

# Striking a Balance: Conscientious Objection and Reproductive Health Care from the Colombian Perspective

LUISA CABAL, MONICA ARANGO OLAYA, VALENTINA MONTOYA ROBLEDO

## Abstract

Conscientious Objection or conscientious refusal (CO) in access to reproductive health care is at the center of current legal debates worldwide. In countries such as the US and the UK, constitutional dilemmas surrounding CO in the context of reproductive health services reveal inadequate policy frameworks for balancing CO rights with women's rights to access contraception and abortion. The Colombian Constitutional Court's holistic jurisprudence regarding CO standards has applied international human rights norms so as to not only protect women's reproductive rights as fundamental rights, but to also introduce clear limits for the exercise of CO in health care settings. This paper reviews Latin American lines of regulation in Argentina, Uruguay, and Mexico City to argue that the Colombian Court's jurisprudence offers a strong guidance for future comprehensive policy approaches that aim to effectively balance tensions between CO and women's reproductive rights.

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LUISA CABAL, LLB, LLM, is Lecturer-in-Law at Columbia University Law School, New York, NY, USA.

MONICA ARANGO OLAYA, LLB, LLM, is Regional Director for Latin America and the Caribbean at the Center for Reproductive Rights, Bogota, Colombia.

VALENTINA MONTOYA ROBLEDO, LLB, MA, LLM, is Harvard Law School Kaufman Fellow and Legal Fellow for Latin America and the Caribbean at the Center for Reproductive Rights, New York, NY, USA.

Please address correspondence to Luisa Cabal. Email: [lcabal@columbia.edu](mailto:lcabal@columbia.edu).

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## Introduction

CONSCIENTIOUS OBJECTION (CO) has been defined as the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs. CO in the context of access to reproductive health care is at the center of legal and policy debates around the world.<sup>1</sup> The Supreme Court of the United States in June 2014 decided a case on whether corporations possess freedom of conscience-related rights. The Supreme Court of the United Kingdom will also determine the scope of who can invoke CO in the provision of abortion services. However, ongoing CO decisions among US and UK courts reveal that domestic policy frameworks in these countries have so far failed to balance freedom of conscience with women's reproductive rights.

International human rights courts in Europe have increasingly addressed the parameters of the right to CO in the provision of reproductive services, but their approach has been limited thus far. The Inter-American Commission on Human Rights (IACHR) has not yet issued a decision on the matter. Latin American countries have been facing these questions. Nevertheless, Argentina, Uruguay, and Mexico have led the conversation through legislation: Argentina admits institutional CO by private and public institutions; Uruguay admits ideology objection by private institutions, including a public registry for objectors, while Mexico City's regulations deny institutional CO to public institutions. The Colombian Constitutional Court (CCC) has, however, adopted a holistic approach, setting standards on CO by medical professionals providing reproductive health care services, but also by judges and administrative personnel. It has further set standards on institutional, individual, and collective CO, thus passing current international human rights principles on the subject. In particular, IACHR has recognized those standards as references ensuring wide-ranging protections for women's reproductive rights, but offering clear parameters for the exercise of the freedom of conscience in the

context of reproductive health services. In this paper, we propose that the Colombian Constitutional Court standards (CCCS) offer a balanced approach to protecting various human rights at stake in CO cases. Moreover, we argue that CCCS could be a holistic model for jurisdictions worldwide.

This paper is divided into three parts: first, we map debates around CO currently taking place before courts in the US and Europe, and reflect upon these adjudicators' partial approach to CO. Second, we assess the right to CO within the context of international human rights law, as determined by the Universal Human Rights System and the European Human Rights System. Third, we situate CCCS in the global and regional context by comparing guidelines issued by the CCC with CO standards established in Argentina, Uruguay, and Mexico City. In this section, we submit that CCCS could provide insights to policy makers and adjudicators within and beyond those in Latin America, to achieve a balanced protection of the right to freedom of conscience and women's reproductive rights.

### Recent legal debates on the right to conscientious objection in the provision of reproductive health care to women

Legal challenges under the right to CO in the US open the possibility that for-profit corporations can object to insuring medically necessary reproductive health services based on the owner's religious beliefs. Moreover, UK decisions on CO can possibly expand the range of health-related personnel that can invoke CO.

US constitutional law has recently acknowledged that private corporations possess "institutional" rights protections. Due to the privatization of health care coverage in the US, decisions granting rights protections to corporations stand to impede access to private health insurance coverage for reproductive health services. For instance, the US Supreme Court ruled in *Citizens United v. Federal*

*Election Commission* that corporate entities can possess free speech rights, as protected under the First Amendment to the US Constitution. In *Sebelius v. Hobby Lobby Stores, Inc.*, the Supreme Court determined that for-profit employers can exercise religious freedom protections, also protected under the First Amendment, to object to a general federal requirement that employers cover contraceptives in their privately insured health plans.<sup>2</sup> This decision granted private entities freedom of conscience protections, denying women necessary health benefits in their insurance plans.

In the UK, where health care coverage and provision is nationalized, the debate centers on whether health providers can refuse to provide basic care to women undergoing abortions. Under UK statutory law, healthcare providers can conscientiously object to participating directly in an abortion procedure. However, in *Doogan & Anor v. NHS Greater Glasgow & Clyde Health Board*, two Catholic midwives submitted to a Scottish court that their right to CO under the 1967 Abortion Act entitled them to refuse to “delegate, supervise and/or support staff in the participation in and provision of care to patients undergoing termination of pregnancy ... throughout the termination process.”<sup>3</sup> The case is now before the UK Supreme Court, which must determine the scope of health care providers’ CO rights in the provision of abortion care.<sup>4</sup>

Debates in US and UK constitutional jurisprudence reveal conceivable threats to women’s rights to access reproductive health services. In the next section, we argue that activists and other stakeholders should look to international human rights standards that offer holistic recommendations to protect the right to conscience, while guaranteeing women’s reproductive rights.

### Current international human rights standards addressing conscientious objection

With respect to CO in the provision of reproductive health care services, guidelines issued by international human rights treaty-monitoring bodies—as well as international human rights courts in Latin America and Europe—clarify States’ human rights

obligations to balance rights to CO with women’s reproductive rights. This section provides an overview of current international human rights standards that address CO in reproductive health care settings.

#### *The International Human Rights System*

International Human Rights Law recognizes that CO claims in health care settings are derived from the right to freedom of thought, conscience, and religion, established under Article 18 of the International Covenant on Civil and Political Rights (ICCPR).<sup>5</sup> The United Nations Human Rights Committee (HRC), for instance, has found that Article 18 entitles individuals to CO protections.<sup>6</sup> However, while the ICCPR notes that States cannot limit the right to freedom of thought, conscience, and religion, various treaty-monitoring bodies have determined that the freedom to manifest religion or beliefs can be subjected to restrictions.<sup>7</sup> For example, the HRC, as well as the UN Committee on Economic, Social and Cultural Rights (CESCR) have conveyed that, to protect individuals’ rights to the highest attainable standard of health, States can restrict CO if the restriction: 1) follows the law; 2) is compatible with other human rights; 3) has legitimate aims; and 4) is strictly necessary to promote general welfare.<sup>8</sup>

These treaty monitoring bodies (TMBs) protecting the right to access reproductive health care, in particular, have issued limitations to the freedom to manifest religion. Within reproductive rights contexts, CO as an exercise of the right to manifest one’s religion or belief cannot supersede women’s rights to health, personal integrity, and privacy, among others.<sup>9</sup> The HRC, for instance, has recognized restrictions to protect women’s equality by submitting that, “Article 18 may not be relied upon to justify discrimination against women by reference to freedom of thought, conscience and religion.”<sup>10</sup> The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has, moreover, addressed the need to fully regulate CO to prevent women’s reproductive rights violations. The Special Rapporteur recommended that inter-

national human rights norms require States to “[e]nsure that conscientious objection exemptions are well-defined in scope and well-regulated in use and that referrals and alternative services are available in cases where the objection is raised by a service provider.”<sup>11</sup>

In addition, General Recommendation No. 24 of the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee) establishes that “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.”<sup>12</sup> It has also affirmed the positive obligations of “States parties to ensure women’s right to safe motherhood and emergency obstetric services.”<sup>13</sup> The recommendation also notes that States parties must “refrain from obstructing action taken by women in pursuit of their health goals” and indicates that States must take “action to prevent and impose sanctions for violations of rights by private persons and organizations.”<sup>14</sup> In addition, according to the recommendation, States have the immediate obligation to safeguard women’s access to reproductive health care based primarily on the non-discrimination principle.<sup>15</sup> State parties to treaties must not only provide access to reproductive health care services, but also monitor private institutions’ compliance with human rights protections, as well as enforce regulations when private institutions breach their responsibilities.<sup>16</sup>

The CEDAW Committee, as well as other TMBs, could also apply standards for private institutions under the right to health to clarify that while States have the obligation to guarantee the right to freedom of religion as a human right, they must also protect women’s rights to equality, personal integrity, privacy, and health.

#### *Conscientious objection in the European system of human rights*

The Parliamentary Assembly Council of Europe Resolution No. 1763 (2010) on “The right to consci-

entious objection in lawful medical care” suggests that entire institutions can object to providing abortion care.<sup>17</sup> This is an unbalanced approach that risks women’s reproductive rights. In contrast, the European Court of Human Rights (ECtHR) has recently issued two decisions affirming that freedom of conscience cannot curtail women’s right to access to reproductive health care services. In *R.R. v. Poland* (2011), the ECtHR established that “States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation.”<sup>18</sup> Moreover, in *P. and S. v. Poland* (2012), the ECtHR followed its reasoning in *R.R. v. Poland* to require Poland to balance doctors’ right to exercise CO with patients’ rights to access legal abortion “by making it mandatory for such refusals to be made in writing and included in the patient’s medical record and, above all, by imposing on the doctor an obligation to refer the patient to another physician competent to carry out the same service.”<sup>19</sup>

Apart from ECtHR jurisprudence, the European Committee of Social Rights (ECSR) considered in *IPPF v. Italy* whether Italy’s CO protections constituted de facto inaccessibility to abortion services that amounted to a violation of the European Social Charter. The Italian Act No. 194/1978 safeguards women’s rights to access abortion under certain circumstances, but also grants medical practitioners the right to exercise CO. In practice, however, widespread CO among medical practitioners has resulted in unequal access to abortion services among women in Italy. In a landmark decision, the ECSR concluded that Italian law requires the State to make abortion available by ensuring that a sufficient number of non-objecting health providers can perform abortion services. The ECSR thus affirmed that States must effectively implement laws that balance CO with the right to certain health services so that CO protections do not impede access to such procedures.<sup>20</sup>

Decisions in the European human rights system recognize that while human rights norms acknowl-

edge CO rights, States should also guarantee that reproductive health services are effectively available. Moreover, the ESCR has underscored that, even when a State has created a policy framework that balances CO with the right to access health services, ineffective implementation of the policy can lead to ongoing reproductive rights violations. Therefore, while international decisions can provide important guidance on State's human rights obligations concerning CO, a holistic approach to addressing the rights in question requires the State to effectively implement a robust policy framework from the outset.

### The Colombian Constitutional Court's approach to conscientious objection within a global and a regional context

#### *Conscientious objection in the Inter-American human rights system*

Although Article 12 of the American Convention on Human Rights (ACHR) recognizes the right to freedom of religion and conscience, the Inter-American human rights system, unlike the European system, has not explicitly considered CO in health care settings. Nevertheless, the Inter-American Court of Human Rights (IACtHR) has determined that the ACHR protects individuals' rights to reproductive autonomy. In *Artavia Murillo v. Costa Rica*, the IACtHR explicitly recognized reproductive rights, and it established the State's obligation around the regulation of reproductive rights by determining that "States are responsible for regulating and overseeing the provision of health services to ensure effective protection of the rights to life and personal integrity."<sup>21</sup> Likewise, it determined that "[T]he lack of legal safeguards that take reproductive health into consideration can result in a serious impairment of the right to reproductive autonomy and freedom."<sup>22</sup> Denial of essential health care can compromise women's lives and personal integrity. Those State obligations have to be read coherently with those derived from the right to manifest religious freedom. In addition, the IACHR has recognized the CCC for its holistic jurisprudence regarding

State obligations to ensure protection of both the freedom of conscience and women's reproductive rights.

From a human rights perspective, CCCS on CO in the context of reproductive health care provision are useful at both the Latin American and global levels for five main reasons: 1) they promote valuable principles that approach CO from a comprehensive perspective by striking a balance between the right to CO, while also ensuring that women can exercise their reproductive rights; 2) given the lack of normative standards on CO in the Inter-American context, CCCS provide a salient human rights framework for addressing similar conflicts regarding CO and reproductive health care in other Latin American jurisdictions; 3) CCCS surpass the European standards in that they are more comprehensive regulating a varied range of actors who can exercise CO, and differentiating among individual, institutional and collective CO to warrant women access to reproductive health care; 4) within the Latin American context, Argentina, Uruguay, and Mexico offer a broad regulation on CO, but CCCS are still more balanced and holistic; and 5) CCCS, by incorporating universal human rights principles, serve as a blueprint for effective policy prescriptions in various countries worldwide.<sup>23</sup>

In 2006, the CCC issued Decision C-355 liberalizing abortion under three circumstances: rape or incest, risk to woman's life or health, or fetal malformation incompatible with life. The Ministry of Health issued Decree 4444 (2006) to regulate access to abortion; it was nullified in 2013 by the State Council, the highest administrative court in Colombia. Even though the regulation was nullified, the CCC continued to secure protections for abortion access in a context of fierce backlash from some institutions, including the Inspector General, and trial court judges.

Several constitutional actions and writs for the protection of fundamental rights to demand access to abortion were submitted before the CCC. The Court "made legal rulings affecting how health care systems should accommodate both CO and patients' rights to lawful care" through decisions C-355 (2006), T-209 (2008), T-946 (2008) and T-388

(2009), which developed the following principles:<sup>24</sup>

- 1) Only personnel directly related to abortion provision can exercise CO.
- 2) CO has to be written, explaining the religious reasons in the concrete case.
- 3) Hospitals whose physicians exercise CO must have available non-objectors providing convenient and timely access.
- 4) Whenever an abortion service is refused a health authority liable to pay compensation for the negligence can sue the physicians who did not follow standards on CO seeking compensation.
- 5) The Ministry of Health and the Health Superintendency should investigate offending hospitals and impose sanctions whenever violations occur.
- 6) “The governmental system responsible for health care security is obliged to ensure an adequate supply of abortion service providers.”<sup>25</sup>
- 7) Judges, as public officials, cannot exercise CO by issuing decisions to limit abortions. Those denying abortion in legal cases must be prosecuted for disregarding the Criminal Code, the Constitution, and the 2006 Constitutional Court decision.
- 8) CO “cannot be invoked with the effect of violating women’s fundamental rights to lawful health care. Women denied abortion services on grounds of conscience must be referred to physicians willing and able to provide such services. Individual objecting physicians have a duty of immediate referral, and institutions must maintain information of non-objecting physicians to whom patients can promptly be referred.”<sup>26</sup>
- 9) Physicians or governmental designated committees must revise the CO request’s legitimacy, observing whether it is “founded on well-based convictions such as the teachings of an acknowledged religion.”<sup>27</sup>
- 10) Institutional CO is forbidden. “The human right to respect for conscience is a right enjoyed by natural human beings, but not by institutions such as hospitals.”<sup>28</sup>
- 11) Collective—where all the personnel of an institution invoke COs—and State CO—where public officers in performing their duties pose

COs to those duties—is forbidden.<sup>29</sup>

These standards offer a holistic approach to CO i) limiting CO to health professionals directly providing abortion services, leaving aside administrative personnel, judges, and legal entities, and limiting institutional CO; ii) restricting negligent conducts beyond the scope of CO, iii) banning it in emergency cases, and imposing requirements for immediate referrals; iv) establishing sanctions for violating the limits of CO; and v) imposing on States the obligation to ensure women’s access to reproductive health care.

Based on the comprehensive and accurate CCCS, particularly on decision T-209 (2008), the IACHR “considered that States must ensure that women’s access to information and reproductive health service is not curtailed, and that in situations of CO by health providers, States must establish referral procedures, as well as sanctions for non-compliance with such obligation.”<sup>30</sup> Other approaches have been adopted in Latin America through legislation.

### *Argentina*

Abortion is legal in Argentina whenever a woman’s life or health is at risk, or in cases of rape.<sup>31</sup> The Argentine National Congress has issued regulations on CO to reproductive health care since 2003.<sup>32</sup> Unlike CCCS, which specify that only persons, and not institutions, have CO rights, Argentina’s regulations acknowledge that public institutions, as well as private religious, health, and educational institutions possess an institutional right to CO. However, these regulations affirm principles in CCCS by requiring institutions to ensure that, despite CO protections, individuals can access sexual and reproductive health services. The regulations establish, for example, that institutions must ensure execution of the National Program on Sexual Health and Responsible Reproduction. In CO cases, institutions must refer patients to non-objecting practitioners. The “technical guidelines from the Ministry of Health, moreover, stipulate that institutions must provide termination of pregnancy through another provider at the institution within five days, or immediately if the situation is urgent.”<sup>33</sup> No legal consequences

will arise for conscientious objectors; however, “any delaying tactics, provision of false information, or reluctance to carry out treatment by health professionals and authorities of hospitals is subject to administrative, civil, and/or criminal actions.”<sup>34</sup> This last provision follows CCCS that sanction medical professionals who do not comply with standards on CO. All women, moreover, must “be informed of the conscientious objections of medical, treating, and/or support staff at first visit.”<sup>35</sup>

Both private and public health institutions and professionals can therefore deny access to services, in opposition to the secular character of the Argentine State. The lack of legal consequences for conscientious objectors also further protects institutions and providers. Paradoxically, institutional CO can force individual physicians for whom the provision of abortion is a moral choice to subsume their individual conscience to an “institutional conscience.” This acts to not only limit the provision of medically necessary and legal public health services, but also to restrict what physicians may consider the exercise of their own professional duties.

The basis to defend institutional CO is set on certain grounds, which include: 1) that corporations and/or institutions can be equated to individuals, since both entities and individuals make decisions based on values, principles, and deliberations grounded in their internal statutes and goals; 2) that collective experiences occurring within a corporation/institution create a group conscience; and 3) that, following the premise that individuals within a corporation share similar moral values, institutional CO can effectively protect individuals employed by the same institution.<sup>36</sup>

Argentina’s provinces regulate CO through national norms but have added specific provisions. Several provinces regulate CO.<sup>37</sup> Buenos Aires Province established through Law 13066 (Provincial Program on Sexual Health and Responsible Reproduction) that the objector should inform medical institutions’ directives and patients about his/her position, and that CO should be stated in a timely written declaration to allow the institution to find non-objectors. Such a requirement is reinstated by Buenos Aires City through Ministry of Health’s

Resolution 1174 (2007) (abortion assistance), Chaco’s Law 5409 (2004) (responsible reproduction), San Luis’s Decree 129 (2003), and Santa Fe’s Law 11888 (2001) (responsible reproduction). San Luis’s Decree establishes that such a declaration must be reasoned. Santa Fe’s Law and its regulatory Decree 2442 (2002) establishes an objector’s registry where all the health professionals who are conscientious objectors are listed, and states that the Province is responsible for free service provision. Buenos Aires City’s Law 1044 (2003) (Procedure on anencephalic fetuses) also recognizes CO; however, it mandates that physicians in the public health system must immediately refer a woman to a non-objector.

These regulations state similar standards as those set by the CCC, as they outline the need for referral, and the written and supported CO, which should be invoked within a timeframe that allows the identification of non-objectors. However, the lack of specific regulations regarding judges’ right to CO, and a committee’s revision of CO’s legitimacy, open the possibility for physicians and public officials to disregard their official duties in public institutions through negligent conduct, which can result in the denial of abortion services. This type of conduct has been referred to as official disobedience.<sup>38</sup>

### *Uruguay*

Since 2012, abortion without restriction is legal in Uruguay until the 12th week of pregnancy. After that time, abortion is legal under certain circumstances, including fetal malformations incompatible with life outside the womb, risk to a woman’s life or health, and rape.<sup>39</sup> Law 18987 and Decree 375 (2012), which regulates the scope of the liberal abortion law, reaffirms that individual CO can only be exercised by doctors or technicians directly related to abortion provision.<sup>40</sup> CO cannot be exercised during post-abortion procedures or regarding access to abortion information. CO has to be provided in writing, and authorities in the health institution where a health professional provides services must be informed. These requirements mirror those of the CCC by limiting CO to medical professionals and preventing others from limiting women’s access to reproductive health care. The law also establishes

a confidential CO registry for objectors.

In contrast to CCCS standards, this framework also introduces the notion of “ideology objection,” an institutional objection in which private health institutions can abstain from practicing an abortion. Unlike in Argentina, public institutions in Uruguay cannot be institutional objectors. Under this framework, a private institution had to declare its objection before the National Health Junta within a maximum of 15 days after the law’s issuance. These institutions also had to provide relevant information from their organization’s statutes showing that the institution cannot provide access to abortion. The Ministry of Health is in charge of determining whether the objection proceeds. If the Ministry finds that the objection is legitimate, it should set an agreement with the institution, finding a way to ensure abortion provision.

The Uruguayan law also covers areas not specifically addressed in the Colombian standards, by establishing that CO can be manifested or explicitly revoked at any time and it can be implicitly revoked whenever the physician provides abortion services. Medical professionals should explicitly declare that they are objectors in every institution where they provide health care. Implicit CO revocation in one institution automatically extends to other institutions where the physician works. These regulations seek to prevent potential official disobedience where physicians who refuse to provide abortion services in public institutions do provide them in their private practices.

The Uruguayan regulations are similar to CCCS, as they outline an individual right to CO only to personnel directly related to abortion provision, and the written and supported CO. It goes beyond CCCS by determining how CO is revoked to prevent official disobedience, as well as establishing a confidential objectors’ registry. Yet the lack of specific regulations that are included in CCCS, regarding judges’ right to CO, the fact that collective CO is not regulated, and the recognition of “ideology objection” similar to institutional CO could potentially limit women’s access to reproductive health care.

There is no official data on the exercise or impact of CO in Uruguay. Anecdotal evidence, however,

implies that physicians are collectively practicing official disobedience and resisting the law, impeding women’s access to care.

### *Mexico City*

Mexico defers abortion regulation to each State. Since 2007, Mexico City has allowed abortion without restriction, up to 12 weeks of pregnancy. After abortion reform, the Federal District Health Secretariat implemented the first public program to provide abortion services.<sup>41</sup> From 2007 through 2013, women accessed 113,111 abortions.<sup>42</sup> Reports from 2008 have revealed that 85% of obstetricians and gynecologists in Mexico City’s public hospitals have exercised CO.<sup>43</sup> The public health system, however, has a continued commitment to ensuring timely access to abortion.

Mexico City’s Health Act states that public institutions must provide abortion services during the five days following a woman’s request.<sup>44</sup> As with Colombian standards, it recognizes the right of medical personnel to object to providing an abortion as long as they refer women to a non-objector, and CO cannot be invoked in emergency cases. Public health institutions must provide timely access to abortion and ensure availability of non-objector health professionals at all times. The Procedural Guidelines for the Legal Interruption of Pregnancy in the Medical Units that operationalize the law establishes that only doctors providing abortions can be objectors. They must write a confidential document establishing their reasons, which is reviewed by the hospital’s bioethical committee.<sup>45</sup>

Mexico City’s regulations are similar to CCCS in requiring a written statement, and in limiting its exercise to directly related medical personnel. The regulation is not as comprehensive as CCCS, as it lacks sanctions for negligent doctors. Nevertheless, practical effects are positive. Women have accessed essential reproductive health care and most obstacles have been removed at the public level, even by implicitly denying the exercise of institutional CO to public institutions, which are the only ones with the duty to provide abortion services.



## Conclusion

The need to regulate CO in Latin America has arisen from the numerous obstacles women continue to face in exercising their reproductive rights. The regulation of CO is part and parcel of the demands to protect a secular State in which the provision of health care is not tied to religious ideology. It also responds to the need to ensure full respect of women's fundamental human rights.

The standards set forth by the CCC and endorsed by the IACHR offer a model for future normative developments on the issue in Latin America and worldwide. They strike a balance by offering a holistic human rights framework that protects the right to religious freedom, while guaranteeing women's rights to reproductive health care. The CCC achieves this balance by seeking to ensure that CO is real and consistent, by establishing accountability mechanisms, and by ensuring the provision of reproductive health services for women. It also defines the limits of the exercise of CO, restricting it to those directly involved in the practice, excluding judges and administrative personnel, and ensuring that in emergency cases CO cannot be invoked.

Such balance is possible by clearly establishing that the State—not an individual—is the primary duty-bearer in securing protection of the right to health and securing access to services. The Court guarantees individual rights by establishing guidelines that organize the burden of the health care oversight and the provision of services on the State and the institutions through which it delivers such services.

CCCS are grounded in the idea that conscience belongs to the individual, in opposition to the views adopted by Argentina, the PACE resolution, and the US Supreme Court. In doing so, it offers an understanding of why the right to freedom of conscience is a fundamental *human* right, and therefore not granted to institutions. As many scholars have outlined, conscience is directly linked to a mind and a human person; therefore, only individuals can exercise the right derived from such conscience.<sup>46</sup> There is no supra-person that can acquire a personal conscience.<sup>47</sup> Individuals within an institution are heterogeneous, so imposing one moral view

on them through CO can limit their freedom and become discriminatory, further limiting the possibility of a pluralist and liberal democracy directly connected to the secular State.<sup>48</sup>

In linking the regulation of CO to Colombia's international and domestic obligations to ensure the human right to health without discrimination, the Court continues to pave the way for other countries to set forth the holistic framework to guarantee women's rights as fundamental international and national human rights imperatives.

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13. *Ibid.* Committee on the Elimination of Discrimination against Women, para. 27.

14. Committee on the Elimination of Discrimination against Women (see note 12), para. 14-15.

15. *Ibid.* para. 11.

16. *Ibid.* para. 15, 17 and 31.

17. Complaint No 99/2013, *Federation of Catholic Family Associations in Europe v. Sweden*, 2013 European Committee of Social Rights. Third-party intervention by the Swedish Association for Sexuality Education and the Center for Reproductive Rights.

18. *R.R. v. Poland*, Judgement, European Court of Human Rights, (May 26, 2011), para. 206. A pregnant woman was denied prenatal genetic testing after her doctor discovered fetal abnormalities through a sonogram. The sonogram results could have influenced the woman's decision to terminate her pregnancy. However, medical personnel, hospitals, and administrators consistently denied her information and diagnostic exams until her pregnancy was too advanced to access legal abortion. The Court found violations of the right to be free from inhuman and degrading treatment and to the right to private life.

19. *P & S v. Poland*, Judgement, European Court of Human Rights (Oct. 30, 2012), para. 107. A 14-year-old girl was raped and became pregnant. She faced multiple obstacles to obtain legal abortion, including violation of her privacy when the press revealed details about her pregnancy, a priest's coercive and biased counseling; removal from her mother's custody; and the unregulated exercise of CO. She finally accessed abortion in a clandestine way and lacked proper post-abortion care. The Court found violations of the right to be free from inhuman and degrading treatment and the right to private for obstructing access to legal reproductive health care information and services.

20. *IPPF v. Italy*, Decision on the Merits, European Committee of Social Rights (Mar. 10, 2014) para. 165-169. The Committee found that Italy violated the European Social Charter, and held that under Italian law, CO cannot be exercised to limit women's right to access sexual and reproductive health care services, such as abortion.

21. *Artavia Murillo et al. ("In vitro fertilization") v. Cos-*

*ta Rica*, Preliminary Objections, Merits, Reparations and Costs, Judgment, Inter-American Court (ser. C) No. 257 (Nov. 28, 2012) para. 148.

22. *Ibid.* para. 147.

23. Official data on CO in reproductive health care is missing both at the global and at the local regional level. According to the white paper on CO to reproductive health care by Global Doctors for Choice that intended to complete a systematic review on the data on the impact of CO concluded that, "A systematic review could not be performed because the data are limited in a variety of ways (which we describe), making most of them ineligible for inclusion in such a process". (Global Doctors for Choice, "White Papers: Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses," *International Journal of Obstetrics and Gynecology* 123/3 (2013), p. 13 and 14.) The lack of data limits the understanding of the impact of the issue in women's lives that has been documented by rights organization and litigated as in the cases decided by the Constitutional Court in Colombia. A human rights perspective could be useful from a qualitative standpoint.

24. R. J. Cook, M. Arango, and B. M. Dickens, "Health care responsibilities and conscientious objection," *International Journal of Gynecology and Obstetrics* 104 (2009), p. 250. Corte Constitucional [C.C.] [Constitutional Court], mayo 10, 2006, Sentencia C-355/06 (Colom.). Corte Constitucional [C.C.] [Constitutional Court], febrero 28, 2008, Sentencia T-209/08 (Colom.) [hereinafter T-209/08]. A 13-year-old was raped, acquiring a STD and becoming pregnant. The Court determined that health care providers violated the girl's fundamental rights by denying her—five times—access to abortion, according to decision C-355/2006. The Court reinstated that CO can only be exercised individually by medical personnel directly involved in the procedure, and cannot be institutional, collective or by the State. Corte Constitucional [C.C.] [Constitutional Court], octubre 2, 2008, Sentencia T-946/08. (Colom.). A minor with mental disabilities was raped and became pregnant. Her mother requested her abortion before a health care institution under the rape exception according to decision C-355/2006. The OBGYN denied the service. The mother submitted a *tutela* a writ for the protection of fundamental rights, which was denied in trial and appellate court. The Constitutional Court stated that health care institutions are obliged to provide access to abortion under one of the constitutional exceptions, and that both the institutions and judges that deny or limit these services can be sanctioned. Corte Constitucional [C.C.] [Constitutional Court], mayo 28, 2009, Sentencia T-388/09. (Colom.). A woman pregnant with a fetus with severe abnormalities incompatible with life requested the termination of her pregnancy. The doctor requested a judicial order to execute the termination. The trial court judge in the *tutela* recused himself arguing that abortion is against

his religious beliefs. The appellate court ordered the termination of the pregnancy within 48 hours. The Constitutional Court stated that access to abortion must be available limitlessly within the national territory.

25. Cook et al (see note 24).

26. Ibid.

27. Ibid.

28. Ibid.

29. T-209/08 (see note 24).

30. Comisión Interamericana de Derechos Humanos, "Acceso a la Información en Materia Reproductiva desde una Perspectiva de Derechos Humanos" 2011, para. 99. (author's translation).

31. Corte Suprema de Justicia de la Nación [CSJN] [National Supreme Court of Justice], 13/03/12, "E., A. L. s/ medida autosatisfactiva" F. 259. XLVI (Arg.).

32. Law No. 25673/03, May. 26, 2003, B.O. (Arg.). (National program on Sexual Health and Responsible Reproduction). Decree No. 1282/03, May 26, 2003, B.O. (Arg.). Law No. 26130, Aug. 28, 2006, B.O. Aug. 29, 2006 (Arg.). (Surgical contraception). Ministerio de Salud, *Guía Técnica para la Atención Integral de los Abortos No Punibles*, (June, 2010). Available at <http://www.msal.gov.ar/saludsexual/pdf/Guia-tecnica-web.pdf>.

33. Global Doctors for Choice (see note 23), p. 37.

34. Ibid., p. 36.

35. Ibid., p. 35.

36. Ibid., p. 20.

37. M. Alegre, "Opresión a conciencia: La objeción de conciencia en la esfera de la salud sexual y reproductiva" Paper 66 (Presentation at Seminario en Latinoamérica de Teoría Constitucional y Política, Asunción, Paraguay, 2009) p. 27. Available at [http://digitalcommons.law.yale.edu/yls\\_sela/66](http://digitalcommons.law.yale.edu/yls_sela/66).

38. A. Shinar, "Dissenting from within: Why and how public officials resist the law," *Florida State University Law Review* 40 (2013), p. 601.

39. Law No. 18.987, Oct. 22, 2012, D.O. Oct. 30, 2012, N° 28585 (Uruguay) Article 6.

40. Ibid. Decree No. 375, 2012, Nov. 22, 2012, D.O. Nov. 29, 2012 (Uruguay).

41. Díaz-Olavarrieta et al., "El Programa de Interrupción Legal del Embarazo en la Ciudad de México: experiencias del personal de salud" *Revista Panamericana de Salud Pública*, 32/6 (2012) pp. 399–404, p. 400.

42. Grupo de Información en Reproducción Elegida (GIRE), *Cifras ILE* (December 2013). Available at [http://www.salud.df.gob.mx/ssdf/transparencia\\_portal/art14frac1/manualile.pdf](http://www.salud.df.gob.mx/ssdf/transparencia_portal/art14frac1/manualile.pdf).

43. E. Malkin and N. Cattán, "Mexico City struggles with law on abortion," *New York Times* (August 24, 2008), p. A5.

44. Ley de Salud del Distrito Federal [LSDF] [Health Law for the Federal District], Gaceta Oficial del Distrito Federal [G.O.D.F.] 17 de septiembre de 2009 (Mex.) Articles 58 and

59.

45. Secretaría de Salud de la Ciudad de Mexico, *Manual de Procedimiento para la Interrupción Legal del Embarazo en las Unidades Médicas* (February 1, 2008). Available at [http://www.salud.df.gob.mx/ssdf/transparencia\\_portal/art14frac1/manualile.pdf](http://www.salud.df.gob.mx/ssdf/transparencia_portal/art14frac1/manualile.pdf).

46. A. Bejarano and M. Castellón, *La objeción de conciencia institucional frente al derecho a la interrupción voluntaria del embarazo*, Universidad de Los Andes Working Paper 4 (Bogotá, Colombia: Grupo de Derecho de Interés Público, 2013) pp. 17-18, Alegre (see note 37) p. 24.

47. Ibid. Bejarano and Castellón (see note 37) p. 20. Alegre (see note 37) p. 24.

48. Ibid.

*All quotations from cases and other Spanish-language material translated into English by Valentina Montoya.*