

REFUSING REPRODUCTIVE HEALTH SERVICES ON GROUNDS OF CONSCIENCE IN LATIN AMERICA

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- *Challenging policies and practises based on human rights standards*

ABSTRACT

The years have seen a rise in the use of conscientious objection (CO) as means to deny women their sexual reproductive health rights. While states have an obligation under international human rights law to protect the freedom of thought, conscience and religion of people, they also have obligations to protect the right to the highest attainable standard of health and other fundamental rights. Over the years, International and regional human rights bodies have indicated the need for CO to be limited so as to protect women's rights.

As a means to balance both rights of medical service providers to exercise their moral beliefs and to protect the right to health of women, countries around the world have also sought different ways to regulate the use of CO. Whereas in some countries, some developments have been made to regulate CO so as to protect fundamental rights of women, in others, few guidelines exist in order to ensure availability of services for women in case refusals are made. This article provides an overview of policies regulating CO in Latin America. It considers the regulation of CO under both international law and under various state laws within the region. It suggests that if women's reproductive rights are to become a reality, then there is a real need that states as well as international and regional human rights bodies continue to find ways to clarify frameworks around CO, so that grounds of conscience do not become an excuse to deny women realisation of their fundamental rights.

KEYWORDS

Abortion | Conscientious objection | Human rights | Sexual reproductive health

1 • Introduction

Conscientious Objection (CO) can be understood as the right of an individual to refuse to participate in an activity that he or she considers incompatible with his or her moral, religious, philosophical or ethical beliefs. While at the outset, the right of an individual to assert a moral objection to performing certain duties may not appear to be problematic, conscientious objections when made by medical providers to refuse certain lifesaving procedures can raise a number of concerns in the context of sexual reproductive health.

Studies suggest that use of CO has increasingly become a strategy through which medical providers have sought to excuse themselves from their duties to provide essential reproductive health services for women on moral grounds.¹ In a number of countries, CO is largely unregulated or regulated minimally, having devastating consequences on health and lives of women. In some countries, the right to CO is said to belong to not only individuals but to an institution itself.² The World Health Organization (WHO) has even recognised that, as a barrier to lawful abortion services, CO can impede women from reaching the services for which they are eligible, potentially contributing to unsafe abortion.³

While states have an obligation under international law to protect medical providers' rights to freedom of thought, conscience and religion, they still have obligations to protect the right to life and health of women. United Nations (U.N.) treaty monitoring bodies, through a number of recommendations and concluding observations, have held that as a means to protect the right to health, that CO must be regulated.⁴ This article suggests that there is a real need that states as well as human rights bodies impose clear limits and guidelines on use of CO so as to protect women's fundamental rights. As much as international law may provide for useful guidelines within this context, the example provided by some state courts may be further beneficial.

Part I considers arguments around CO and its status under international and regional human rights law. Part II then addresses the different ways in which states have sought to regulate CO to ensure that women's sexual and reproductive rights are fully protected. In particular, it considers the status of CO in Latin America. The example of Latin America is taken, as women's right to access to reproductive health services within the region has consistently come under attack as regulations around abortion and emergency contraception have been in a constant state of flux. Over the years, as countries within the region have sought to decriminalise abortion, there has been a backlash felt with doctors claiming protection of their right to CO, which is having devastating impacts on the life and health of women. Ultimately, the paper analyses some country-case studies from Latin American and concludes with suggestions for governments, to secure protection of fundamental rights of women.

2 • Sexual Reproductive Health Rights & Limits to CO under International Human Rights Law

CO brings to the forefront the need for governments to balance their obligations to protect the moral beliefs of individuals and the right of patients to receive adequate care. While the right to thought, conscience and religion is recognised under international human rights law, so is the right to the highest attainable standard of health.

Today, rights to sexual reproductive health are well established under international human rights law. And international law, through the pronouncement of treaty monitoring bodies has recognised the need to regulate CO to accommodate both medical providers' beliefs and women's rights to timely medical care. Regulations for example, are to ensure availability of willing providers and should clearly establish the types of services and circumstances in which CO can be invoked. They should further establish oversight mechanisms, provide penalties for health care professionals who do not comply with their duties⁵ and allow women to claim remedies where their rights are violated.⁶

The Committee on Economic and Social Rights, states human rights bodies have held that in order to protect the right to health and life of women, that rights to conscience can be limited.⁷ The U.N. Special Rapporteur on Health has even explained that the exercise of CO cannot be upheld to supersede the right to health, integrity and privacy of women.⁸ Laws which protect rights to conscience and which restrict access to abortion, and other reproductive services violate women's rights to privacy and reproductive decision-making. When CO is used to further deny such services, it undermines women's ability to control their reproductive autonomy and infringes upon their ability to have control over their bodies.

The Committee on the Elimination of Discrimination against Women (CEDAW Committee) has held that "it is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women."⁹ Thus when CO is invoked, it recommends that, "measures be introduced to ensure that women are referred to alternative health providers."¹⁰ With respect to abortion, it specifically notes that policies allowing for CO without ensuring alternative means of accessing abortion services violate women's reproductive rights and recommends that steps be taken to guarantee referrals in such circumstances.¹¹ The Human Rights Committee, which monitors states compliance with the ICCPR, has recognised CO as a barrier to abortion. It recommends that states under their obligation to protect the right to life remove barriers to the procedure.¹²

U.N. bodies have further elaborated the conditions upon which CO can be limited. The Committee on Economic, Social and Cultural Rights (CESCR) and the Human Rights Committee have identified that in order to protect the right to the highest attainable standard of health, states can restrict CO as long as 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.¹³ Thus one sees the need for exemptions

and limits of CO to be clearly stated, so that both rights to conscience and women's right to health are balanced. It is additionally important that limits are explicitly stated and that accountability mechanisms exist in order to ensure that CO does not become a means to deny women life saving care. In his interim report on the criminalisation of abortion in 2011, the U.N. Special Rapporteur on the Right to the Highest Attainable Standard of Health specifically recommended that states clearly define exemptions to CO¹⁴ and the CEDAW Committee has called on states to "take action to prevent and impose sanctions for violations of rights by private persons and organisations."¹⁵ When legislation clearly imposes limits on CO and calls for accountability means it clarifies any misunderstanding that can occur when a variety of rights may conflict.

3 • Regional developments on human rights standards to limit CO

Regional human rights bodies have also sought to establish limits around CO in health care settings. The European Court of Human Rights (ECtHR) for example, has addressed the need to restrict CO in matters of sexual reproductive health in a number of instances. It has held that pharmacists cannot refuse to sell contraceptives, as the right to exercise one's beliefs in public is not always guaranteed.¹⁶ Additionally it has found that CO can only be exercised by individuals and not by institutions.¹⁷ With respect to abortions it has held that states have a positive obligation to regulate the practice of CO.¹⁸ In the case of *RR v. Poland*, for example where a woman was denied access to a prenatal genetic examination because of a doctor's objection, the ECtHR held that effective implementation of abortion laws is a necessary means to ensure respect for one's private life.¹⁹

Reaffirming this decision one year later in the case of *PS v. Poland*, where a teenager became pregnant as a result of rape, the ECtHR held that legal frameworks around abortion must ensure effective access to the procedure.²⁰ Denial of life saving care in such circumstances amount to a violation of women's right to privacy, life and can even amount to torture. Taking into consideration the rights of women in light of the right to life of a fetus, the ECtHR in *Vo v. France* explained that any rights of the unborn are limited by the rights and interests of the mother.

A - Regulation of CO & the Inter-American System of Human Rights

Where some developments have been made with respect to CO and women's sexual reproductive health within the regional system in Europe, no such standards have been issued under the Inter-American system of Human Rights.²² The Inter-American Court of Human Rights for example, has yet to decide a case explicitly calling for a balance between rights to conscience and health. The Court however, tangentially addressed the issue in the case of *Artavia Murillo v. Costa Rica*. In this case, the Inter-American Court explicitly recognised reproductive rights, and sought to establish states obligations around the regulation of such rights. It specifically held that, "states are

responsible for regulating and overseeing the provision of reproductive health services in order to ensure effective protection of the rights to life and personal integrity.”²³ While the decision *per se* does not make specific reference to CO in health settings, it still marks a significant recognition by the Inter-American System to uphold the need for the protection of sexual reproductive health via an effective regulatory framework.

B - The Colombian Constitutional Court

A lack of precedence as established by the Inter-American Court however, has not thwarted developments by national courts in the region. National courts have ruled upon CO and sought to define its limits. The Constitutional Court of Colombia for example, has issued a number of decisions to clarify the limits of CO and define its normative components with respect to matters of health. In the landmark decisions of C-355 (2006), T-209 (2008), T-946 (2008) and T-388 (2009), the Court liberalised abortion and specifically made legal rulings as to the way health care institutions are to accommodate both medical providers right to conscience and the right to lawful medical care of women.²⁴ The Court for example established that: a.) CO can only be invoked by direct providers of abortions and not by medical assistants, nurses etc.;²⁵ b.) CO is an individual right and cannot apply to institutions; c.) CO claims must be provided in writing; d.) Physicians can be sued for failing to comply with standards around CO, and e.) “Because CO cannot be invoked with the effect of violating women’s fundamental rights to health care...[that] 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.”²⁶ In a report entitled, *Access to Information on Reproductive Health from a Human Rights Perspective*, the Inter-American Commission of Human Rights even referred to the decisions by the Colombian Constitutional Court and legitimised the Court’s guidelines around CO as human rights standards for the region.²⁷ The decisions as such have been heralded by some scholars as providing a holistic approach to CO and serving an effective “blueprint” for countries to consider in the regulation of CO.²⁸

The position under international human rights law is clear. While states are to protect the rights to conscience and belief of medical providers, they can still limit the manifestation of one’s right to thought to protect fundamental rights of women. Following such trends, states have found different ways to regulate CO in the medical setting. To date, little research and evidence exists as to the practice of CO internationally. Nonetheless, particular emblematic cases in Latin America such as Colombia, Argentina, Brazil and Uruguay provide interesting analysis for a human rights based approach to regulating CO in the reproductive sphere.

4 • CO in Latin America

Conscientious objection has increasingly become a contentious issue in a number of countries in Latin America. Latin America is home to some of the most restrictive laws on abortion. While abortion is criminalised in Nicaragua, the Dominican Republic, Chile,

Honduras, and El Salvador, it is legal subject to conditions in other countries. As a means to protect both interests of providers and women's right to health, states throughout the region have taken significant steps to regulate CO in the medical sphere.

A number of countries specifically require through legislation that medical providers and institutions refer patients to non-objecting providers,²⁹ that CO claims be provided in writing³⁰ and that doctors explain why performing certain procedures run counter to their deepest beliefs.³¹ Despite such improvements, CO still poses impediments to women's rights.

Where countries have sought to impose restrictions on CO, few oversight mechanisms exist to hold objecting providers accountable. With lack of proper regulation and oversight mechanisms, medical providers have increasingly been able to invoke claims to conscience as a means to "abuse" the right. In light of such findings, there is a real need that states continue to tighten regulations around CO so as to ensure that women's rights are not compromised in light of the need to protect freedoms of thought, conscience and religion.

Argentina is a case in point. Despite the fact that abortion is legal subject to certain conditions and that CO is extensively regulated through law, medical providers consistently refuse to perform essential services for women.³² Since 2003, the National Congress has sought to regulate CO in the sphere of sexual reproductive health.³³ While the regulations stipulate in a number of ways that CO not be invoked in ways to deny women access to sexual reproductive health services,³⁴ the regulations are still limited as they fail to limit the right solely to individuals and fail to provide means to hold objecting providers responsible for their obligations.³⁵ Accordingly, both public and private institutions and medical professionals can deny access to services. A number of studies indicate that lack of legal accountability mechanisms have provided an impetus for medical providers in the country to deny women information and access to reproductive services on grounds of conscience.³⁶ In some instances, health professionals and pharmacists have even claimed CO as a way to refuse providing information on abortion or to refer women to other willing providers, even when obligated by the law.³⁷ Access to information is a vital component of the right to health and when CO is used to deny women information on the availability of essential reproductive services, it infringes on the right of individuals to information and privacy in health.³⁸ Nonetheless, a survey carried out by CEDES in 2001, showed that 50 per cent of the professionals surveyed considered that they must not perform vasectomies or tubal ligations or provide information on those services.³⁹ More than 30 per cent held the same beliefs regarding contraception.⁴⁰

In Brazil, where CO has been regulated since 2005, women have been denied access to abortion because doctors have refused to provide such services. Even though the Ministry of Health issued Decree 1,508/2005 in 2005⁴¹ as a means to limit CO and to protect sexual reproductive health of victims of rape, there have been incidents where doctors have blatantly

overlooked the Decree. The Decree as it stands specifically provides for the “presumption of truth in a woman’s word.”⁴² Nonetheless, there have been instances where women have been denied legal abortions because doctors were unwilling to believe their stories.⁴³ Research shows that physicians, who interrogate rape victims, often require extensive documentation with detailed facts; creating unnecessary barriers to legal abortion care.⁴⁴

In Colombia, where regulations have stipulated legal consequences for objecting providers, doctors have still sought to abuse their rights. After the Constitutional Court liberalised abortion in 2006 and developed its ground breaking guidelines for the regulation of CO; recent cases have shown that medical providers refuse to provide abortion services though obliged to do so.⁴⁵ In Decision T-388/09, where the Court looked to further clarify its guidelines on CO – by holding that public authorities, judges, and healthcare providers, whether public or private, could be subject to legal sanctions⁴⁶ if standards on CO are not complied with – steps were taken to challenge the holding. Immediately after the decision, “three citizens and the Inspector General of Colombia himself petitioned the Constitutional Court to reverse the Decision, arguing, among others, that the creation of rules on conscientious objection to abortion”⁴⁷ went beyond those of its Decision from 2006.

In Uruguay for example, abortion is legal until the 12th week of pregnancy.⁴⁸ As a means to ensure access to abortion and other reproductive health services, the government implemented Law 18.987 and Decree 375 (2012), which regulate the scope of the liberal abortion law and seek to clarify the limits of CO.⁴⁹ To this extent, the regulations require that institutions who are opposed to the practice of abortion, declare their objections to the National Health Junta.⁵⁰ Additionally, the regulations also try to address concerns where CO may amount to civil disobedience or be abused. Accordingly, the regulations stipulate that CO can be revoked at any time, and can be “implicitly revoked anytime a physician provides abortion services.”⁵¹ Given the broad reaching scope of the provisions, a number of doctors challenged the decree, arguing that it unduly restricted their right to freedom of thought. Accordingly, in August 2015, the highest administrative court annulled several of the provisions limiting the exercise of CO.⁵² In particular, the Court rendered null article 12, which prohibits physicians from forming any value judgment on a patient’s decision.⁵³ Given the effect of the decision, there is real concern that any further gains that may be made in the realm of sexual reproductive will also only be thwarted.

In Latin America, the varying extent to which CO has been used as a strategy to systematically deny women’s access to reproductive health services has created an environment where it has become more difficult for women to realise their fundamental rights. Given the concerns that the abusive use of CO poses on women’s health and rights, there is a real need for governments to strengthen legislation around CO and provide enforcement mechanisms so as to ensure accountability within the health system. When legal policies lack grounds for enforcement, their potential to be overlooked thereby violating women’s human rights increases, as they stand only as “principles” to be considered.

5 • Conclusion

Clearly the illegitimate use of CO poses immense concern for women's access to essential reproductive health services and constitutes not only a violation of the right to health, but right to information, non-discrimination and equality in health care, and privacy of women as established under international human rights law. In this respect, guidance as afforded by the Colombian Constitutional Court on CO and those recommendations made by treaty monitoring bodies provide effective means for states to consider in the implementation of their policies. Clearly if the sexual reproductive health of women is to become a reality, then steps must be taken to ensure that one's right to conscience cannot be abused so as to deny access to life saving treatment for women around the world.

NOTES

1 • Kathleen M. Morrell and Wendy Chavkin, "Conscientious objection to abortion and reproductive healthcare: A review of recent literature and implications for adolescents," *Current Opinion in Obstetrics and Gynecology*, 27, no. 5 (2015): 333–338.

2 • In Uruguay for example, after the decriminalisation of abortion, the concept of ideological objection by institutions was introduced through the law. See, Lionel Briozzo, "From Risk and Harm Reduction to Decriminalizing Abortion: the Uruguayan Model for Women's Rights," *International Journal of Gynecology and Obstetrics* 134 (2016): S3–S6.

3 • See, WHO. *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2nd ed. (Geneva: WHO, 2012), 69; Christina Zampas, "Legal and Ethical Standards for Protecting Women's Human Rights and the Practice of Conscientious Objection in Reproductive Healthcare Settings," (2013) 3 *International Journal of Gynaecological Obstetrics* 123, suppl. 3 (2013): S63–S65.

4 • See, e.g., United Nations, Committee on the Elimination of Discrimination against Women (CEDAW), "Concluding Observations regarding Slovakia," A/63/38, 14 July 2008, para. 42–43; United Nations, Human Rights Committee (OHCHR),

"Concluding Observations regarding Poland," CCPR/C/POL/CO/6, 29 September 2010, para 12.

5 • *Tysiac v Poland*, Application no. 5410/03, Merits and Just Satisfaction, 2007, para 116–117.

6 • The right to an effective remedy is a fundamental right recognised in most international and regional human rights treaties. See, e.g., International Covenant on Civil and Political Rights, adopted 16 Dec. 1966, Art. 2, para 3, G.A. Res. 2200A XXI, UNGAOR, 21st Sess., Supp. no.16, U.N.Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force 23 March 1976).

7 • See, eg. United Nations, Committee on Economic, Social and Cultural Rights (CESCR), "Concluding Observations: Poland," U.N. Doc. E/C.12/POL/CO/5 (2009) para 28.

8 • United Nations, "Special Rapporteur on Health," *supra* note 29 para 8.

9 • United Nations, Committee on the Elimination of Discrimination against Women (CEDAW), "General Recommendation no. 24: Article 12 (women and health)," 20th Sess., 1999, in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, Vol. II, p. 358, para 11, U.N. Doc. A/HRI/GEN/1/Rev.9 (2008).

10 • CEDAW, "General Recommendation no. 24".

- 11 • See, e.g., United Nations, Committee on the Elimination of Discrimination against Women (CEDAW), “Concluding Observations: Slovakia,” U.N. Doc. A/63/38 (2008) para 42–43.
- 12 • See, e.g., United Nations, Human Rights Committee (OHCHR), “Concluding Observations: Poland,” U.N. Doc. CCPR/C/POL/CO/6 (2010) para 12.
- 13 • United Nations, Human Rights Committee (OHCHR), “General Comment no. 22, The Right to Freedom of Thought, Conscience and Religion (Article 18),” UN Doc. CCPR/C/21/Rev.1/Add.4 (1993) para 8; United Nations, Committee on Economic, Social and Cultural Rights (CESCR), “General Comment no. 14, The Right to the Highest Attainable Standard of Health,” UN Doc. no. E/C.12/2000/4 (2000).
- 14 • United Nations, “Special Rapporteur,” para 65.
- 15 • CEDAW, “General Recommendation no. 24,” para 14–15.
- 16 • See, *Pichon and Sajous v. France* no. 49853/99, Merits and Just Satisfaction, 2 October 2001.
- 17 • *Pichon and Sajous v. France*.
- 18 • *R.R. v. Poland* no. 27617/04, Merits and Just Satisfaction, 26 May 2011, para 197.
- 19 • *R.R. v. Poland*, para 213–214.
- 20 • *P and S v. Poland* no. 57375/08, Merits and Just Satisfaction, 5 November 2012.
- 21 • *P and S v. Poland*.
- 22 • Standards however, have been developed with respect to CO in the military. See e.g. Case 12219, *Cristian Daniel Sahli Vera et al. v Chile*, Report no. 43/05 (2005); Case 14/04, *Alfredo Diaz Bustos v Bolivia*, Report no. 97/05 (2005).
- 23 • Case of *Artavia Murillo et al. v Costa Rica*, IACtHR Series C 257 (2012) para 148.
- 24 • Colombia, Corte Constitucional [C.C.] [Constitutional Court], *Sentencia C-355/06*, May 10, 2006; Colombia, Corte Constitucional [C.C.] [Constitutional Court], *Sentencia T-209/08*, February 28, 2008; Colombia, Corte Constitucional [C.C.] [Constitutional Court], *Sentencia T-388/09*, May 28, 2009, accessed November 30, 2016, <http://www.corteconstitucional.gov.co/relatoria/2009/t-388-09.htm>.
- 25 • This requirement was recently also upheld by the Supreme Court of the UK in the case of *Doogan & Woods*. In this case, two midwives working as Labor Ward Coordinators, wished to invoke the right of conscientious objection in accordance with section 4 of the Abortion Act 1967 which provides that ‘no person shall be under any duty [...] to participate in any treatment [...] to which he has a conscientious objection’. The Health Board objected to the midwives’ claim, stating that their activities were not proximate enough to the termination procedure to qualify under section 4. Whilst the appeal to the Inner Court had seen the midwives claims accepted, the Supreme Court restated the test of proximity that preceding case law had developed and accepted (*Doogan and Woods v Greater Glasgow and Clyde Health Board*, UKSC 68, 2014).
- 26 • Rebecca J. Cook, Mónica Arango Olaya and Bernard M. Dickens, “Health care responsibilities and conscientious objection,” *International Journal of Gynecology and Obstetrics* 104, no. 3 (2009): 250.
- 27 • OAS, Inter-American Commission on Human Rights (IACHR), *Access to Information on Reproductive Health from a Human Rights Perspective*, OEA/Ser.LV/II., doc. 61 (2011) para 63.
- 28 • Luisa Cabal, Monica Arango Olaya, and Valentina Montoya Robledo, “Striking a Balance: Conscientious Objection and Reproductive Health Care from the Colombia Perspective,” *Health & Human Rights* 16 (2014): 77.
- 29 • See, Argentina, Decree no. 1282/03, May 26, 2003, Boletín Oficial; Argentina, *Law no. 26130*, August 28, 2006, Boletín Oficial, August 29, 2006; Uruguay, *Decree no. 375*, November 22, 2012, Diario Oficial, November 29, 2012; México, *Ley de Salud del Distrito Federal [LSDF] [Health Law for the Federal District]*, Gaceta Oficial del Distrito Federal [G.O.D.F] September 17, 2009, Articles 58–59.
- 30 • See example, Uruguai, *Decree no. 375*.
- 31 • Colombia, Corte Constitucional [C.C.], [Constitutional Court], *Decision T-388/09*, Gaceta de la

- Corte Constitucional [G.C.C.], May 28, 2010, para 53.
- 32 • Abortion is legal in Argentina whenever a woman's life or health is at risk, or in cases of rape. See, Argentina, Corte Suprema de Justicia de la Nación [CSJN] [National Supreme Court of Justice], "F., A. L. s/ medida autosatisfactiva" F. 259. XLVI, March 13, 2012.
- 33 • Argentina, *Law no. 25673/03*, May 26, 2003, Boletín Oficial (National Program on Sexual Health and Responsible Reproduction); Argentina, *Decree no. 1282/03*, May 26, 2003, Boletín Oficial; Argentina, *Law no. 26130/06*, August 28, 2006, Boletín Oficial, August 29, 2006 (Surgical contraception); Argentina, Ministerio de Salud, *Guía Técnica para la Atención Integral de los Abortos no Punibles* (Buenos Aires, June 2010).
- 34 • For example, Decree no. 1282/03 provides that institutions must ensure execution of the National Program on Sexual Health and Responsible Reproduction. That in CO cases, institutions must refer patients to non-objecting practitioners and that in case of refusal that institutions provide termination of pregnancy through another provider at the institution within five days, or immediately if the situation is urgent (Argentina, *Decree no. 1282/03*).
- 35 • Luisa Cabal, Monica Arango Olaya, and Valentina Montoya Robledo, "Striking a Balance: Conscientious Objection and Reproductive Health Care from the Colombia Perspective," *Health & Human Rights* 16 (2014): 79.
- 36 • Marcelo Alegre, "Conscious Oppression: Conscientious Objection in the sphere of sexual and reproductive health," *Seminario en Latinoamérica de Teoría Constitucional y Política* (Asunción, Paraguay, 2009) 94. Paper 66.
- 37 • Alegre, "Conscious Oppression".
- 38 • Sandra Coliver, ed., *Article 19, The Right to Know: Human Rights and Access to Reproductive Health Information* (Philadelphia: University of Pennsylvania Press, 1995), 39, 61–72.
- 39 • Alegre, "Conscious Oppression," 94, citing to Silvina Ramos et al., *Los médicos frente a la anticoncepción y el aborto ¿Una transición ideológica?* (Buenos Aires, CEDES, 2001).
- 40 • *Ibid.*, 94.
- 41 • Brasil, Ministério da Saúde, Portaria no 1.508/GM, 1 September, 2005.
- 42 • Brasil, Ministério da Saúde. *Prevenção e tratamento dos agravos resultantes da violência sexual contra mulheres e adolescentes: norma técnica*, 2 ed. (Brasília: Ministério da Saúde, 2005).
- 43 • Beatriz Galli and Edlaine C. Gomes, "Representações dos profissionais de saúde em relação ao aborto: entre direitos e deveres na atenção," *Seminário Internacional Fazendo Gênero*, 7 (Florianópolis: EDUFSC, August 2006).
- 44 • Debora Diniz, Alberto Pereira Madeiro and Cristiano Rosas, "Conscientious objection, barriers, and abortion in the case of rape: a study among physicians in Brazil," *Reproductive Health Matters* 22, no. 43 (2014): 141.
- 45 • O'Neill Institute & Women's Link Worldwide, *T-388/2009: Conscientious Objection and Abortion A Global Perspective on the Colombian Experience*, (Colômbia: Women's Link Worldwide & O'Neill Institute: 2014), 10.
- 46 • Colômbia, Sentencia T-388/09.
- 47 • O'Neill Institute & Women's Link Worldwide, *T-388/2009*, 10.
- 48 • Uruguay, *Law no. 18.987/2012*, 22 October 2012, D.O. October 30, 2012, no. 28585, Article 6.
- 49 • Uruguay, *Law no. 18.987/2012*; Uruguay, *Decree no. 375/2012*, 22 November 2012, D.O. November 29, 2012.
- 50 • Luisa Cabal, Monica Arango Olaya, and Valentina Montoya Robledo, "Striking a Balance: Conscientious Objection and Reproductive Health Care from the Colombia Perspective," *Health & Human Rights* 16 (2014) 80.
- 51 • *Ibid.*
- 52 • See, *Alonso, Justo and others v Poder Ejecutivo*, no 586 (11 August 2015); Lucia Berro Pizarossa, "Conscientious Objection or Conscious Oppression?: The Uphill Battle to Access Abortion Services in Uruguay," *Oxford Human Rights Hub*

Sept. 11, 2015, accessed October 10, 2015, [http://ohrh.law.ox.ac.uk/conscientious-objection-or-conscientious-oppression-the-uphill-battle-to-access-](http://ohrh.law.ox.ac.uk/conscientious-objection-or-conscientious-oppression-the-uphill-battle-to-access-abortion-services-in-uruguay/)

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53 • *Alonso, Justo and others v Poder Ejecutivo*, no. 586; Pizzarossa, "Conscientious".



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Received in November 2016.
Original in English.



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Received in November 2016.
Original in English.



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