem is the **lack of information on how many objectors there are throughout the territory. What we do know is that it is indeed a massive phenomenon.** The estimate is that between 80 and 90% of doctors in the country do not want to perform abortions.

Furthermore, in many hospitals, **COs are accompanied by poor health practices,** violence, abuse of power, misinformation, etc.

We also have an intimidating regulatory framework on the matter, because many states have modified their local constitutions establishing that life must be protected from the moment of conception. For health personnel, this is frightening: not knowing whether or not it is legal to perform abortions even in circumstances protected by law is daunting.

Another problem is the **ethical training of health personnel.** When we talk to doctors, often they tell us that they do not necessarily object out of religious fervor, but because in medical schools they were taught that it is not ethical to perform abortions; that it is a crime.

And, of course, there is also the organized resistance of conservative sectors.

What is the current legal framework in Mexico?

- In Mexico City, the CO regulation served to contain it. These are some of the criteria that Agustina mentioned when she spoke of the global map of norms:
    - The objector must refer the patient to another doctor.
    - CO cannot be invoked in an emergency.
    - Another important thing is the State's obligation to always have non-objecting personnel in order to ensure the service.

- In Jalisco, in 2004, there was recognition of the collective CO in the opposite sense.

- And in 2018, there was an addition to the Ley General de Salud [General Health Law] at the federal level, particularly its article 10 bis, which, likewise, accepted a very broad use of CO for health system servers.

This law was challenged and gave rise to a ruling by the Supreme Court of Justice of the Nation (SCJN) in 2021:

Resolution of the Mexican Supreme Court of December 21, 2021:

Article 10 Bis of the General Health Law, added by means of the Decree published in the Official Gazette of the Federation on May 11, 2018, along with the second and third transitory articles of the aforementioned decree, are declared invalid. This will take effect upon notice of these observed points to the Congress of the Union (...) The Congress of the Union is urged to regulate conscientious objection in health matters, taking into account the reasons given in this judgment."

(See the complete judgment **here**)

Article 10 bis of the Mexico's General Health Law that was declared invalid:

Medical and nursing staff that are part of the National Health System may exercise conscientious objection and refuse to participate in the provision of services established by this Law.
When there is a threat to the patient's life or when there is a medical emergency, conscientious objection may not be invoked, otherwise professional responsibility shall be assumed.
The exercise of conscientious objection will not lead to any type of discrimination in the workplace.

(Translation. See full text in original language **here**)

This judgment is part of the Court's efforts to address the issue of abortion in Mexico:

- Two judgments established the unconstitutionality of the absolute criminalization of abortion in Mexico;

- Furthermore, the judges recognized the right to choose for women and pregnant people and also considered that these local provisions that guarantee the right to life from conception to natural death are unconstitutional, precisely because they violate other human rights, women's in particular.

So, the position of the Supreme Court of Justice of the Nation was to **challenge** article 10 bis **which recognized a broad use of CO.** Its unconstitutionality was declared, and an attempt was made to regulate this objection by identifying a series of criteria:

1) The individual nature of CO.

2) The State's obligation to have available personnel.

3) That the objection cannot be claimed in cases of emergency, nor when it implies a disproportionate burden for new users, especially in rural areas.

4) It was also stated that CO cannot be claimed against constitutional principles and in particular against the principle of equality. This came up because some doctors refused to treat people who are part of the LGBT community.

5) It should not seek to hinder the exercise of rights.

6) It is limited to personnel who are directly involved in the rejected procedure.

7) The obligation to refer to a non-objecting colleague.

8) The obligation of dignified, decent treatment, without discrimination or value judgments. This was added because doctors tried to make women who came to seek an interruption of pregnancy change their minds.

9) The obligation to have action protocols when there is no objecting personnel in the health facility.

10) Finally, the provision of mechanisms to identify objectors.

Thus, the Court sent this document to the Congress of the Union to redraft an article that met these criteria. This is happening now: an open parliament was held where different sectors of the population were summoned to listen to their positions on the matter, and it seems that we already have a bill that would be pre-approved.

Press release from the SCJN of Mexico on the action of unconstitutionality 54/2018, which summarizes its judgment:

The Supreme Court of Justice of the Nation (SCJN), in a session of the Full Court, invalidated article 10 Bis of the General Health Law, which broadly established the conscientious objection of medical and nursing personnel who are part of the National Health System, limiting it only when the life of the patient is at risk or it is a medical emergency.
The Court determined that the law did not establish the necessary guidelines and limits so that conscientious objection can be exercised without endangering the human rights of other people, especially the right to health.

(See the full statement **here**)

SOUTH AFRICA - Matokgo Makutoane

The **Choice on Termination of Pregnancy Act** (CToP Act – 1996) and its amendments liberalized the previous restrictive provisions making abortion a crime:

Up to 12 weeks + 6 days	From 13-20 weeks + 6 days	After 20 weeks+ 6 days

• Upon request of a woman.
• No reason required.
• Perfomed by: registered and trained midwife / nurse / medical practitioner
	• Performed by: Registered and trained medical practitioner
	• Continued pregnancy poses:
	  • Risk of injury to woman's physical or mental health.
	  • Substantial risk that foetus will suffer mental/ physical disability
	  • Rape / incest
	  • Significantly affect the socio-economic circumstances of the woman.
		• Performed by: Registered and trained medical practitioner after consulting with another MP/Nurse/Midwife
		• Only if:
		  • Woman's life endangered;
		  • Severe malformation /injury or risk to the foetus.

The **Choice on Termination of Pregnancy Act is silent on the right to CO.** However, the Act only sets out duties of health professionals. And also indicates **obstruction to access**, which is defined as preventing lawful termination of pregnancy or obstructing access to a facility where the procedure takes place, and makes that in a criminal offense.

- If found guilty, a person can be imprisoned for a period not exceeding 10 years.

- But, **how many people have been in prison based on this? none that we have known** since the act has been in place. The act also says. Their providers should provide non-mandatory and non-direct counseling to make sure that women are not coerced. To having procedures which they they they actually were directed to by a provider or any other person besides the consent of a woman.

La CToP Act does not force all health professionals to perform to your piece. **Only force them to give information and prevents one from obstructing access.**

Who can refuse to care?

- When life of a woman is in danger or in an emergency, nobody can refuse to care because it is act of negligence.
- In termination of pregnancy, **only persons directly involved in the procedure** can refuse.

However, support staff can participate in event and stratification workshop to exercise and verify their values and contribute to a cohesive work environment.

The **National Clinical Guideline for Implementation of CToP Act (2019) set more guidelines:**

1) Facilities should have a register, where they will be able to indicate providers who refuse to care.
2) Providers who refuse to care should inform the facility manager by writing when applying for the job.
3) Name and clinical details of the person that they refused to care should be registered.
4) The facility manager must confirm ability to do termination of pregnancy of the new applicants when appointing staff.
5) Refusal must be treated individually, cannot be a group issue. It only applies to individual trained and not to groups, institutions, support personnel or complimentary stuff.

In non-emergency cases, health care professionals who refuse to provide TOP must still:

1) Explain their refusal to the individual in a manner that is non-judgmental and does not stigmatize,
2) Explain to the individual their right to request the safe termination of pregnancy
3) Refer that individual to a facility or provider who will conduct the procedure
4) And update the facility, register to note the refusal to treat

National Clinical Guide for Implementation of the Choice on the Termination of Pregnancy Act, 2019

REFUSAL TO CARE

This refers to individuals who prevent a lawful termination of pregnancy or obstruct access to a facility for a lawful termination of pregnancy based on personal beliefs, usually religious or spiritual in nature.
According to Section 15 (1) of The Constitution of the Republic of South Africa, 1996, "everyone has the right to freedom of conscience, religion, thought, belief, and opinion." Access to TOP under the CTOP Act is, similarly, regarded as a constitutional right. Although Section 15 of the Constitution implicitly accommodates provider refusal to provide TOP services, this creates harm and additional barriers for patients who are entitled to receive comprehensive SRH&R care.
A provider that refuses to provide TOP services, and thus exercises Section 15 of the Constitution, should not be a detriment to the individual seeking a TOP.
Given stewardship obligations within the public service, public servants must acknowledge their fiduciary duties.
Only the direct TOP provider can refuse care (no other health care or support staff member can refuse care). As such, a direct TOP provider who refuses care based on personal beliefs must refer the individual to a colleague or facility that is able to offer such services. The individual's right to information and access to health care services, including TOP, should always be provided for.
In the case of a direct provider's refusal to care, the following standard protocol should be exercised:

1. Section 36 of the Constitution imposes a duty to, at a minimum, provide the individual with information about where the individual can obtain a TOP and refer the individual accordingly.

2. A register of TOP services refused should be kept in each facility, noting:

    - the clinical details of the individual
    - the referral process
    - the name of the clinician who refused services

3. A health care professional's refusal to care cannot violate the right of other health care professionals who are willing to provide TOP services:

- Health care professionals who are not willing to provide TOP services must inform their Facility Manager in writing when applying for a position in the facility.

- Facility Managers must confirm whether a staff member is fit to provide TOP services when appointing staff.

- Each staff member who exercises a refusal to treat must be handled individually. TOP service provision should never be handled in a group, or as a group action.

- Refusal to treat only applies to individual trained health care professionals and not to groups, institutions, support personnel, or complementary services.

4. In non-emergency cases, health care professionals who refuse to provide a TOP service must still:

- Explain their refusal to the individual in a manner that is non-judgemental and does not stigmatise.

- Explain to the individual their right to request a safe TOP.

- Refer the individual to a facility/provider who will conduct the TOP.

- Update the facility register to note the refusal to treat.

REFUSAL TO CARE FOR OTHER HEALTH CARE PROFESSIONALS

Ancillary staff (e.g. reception, ward clerks, janitorial, catering, etc.) and other health care professionals involved in the general care of a patient (e.g. pharmacist) may not refuse to provide general or standard care to an individual under any circumstances.
Thus, conditions of unlawful violation of the CTOP Act includes the following and would be found chargeable of offence:

- If a direct provider is found to be denying an individual access to safe TOP services by failing to provide the TOP service and failing to provide referral to a colleague or facility that will provide the TOP service and/or obscuring other health care workers to provide safe TOP services, the health care professional has unlawfully violated the CTOP Act.
- If a health care professional refuses to assist and is not directly involved in performing the TOP, the health care professional has unlawfully violated the CTOP Act.

OBLIGATIONS IN EMERGENCY SETTINGS

Section 36 of the Constitution limits the right to refuse treatment or care to when there is a medical emergency and maternal life or health is in danger. A health care professional can therefore not legally or ethically object to the rendering of care in cases of life- or health-endangering emergencies associated with TOP procedures.
According to the law, health care professionals, regardless of their religious or moral objections, have a duty to perform a TOP procedure if the individual will suffer adverse health consequences if the TOP is not promptly carried out. When an individual faces a risk to their health because a health care professional refuses to provide a TOP, the individual's right to health is jeopardised.

(See complete regulation **here**)

SA Research study: Perspectives, and Reasons for Conscientious Objection among Healthcare Workers, Facility Managers, and Staff in South Africa: A qualitative study (2020)

- CO on the part of healthcare providers is a **growing threat to safe abortion access.**
- Although there has been progressive shifts in attitudes towards abortion over time, but **stigma against women and girls who seek abortion the main substantial** among staff at facilities providing abortions.

ITALY - Letizia Mencarini

I think that Italy is well-known case that sometimes is taken as an example of what it can be or you will be in the future.

Italian abortion is regulated by a law that is called 194 from 1978.

- It has never been changed.
- It is called "law for the social protection of motherhood and involuntary termination of pregnancy".
- It permits the abortion in the first 90 days almost freely and after the first trimester, only for danger to the women's health.

- Abortion is free of charge and is granted in public hospitals in 94% of cases.
- The law sets also a quite complicated procedure to access to abortion.
- And what is important: the same legislation applies in all regions of Italy, and women can go everywhere in the territory of the country.

The same law also:

- Grants CO to all gynecologists, but also statistics and no medical staff in gynecology and in obstetrics. And this is on the ground of CO.
- And so, for example, perform abortions, all these practitioners must declare their core objection formally to the local AFCA authority and to the director of the facility where they work. And, usually, this declaration became effective after one month. So, it is something that is individual, and it is something that needs to be stated. And then it became a status for the person. So, practitioners is objector or non-objector; is not something that they can decide along the way several times; they need to change it formally.
- Does not require conscientious objectors to refer women to non-objecting practitioners. And the code of conduct of Italian Federation of Medical Association also does not set out any obligation in this sense.
- if there is some emergency, CO does not allowed refuse to care. Otherwise, the law states that objecting physicians must provide any useful information to enable the woman to access such services. This is very vague, and it does not really give any direction on how to act.
- The same law also mandates that different regions in Italy need to grant adequate access to abortion at the local level. However, in practice, the proportion of the objection is quite high:
    - In the northern regions, only one out of four in some northern region, while in Sicily there are 86% objectors.
    - The last data published that said that 67% of Italian gynecologists are objections and almost half percent of our institution and 40% of non-doctor practitioner are.
    - But the variability between regions is very high:

- In the northern regions, only one out of four in some northern region, while in Sicily there are 86% objectors.

- There is a certain correlation with religiosity, but not exclusively because the prevalence of OC is greater in the central part of the map.

Article 9, Act No. 194 on the social protection of motherhood and the voluntary termination of pregnancy, 1978

Health personnel and allied health personnel shall not be required to assist in the procedures referred to in Sections 5 and 7 or in pregnancy terminations if they have a conscientious objection, declared in advance. Such declaration must be forwarded to the provincial medical officer and, in the case of personnel on the staff of the hospital or the nursing home, to the medical director, not later than one month following the entry into force of this Law, or the date of qualification, or the date of commencement of employment at an establishment required to provide services for the termination of pregnancy, or the date of drawing up of a convention with insurance agencies entailing the provision of such services.
The objection may be withdrawn at any time, or may be submitted after the periods prescribed in the preceding paragraph, in which case the declaration shall take effect one month after it has been submitted to the provincial medical officer.
Conscientious objection shall exempt health personnel and allied health personnel from carrying out procedures and activities specifically and necessarily designed to bring about the termination of pregnancy, and shall not exempt them from providing care prior to an following the termination.
In all cases, hospital establishments and authorized nursing homes shall be required to ensure that the procedures referred to in Section 7 are carried out and pregnancy terminations requested in accordance with the procedures referred to in Sections 5, 7, and 8 are performed. The regions shall supervise and ensure implementation of this requirement, if necessary by the movement of personnel.
Conscientious objection may not be invoked by health personnel or allied health personnel if, under the particular circumstances, their personal intervention is essential in order to save the life of a woman in imminent danger.
Conscientious objection shall be deemed to have been withdrawn with immediate effect if the objector assists in procedures or pregnancy terminations provided for under this Law, in cases other than those referred to in the preceding paragraph.

(See complete regulation **here**)

In addition, many women travel between regions to have an abortion. We know that the **United Nations Human Rights Committee expressed concern** about this several times. There is a lively debate there, because opponents say that the lack of limits on CO constrains

access to abortion, while, every year, ministers report that the number of abortion providers is sufficient to grant easy access to the service at the national level and that the problem is simply one of local management.

As demographers, we simply want to explain why women have abortion outside their regions of residence; and if there is a link up with the CO. And in fact, we have published a paper where we analyzed more than one million records of individual abortion; and we find that, in fact, **the proportion of objectors is linked** - and is almost causally associated, I would say, according to our model - **to the fact that women are moving to another region** and also to the waiting time before the intervention.

So, the conclusion is that our empirical findings support the hypothesis that **CO induces women to travel between regions to have abortions,** and also that this creates some disparity in different parts of the country and imposes additional time and travel costs on some women; and especially on those who have a lower socioeconomic level and possibilities.

So, what we think is that we need to do further research on on the correspondence between the law and the data that is provided by Ministry, because **it seems that the real rate of availability of doctors is lower than what is reported.**

Finally, I want to reflect on the fact that now, **with the abortion pill, the relevance of CO may be different,** or it may act differently + we ought to wonder if the COVID 19 pandemic has changed something we got.

FIGO'S POSITION (International Federation of Gynecology and Obstetrics - Rodica Comendant

FIGO statement on conscientious objection is a good summary of all the presentations. And of course, me as a member of the subcommittee goes, I would encourage you to use the statement to advocate for the regulation of this issue and for removal of these unnecessary barriers to care.

The OC:

- Is the manifest when the health care provider refuses to administer abortion services or information on the ground of conscious of religious belief.
- Become recently a more and more serious problem even in Eastern Europe or the region where abortion is legal and broadly accessible.
- So, this map is another step forward and provides a better understanding of the

classification of CO and its regulation in different countries.

FIGO is committed to reducing maternal mortality and morbidity from unsafe abortions:

- We unequivocally recognize that the primary **conscientious duty** of health care providers at all times is to treat, provide benefit and prevent harm to the patients whose care they are responsible for.

- Any **CO** to treating a patient **is secondary** to this **primary duty;** therefore, essential services cannot be denied.

- FIGO further recognizes that while providers should not be discriminated against or disrespected for their beliefs, should they refuse to provide abortion services, they **must provide appropriate referrals** to ensure women and girls in need can access these services in a timely manner.

- Providers **should not invoke CO:**

    - In emergency situations

    - Where referral is not possible or timely or where this results in undue barriers

    - For post-abortion care

    - By auxiliary staff or institutions..

- FIGO acknowledges that the terminology of co implies that those **who do provide abortion services** do so without conscience, when often the reverse is true; **FIGO recognises these "conscientious providers".**

- Furthermore, FIGO **recognise the burden and stigma that CO puts** on those who do provide abortion care, often leading to such **providers being stigmatised**, over-burdened, working without support of colleagues and management, and facing a detrimental impact on their careers.

FIGO urges its national member societies and other stakeholders to work towards sensitising health care providers to their ethical and legal duties, aiming to **reduce use of CO globally.**

FIGO's Resolution on Conscientious Objection (2006)

FIGO affirms that to behave ethically, practitioners shall:

1. Provide public notice of professional services they decline to undertake on grounds of conscience;

2. Refer patients who request such services or for whose cares such services are medical options to other practitioners who do not object to the provision of such services;

3. Provide timely care to their patients when referral to other practitioners is not possible and delay would jeopardize patients' health and well-being; and

4. In emergency situations, provide care regardless of practitioners' personal objections.

(See FIGO's statement **here**)

REDAAS is a network of health and legal professionals associated with public and community health services in Argentina. Our commitment is to accompany and assist women in situations of legal abortion, understanding it as part of our professional, ethical and legal duty. Our goal is to promote the implementation of Law 27.610 on Access to Voluntary Termination of Pregnancy and promote access to legal abortions, to help eliminate institutional and political barriers to access safe and legal abortions and build a community to share information, exchange experiences and offer a space of solidarity, encouragement and political support.

The creation of this network started in 2011 as an initiative of the Health, Economy and Society Area of CEDES - Centro de Estudios de Estado y Sociedad - and was institutionalized under the name of REDAAS in 2014, in a joint construction with ELA - Equipo Latinoamericano de Justicia y Género.

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