Seeking to square the circle: A sustainable conscious objection in reproductive healthcare

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Abstract:
While the right to abortion is not spelled out as such in the international or regional human rights treaties, recent developments strongly support the view that a right to safe and legal abortion is a woman’s human right. A sustainable model of conscientious objection in reproductive healthcare must take into account the human rights developments concerning induced abortion. For the past hundred years, conscientious objection has been used almost exclusively in the context of refusal to perform compulsory military service. There are major difficulties in trying to transpose the debate surrounding conscientious objection to the realm of reproductive health. The wider context of conscience claims raised after the legalisation of same-sex unions is even more disturbing. It shows the detrimental effect that accommodation policies could have on the full operation of non-discrimination law. Recent supranational and national cases show that the recognition of conscientious objection in reproductive healthcare is hardly sustainable on the ground. A snowball effect seems inevitable. And even well-defined legal safeguards are failing. This leads to wide discriminatory treatment based on gender, territorial status, low social condition and ethnicity. This also leads to the failure to recognise the dignitary harm to women and the perpetuation of social prejudice and structural inequality which result from this approach. In other words, designing, implementing and monitoring a strictly regulated conscience clause in reproductive healthcare resembles an effort to square the circle. Something always falls by the wayside, and the ‘something’ is no less than women’s human rights.

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1. Introduction

Conscientious objection strongly resonates with Belgian lawyers. On the 30th March 1990, King Baudouin the 1st, a practicing catholic, refused to sign the law which decriminalised induced abortion when performed during the first twelve weeks of pregnancy. Our King alleged a ‘serious problem of conscience’. He argued that he could not reconcile the duties of his office and the duties of his conscience and relied on the prime minister to guarantee the functioning of parliamentary democracy. The showdown translated into a political backlash that remains in living memory. This was totally untested in the history of Belgium, a representative democratic constitutional monarchy born in 1831 where no personal power has ever been vested in the King. Our head of state mainly has formal functions and certainly no right to veto. Yet Baudouin the 1st claimed that he could not be ‘the only Belgian citizen to be forced to act against his conscience in a key area’. In the end, the prime minister, with the help of constitutional lawyers, found a loophole to save the monarchy and keep both the King and the law partially decriminalising induced abortion.

For quite some time now, it has been well documented that there is no correlation between highly restrictive abortion laws and lower abortion rates. The World Health Organisation (WHO) recognizes that ‘whether abortion is legally restricted or not, the likelihood that a woman will have an abortion for an unintended pregnancy is about the same’. The key issue is about access to safe abortion to avoid putting women’s health and lives in jeopardy. The numbers speak for themselves. Worldwide, 25% of pregnancies ended in abortion in 2010-2014. Although unsafe abortion is a very tricky indicator to measure, the WHO manages to maintain a database showing that unsafe abortions performed annually are estimated to be between 21 million and 22 million, resulting in 47 000 maternal deaths and causing disability in millions of women. Unsafe abortion remains the third leading cause

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4 King Baudouin of Belgium, Letter to the Prime Minister Wilfried Martens, 30 March 1990 (translation from the French version).
5 Belgian Constitution of 7 February 1831 as promulgated by the National Congress, esp. Articles 63-64.
6 Belgian Constitution (as lastly modified on 7 Feb. 2014), Article 106.
7 King Baudouin of Belgium, Letter to the Prime Minister Wilfried Martens, 30 March 1990 (our translation from the French version).
10 World Health Organization (WHO), Safe Abortion: technical and policy guidance for health systems (2nd ed., 2012) p. 23 (hereinafter, WHO ‘Safe abortion’).
13 Five million women according to WHO, Women and health: today’s evidence, tomorrow’s agenda (2009).
of maternal death (accounting for nearly 13% of all maternal deaths), after haemorrhage and sepsis due to childbirth.\textsuperscript{14}

While most European countries ensure legal access to abortion,\textsuperscript{15} some national laws are still very restrictive. The UN Human Rights Committee recently condemned Ireland, where abortion is only permitted to save the woman’s life. According to the Committee, forcing a woman to choose between carrying her non-viable foetus to term and seeking an abortion abroad at personal expense amounts to discrimination and cruel, inhuman or degrading treatment.\textsuperscript{16} The Commissioner for Human Rights of the Council of Europe expressed concern at a 2016 bill prepared in Poland which introduced a similarly restrictive law, despite three rulings from the European Court of Human Rights in the past decade which have criticised the country for hindering access to abortion.\textsuperscript{17}

Aside from restrictive laws, many European countries still tolerate various barriers which prevent women from accessing the procedure for the termination of pregnancy such as waiting periods, mandatory counselling and other administrative requirements, or limitations on abortion funding.\textsuperscript{18} Conscientious objection is one of these barriers. It refers to the refusal by healthcare personnel, including doctors (general practitioner, gynaecologist, anaesthetics), nurses and other non-medical staff, to perform abortion or provide pre-abortion or post-abortion care on the grounds of their moral, religious or philosophical beliefs.\textsuperscript{19} With few exceptions, a refusal clause, most commonly known as a conscience clause in Europe, is enshrined in many European legal systems, although it takes different forms (statutory law, medical policies or code of ethics).\textsuperscript{20}

Today, human rights defenders are denouncing the worrying trend against abortion rights worldwide which puts women’s rights and gender equality at risk.\textsuperscript{21} In the European Union, the Estrela report on

\textsuperscript{14}WHO, ‘Unsafe abortion’.

\textsuperscript{15}In the European Union (including the UK), Malta is the only country that still criminally bans abortion in all cases. Within the Council of Europe, similar laws are in force in San Marino or Andorra. More generally, see the \textit{World’s Abortion Laws map} designed by the Centre for Reproductive Rights (www.worldabortionlaws.com).

\textsuperscript{16}\textit{Mellet v. Ireland}, (UN Human Rights Committee (UNCCPR), 31\textsuperscript{st} March 2016), CCPR/ C/116/D/2324/2913, (hereinafter, UNCCPR, \textit{Mellet v. Ireland}), para. 7.6 and 7.11.

\textsuperscript{17}N. Muizni\v{e}ks, ‘Protect women’s health’. The rulings of the European Court of Human Rights referred to are: \textit{P. and S. v Poland}, App. no 57375/08 (ECHR, 30 October 2012); \textit{R.R. v Poland}, App. no 27617/04 (ECHR, 28 November 2011); \textit{Tysiac v Poland}, App. no 5410/03 (ECHR, 20 March 2007).


\textsuperscript{20}In EU Member States, conscientious objection to performing abortion is granted by law, except in countries such as Sweden, Finland, Bulgaria and the Czech Republic. Within the Council of Europe, the same applies with a few exceptions such as Norway, Switzerland or Iceland. The lack of express regulation does not mean that there is no use of conscientious objection in practice. See A. Heino, M. Gissler, D. Apter and Ch. Fiala, ‘Conscientious objection and induced abortion in Europe’ (2013) \textit{Eur J Contracept Reproductive Health Care}, 18(4), pp. 231-233 (hereinafter, Heino & al., ‘Conscientious objection and induced abortion’).

\textsuperscript{21}N. Muizni\v{e}ks, ‘Women’s rights and gender equality in Europe’ (2016) \textit{Human Rights Comment - CoE Commissioner for Human Rights’ Blog}, para. 48-53; N. Muizni\v{e}ks, ‘Protect women’s health’. A. Hodzic & N. Bjelic, \textit{Neo-Conservative Threats to Sexual and Reproductive Rights in the European Union} (CESI, 2014). This report is based in part on monitoring carried out by the European Humanist Federation, Sexual and reproductive Rights RE Human Rights, EHF campaign 2013/2014. At the global level, see the retrogressive measures denounced by the CECSR in its ‘General Comment no 22’.
Sexual and Reproductive Health and Rights is an emblematic instance of this development. Prepared in 2013 by Edite Estrela, a Portuguese MEP, it was finally defeated in the European Parliament by a margin of a few votes after intense lobbying from religious and political conservatives. The extensive report of nearly 90 recommendations and opinions called for strong EU action on sexual and reproductive health and rights to ensure their universal accessibility throughout Europe, including safe and legal abortion services. It was replaced with a Resolution noting that the formulation and implementation of policies in sexual and reproductive health and rights is a competence of the Member States.

The same dynamic is noticeable in the Council of Europe. In 2010, the adoption of the 1763 European Resolution on ‘The right to conscientious objection in lawful medical care’ is a salient example of the way reactionary religious groups are using human rights rhetoric in order to push forward their interests. At first, the resolution proposal came from the Social, Health and Family Affairs Committee of the Parliamentary Assembly of the Council of Europe. It was based on a report presented by Christine McCafferty, a British Labour MP, which stressed the urgent need to regulate and monitor the use of conscientious objection in health services as women were at risk of being unable to access lawful services such as abortion and emergency contraception. The balanced framework of this resolution proposal was completely reversed with the support of a narrow majority. The result is an incoherent text, prefixing some parts of the original with unfettered rights to conscientious objection not only for individuals, but also for institutions, even though the report in its original form expressly excluded the latter. Its first paragraph reads as follows: ‘No person, hospital or institution shall be coerced, held liable or discriminated against in any manner because of a refusal to perform, accommodate, assist or submit to an abortion, the performance of a human miscarriage, or euthanasia or any act which could cause the death of a human foetus or embryo, for any reason’.

As Lady Hale put it in a 2014 ruling of the Supreme Court of the UK: ‘The conscience clause was the quid pro quo for a law designed to enable the health care profession to offer a lawful, safe and accessible service to women’. What is true for the UK Abortion Act 1967 is true in many other countries. At first sight, such a path is actually very attractive. A way to reconcile the fundamental rights of women with the conscience claims of healthcare providers. And if we take the human rights standards seriously (point 2), this should involve a strict regulatory framework to keep the balance. Our aim in this paper is to bring the argument one step forward and to show, against the background of supra-national and national legal cases, that the recognition of a right to conscientious objection in

In the US, see, for instance, House Bill 2 enacted in 2013 in Texas and struck down by the Constitutional Court in Whole Woman's Health v. Hellerstedt, 579 US (2016).


26 PACE, ‘Resolution on the right to conscientious objection’

reproductive healthcare is hardly sustainable (point 3). Besides, even if a balanced framework were enforceable, we argue that there are strong legal and principled arguments for refusing to accommodate conscientious claims in the field of reproductive health. Conscience clauses involve not only direct harm to women who wish to access abortion services, but also indirect or symbolic harm (point 4).

2. International and European human rights law standards

While the right to abortion is not spelled out as such in the international or regional human rights treaties, recent developments strongly support the view that a right to ‘safe and legal abortion is a woman’s human right’. In May 2016, the UN Committee on Economic, Social and Cultural Rights in its General Comment no 22 considered that the right to sexual and reproductive health stems from the combination of several human rights such as the general right to health, the right to individual autonomy, privacy and respect for family life, equality and non-discrimination, the right to education as well as the right to life and freedom from torture and other cruel, inhuman or degrading treatment. The Committee embraced a gender perspective and emphasised the pressing need to reform discriminatory laws, policies and practices to prevent unintended pregnancies and unsafe abortions. States are required ‘to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents; to liberalize restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health’.

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28 At the regional level, the Maputo Protocol on the rights of women in Africa explicitly states that the right to health includes access to safe and legal abortion and calls on States Parties to ‘take all appropriate measures to protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus’ (Article 14). See also: Ch. Zampas & J. M. Gher, ‘Abortion as a Human Right : International and Regional Standards’ (2008) Human Rights Law Review 2 249-294 at 287 (hereinafter, Zampas & al., ‘Abortion as a human right’).

29 Centre for Reproductive Rights, ‘Safe and legal abortion is a Woman’s Human Right’, Briefing paper, October 2011 (online: www.reproductiverights.org).

30 CECR General Comment no 22.

31 The CECR defines the right to sexual and reproductive health as entailing ‘the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one’s body and sexual and reproductive health. The entitlement includes unhindered access to a whole range of health facilities, goods, services and information’ (CECSR General Comment no 22, para. 5).

32 Article 16 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) guarantees women equal rights in deciding ‘freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.’


34 CECR General Comment no 22, para. 28 (the accent is ours).
In Europe, in the wake of a 2008 Resolution of the Parliamentary Assembly of the Council of Europe\textsuperscript{35}, the Commissioner for Human Rights strongly supported ‘the need to ensure access to safe and legal abortion’.\textsuperscript{36} In July 2016, he called for the decriminalization of abortion in the few countries where it is still totally forbidden and for the amendment of unduly restrictive abortion laws. His opinion widely relied on the requirements issued by the UN human rights treaty bodies. For instance, he endorsed the conclusions of the Human Rights Committee, adopted in June 2016, according to which Ireland ‘should amend its law on voluntary termination of pregnancy, (…) including ensuring effective, timely and accessible procedures for pregnancy termination in Ireland and take measures to ensure that healthcare providers are in a position to supply full information on safe abortion services without fearing being subjected to criminal sanctions’.\textsuperscript{37}

One must concede that the case law of the European Court of Human Rights is not as bold.\textsuperscript{38} Despite a European consensus amongst a large majority of Member States that abortion should be permitted on health and wellbeing grounds,\textsuperscript{39} the right to private and family life has so far not been construed so as to enshrine a right to induced abortion.\textsuperscript{40} This has to be put into perspective with the mandate of the Court which is a supra-national body operating in a subsidiarity-based framework. In recent years, the link between the legitimacy of the Court and subsidiarity has been clearly made.\textsuperscript{41} The fact that the Court is walking on eggshells to defend its mandate explains in part its cautious position regarding some sensitive issues. Thus, a broad national margin of appreciation as regards the circumstances in which an abortion should be permitted is left to Member States. Yet the Court monitors the coherence and the effectiveness of the national legal framework and requires that ‘once the legislature decides to allow abortion, it must not structure its legal framework in a way which would limit real possibilities to obtain it’.\textsuperscript{42}

Conscientious objection in reproductive healthcare can create a structural obstacle. Many issues stem from the fact that the use of conscientious objection is highly unregulated in a great number of


\textsuperscript{36} N. Mužnieks, ‘Protect women’s health’.

\textsuperscript{37} UNCCPR, Mellet v. Ireland, para. 9. See also UNCCPR, Concluding observations adopted by the Committee at its 111th session, 7–25 July 2014, CCPR/C/IRL/CO/4, para. 9.


\textsuperscript{39} A., B. and C. v Ireland, App. no 25579/05, (ECHR, (GC), 16 December 2010), para. 235. See also, Fabbrini, ‘Fundamental rights in Europe’, pp. 199-209.

\textsuperscript{40} A., B. and C. v Ireland, App. no 25579/05 (ECHR, (GC), 16 December 2010), para. 214-215. According to the Court, Article 8 ECHR cannot be interpreted as meaning that pregnancy and its termination pertain uniquely to the woman’s private life. The latter should be weighed against other competing rights, including those of the unborn child (see also Tysiac v. Poland, App. no. 5410/03 (ECHR, 20 March 2007), para. 76; Vo v. France, App. n° 53924/00 (ECHR, (GC), 8 July, 2004), para. 76, 80 and 82).

\textsuperscript{41} High Level Conference on the Future of the European Court of Human Rights, Brighton Declaration (19 February 2010).

jurisdictions. Doubts persist regarding its scope, especially as to who is entitled to object and with respect to what kind of activity. This is particularly salient in a context in which hospitals and corporations are also claiming a right to conscientious objection. Other questions relate to the moment when it should be raised and whether it also applies to urgent procedures. In addition, the duties of the objector are often not well-defined and the compliance and oversight mechanisms vary. Beyond these legal aspects, the escalating number of objectors in some jurisdictions also produces stigmatising effects on other health practitioners who may then use conscientious objection in order to avoid being subjected to discrimination.

A sustainable model of conscientious objection in reproductive healthcare must take into account the human rights developments concerning induced abortion. To start with, one has to keep in mind that military service is the only area in which conscientious objection has been recognized as a human right. As the European Court of Human Rights put it, freedom of religion does not protect every act motivated or inspired by a religion or belief and a medical doctor cannot rely on her faith to escape from her professional duties. In other words, ‘States are obliged to organize their health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation’. And since a 2016 decision of the European Committee of Social Rights, it is clear that states are under no positive obligation to provide a right to conscientious objection for healthcare workers under the right to health (enshrined in Article 11 of the European Social Charter).

While UN Human Rights bodies refrain from ruling on a theoretical human right to conscientious objection in reproductive healthcare, they call on states to use caution when allowing health-care providers to raise conscience refusals. In this line, states have to ‘appropriately regulate this practice to ensure that it does not inhibit anyone’s access to sexual and reproductive health care, including by

43 See McCafferty Report (n 8).
45 Bayatyan v. Armenia, App. no 23459/03 (ECHR, GC, 7 July 2011), (concluding that in some cases conscientious objection can fall within the ambit of Article 9 ECHR which guarantees freedom of thought, conscience and religion). UNCCPR, General Comment no 22: Article 18, (Forty-eighth session, 1993), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, (1994), U.N. Doc. HRI/GEN/1/Rev.1 at 35, para. 11 (concluding that refusal to perform military service can be derived from Article 18 ICCPR, ‘inasmuch as the obligation to use lethal force may seriously conflict with the freedom of conscience and the right to manifest one's religion or belief’); OHCHR, Conscientious objection to the Military Service, 2012, online: <http://www.ohchr.org/Documents/Publications/ConscientiousObjection_en.pdf> (hereinafter, OHCHR, ‘Conscientious objection to the Military Service’)
requiring referrals to an accessible provider capable of and willing to provide the services being sought,\textsuperscript{50} and that it does not inhibit the performance of services in urgent or emergency situations.\textsuperscript{51} States also need to ensure that ‘conscientious objection is accompanied by information to women about existing alternatives and that it remains a personal decision rather than an institutionalized practice’.\textsuperscript{52} A regulatory framework and a monitoring mechanism of the practice are also required.\textsuperscript{53}

Before it was overturned by religious lobbies in the Parliamentary Assembly of the Council of Europe, the MacCafferty Report shared a similar standpoint: a deep concern for the rise of largely unregulated conscience refusals in reproductive health care which especially impact women with low incomes or living in rural areas.\textsuperscript{54} In its original form, the report called for a comprehensive legal and policy framework governing the practice, coupled with an effective oversight and complaint mechanism so as to ‘ensure that the interests and rights of both healthcare providers and individuals seeking legal medical services are respected, protected, and fulfilled’.\textsuperscript{55}

3. The tricky monitoring of conscience clause in reproductive healthcare

The downside of a conscience clause, even if it is regulated by the legislator, is well illustrated in \textit{IPPF v. Italy}, a case the European Committee of Social Rights decided in 2013.\textsuperscript{56} In Italy, a 1978 Act allows medical practitioners and other health personnel to exempt themselves from assisting legal abortion procedures if they raise a conscientious objection beforehand. This objection covers activities which are ‘specifically and necessary designed to bring about the termination of pregnancy’ but excludes pre-abortion and post-abortion care.\textsuperscript{57} The law provides for a duty to promptly refer the patient to someone who can help her. The law also provides that conscientious objection cannot be raised in emergency cases. In any event, hospitals and authorized nursing homes are required to ensure that women have

\begin{itemize}
\item \textsuperscript{50}CEDAW, \textit{General Recommendation no 24: Article 12 of the Convention (Women and Health)}, 1999, A/54/38/Rev.1, para. 11.
\item \textsuperscript{51}CECSR \textit{General Comment no 22}, para. 43.
\item \textsuperscript{52}CEDAW, Article 10 (h); CEDAW, \textit{General Comment no. 24, Article 12}, para. 20. See also CESCR, \textit{General Comment no. 14}, para. 12.b).
\item \textsuperscript{53}CEDAW, \textit{Concluding observations on the combined seventh and eighth periodic reports of Hungary adopted by the Committee at its Fifty Fourth Session}, CEDAW/C/HUN/CO/7-8, 2003. See also the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, presented at the fourteenth session of the Human Rights Council (20 May 2010) (A/HRC/14/20/Add.3), para. 50 ; WHO, \textit{Safe abortion : technical and policy guidance for health systems, second edition}, 2012, pp. 94-96.
\item \textsuperscript{54}‘McCafferty Report’.
\item \textsuperscript{56}\textit{International Planned Parenthood Federation European Network (IPPF-EN) v Italy}, Complaint no. 87/2012 (ECSR, decision adopted on 10 September 2013 and delivered on 10 March 2014) (hereinafter, \textit{IPPF-EN v. Italy}). See also Bribosia, Isailovic & Rorive, ‘Objection ladies!’.
\item \textsuperscript{57}Section 9 of the Italian Act No. 194/1978 relating to the Norms on the social protection of motherhood and the voluntary termination of pregnancy (\textit{Norme per la tutela sociale della maternità e sull’interruzione volontaria della gravidanza}), \textit{Gazzetta ufficiale} 22/05/1978, n. 140.
\end{itemize}
access to abortion procedures. Regional authorities have the duty to supervise and ensure the implementation of the law. On paper, the law seems to provide enough safeguards to avoid any snowball effect.

IPPF – International Planned Parenthood Federation (Europe)\(^{58}\) launched a collective complaint before the European Committee of Social Rights to denounce the fact that conscientious objection is pervasive in Italy and the figures are much higher than the official data declared by the Government (for instance in the region of Rome, Lazio, the number of objectors is as high as 91.3\%).\(^{59}\) The number of objecting doctors skyrocketed in the past years and the health system as a whole has many downfalls. New doctors are not trained to perform abortions and those who are willing to do so might face discrimination at the hiring stage and in the workplace.\(^{60}\) For IPPF, the European (revised) Social Charter provided a great opportunity for challenging the Italian system as a whole before the Committee without having to rely on an identified victim. Although it is a quasi-judicial body issuing non-binding decisions, the action before the Committee had some strategic benefits when compared to the opportunities offered by other forums including the European Court of Human Rights. By seizing the Committee and arguing that access to abortion is a matter of *right to health*\(^{61}\), the plaintiff avoided the pitfalls of the current jurisprudence of the European Court of Human Rights under which the issue is often framed as a question of right to private life\(^{62}\) coupled with a wide margin of appreciation left to the State to define the domestic regime applicable to the termination of the pregnancy, on the grounds that there is no European consensus as to when life begins.\(^{63}\)

In *IPPF-EN v. Italy*, the European Committee of Social Rights found that ‘shortcomings exist in the provision of abortion services’ which violated the right to health (Article 11 of the Social Charter) alone and read in conjunction with the non-discrimination clause (Article E of the Social Charter).\(^{64}\) Discriminatory treatment occurred on the grounds of socio-economic and territorial status, health status and gender which constituted, according to the Committee, an instance of ‘overlapping’, ‘intersectional’ and ‘multiple’ discriminations.\(^{65}\) In other words, certain categories of women were

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58 IPPF is one of the largest non-governmental organisations working in the field of sexual and reproductive health.


60 *Confederazione Generale Italiana del Lavoro* (CGIL) v. Italy, Complaint no. 91/2013, (ECSR, registered on 17 January 2013).

61 ‘The WHO defines “health” as a state of complete physical, mental and social well-being, going beyond the mere absence of disease or infirmity. Seen in this light, good reproductive (or sexual) health, which concerns the reproductive processes, functions and system at all stages in an individual’s life, requires not only ensuring each person can have a satisfying, responsible and safe sex life, but also the right to decide if, when and how to reproduce’.

62 Article 2 ECHR (right to life) and Article 3 (degrading and inhuman treatments) are also at stake in some cases. See, P. Londono, ‘Redrafting Abortion Rights’, pp. 95-120

63 See J. Erdmann, ‘The Procedural Turn: Abortion at the European Court of Human Rights’, in Cook, ‘Transnational Abortion’, pp. 121-142 (which argues that the ECtHR actually manages to protect pluralism in Europe by framing access to abortion as a ‘procedural question’: once the procedure for access to abortion is defined it needs to be implemented).

64 IPPF-EN v. Italy, para. 174.

65 Id., para. 190. In the more recent case, *CGIL v. Italy*, the Committee refers only to ‘overlapping’ or ‘multiple discrimination’, without mentioning ‘intersectional discrimination’. See *Confederazione Generale Italiana del Lavoro* (CGIL) v. Italy, Complaint no. 91/2013 (ECSR, decision adopted on 12 October 2015 and delivered on 11 April 2016), para. 206 (hereinafter, *CGIL v. Italy*).
subject to less favourable treatment in the form of impeded access to lawful abortion as a consequence of the combined effect of where they live and low social condition.

Such a stance was reaffirmed by the Committee in the later case, *CGIL v. Italy*, decided in 2016 and involving a major Italian trade union. Once again, the Committee was ‘called to rule on the adequacy of measures taken by the relevant authorities to ensure effective access to the services responsible for carrying out abortion procedures defined by national legislation as a form of medical treatment related to the protection of health and well-being’. Significant evidence pointed to the fact that the Italian authorities had not remedied the many problems found by the Committee in *IPPF-EN v. Italy*. Furthermore, the Committee found a violation of the right to work which entails ‘the right of the worker to earn one’s living in an occupation freely entered upon’ (Article 1(2) of the Social Charter). In this aspect, the right to work requires Member States to remove all forms of discrimination in employment regardless of the legal nature of the professional relationship. According to the majority of the Committee, the medical practitioners who raise conscientious objection to abortion within the meaning of the Italian Act of 1978 and those who do not ‘are in a comparable situation because they have similar professional qualifications and work in the same field of expertise’. And a wide range of evidence point to the fact that ‘non-objecting medical practitioners face several types of cumulative disadvantages at work both direct and indirect, in terms of workload, distribution of tasks, career development opportunities, etc.’ The aggravated working conditions of non-objecting medical practitioners were of such a nature that the majority of the Committee found a violation of the right to dignity at work (Article 26(2) of the Social Charter). Not only are the few non-objecting practitioners available left to perform repeated abortion procedures that are often outside their field of specialisation, but they must also work in a hostile environment, are placed under intense pressure to suspend their duties and are subject to mobbing. Moreover, the Italian government could not point to any preventive or reparatory measures taken to protect non-objecting medical practitioners against such recurring instances of moral harassment.

The *IPPF* and the *CGIL* cases show the extreme difficulty of monitoring refusal clauses. A balanced regulatory framework fails to overcome the strength of the web of religious and patriarchal structures of society, in which women are still being caught. And Italy is not an isolated example. Many other instances are documented elsewhere in Europe, the US, South-Africa or Latin America. It seems that

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66 *CGIL v. Italy*, para. 204-213.
67 *CGIL v. Italy*, para. 165.
68 *CGIL v. Italy*, para. 173-179.
69 *CGIL v. Italy*, para. 235.
70 *CGIL v. Italy*, para. 241.
71 *CGIL v. Italy*, para. 243.
72 *CGIL v. Italy*, para. 294-298.
once the principle of conscientious objection is accepted in reproductive healthcare, it becomes very tricky to control. ‘Who will be in charge of deciding? Where does it stop? What criteria will determine the limits? Who will enforce it? And what are the sanctions?’.

4. Beyond direct harm, the dignity of women

Non-discrimination is not only about procedural fairness (i.e. treating like cases alike). Equality also relates to recognition and dignity as humiliation, stigma or stereotyping can be experienced regardless of any particular material disadvantage. As the Canadian Supreme Court put it, ‘equality means that our society cannot tolerate legislative distinctions that treat certain people as second class citizens, that demean them, that treat them as less capable for no good reason, or that otherwise offend fundamental human dignity’.

Indirect harm is part of Robert Wintemute’s test to define when accommodation of the manifestation of a religious belief is legally allowed (or even required). This test is designed around three conditions assessing the lack of direct and indirect harm to others, as well as the minimal cost, disruption or inconvenience to the accommodating party. Cecile Laborde also recommends a strict balancing test which takes dignitary harm into account in order to decide when a conscience claim (which she places into the category of ‘integrity-protecting claim – IPC’) justifies an exemption from a fair law of general application. The test consists of ‘[weighing] up the interests pursued by the law, the severity of the IPC burden, and the costs incurred in alleviating it’. To assess the interests pursued by the law, one has to make sure that ‘the rights of the individuals that the law is designed to protect are actually protected, even if exemptions are granted’. And in delineating such rights, one has to consider ‘whether laws demanded by justice only protect rights, narrowly construed, or whether they also expressively affirm the equal civic status of persons. In that case, a publicly endorsed exemption can constitute something like an expressive or dignitarian harm’.

women’s rights, especially where it is construed to have no limits, as in Peru. Conscientious objection must be distinguished from politically-motivated attempts to undermine the law; otherwise, the still fragile re-democratisation processes underway in Latin America may be placed at risk.

Ch. Fiala and J. H. Arthur, ‘‘Dishonourable disobedience” – Why refusal to treat in reproductive healthcare is not conscientious objection’ (2014) Woman Psychosomatic Gynaecology and Obstetrics, 1 12-23 at 13 (hereinafter, Ch. Fiala & al., ‘Dishonourable disobedience’).


Law v. Canada (1999) I SCR 497 (Canadian Supreme Court), para. 51.

R. Wintemute, ‘Accommodating Religious Beliefs: Harm, Clothing or Symbols, and Refusal to serve Others’ (2014) The Modern Law Review, 77(2), 228-229 (hereinafter, Wintemute, ‘Accommodating Religious Beliefs’). Wintemute’s triple test reads as follows: ‘(i) the particular manifestation of religious beliefs itself causes no direct harm to others; and (ii) the requested accommodation involves minimal cost, disruption or inconvenience to the accommodating party; and (iii) the requested accommodation will (upon further examination) cause no indirect harm to others’.


To address tensions between religious freedom and equality, the International Network of Civil Liberties Organizations stresses the obligation, grounded in human rights, to outlaw religious exemptions or accommodations that cause direct or indirect harm to others. ‘Religious freedom does not give us the right to impose our views on others, including by discriminating against or otherwise harming them’. 80 And according to the Ontario Human Rights Commission, ‘a duty to accommodate may not extend to situations in which discrimination against another group is the by-product of accommodating a particular belief’. 81 Dignity as a component of equality is a key concept in solving conflicts between religious freedom and non-discrimination. Religious freedom does not give a blank cheque ‘to denigrate the dignity of other individuals, for example because they are women or gay’. 82

Conscience claims raised in the aftermath of the legalisation of same-sex unions in various countries (such as the Netherlands, Canada, the UK, France, or the US) offer a useful benchmark to further develop the issue. 83 Cases of civil servants who refuse to celebrate or to register same-sex unions are flourishing in several jurisdictions and provide insightful thought. 84

In this respect, Canada is a fascinating case study as it provides different legal answers to conscience claims raised by civil marriage commissioners. 85 Once same-sex marriage was allowed at federal level, 86 taking into account the religious freedom of marriage commissioners was a pressing issue. 87 The federal Civil Marriage Act (2005) only provides for an exemption of officials of religious groups. Actually, while the definition of marriage belongs to the federal state in Canada, the conditions of its solemnisation, including the duties of civil marriage commissioners, are a competence of the

80 INCLO, ‘Drawing the line’, pp. 5-6.
83 According to D. Nejaime & R. Siegel, in the US context ‘advocates look to the healthcare context as a model for how similar conscience claims might function within campaigns against same-sex marriage and LGBT* equality’ (Nejaime & Siegel, ‘Conscience Wars’ 2554). LGBT* and reproductive rights are also addressed together in the INCLO’s report, ‘Drawing the line’.
86 In Canada, the principle of same-sex marriage was first decided by the Supreme Court in 2004 (Reference re Same-Sex Marriage, [2004] 3 SCR 698, 2004 SCC 79) before being embodied in statute (Civil Marriage Act, SC 2005, c. 33).
87 Although the Federal government is not competent to regulate marriage ceremonies, the Civil Marriage Act provides that ‘3.1. For greater certainty, no person or organization shall be deprived of any benefit, or be subject to any obligation or sanction, under any law of the Parliament of Canada solely by reason of their exercise, in respect of marriage between persons of the same sex, of the freedom of conscience and religion guaranteed under the Canadian Charter of Rights and Freedoms or the expression of their beliefs in respect of marriage as the union of a man and woman to the exclusion of all others based on that guaranteed freedom’.
Provinces.\(^8\) The latter have implemented the whole range of legal options.\(^9\) Alberta provided for a very broad exemption,\(^10\) Saskatchewan denied civil marriage commissioners any form of accommodation,\(^11\) and Ontario provided for a statutory exemption limited to religious officials, while relying on informal \textit{ad hoc} accommodation for civil marriage commissioners.\(^12\)

To bar conscience claims altogether, the Court of Appeal of Saskatchewan convincingly relied on the recognition dimension of the principle of equality and non-discrimination. According to Justice Smith, the major aspect of the issue ‘is the affront to dignity, and the perpetuation of social and political prejudice and negative stereo-typing that (the) refusals to celebrate same-sex marriage would cause. Furthermore, even if the risk of actual refusal were minimal, knowing that legislation would legitimize such discrimination is itself an affront to the dignity and worth of homosexual individuals’.\(^9\)

In the UK, the England and Wales Court of Appeal defended a similar line of reasoning in the famous \textit{Ladele v. Borough of Islington} case it decided in 2009. The case concerned a civil servant, Mrs Ladele, fired from the London Borough of Islington after repeated refusals to register same-sex civil partnerships based on her religious view of marriage.\(^9\) According to the Court of Appeal, ‘Ms Ladele was employed in a public job and was working for a public authority; she was being required to perform a purely secular task, which was being treated as part of her job; Ms Ladele’s refusal to perform that task involved discriminating against gay people in the course of that job; she was being asked to perform the task because of Islington’s Dignity for All policy, whose laudable aim was to avoid, or at least minimise, discrimination (…); Ms Ladele’s objection was based on her view of marriage, which was not a core part of her religion; and Islington’s requirement in no way prevented her from worshipping as she wished.’\(^9\) Furthermore, the Court stressed that ‘once Ms Ladele was designated a civil partnership registrar, Islington were not merely entitled, but obliged, to require her to (perform civil partnerships)’. The prohibition of discrimination enshrined in the law ‘takes precedence over any right which a person would otherwise have by virtue of his or her religious belief

\(^{88}\) In this line the Court of Appeal of Saskatchewan ruled that ‘Section 3 of the Civil Marriage Act [reproduced in the previous footnote] is confined to the federal legislative sphere. (…) Accordingly, the section does not implicate matters beyond the limits of federal jurisdiction and, as a result, (…) (a) provincial requirement that marriage commissioners solemnize same-sex marriages does not contradict or in any way frustrate the operation of Section 3 of the Civil Marriage Act’ (Court of Appeal of Saskatchewan, 2011 SKCA 3, \textit{In the Matter of Marriage Commissioners Appointed Under The Marriage Act, 1995}, S.S. 1995, c. M-4.1; and \textit{in the Matter of a Reference by the Lieutenant Governor in Council to the Court of Appeal Under The Constitutional Questions Act}, RSS 1978, c. C-29. para. 52) (hereinafter, Court of Appeal of Saskatchewan, 2011).

\(^{89}\) \textit{MacDougall \& al., ‘Conscientious Objections to Creating Same-Sex Unions’} 132.

\(^{90}\) In Alberta, ‘those who hold social, or cultural beliefs or values, whether religious or non-religious, will be free to express opposition to the change to the traditional definition of marriage and will not be required to advocate, promote, or teach about marriage in a way that conflicts with their beliefs.’ (D. Girard, ‘Gay Marriage Fight Over; Alberta to begin issuing licenses. But law to protect opponents’ rights’ \textit{Toronto Star} (13 July 2005), A12).

\(^{91}\) Court of Appeal of Saskatchewan, 2011.

\(^{92}\) In the wake of the legalization of same-sex marriage, the Ontario government introduced Bill 171, in 2005, \textit{An Act to amend various statutes in respect of spousal relationships}. Statutory law was amended to reflect the same-sex marriage ruling of the Court of Appeal of Ontario (June 2003). Bill 171 amendments to the Ontario \textit{Human Rights Code} and \textit{Marriage Act} explicitly provide that registered religious officials for whom same-sex marriage is contrary to their religious beliefs are not required to solemnize such marriages (M. C. Hurley, \textit{Sexual orientation and legal rights : a chronological overview, Law and Government Division}, Revised 26 September 2005).

\(^{93}\) Court of Appeal of Saskatchewan, 2011, concurring opinion, para. 107.

\(^{94}\) This followed the enactment of the Civil Partnership Act 2004.

or faith, to practice discrimination on the ground of sexual orientation’. The European Court of Human Rights has upheld the legitimacy of a public policy that requires employees to act in a non-discriminatory way despite their religious belief. Such a policy falls within the wide margin of appreciation national authorities deserve when they strike a balance between competing rights.

Beyond the issue of civil servants who raise conscience claims so as not to participate in the celebration of same-sex unions, a real concern is the detrimental effect that accommodation policies could have on the full operation of non-discrimination law. This is particularly alarming when we consider the strategies led by religious and neo-conservative groups in order to model conscientious exemption regarding same-sex marriage on refusal laws in the field of abortion. In the last few years, an emblematic line of cases in the UK, the US and Canada relates to for-profit companies with no religious corporate object, which refuse to provide services to LGBT* customers on the basis of the Christian beliefs of their managers. Major cases have involved a bed and breakfast owner denying double-bedded rooms to same-sex couples, a photography company refusing to cover the wedding ceremony, a bakery refusing to make custom cakes honouring same-sex marriage, a print shop turning down an LGBT* organisation asking for printed envelopes and business cards, etc. So far, national courts have held that those denials of services based of sexual orientation were discriminatory, but there are still pending issues related to free speech. Unequal treatment occurred even if customers could get the same service elsewhere without additional cost. The crucial aspect of these cases is the injury to dignity and the humiliation suffered. According to the different courts, for-profit organisations that open their doors to the public should not be able to claim religious exemptions that could perpetuate structural prejudice and breach human rights.

The point we want to make here is that a commitment to equality and non-discrimination requires including indirect harm into the equation. If dignity is still undermined, social prejudice perpetuates and the structural discrimination often embedded in power relationships is not questioned. Yet, in most cases dealing with religious exemptions in reproductive healthcare, the focus is chiefly on direct harm. ‘The case law in this area does not yet robustly engage questions about discrimination, stigma, and harm to dignity’.

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96 Ibid., para. 69 & 70.
97 Eweida and others v. United-Kingdom, App. nos. 48420/10, 59842/10, 51671/10 and 36516/10, (ECHR, 15 January 2013), para. 104-106. Note that in Ladele, the European Court of Human Rights only clearly rejected the obligation for the state to accommodate the religious belief of a civil servant. It did not decide whether such an accommodation is prohibited by the Convention because of the indirect harm it entails for LGBT* people (see Wintemute, ‘Accommodating Religious Beliefs’ 243).
98 Nejaime & Siegel, ‘Conscience Wars’ 2554.
101 Charlie Craig and David Mullins v. Masterpiece Cakeshop (2015), Colorado Court of Appeals no. 14CA1351, and the petition for a writ of certiorari introduced before the US Supreme Court on January 8, 2016 ; Lee v. Ashers Baking & Anor [2015] NICty 2. Note that an appeal was still pending in June 2016 before the Belfast Court of Appeal.
The highly debated decision of the US Supreme Court in *Hobby Lobby*\(^\text{106}\) illustrates this tendency. For-profit corporations with no religious affiliation relied on their freedom of conscience to refuse to provide compulsory insurance coverage for some contraceptives to their employees.\(^\text{107}\) The majority of the US Supreme Court ruled in favour of the closely held family businesses. According to the Court, there are other ways the government could ensure that every woman has cost-free access to the particular contraceptives, making the impact on women employed by the companies ‘precisely zero’. The majority of the Court seems to ignore the administrative burden that the Obama care aimed to alleviate. Chiefly, it totally overlooks the dignity of women and gender equality.\(^\text{108}\)

The Colombian Constitutional Court is a notable exception to this general tendency. Its 2006 ruling legalised abortion in cases of rape, endangerment to the woman’s life or health and conditions that would result in foetal death.\(^\text{109}\) As this was totally undermined on the ground with the use of wide-ranging conscience claims, the Court provided detailed conditions that objecting medical practitioners should fulfil. Its line of reasoning was based on the social implications raised with the use of conscientious objection in reproductive healthcare. According to the Court, such conscience claims interfere with ‘women’s fundamental constitutional rights to health, personal integrity and life in conditions of quality and dignity. It would also violate their sexual and reproductive rights and cause them irreversible harm’.\(^\text{110}\)

As we have seen, there are strong arguments to rely on the test of indirect or dignitary harm in reproductive healthcare. In particular, ‘there is a clear stigma placed on woman when the doctor refuses to provide her a legal abortion’.\(^\text{111}\) Even though a medical doctor is not a civil servant, he is in a powerful relationship with a woman seeking an abortion. He enjoys a kind of monopoly. Conscientious objection is a way to exert personal power over the patient by imposing one’s own beliefs,\(^\text{112}\) and this applies whether the woman manages to get an abortion or not in the end. In other words, access is not enough. The right to health coupled with the non-discrimination clause requires access on an equal footing, without any moral judgment by an authority.

5. Conclusion


\(^{107}\) The case relates to the *Patient Protection and Affordable Care Act* (2010), known as *Obama care*, under which employers with more than fifty employees were required to provide coverage for contraception under their group health plans.

\(^{108}\) Compare to the *Pichon & Sajou* case (App. no. 49853/99, 2 October 2001) where the European Court of Human Rights ruled that the freedom to manifest one’s beliefs does not always guarantee the right to behave in a manner governed by that belief. Here the pharmacists were denied the right to refuse to deliver contraceptive pills.


\(^{110}\) 2009 decision of the Constitutional Court of Colombia (T-388/2009), para. 5.1.

\(^{111}\) INCLO, ‘Drawing the line’, pp. 28 & 33. On stigma and stereotyping, see the very well argumented concurring individual opinion of Sarah Cleveland in UNCCPR, *Mellet v. Ireland*.

\(^{112}\) Heino & al., ‘Conscientious objection and induced abortion’, point 9.
For the past hundred years, conscientious objection has been used almost exclusively in the context of refusal to perform compulsory military service.\textsuperscript{113} There are major difficulties in trying to transpose the debate surrounding conscientious objection to the realm of reproductive health. The question of whether or not conscientious objection should be granted plays out very differently in the two fields: military service is mandatory, while no one is required by law to become a gynaecologist or an obstetrician. Besides, the power relationship between a doctor and a woman seeking an abortion differs significantly from the one between a soldier and his commander. The legitimate exercise of conscientious objection is much more delicate when it is used against a person in a vulnerable situation. In addition, the impact of the use of conscientious objection is not comparable in the two situations.\textsuperscript{114}

While there is little impact on the rights of others when conscientious objection is raised in the military service, objecting to providing reproductive health services greatly impairs women’s human rights. Undue delay puts women’s lives at risk, and may result in unsafe, clandestine and illegal abortions, which endangers the lives and physical and mental health of women.\textsuperscript{115}

The wider context of conscience claims raised after the legalisation of same-sex unions is even more disturbing. It shows the detrimental effect that accommodation policies could have on the full operation of non-discrimination law. Empirical studies of religious actors show that alongside the liberal and fundamentalist representatives of a religious tradition, one can find a middle group (sometimes called ‘traditionalists’) which pushes religious claims in liberal democracies and international regimes.\textsuperscript{116} This group forges transnational alliance, enters into public debates using ‘non-religious language, adapting to a secular legalistic human rights terminology’,\textsuperscript{117} lobbies national parliaments and supranational organisations and brings cases to courts. As a moral tool which imposes what ‘the good life’ is, conscientious objection framed as reasonable accommodation might well be the Trojan horse of ultra-conservative religious groups attempting to regain some legal battles.\textsuperscript{118}

Those who support the view that the right to sexual and reproductive health, including access to safe abortion services and quality post-abortion care, is a human right are divided along two lines of thoughts. Some defend the view that “As a ‘refusal to treat,’” conscientious objection should more aptly be called dishonourable disobedience, because it violates women’s fundamental right to lawful healthcare and places the entire burden of consequences, including risks to health and life, on the shoulders of women. (…) Why should a doctor’s private beliefs trump the medical needs of an individual? No other sector of medicine or other kind of service delivery would allow a service refusal with so little resistance’.\textsuperscript{119} Others call for a comprehensive legal and policy framework to take into account the interests of both the medical practitioners and the women seeking an abortion.\textsuperscript{120} This would include at least, first, that only individuals directly related to abortion provision can exercise a

\textsuperscript{113} OHCHR, ‘Conscientious objection to the Military Service’, p. 2.


\textsuperscript{115} WHO ‘Safe abortion’. See above part. 1 of this article.


\textsuperscript{117} Ibid., p. 4.

\textsuperscript{118} In this line, see also Nejaime & Siegel, ‘Conscience Wars’ 2542-2552.

\textsuperscript{119} Ch. Fiala & al., ‘Dishonourable disobedience’, 18.

\textsuperscript{120} For instance, ‘McCafferty Report’ and 2009 decision of the Constitutional Court of Colombia (T-388/2009).
conscience claim. Second, that hospitals must have available non-objectors providing convenient and timely access. Third, that women denied abortion services on the ground of conscience are well informed about existing alternatives and duly referred to physicians who are able to provide such services in a timely manner. Fourth, that in the absence of an appropriate referral or in emergency situations, no conscientious objection can be raised. Fifth, that adequate monitoring as well as effective, proportionate and dissuasive national remedies and sanctions are available.

The second path is very appealing: it is a way to reconcile the fundamental rights of women with the conscience claims of healthcare providers. However, recent supranational and national cases show the downside of such a position. The recognition of conscientious objection in reproductive healthcare is hardly sustainable on the ground. A snowball effect seems inevitable. And even well-defined legal safeguards are failing. One cannot deny that ‘allowing limited conscientious objection rests on the misconception that objecting healthcare personnel will make the required compromises, including referring for abortion or providing accurate information on the procedure. But this relies on trusting people to set aside deeply held beliefs that have already been deemed strong enough to invoke conscientious objection, making any compromise far less likely’.\footnote{Ch. Fiala \& al., ‘Dishonourable disobedience’, 14.} This leads to wide discriminatory treatment based on gender, territorial status, low social condition and ethnicity. In addition, it fails to recognise the dignitary harm to women and the perpetuation of social prejudice and structural inequality which result from this approach. In other words, designing, implementing and monitoring a strictly regulated conscience clause in reproductive healthcare resembles an effort to square the circle. Something always falls by the wayside, and the ‘something’ is no less than women’s human rights.