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Regulation of Religious Refusals for Abortion Care

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1. Introduction

"Religious refusals" are carve-outs from current laws, policies, or standard practices that enable certain people or entities to be exempt from a law if adhering to it would violate their religious or moral/conscience beliefs.[a] In the health context, such refusals can arise at various levels of the health system, from the individual to the administrative and the institutional — as well as in judicial systems.

Religious refusals can impact a wide range of health services. Despite their sometimes broad applicability, religious refusals are most commonly evoked in the context of sexual and reproductive health. The Ethical and Religious Directives (ERDs), which guide Catholic health facilities and Catholic health professionals working in other settings, have prohibited a range of reproductive health services (e.g., contraception, sterilization, tubal ligations, many infertility treatments, and abortion[b]), as well as euthanasia or assisted suicide.[1] In 2023, the U.S. Conference of Catholic Bishops added gender-affirming care to the list of prohibited health services, explaining that it does "not respect the fundamental order of the human person as an intrinsic unity of body and soul, with a body that is sexually differentiated."[2] While other religions may inform the exercise of religious refusals, Catholic ERDs are particularly relevant, given that the Catholic Church is the largest non-governmental provider of health care services in the world.

The United States has some of the strongest legal protections for religious refusals in the world, with relevant laws at both the federal and state levels. Shortly after the Supreme Court established the federal right to abortion in *Roe v. Wade* (1973), Congress enacted statutory protections for both individuals and entities who refuse to provide or assist in abortion care and sterilizations for primarily religious reasons.[3] These include the Church, Coates-Snowe, and Weldon Amendments — collectively known as the Federal Health Care Provider Conscience Protection Laws — which prohibit recipients of certain federal funding from discriminating against individuals, institutions, and others that refuse to provide or pay for abortion care or undergo related training.[c] Select provisions of the Affordable Care Act (ACA) also granted certain protections for individuals, institutions, and health insurance companies that refused to provide or pay for abortion care. In addition, **46 states** have their own religious refusal laws that grant protections for individual providers who refuse to provide abortions; **44** of those states also protect institutions that refuse to provide abortion care.[4]

When protections for religious refusals are broad and subject to limited regulation, as is the case in the United States, they can undermine patients' access to care, possibly putting their health in jeopardy and infringing on that patient's right to health and other related rights (autonomy, dignity, etc.). The failure to receive timely sexual and reproductive health care affects all people. In particular, women, LGBTQ+ people, their families, and others who are disproportionately affected by barriers to health care bear the heaviest burdens.

Human rights bodies and international organizations have weighed in on this tension, emphasizing the need for effective regulations to ensure that religious refusals do not hinder access to sexual and reproductive health care. These regulations can be framed as "limitations" on the right to religious refusals, and "obligations" that must be fulfilled to receive the protections. In many countries, moreover, high courts and legislatures have adopted such regulations to minimize the extent to which religious refusals affect patients' access to essential health services.

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a While this definition of religious refusals could encompass carve-outs whereby the law protects health care providers whose beliefs require them to provide abortion care in violation of abortion bans or restrictions, religious refusal laws are, by and large, designed or applied asymmetrically to protect providers who refuse to provide abortion care under circumstances where it is legal.

b This includes abortion in cases of rape, extrauterine pregnancy, and when the pregnancy jeopardizes the pregnant person's life or health.

c The Church Amendments prohibit discrimination against any physician or other health care personnel, "because he performed or assisted in the performance of a lawful sterilization procedure or abortion, because he refused to perform or assist in the performance of such a procedure or abortion on the grounds that his performance or assistance in the performance of the procedure or abortion would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting sterilization procedures or abortions." Church Amendments, 42 U.S.C. § 300a-7.

This report analyzes how human rights bodies, international organizations, and decision-makers around the world have regulated religious refusals, primarily for abortion care, in light of their ability to affect patients' access to care. While not intended to be comprehensive, the report seeks to bring greater visibility to many of the approaches taken and arguments relied on in different parts of the world.

Part 2 outlines the limitations and challenges associated with the unregulated exercise of religious refusals, as identified by experts from various disciplines.

Part 3 briefly situates United States religious refusal laws in a global context, comparing them to corresponding laws in other countries.

Part 4 lays out the relevant human rights principles, describing how human rights bodies and international organizations have assessed and provided recommendations on religious refusals.

Parts 5 and 6 highlight the most common religious refusal regulations that human right bodies recommend and that countries around the world adopt, whether limitations or obligations.

Part 7 offers policy messages and additional resources for advocates and decision-makers in the United States seeking to integrate these arguments and approaches into their local law and policy reform efforts.

2. Calls for Regulating the Exercise of Religious Refusals

The term "conscientious objector" has a long history of describing those who refuse to perform military service out of a moral sense of right and wrong.[5] Following World War II, several countries provided legislative or constitutional protections for conscientious objection.[6] Similarly, newly formed human rights bodies recognized their relation to the right to the freedom of conscience, religion, belief, and thought under the Universal Declaration of Human Rights, and subsequently the International Covenant on Civil and Political Rights.[7] Over time, the terms "religious refusals" and "conscientious objector" have been extended to apply to the health care context. In these instances, health care providers refuse to provide care that is both legal and within the current standard of practice due to their religious or moral beliefs.[8]

Notably, religious refusals bear vastly different considerations and consequences in the health care context compared to those in the military context.[9] For one, entering a particular health profession involves a higher degree of choice than military conscription. Secondly, religious refusals in the health care context "cannot be framed solely as an issue of individual rights or beliefs because it always affects someone else's health or access to care."[10] Refusing to provide health services to a patient based on one's own convictions undermines the patient-provider relationship by allowing them to prioritize their personal beliefs ahead over their patient's needs. This refusal directly impacts patients' access to care, putting their health in jeopardy and infringing on their rights to autonomy, dignity, health, and more.

Various international health organizations and experts have weighed in on the need for effective regulation of religious refusals related to the provision of sexual and reproductive health services. The World Health Organization (WHO), International Federation of Gynecology and Obstetrics (FIGO), and leading ethicists are among those who have weighed in. In its Abortion Care Guideline (2022), the WHO recognizes that religious refusal of abortion care imposes a barrier to access to safe and timely care, resulting in violations of human rights and an increase in women seeking unsafe abortion.[11] The guideline emphasizes that, under international human rights law, States allowing religious refusals for abortion must "regulate the exercise of conscientious objection in a way that reflects best international clinical practice, protects abortion seekers, and ensures that provider refusal does not undermine or hinder access to quality abortion care."[12]

In their Ethics and Professionalism Guidelines, FIGO states that "[a]ll obstetrician-gynecologists have the professional responsibility to see to it that all of their patients receive clinical management to which the patient has consented. All conscientious objections to treating a patient are secondary to this professional responsibility."[13] It further provides that "[a]ll obstetrician-gynecologists have the professional responsibility to abide by scientifically and professionally determined definitions of reproductive health services, and to exercise care and integrity not to misrepresent or mischaracterize them on the basis of personal beliefs."[14] FIGO has further stated that, "whenever the exercise of conscientious objection results in delays, increased burdens for women and girls, or no access at all, it should no longer be accepted as conscientious objection but defined as an unjustified denial of health services."[15]

> Denying or restricting access to reproductive health care, including through the abuse of religious refusals, can result in violations of the rights to life, health, privacy, equality, physical and mental integrity, and freedom from torture or ill-treatment.
>
> —*Working Group on discrimination against women and girls*

> "[W]heneverthe exercise of conscientious objection results in delays, increased burdens for women and girls, or no access at all, it should no longer be accepted as conscientious objection but defined as an unjustified denial of health services."
>
> —*FIGO Ethics and Professional Guidelines*

Leading ethicists have also weighed in on the tension between religious refusals as an exercise of the right to freedom of thought, conscience, or religion — as well as the burden they can place on patients' access to health care and related rights.[16] At the individual level, allowing health care professionals to refuse to provide care based on religious or moral convictions aims to protect their moral integrity and act within the bounds of their individual conscience.[17] However, providers' duty to their patients does not simply evaporate in the face of religious refusals.[d] As stated by ethicist Alan Cribb, "[w]e may exercise conscientious objection to involvement in certain activities – but surely we cannot entirely float above the network of obligations in which we have immersed ourselves."[18] Further, public health researchers have examined the misuse of religious refusals, particularly in the context of abortion, where abortion care is refused for reasons unrelated to religion or morals, including "fear of experiencing discrimination if [the health care provider] perform[s] legal abortions or for other personal reasons that do not constitute genuine conscientious objection."[19] In practice, the exercise of religious refusals shrinks the pool of providers, resulting in delays and stigmatizing care.[20]

Where permitted at the institutional level, religious refusals result in even greater burdens on access to care and greater breaches of the duty to care for and provide patients with all relevant clinical options.[21] Ethicists have argued that hospitals are buildings and do not have a conscience; recognizing them as such erodes the conscience of individual providers who would otherwise be willing to provide the particular service under their own personal morals.[22] This is especially relevant given that, as interdisciplinary research has pointed out, religious refusal laws "fail to protect providers whose faith *requires* them to provide comprehensive care," including abortion care.[23] The distinctions between religious refusals at the individual and institutional levels are explored in **Part 5**

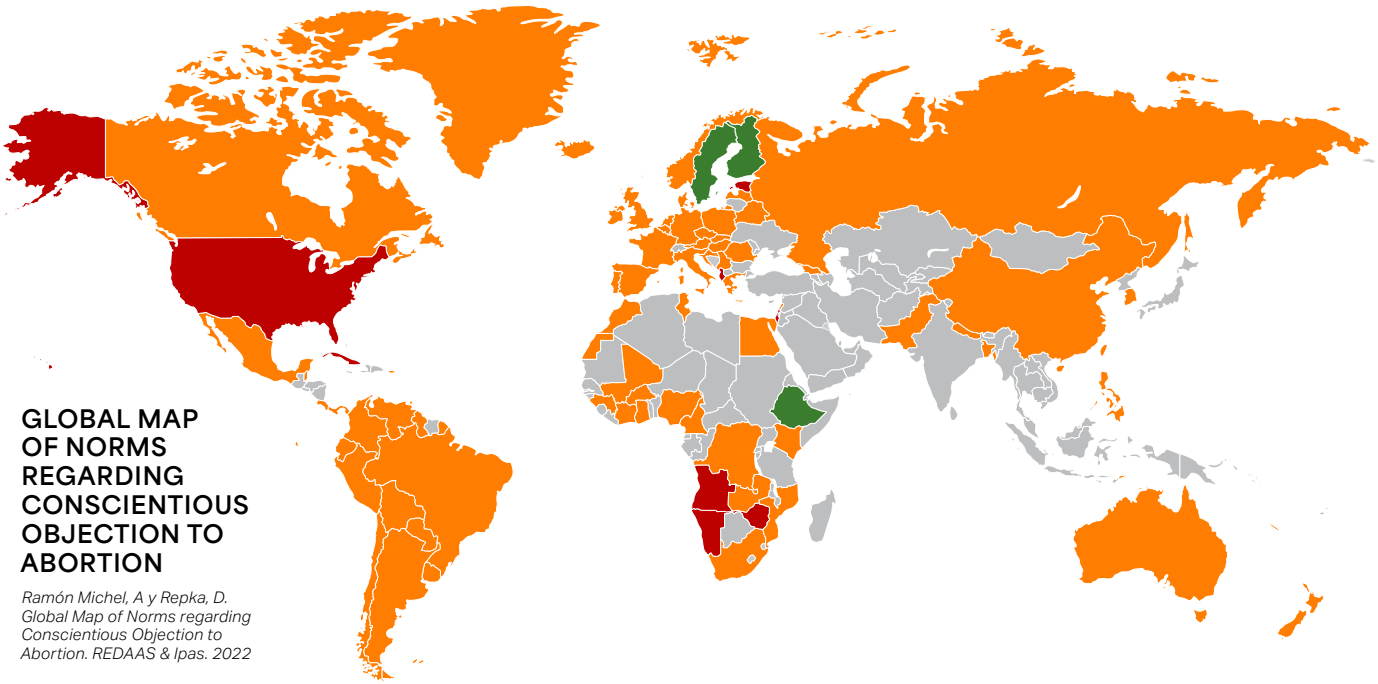
d "Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician." AMA Code of Ethics, Opinion 1.1.7 Physician Exercise of Conscience. https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-exercise-conscience.

3. United States Religious Refusals in Global Context

Countries have adopted various legal and regulatory approaches to religious refusals. Overall, there is a strong trend in explicitly allowing religious refusals in abortion care, with 87 countries allowing it.[24] Some of these refusal laws apply to all sexual and reproductive health services (or even more broadly), but are more commonly triggered by refusals to provide abortion; others are specific to abortion. Only three countries (**Ethiopia**, **Finland**, and **Sweden**) have laws that explicitly prohibit religious refusals for abortion care.[25]

It is far less common for countries to extend their religious refusal laws to a broader range of health services than it is to apply to a specific type of care or service. States in the **United States** that have expanded their protections to apply to nearly all types of health care, such as Florida and Montana, are outliers globally.[26] Florida, for example, enacted a law in 2023, stating that a "health care provider or health care payor has the right to opt out of participation in or payment for any health care service on the basis of a conscience-based objection."[27]

Among the 87 countries allowing religious refusals for abortion, the provisions appear in general laws, health laws, employment laws, abortion laws, as well as in health care regulations, protocols, and directives, or through judicial precedent. Provisions vary by: the scope of their protection (e.g., freedom from punishment under the law or retaliation from an employer); who is protected (e.g., individual physicians, nurses, institutions, etc.); the services covered (e.g., the abortion, pre- or post- care); as well as the steps that an objector must take to receive the relevant protections.



GLOBAL MAP OF NORMS REGARDING CONSCIENTIOUS OBJECTION TO ABORTION

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

10 Unlimited Recognition

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

77 Limited Recognition

Countries in this category are those that, under their main regulation regarding CO or in their set of regulations, contemplate a limit to exercising CO.

3 Ban

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

90 No Recognition

Countries in this category are those that neither recognize nor explicitly ban CO.

GLOBAL MAP OF NORMS REGARDING CONSCIENTIOUS OBJECTION TO ABORTION

10 Unlimited Recognition | **77** Limited Recognition | **3** Ban | **90** No Recognition

Albania
Angola
Cuba
Estonia
Isreal
Luxemburg
Montenegro
Namibia
United States
Zimbabwe

Germany
Argentina
Australia
Austria
Bangladesh
Belgium
Belize
Belarus
Bolivia
Bosnia & Herzegovina
Brazil
Burkina Faso
Cameroon
Cape Verde
Canada
Chile
China
Colombia
South Korea
Côte d'Ivoire
Costa Rica
Coatia
Denmark
Ecuador
Egypt
East Timor
Slovakia
Slovenia
Spain
France
Georgia
Ghana
Great Britain
Greece
Guyana
Guinea
Hungary
Ireland
Northern Ireland
Iceland
Italy
Kenya
Latvia
Lebanon
Mali
Morocco
Mauritius
Mexico
Monaco
Mozambique

Nepal
Nigers
Nigeria
Norway
New Zealand
Netherlands
Pakistan
Panama
Paraguay
Peru
Poland
Portugal
Chec Republic
Philippines
Republic of Congo
Romania
Russia
Senegal
Serbia
Singapore
South Africa
Trinidad and Tobago
Tunisia
Uruguay
Venezuela
Zambia

Ethiopia
Finland
Sweden

Afganistan
Andorra
Saudi Arabia
Algeria
Armenia
Azerbaijan
Bahamas
Barbados
Benin
Botswana
Bulgaria
Brunei Darussalam
Burundi
Bhutan
Cambodia
Chad
Cyprus
North Korea
Djibouti
El Salvador
United Arab Emirates
Eritrea
Vatican City
Fiji
Gabon
Gambia
Guatemala
Equatorial Guinea
Guinea-Bissau
Haiti
Honduras

India
Indonesia
Iraq
Iran
Solomon Islands
Jamacia
Japan
Jordan
Qatar
Kazakhstan
Kyrgyzstan
Kiribati
Kuwait
Lesotho
Liberia
Libya
Liechtenstein
Lithuania
Macedonia
Madagascar
Malaysia
Malta
Mauritania
Moldova
Mongolia
Myanmar
Nicaragua
Oman
Palua
Papua New Guinea
Central African Republic
Lao People's Democratic Republic
Dominican Republic
Rwanda
San Marino
Sierre Leone
Syria
Somalia
Sri Lanka
Sudan
South Sudan
Switzerland
Suriname
Swaziland
Thailand
Taiwan
Tanzania
Tajikstan
Turkmenistan
Turkey
Tuvalu
Ukraine
Ugana
Uzbekistan
Vanuatu
Vietnam
Yemen

Regulation of religious refusals can be characterized as "limitations" on the right to religious refusals and "obligations" that must be fulfilled to receive the protections. Of the 87 countries with religious refusal clauses for abortion, the large majority — 74 countries — include some form of limitation.[28] Only four countries explicitly allow religious refusals to abortion at the institutional level (**Chile**, **France**, **United States**, and **Uruguay**).[29] Fifty-seven countries prohibit a provider from exercising conscientious objection when the patient is experiencing a medical emergency.[30] This limitation exists in at least **nine states** in the **United States** but is complicated by evolving federal case law.[31]

In terms of obligations, 33 countries require the objecting provider to refer the patient to another provider who can care for them; 29 countries require the objecting provider to inform the patient of their objection.[32] In the **United States**, only Illinois and Louisiana have similar referral and notification requirements.[33] Even where strong limitations and obligations are in place, frequent and widespread use of religious refusals at the individual level can significantly impact patients' access to abortion care. Twenty-six countries have an institutional procedural obligation to address this, requiring health institutions to, for example, have a minimum number of willing providers, maintain a database of willing providers, or have a plan to refer patients to other facilities where they can receive abortion care.[34] While a few states have referral requirements in place,[35] the **United States** is generally less likely to require a minimum number of willing providers or willing provider databases.

Meanwhile, 13 of the 87 countries with religious refusal laws do not attach any limitations or obligations to their religious refusal laws, including the **United States**. Ninety countries do not have a law that explicitly recognizes or bans religious refusals.[36] While this lack of regulation or legal clarity can contribute to barriers to sexual and reproductive health care, it is important to recognize that health care providers and institutions in these settings are still bound by professional duties, and countries are bound by the human rights treaties to which they are parties.

4. Religious Refusals Under International Human Rights Law

Certain actors have tied religious refusals to the right to freedom of thought, conscience, and religion, as outlined in Article 18 of the International Covenant on Civil and Political Rights (ICCPR), under international human rights law.[37] However, human rights bodies have never interpreted Article 18 as imposing a positive obligation on countries to recognize a right to conscientious objection in the context of health care. Several human rights bodies at both the universal and regional levels have emphasized that human rights law requires States to protect patients' access to health care through regulatory measures addressing religious refusals.

ARTICLE 18 ICCPR

1. Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

2. No one shall be subject to coercion which would impair his freedom to have or to adopt a religion or belief of his choice.

3. Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.

a. Universal Human Rights System

According to the Human Rights Committee (HRC, which monitors compliance with the ICCPR) "the right to freedom of thought, conscience and religion (which includes the freedom to hold beliefs) (...) encompasses freedom of thought on all matters, personal conviction and the commitment to religion or belief, whether manifested individually or in community with others."[38] The HRC recognized that the freedom of thought, conscience, religion, or belief differs from freedom to *manifest* religion or belief. While no limitations are permissible on the freedom of thought and conscience, or on the freedom to have or adopt a religion or belief of one's choice, Article 18.3 permits restrictions on the freedom to manifest religion or belief if limitations are prescribed by law and are necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others.[39]

In a 2019 general comment on the right to life, the HRC stated that "States parties may not regulate pregnancy or abortion ... in a manner that runs contrary to their duty to ensure that women and girls do not have to resort to unsafe abortions, and they should revise their abortion laws accordingly."[40] This expressly includes laws surrounding conscience protections.

UN treaty monitoring bodies have raised concern on the impact of religious refusals on access to sexual and reproductive health care. For example in 1999, the Committee on the Elimination of Discrimination against Women (CEDAW Committee, which interprets the Convention on the Elimination of Discrimination Against Women) recognized the "discriminatory" nature where States enable health providers to refuse to provide certain reproductive health services for women

based on conscientious objection — in violation of the right o non-discrimination.[41] The CEDAW Committee underscores that ailures to adequately regulate religious refusals also constitute a violation of Article 12 of the Convention on the right to health, including reproductive health, which can lead to increased maternal mortality and morbidity.[42]

In a 2013 general comment, the Committee on the Rights of the Child (CRC Committee, which interprets the Convention on the Rights o the Child) stated that "States should ensure that adolescents are not deprived of any sexual and reproductive health information or services due to providers' conscientious objections."[43]

In 2016, the Committee on Economic, Social and Cultural Rights (ESCR Committee) emphasized that States must regulate religious refusals and conscientious objections so that they do not impede the fulfillment of individuals' rights to sexual and reproductive health services.[44] The ESCR Committee has applied the "AAAQ" ramework to the right to sexual and reproductive health services as part of the right to health — meaning that States are obligated to meet four essential elements: availability, accessibility, acceptability, and quality.[45] Regarding availability, the ESCR Committee stated, "Unavailability o goods and services due to ideologically based policies or practices, such as the refusal to provide services based on conscience, must not be a barrier to accessing services."[46]

UN Special Procedures have also weighed the impact o religious reusals on human rights. In 2011, the UN Special Rapporteur on the Right to Health recognized how religious refusals can make legal abortion inaccessible.[47] In 2020, the UN Special Rapporteur on Freedom o Religion or Belie similarly recognized how religious refusals impede access to abortion and contraception and that international law offers no protection for manifestations of belief that deny the rights of others.[48] The report highlights how 87% of medical providers refused to provide abortion in **Uruguay**, as well as instances in the **United States** and **South Africa** where religious refusal laws enabled individuals to refuse to provide various services to LGBTQ+ persons.[49] It was thus recommended that States "[e]nsure that legal protections or individuals to mani est their religion or belie , such as in health-care settings, do not have the effect of denying women, girls or LGBT+ persons the right to non-discrimination or other rights."[50]

In 2024, the Working Group on discrimination against women and girls (Working Group) provided key considerations on the impact of conscientious objection to abortion.[51] The Working Group highlighted various concerning trends in religious refusals, including infringements on women's lives, health, autonomy, agency, and found that human rights law requires that the legal and ethical limits of religious refusals be clearly defined and regulated across health care settings.

> "States have due diligence obligations to ensure that health-care providers fully respect women's and girls' sexual and reproductive health rights, and must take all measures necessary to create an environment that facilitates the fulfilment of those responsibilities and promotes respect for those rights. In States that permit conscientious objection, the State has an affirmative obligation to ensure that the invocation of conscientious objection by health-care providers does not infringe upon the sexual and reproductive health rights of women and girls. Everyone seeking reproductive health care must be able to access such care without delay or judgment, in full exercise of her human rights."[52]
>
> —*Working Group on discrimination against women and girls*

The Working Group also provided several specific recommendations on setting limitations and obligations on religious refusals that are discussed in Part 4b.

b. Regional Human Rights System

In the European human rights system, both the European Court of Human Rights and the European Committee of Social Rights have held that States are not required to provide a right to conscientious objection in health care settings, either under the European Convention on Human Rights or the European Social Charter.[53] However, when States do provide such a right, they are obligated under both instruments to ensure that religious refusals do not prevent patients from timely and effective access to health services, including lawful abortion.

Similarly, in the African human rights system, General Comment 2 on Article 14 of the Maputo Protocol on the Rights of Women in Africa recognizes that where providers invoke religious refusals, States must ensure that women continue to have access to timely abortion care.[54] The African Commission on Human and Peoples' Rights states that "States parties should particularly ensure that health services and health-care providers do not deny women access to contraception/family planning and safe abortion information and services because of, for example, requirements of third parties or for reasons of conscientious objection."[55] As discussed below, the Commission also recommends that religious refusals be limited to only those providers directly involved in abortion care and cannot be invoked in health emergencies.

In 2011, the Inter-American Commission on Human Rights (IACHR) issued a report recognizing that a health care professional may refuse to provide medical services, such as those related to "family-planning methods, emergency oral contraception, sterilization, and legal abortion, where the refusal is based on one's own convictions.[56] Conscientious objection cannot be used as "a mechanism for discrimination and the violation of women's fundamental rights."[57]

In short, there is wide consensus among human rights bodies at the regional and universal levels that, when States permit religious refusals to provide sexual and reproductive health care, it is imperative, under international human rights law and professional medical ethics, that they be well-regulated in light of patients' rights and interests.

5. Limitations on the Exercise of Religious Refusals

There is broad consensus on the need for clear, explicit regulations that impose limits on religious refusals to ensure that access to services is not obstructed.

THREE COMMON LIMITATIONS ON RELIGIOUS REFUSALS

1. Limits on the types of individuals that can invoke religious refusals — from health care providers directly involved in the particular services, to others more tangentially involved

2. Limits on whether an institution can invoke a religious refusal on behalf of all employees, such that no one employed by the institution can provide the particular service

3. Limits on whether religious refusal can be invoked in circumstances where the patient is experiencing an emergency, such that their health or life is in danger

a. Individual Subjects

Aligning with recommendations from various UN special procedures and treaty-monitoring bodies, the Working Group stressed that "any human rights-based approach for States wishing to permit the exercise of conscientious objection requires narrowly defining individual health-care providers' ability to invoke conscientious objection."[58] The UN Special Rapporteur on the Right to Health has stated that "conscientious objection laws create barriers to access by permitting health-care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion care, information about procedures and referrals to alternative facilities and providers."[59] The UN Special Rapporteur on the Right to Health has thus recommended that States "[e]nsure that conscientious objection exemptions are well-defined in scope and well-regulated in use."[60] Where religious refusals are allowed, they should be limited to providers directly involved in the service to help preserve access to sexual and reproductive health care.

In the **United States**, at the federal level, the Church Amendments establish that:

> "No individual shall be required to perform or assist in the performance of any part of a health service program or research activity funded in whole or in part under a program administered by the Secretary of Health and Human Services if his performance or assistance in the performance of such part of such program or activity would be contrary to his religious beliefs or moral convictions."[61]

Since the early 2000s, the types of individual health care providers protected under the Church Amendments have depended on rulemaking by the Department of Health and Human Services (HHS). For example, under the Trump administration in 2019, HHS expanded the scope of people protected under the statute by defining "assist in the performance" as taking an action "that has a specific, reasonable and articulable connection to furthering a procedure."[62] This broadened definition extended beyond those who directly participate to encompass those carrying out other activities, such as providing information, scheduling services, or cleaning tools related to procedures like abortion.[63] Notably, three federal district courts struck down the 2019 rule, and in 2024, the Biden administration implemented a new rule that essentially restored the narrower scope of people protected under federal conscience laws. However, it remains unclear whether the second Trump administration will attempt to alter the rule once again.[64]

At the state level, among the **45 states** with laws that allow religious refusals to provide abortion, **42** of them explicitly allow persons who are not medical providers to refuse to participate in an abortion.[65]

At the country level, there is variation among the laws that limit individuals' ability to exercise religious refusals. The Working Group noted in their report that only nine countries explicitly restrict religious refusals to those who are directly involved in abortion. Comparatively, 41 countries allow any health care provider to invoke a religious refusal to abortion, without consideration to their proximity or level of involvement in the service.[66] In some settings, religious refusals are invoked by those beyond health care providers, such as administrative personnel or judges.

For example, in **Argentina**, Law No. 27.610, which came into force in January 2021, stipulates that only health professionals who intervene directly in the interruption of pregnancy have the right to exercise religious refusal.[67] Under the law, exercising religious refusal should be explicit and timely and does not cover professionals that participate in preparatory or post-abortion care.



Courts have played a crucial role in establishing the scope of religious refusals. For example, in **Colombia**, its approach has not been legislative but rather through several rulings from the Constitutional Court (decisions C-355 (2006),[68] T-209 (2008),[69] T-946 (2008),[70] and T-388 (2009)).[71] These various decisions have established a number of key principles surrounding religious refusals. In 2009, the Court recognized the right to conscientious objection and that it is possible to exercise it against the practice of providing abortion care.[72] To strike a balance with reproductive and other rights, the Court limited who can exercise the right of conscientious objection: only the persons directly involved in the procedure are entitled to this right; as a result, personnel who perform administrative functions cannot be objectors, nor "whoever or whoever carries out the medical activities preparatory to the intervention" nor "whoever or whoever is in charge of the activities subsequent to the intervention."[73] In addition, these decisions excluded judicial officers from being able to exercise conscientious objection, since their sole function is to resolve the issues presented to them by applying the legal framework and not their own conscience.[74]

By limiting religious refusals to those directly involved in providing abortion care and excluding administrative personnel, judges, and others, Colombia's Constitutional Court sought a balanced approach for health care systems to accommodate both providers' objections and patients' access to legal care. While the Court's guidelines have not been codified into law, they have been encompassed in various resolutions, guidelines, and protocols surrounding abortion.[75] Further, in its 2011 report, "Access to Information on Reproductive Health from a Human Rights Perspective," the IACHR acknowledged several important factors from Colombia's decisions, including that religious refusals apply only to direct providers and not to administrative personnel.[76] Such limitations are essential in ensuring that religious refusals do not "constitute a mechanism for discrimination and the violation of women's fundamental rights."[77]



In **Mexico**, a 2018 amendment to the General Health Law explicitly introduced religious refusals in the health care context to the federal legal framework. This amendment introduced article 10bis, which broadly established the right of "medical and nursing" personnel to "exercise the conscientious objection" and excuse themselves of participating in the "provision of the services established" in the General Health Law.[78] Subsequently, in 2021, the Supreme Court issued a ruling that declared this amendment invalid. In its decision, the Court considered that article 10bis "hinder[ed] the availability of the right to health"[79] and that the

unlimited use of conscientious objection carries a high risk to sexual and reproductive rights.[80] As a result, the Mexican Supreme Court invalidated Article 10bis and urged the federal Congress to regulate religious refusals "urgently and with priority."[81]

At the same time, the Court listed several guidelines that for the federal legislature to consider when regulating religious refusals in the health legal framework, such as only health care professionals who are directly participating in the health care procedure should be able to raise a religious refusal claim.[82] While Congress has yet to adopt a new framework[e] for religious refusals, some Mexican states have adopted the Court's guidelines.[f]



In May 2023, **Spain's** Constitutional Court issued a decision interpreting the country's abortion law, which allows for abortion through the 14th week — specifically its provision on religious refusal available to "health care providers directly involved in voluntary termination of pregnancy."[83] While the Court upheld a right to religious refusal, the Court strictly interpreted it. While the Court upheld a right to religious refusal, the Court strictly interpreted it. The Court stated:

"The only actions that can be exempted from the legal duty because they are covered by conscientious objection are direct clinical interventions, not other auxiliary, administrative or instrumental support actions carried out by professionals who, moreover, do not need to know the nature and circumstances of the clinical intervention in question. It is precisely with regard to these direct clinical interventions that it should be noted that there may be situations of emotional conflict (due to ideological or moral convictions) that justify the health professional's withdrawal from an intervention that is, in general, a legal imperative. Beyond these cases, conscientious objection would not only lack a constitutional basis, but would also put at extreme risk the effectiveness of the healthcare provision under consideration."[84]

Alternatively, some countries' laws explicitly allow those beyond direct providers to exercise religious refusals. For example, in **Chile**, Article 119 of the Health Code regulates religious refusals in the context of voluntary termination of pregnancy.[85] This legal provision establishes that "the surgeon required to terminate a pregnancy," as well as "other personnel responsible for performing their duties within the operating room during the intervention," can refrain from carrying out their duties if they express their conscientious objection in advance.[86]

b. Institutional Subjects

Various federal statutes protect institutional religious refusals in the **United States**. The Church Amendments (1974) prohibit public officials and authorities from requiring recipients of certain federal funding, including individuals and hospitals, to provide or make their facilities available for abortion or sterilization when the recipient has a religious or moral objection. They also forbid relevant hospitals from conditioning employment on whether a provider is willing to provide an abortion or sterilization. The Coates-Snow Amendment (1996) provides that the federal government and any state or local government that receives federal funding cannot subject "any health care entity" to discrimination on the basis that the entity refuses "to undergo training in the performance of induced abortions, to require or provide such training, to perform such abortions, or to provide referrals for such training or such abortions."[87] The Weldon Amendment (2005) requires that no HHS appropriation funds be made available to federal agencies or programs, or state or local governments that discriminate against any institutions or individuals based on refusal to provide, pay for, provide coverage of, or refer for abortions.[88]

At the state level, **41 states** have laws that explicitly allow a medical institution to refuse to participate in abortion.[89] Further, a 2024 report on Catholic hospitals found that **35 states** provide liability shields to hospitals, meaning that patients harmed by the hospital's refusal to provide abortion cannot sue the hospital under state law, despite the fact that abortion remains broadly legal in **25** of those states.[90] **Sixteen states** prohibit lawsuits against hospitals for refusing to perform sterilizations.[91]

e Although the Chamber of Deputies approved reforms to the General Health Law regarding conscientious objection in October 2023, the legislative process remains unfinished, with the initiative currently pending in the Senate.

f Some states that have provisions on conscientious objection in their local health law are Baja California, Baja California Sur, Colima, Ciudad de Mexico, Hidalgo, Jalisco, and Sinaloa.

Notably, institutional refusals are common in the United States, even beyond Catholic hospitals. For example, a 2021 report characterized strict limits on providing abortion as "ubiquitous" at Baptist hospitals and Protestant-affiliated facilities in southern states.[92] Even where hospitals and facilities are no longer owned by religious institutions, they have frequently retained religion-derived policies (e.g., refusals to provide abortion) for various reasons, including rules on how board of trustee members and others in positions of authority are nominated. Furthermore, religious institutions have also expanded their reach by requiring physicians in group and private practices to abide by institutional religious restrictions to be part of their larger health systems.

Drawing from case law and academic literature, scholars have synthesized six reasons why religious refusals should not be allowed at the institutional level, encompassing human rights as well as ethical justifications:

1. Institutions lack a conscience
2. Institutional religious refusals undermine access to health services
3. Institutional religious refusals undermine individuals' moral agency
4. Institutional religious refusals violate the rights of health care personnel
5. The nature of religious refusals are tied to a procedure performed by an individual, not by an institution
6. Institutions have assumed obligations by offering health services, to which religious refusals run contrary[93]

There is widespread agreement across human rights bodies that religious refusals must be limited to individuals based on their personal, deeply held convictions — and not afforded at the collective or institutional level. The Working Group states that institutional conscientious objection must be impermissible, noting how it "may undermine the goals of public funding, adversely impacts patient well-being, compromises medical professionalism and can be used to discriminate against patients," and that it also "significantly restrict[s] the availability of abortion services on a broader scale, constituting a systemic denial of the right to equality and sexual and reproductive health rights."[94]

Regional human rights bodies affirm this limitation. The African Commission on Human and Peoples' Rights has provided that religious refusals apply to providers directly involved, not to institutions.[95] The Inter-American Commission on Human Rights has stated that religious refusals are "an individual, not an institutional or collective, decision."[96] The European Committee of Social Rights has recognized how institutional conscientious objection constrains individual providers' freedom of conscience of within the objecting institution, forcing them to align with the objection even against their own moral convictions, which can ultimately result in discriminatory treatment.[97]

Eighty-three out of the 87 countries with laws recognizing religious refusals prohibit institutions from exercising it.[98] For example, in **Argentina**, under Law No. 27.610 and a 2021 Protocol for Comprehensive Care for People with the Right to Interrupt their Pregnancy from the Minister of Health, institutions in both the private and public sectors must be able to provide abortions; religious refusals cannot be exercised at the institutional level.[99] If an institution does not have professionals to carry out an abortion due to the individual right of conscientious objection being exercised, it must anticipate and arrange a referral to a similarly-qualified health provider that provide the service. The country's law further establishes that the costs associated with the transfer should be covered by the referring institution.[100]

At the judicial level, the high court decisions from **Colombia** and **Mexico** also restrict institutional religious refusals. In its 2009 decision, Colombia's Constitutional Court provided that "[t]he human right to respect for conscience is a right enjoyed by natural human beings, but not by institutions such as hospitals," thus forbidding institutional religious refusals.[101] In the 2021 decision from Mexico's Supreme Court, the guidelines stipulated that "[t]he right to conscientiously object is personal, and no institutional CO can be invoked by health care institutions."[102]

Aside from the United States, only three countries – **Chile**, **France**, and **Uruguay** – explicitly allow for religious refusals at the institution level.

For example, in **Uruguay**, the scope of religious refusals is regulated by Law 18.987 and Regulatory Decree 375/2012. The law recognizes an individual right to "conscientious objection" and a collective right to "ideological objection," which encompasses the right of private medical institutions to raise institutional objections and refuse abortion care.[103] The law fails to impose any limits on its exercise, accountability mechanisms, or measures to ensure the adequate provision of the services in cases of institutional objections.[104] The CEDAW Committee in both 2016 and 2023 has recognized the barriers to abortion arising from Uruguay's lack of limits on religious refusals, particularly in rural or remote areas.[105]

In **Chile,** Law No. 21.030 established the legal framework permitting religious refusals to abortion by private institutions.[106] However, the original bill approved by Congress included an express clause prohibiting institutional conscientious objection. In 2017, the Constitutional Court modified the text approved by Congress, removing the phrase "in no case" from the original language of "in no case [religious refusal] may be invoked by an institution."[107] This amendment resulted in the broad legalization of institutional religious refusals in Chile. The Ministry of Health subsequently issued a regulation that prohibited public institutions, as well as private institutions that receive public funding to provide obstetric and gynecologic services, from exercising religious refusals.[g] However, in 2019, the Constitutional Court declared the restriction on private institutions unconstitutional, thus enabling all private institutions — including those that receive public funding — to exercise religious refusals.[108]

The Working Group addresses the issue of private hospitals and institutional refusals in their report, stating that, "[p]rivate hospitals often receive public funding and may be the only providers of health services in certain areas. The partial or total privatization of public services does not exempt the State from its international legal obligation to ensure non-discriminatory access to health-care services. States must prohibit the practice of institutional conscientious objection (including de facto institutional conscientious objection), to comply with their obligations to ensure equal access to health services."[109]

In many countries, "de facto" institutional refusals have become pervasive, even where national laws prohibit institutions from refusing to provide abortion based on an institution's asserted religious beliefs.[110] This is especially prevalent in private faith-based or religious hospitals that continue to assert the refusal at the institutional level despite a law prohibiting it, or engage in hiring practices that result in high numbers of individual employees seeking refusals. Even in jurisdictions where hospitals are under a legal obligation to ensure a sufficient number of willing providers, additional challenges remain, such as claims of religious discrimination in hiring.[111]

c. Circumstances

In the **United States**, among the **45 states** with laws permitting individuals to exercise religious refusals in abortion care, only **nine** carve out an exception for medical emergencies. Of those **nine states**, exceptions extend to only life endangerment in **four states**, serious health risks in **four states**, and any health risk in **one state**.[112] Among the **41 states** with laws permitting religious refusals for abortion at the institutional level, only **three** include an exception for life endangerment and five include an exception for serious health risks.[113]

At the federal level, the Emergency Medical Treatment and Active Labor Act (EMTALA) arguably limits religious refusals for obstetric care in cases of a medical emergency. EMTALA requires participating emergency rooms to provide stabilizing care, including abortion, to patients during obstetric emergencies. However, the particular state's civil liability law may limit EMTALA by immunizing the institution from liability in cases of religious refusal.[114] Moreover, the Trump administration dismissed a lawsuit brought by the Biden administration challenging Idaho's broad abortion ban as a violation of EMTALA, given that it lacked a health exception — signaling that the Trump administration will not enforce EMTALA in cases where abortion constitutes necessary stabilizing care.[115] Many scholars view EMTALA a well-established exception to federal protections for religious refusals; however, whether courts will uphold this interpretation is currently unclear.[116] How courts rule in a similar, pending lawsuit brought by a private health care system may be instructive.[117]

Globally, there is also broad consensus that religious refusals to sexual and reproductive health care should not be available under circumstances where the patient is in a medical emergency, such that their life or health would be jeopardized if they do not receive that care. Notably, the Human Rights Committee has made clear that measures regulating the voluntary termination of pregnancy must not violate the right to life of the pregnant person.[118] Under circumstances where "the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering," States are obligated to provide access to safe and legal abortion; conscientious objection must not impose a barrier to care in these circumstances.[119]

Similarly, the ESCR Committee has stated that "States must appropriately regulate [religious refusals] to ensure that … it does not inhibit the performance of services in urgent or emergency situations."[120] At the regional level, the African Commission provides that "the right to conscientious objection "cannot be invoked in the case of a woman whose health is in a serious risk, and whose condition requires emergency care or treatment."[121] FIGO further recommends, and the Working Group affirms, that States "[t]rain and sensitize providers about

g Decree with the Force of Law No. 36 of 1980 applies to agreements where a private organization, entity, or individual replaces the public health system in carrying out health care-related tasks, such as health promotion, protection, recovery, or patient rehabilitation. These agreements allow private institutions to act on behalf of the State to provide care to public health beneficiaries. Since these institutions are fulfilling a public function, they must comply with the same obligation as public health care providers and cannot deny services based on religious beliefs. The logic was that, since these private institutions were contracted to replace the Health Service in providing care to public health beneficiaries, they were subject to the same rules as public institutions and could not invoke conscientious objection.

their obligations, including the duty to render care in emergency situations and post-abortion care."[122]

The Working Group recommends that, "States should … clarify that conscientious objection will not be permitted in emergency situations."[123] The restriction on religious refusals should be expressly provided; it is not enough to rely on the general duties to care for patients during emergencies to meet human rights obligations.

At the country level, prohibiting religious refusals in cases of medical emergencies is the most common type of limitation, with one study finding that 57 countries include this limitation.[124] The Working Group pointed to another study that found that only 21 countries directly stipulate that providers must provide abortion in medical emergencies where the life of the pregnant person is threatened. Thus, despite being the most common restriction, there are many variations and gaps across countries' laws.[125]

Among countries with express limits on religious refusals during medical emergencies, **Zambia**'s Termination of Pregnancy Act states that "no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection."[126] However, this provision shall not "affect any duty to participate in any treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman."[127]

In **Costa Rica**, the Executive Decree Nº 42113-S on the "Officialized Technical Norm for the Medical Procedure Linked to Section 121 of the Criminal Code" stipulates that, "[i]n cases of obstetric emergencies, [religious refusal] cannot be invoked when there is only one available objecting health care professional in the health care institution, since the paramount interest is that of protecting the life of the woman."[128] Similarly, in **Colombia**, the Protocol for the prevention of unsafe abortion provides that, in emergency situations, in which there is imminent danger to the woman's life and there is only one service provider, conscientious objection cannot be claimed; the service must be provided in compliance with the ultimate obligation to protect the woman's fundamental rights.[129]

In its 2021 decision, the **Mexican** Supreme Court established that "[a conscientious objection] claim cannot be invoked when the life or health of a patient is at risk, or when its exercise implies a disproportionate burden for patients."[130] Further, conscientious objection cannot be used to delay or hinder the provision of health care services.[131]

As outliers to global trends, two countries — the **Philippines** and **Poland** — have rolled back limitations on the exercise of religious refusals in the context of emergencies. In 2018, the Philippines' Department of Health repealed a 2016 prohibition on health care providers from exercising conscientious objection to denying post-abortion care to women experiencing medical emergencies.[132] In Poland in 2015, the Constitutional Court invalidated a provision that required a physician invoking a religious refusal to provide viable alternative options for the patient to access abortion care.[133] In the process, the Court eliminated the requirement that objectors ensure patients' access to abortion in cases of life-threatening emergencies.[134] In 2024, the CEDAW Committee recommended that Poland reintroduce the obligation that objectors refer patients to alternative health providers and ensure "effective, timely and accessible" abortion care.[135]

6. Obligations Related to Exercise of Religious Refusals

The Working Group emphasizes that "any recognized approach to conscientious objection is conditional on the State's ability to protect the rights of others, specifically women and girls seeking to access sexual and reproductive health services."[136] Imposing legal obligations on those seeking religious refusals is necessary for States to preserve access to sexual and reproductive health care.

THREE COMMON OBLIGATIONS RELATED TO RELIGIOUS REFUSALS

1. Referral requirements, such that the objecting provider must refer the patient to a willing provider who can give timely and adequate care

2. Presentation/registration requirements, such that those seeking to exercise religious refusal must present their refusal in a specified manner and, in some cases, be entered into a database maintained by their institution

3. Adequate services, such that health care institutions must have the capacity to provide adequate services even where certain providers may exercise religious refusals at the individual level

a. Referral

In the **United States**, only **two states** (Illinois and Louisiana) have referral requirements in cases where an individual provider exercises religious refusal to provide abortion.[137] Illinois also requires referral in cases of institutional refusal.[138] There is no referral requirement at the federal level; in fact, both the Coates-Snow and Weldon Amendments prohibit recipients of certain federal funds from requiring referrals for abortion care. However, the lack of federal definition for "referral" enables states to establish certain requirements to help patients access abortion care in cases of religious refusal (as mentioned above). Notably, the proposed 2019 rule, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority — finalized by the Trump administration but struck down by courts — would have set a broad definition for referral as the "provision of information in oral, written, or electronic form (including names, addresses, phone numbers, email or web addresses, directions, instructions, descriptions, or other information resources)."[139] Notably, this definition could encompass the provision of accurate and unbiased information by providers to patients regarding their pregnancy options.[140]

At the international level, the ESCR Committee has stated that States' human rights obligations surrounding religious refusals include "requiring referrals to an accessible provider capable of and willing to provide the services being sought."[141] The Working Group provides that,"[s]tate-sanctioned refusals to provide abortion services based on conscientious objection must be contingent on the provision of timely referrals, ensuring that access is not compromised by delays or denials."[142] This recommendation comes in light of concerning trends where religious refusals have been used to deny the sharing of information on abortion care, even in cases where abortion was necessary to save the life of the pregnant person.

Still, the Working Group has highlighted how "many existing referral mechanisms have posed additional barriers to accessing timely care, often requiring patients to navigate a 'circuitous and burdensome' referral process."[143] The resulting delays and difficulties can push people past the legal limit for abortion care where they live or later into the pregnancy than they had desired, which can be accompanied by increased cost and risk of complications. The UN Special Rapporteur on the Right to Health has further highlighted how, even where referrals are required under religious refusal laws, marginalized women, such as low-income, young, and displaced women, face greater difficulties in accessing referrals.[144] In light of these concerns, the Working Group recommends that States clarify that religious refusals are only permissible when followed by an effective referral — and access — to an alternative provider.[145]

At the regional level, the European Court of Human Rights in *P. and S. v. Poland* (2012) required **Poland** to balance providers' right to religious refusals with patients' right to access 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."[146] In its 2011 report, the IACHR stated that, if a conscientious objection is raised, the patient must be referred to another professional who is willing and able to provide the services the patient is seeking,[147] with States required to "establish referral procedures, as well as appropriate sanctions for failure to comply with their obligation."[148]

Referral requirements are the second most common type of regulation on religious refusals, with 33 countries imposing a duty on the objecting provider to refer the patient seeking abortion care to another provider.[149]

In **Argentina**, Law No. 27.610 and the 2021 Protocol for Comprehensive Care for people with the Right to Interrupt their Pregnancy from the Minister of Health establish that religious refusals must always be governed by the principles of good faith and non-obstruction.[150] According to the Protocol, these principles require professionals to:

1. Deliver all the necessary information about the interruption of the pregnancy and about the referral and avoiding re-victimization, blaming or signaling
2. Refer to a professional who is trained, available, and able to carry out the practice in reasonable time
3. Make all the arrangements so that the intervention effectively takes place and is carried out by the professional to whom the pregnant person was referred

According to the Constitutional Court of **Colombia**, women denied abortion services on grounds of conscience must be referred to physicians willing and able to provide such care.[151] 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. In its 2011 report, the IACHR affirmed this obligation of immediate referral, so that the refusal does not impose a barrier to one's access to health care services.[152]

Similarly, in its 2021 decision, **Mexico's** Supreme Court found that religious refusals could not serve as a restriction on the right to health and "can never result in the denial of health services to people who come to health institutions."[153] Thus, the Court held that, if a health care professional invokes a religious refusal, they must continue to inform the patient of the medical options available to them and immediately refer the patient to a non-objecting provider.[154]

In a 2021 case in **New Zealand**, the High Court examined recent abortion legislation that requires a health provider seeking to invoke a religious refusal to inform the patient of the objection at the earliest opportunity, and to provide information on "how to access the contact details of another person who is the closest provider of the service requested."[155] The law further provides that determining the "closest provider" must take into account the physical distance to the provider, the date and time, and the operating hours for the requested service. The High Court upheld these obligations, finding that the duty to inform the patient is rationally related to the objective of facilitating access to abortion in a timely way when delays can result in health risks, costs, and stress for the pregnant person.[156]

Further, the Court found that an obligation to refer is the "quid pro quo" of the right to conscientiously object at all.[157] To the extent that referral requires participation in the abortion procedure, the Court regarded such participation as so minimal and remote as to only minimally affect the right to conscientious objection.[158] The Court also acknowledged that, while some women seeking abortion may not need a referral because they can "self-refer" using their own knowledge, skills, or resources, others — particularly young women — may not have the means to navigate the health system on their own.[159] The Court therefore found the obligations to inform and refer the patient to be duly justified.[160]

Despite a trend in increasing referral requirements among countries with religious refusal laws, some countries have moved in the opposite direction. For example, as discussed above, in 2015, the Constitutional Court of **Poland** struck down a requirement on providers invoking a religious refusal to refer patients seeking abortion to another provider who would be willing and able to provide the service.[161] This erosion of protection for sexual and reproductive health rights operates as part of a restrictive framework where stigma and fear of prosecution has led high numbers of providers to seek religious refusals — resulting in "abortion-free" zones and high barriers to care, especially for the most socioeconomically disadvantaged.[162]

b. Registration, Presentation, and Notification Requirements

In the **United States**, only **two states** (Illinois and Louisiana) have patient notification requirements in cases where an individual provider exercises religious refusal to provide abortion.[163] Among the states that permit institutional religious refusals, only **six states** require patient notification of the institutional refusal.[164] Some states require additional or alternate resources be provided to the patient in cases in a refusal, whether the refusal is by a non-medical provider (Illinois) or an institution (Illinois and New York).[165] However, even these obligations to provide patients with additional or alternative resources can be fairly minimal.

Globally, many jurisdictions that allow religious refusals to sexual and reproductive health care impose a legal obligation on the objecting provider to present and document their objection in a specified manner. Doing so helps ensure that the patient is adequately informed of the objection so that they can receive services elsewhere, and that the larger institution is informed of the objection so that they can properly accommodate patients' needs. The Working Group emphasizes that "States must create and invest in systems capable of monitoring the use of conscientious objection routinely and preventing abuse of it."[166] The CEDAW Committee has recommended that Uruguay, in particular, "[t]ake measures to ensure that women have access to legal abortion and post-abortion services and introduce stricter justification requirements to prevent the blanket use by medical practitioners of their right to conscientious objection to performing an abortion."[167]

At the regional level, the European Court of Human Rights has mandated that religious refusals to abortion be submitted in writing and included in a patients' medical record.[168] The IACHR has also found that conscientious objection to sexual and reproductive health services applies when it truly involves a religious conviction that is properly reasoned and submitted in writing (mirroring Colombia's guidelines as described below).[169]

At the country level, 29 countries impose a duty on objecting providers to inform the patient about the objection.[170] Many also require that objectors inform authorities at the institution where they work. For example, the guidelines from **Colombia**'s Constitutional Court in its 2008 and 2009 decisions (as discussed above) note that the objection must be stated in writing, in part to help ensure that only "true" conscientious objections be permitted.[171] As for its content, the objection must include "the reasons why it is against the provider's deepest convictions to perform the procedure to terminate the pregnancy in that specific case, … general collective forms or those made by a person other than the person exercising the conscientious objection will not be valid."[172] The objecting provider must present concrete reasons for objecting for each particular case.

Other countries go beyond the individual written requirement to require a registry of conscience objections. For example, **Spain**'s 2023 amendments to the Organic Law 2/2010 on sexual and reproductive health and the voluntary interruption of pregnancy, which requires providers to submit religious refusals in advance and in writing, also requires creation of "a registry of health professionals who decide to object for reasons of conscience to direct intervention in the practice of voluntary termination of pregnancy."[173] Health professionals that declare themselves as objectors to abortion must remain so for both public and private health care. Organizations are further required to adopt measures to guarantee non-discrimination for both objecting and non-objecting providers.[174]

In 2023, Spain's Constitutional Court weighed a challenge to this provision and concluded that these obligations imposed on conscientious objection are constitutional, as they adequately balance the rights of health professionals with the woman's right to access these services.[175] Further, requiring providers to make objections "in advance" and "in writing" were held to be "reasonable and proportionate conditions for exercising the right, which do not in themselves violate article 16 (2) (Spain's Constitutional provision providing for the freedom of ideology, religion or beliefs)."[176]

c. Adequate Services at the Institutional Level

The third common obligation is adequate services, which requires health care institutions to have the capacity to provide adequate services even where certain providers may exercise religious refusals at the individual level. Federal law in the **United States** fails to explicitly provide for institutional obligations to ensure patients' access to services in cases of religious refusals.

At the regional human rights level, in *R.R. v. Poland* (2011), the European Court of Human Rights held that "[s]tates 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."[177] Even where other procedural safeguards are in place, regional human rights bodies have recognized that high numbers of objecting providers can result in human rights violations, thus imposing certain obligations on States.[178] In *IPPF EN v. Italy* (2012), the European Committee of Social Rights considered how the widespread use of religious refusals resulted in inaccessibility to abortion, which violated the right to health under the European Social Charter.[179] The European Committee held that Italy was required to ensure a sufficient number of willing abortion providers under Italian law.

One study found that, while only 23 countries have an institutional safeguard included within their religious refusal laws, there has been an increasing trend among countries toward including these safeguards over the last decade.[180] These safeguards include a guaranteed number of health professionals not claiming a religious refusal and the requirement for health institutions to have an updated registry of professionals willing to offer abortion care.

For example, in **Norway**, the law places a duty on health care institutions to ensure access to abortion within the first 12 weeks of pregnancy.[181] Public hospitals are required to provide abortion care; the fact that several individuals may have invoked religious refusals does not justify breaching this duty.

In **Argentina**, under Law No. 27.610 and a 2021 Protocol for Comprehensive Care for People with the Right to Interrupt their Pregnancy from the Minister of Health, if an institution does not have professionals to carry out an abortion due to the exercise of the individual right of conscientious objection, it must anticipate and arrange a referral to a similarly-qualified health provider that provide the service.[182] The law further establishes the referring institution must cover the costs associated with the transfer.

In 2021, **Mexico**'s Supreme Court held that, at all times, health care institutions should have professionals who are not conscientious objectors and are available and willing to provide health care services.[183] Similarly, **Colombia**'s Constitutional Court has held that the Social Security Health System must guarantee an adequate number of providers authorized to provide termination of pregnancy services.[184] These requirements help ensure that religious refusals do not lead to discrimination and violation of one's fundamental rights.

7. Toolkit for Strengthening the Regulation of Religious Refusals in the United States

The United States remains an outlier when it comes to the broad protections afforded to both individuals and institutions that refuse to provide sexual and reproductive health services — particularly abortion care — for religious reasons. As state lawmakers in the United States explore opportunities to remove barriers and improve access to abortion care, they can look to the standards established by human rights bodies and international organizations, as well as the approaches taken by decision-makers around the world.

a. Policy Proposals

1. Limit **individual** religious refusals to providers directly involved in the service and explicitly exclude those involved in auxiliary, administrative, or instrumental support from religious refusals protections
2. Prohibit or limit the exercise of **institutional** religious refusals
3. Prohibit religious refusals in **urgent or emergency** situations
4. Require prompt **referrals** to accessible non-objecting providers
5. Effectively regulate the **presentation and documentation** of religious refusals, including by requiring objecting providers to present and document their objection in a specified manner (e.g., in writing, in a database, in a patient's medical record, etc.)
6. Organize health institutions and systems to ensure that **sufficient non-objecting providers** are hired and are distributed fairly across the state

b. Additional Resources

UN Working Group on Discrimination Against Women and Girls, *Conscientious objection to abortion: key considerations* (July 30, 2024).

Agustina Ramón Michel & Dana Repka, *Global Map of Conscientious Objection to Abortion* (REDAAS 2024).

Human Rights Watch et al, Conscientious Objection: International Human Rights Standards in Reproductive Health Care (October 2025).

Movement Advancement Project and National Center for Transgender Equality, *Religious Refusals in Health Care: A Prescription for Disaster* (March 2018).

National Women's Law Center, *Refusals to Provide Health Care Threaten the Health and Lives of Patients Nationwide* (2020).

US Department of Health and Human Services, *Your Protections Against Discrimination Based on Conscience and Religion.*

Law Atlas, *Procedural Protections in Reproductive Health Care Conscience Laws.*

Catholics for Choice, Lawful Discrimination: The Abuses of Religious Freedom in U.S. Healthcare (2021).

Endnotes

1 United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* (6th ed. 2018), https://www.usccb.org/resources/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06_0.pdf.

2 United States Conference of Catholic Bishops, *Doctrinal Note on the Moral Limits to Technological Manipulation of the Human Body* (Mar. 20, 2023), https://www.usccb.org/resources/Doctrinal%20Note%202023-03-20.pdf.

3 Church Amendments, 42 U.S.C. § 300a-7; Coats-Snowe Amendment, 42 U.S. Code § 238n; Weldon Amendment, originally adopted as section 508(d) of the Labor-HHS Division (Division F) of the 2005 Consolidated Appropriations Act, Public Law 108-447, 118 Stat. 2809, 3163 (Dec. 8, 2004); Alexandra Brown et al., *Religious Exemptions*, 22 Geo. J. Gender & L. 335, 358 (2021), https://www.law.georgetown.edu/gender-journal/wp-content/uploads/sites/20/2021/08/Religious-Exemptions-2021.pdf.

4 Guttmacher Institute, *Refusing to Provide Health Services* (Mar. 6, 2025), https://www.guttmacher.org/state-policy/explore/refusing-provide-health-services.

5 UN Office of the High Commissioner for Human Rights, *Conscientious Objection to Military Service*, UN Doc. HR/PUB/12/1, 1 (2012), https://www.ohchr.org/sites/default/files/Documents/Publications/ConscientiousObjection_en.pdf.

6 *Id.*

7 International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 UNT.S. 171.

8 Center for Reproductive Rights, *Conscientious Objection and Reproductive Rights: International Human Rights Standards* (July 2013), https://reproductiverights.org/sites/crr.civicactions.net/files/documents/_Conscientious_FS_Intro_English_FINAL.pdf.

9 Christian Fiala & Joyce H. Arthur, *There is no defense for 'Conscientious objection' in reproductive health care*, 216 Eur. J. Obstet. Gynecol. & Reprod. Biol. 254 (2017), https://pubmed.ncbi.nlm.nih.gov/28757115/#:~:text=In%20response%2C%20many%20recommendations%20have,Dishonourable%20disobedience;%20Reproductive%20health%20care.

10 Nancy Berlinger, *Conscience Clauses, Health Care Providers, and Parents*, Hastings Ctr. (June 30, 2023), https://www.thehastingscenter.org/briefingbook/conscience-clauses-health-care-providers-and-parents/#:~:text=Conscientious%20objection%20in%20health%20care,access%20or%20decision%2Dmaking%20rights.

11 World Health Organization, *Abortion Care Guideline* (2022), https://www.who.int/publications/i/item/9789240039483.

12 *Id.*

13 International Federation of Gynecology and Obstetrics, *Ethics and Professionalism Guidelines for Obstetrics and Gynecology* (2d ed. 2021), https://www.figo.org/sites/default/files/2021-11/FIGO-Ethics-Guidelines-onlinePDF.pdf.

14 *Id.*

15 International Federation of Gynecology and Obstetrics, *Conscientious Objection: A Barrier to Care* (Oct. 19, 2021), https://www.figo.org/resources/figo-statements/conscientious-objection-barrier-care.

16 Isa Ryan, Ashish Premkumar & Katie Watson, *Why the Post-Roe Era Requires Protecting Conscientious Provision as We Protect Conscientious Refusal in Health Care*, 24 AMA J. Ethics 906 (2022), https://journalofethics.ama-assn.org/article/why-post-roe-era-requires-protecting-conscientious-provision-we-protect-conscientious-refusal-health/2022-09.

17 Nancy Berlinger, *supra note* 10.; Mark R. Wicclair, *Managing Conscientious Objection in Health Care Institutions*, 26 HEC Forum 267 (2014), https://redaas.org.ar/wp-content/uploads/Managing_co_in_health_care_institutions.pdf.

18 Nancy Berlinger, *supra note* 10.

19 Bronwen Merner et al., *Institutional Objection to Abortion: A Mixed-Methods Narrative Review*, 19 Women's Health 1 (2023), https://www.sciencedirect.com/science/article/abs/pii/S1521693417300044#:~:text=The%20stigma%20attached%20to%20abortion,1%5D%2C%20*%5B2%5D.

20 *Id.*

21 Anibal Faúndes & Laura Miranda, *Ethics Surrounding the Provision of Abortion Care*, 43 Best Prac. & Res. Clin. Obstetrics & Gynaecology 50 (2017), https://www.sciencedirect.com/science/article/abs/pii/S1521693417300044#:~:text=The%20stigma%20attached%20to%20abortion,1%5D%2C%20*%5B2%5D.

22 Bronwen Merner et al., *supra* note 19.

23 Lori Freedman, Debra Stulberg, & Elizabeth R. Platt, *Not Here or There: How Catholic Hospital Abortion Bans Interact with State Bans*, 28 J. Health Care L. & Pol'y (2025), https://digitalcommons.law.umaryland.edu/jhclp/vol28/iss2/4.

24 Agustina Ramón Michel & Dana Repka, *Global Map of Conscientious Objection to Abortion* (REDAAS 2024), https://redaas.org.ar/wp-content/uploads/Global-map-of-co-to-abortion-2024-update.pdf.

25 *Id.*

26 CS/S.B. 1580, 2023 Leg., Reg. Sess. (Fla. 2023), https://www.flsenate.gov/Session/Bill/2023/1580/BillText/er/PDF; H.B. 303, 68th Leg., Reg. Sess. (Mont. 2023), https://archive.legmt.gov/bills/2023/billhtml/HB0303.htm.

27 A conscience-based exception is broadly defined as an *"objection based on a sincerely held religious, moral, or ethical belief."* CS/S.B. 1580, *supra note* 26.

28 Agustina Ramón Michel & Dana Repka, *supra* note 24.

29 *Id.*

30 *Id.*

31 LawAtlas, "Refusal to Perform Abortions," November 1, 2022. https://lawatlas.org/datasets/refusal-to-perform-abortions?g3=6628/.

32 Agustina Ramón Michel & Dana Repka, *supra* note 24.

33 LawAtlas, *supra* note 31.

34 Agustina Ramón Michel & Dana Repka, *supra* note 24.

35 LawAtlas, *supra* note 31.

36 Agustina Ramón Michel & Dana Repka, *supra* note 24.

37 International Covenant on Civil and Political Rights, *supra* note 7.

38 Human Rights Committee, General Comment No. 22, Article 18, UN Doc. HRI/GEN/1/Rev.1, ¶ 1 (1994).

39 *Id.* at ¶ 3.

40 *Id.*

41 Committee on the Elimination of Discrimination against Women, General Recommendation No. 24: Article 12 of the Convention (Women and Health). UN Doc. A/54/38/Rev.1, ¶ 11 (1999).

42 *See,* Committee on the Elimination of Discrimination against Women, Concluding observations on the tenth periodic report of Uruguay, UN Doc. CEDAW/C/URY/CO/10 (2023).; Committee on the Elimination of Discrimination against Women, Concluding observations on the combined eighth and ninth periodic reports of Uruguay, UN Doc. CEDAW/C/URY/CO/8-9 (2016).

43 Committee on the Rights of the Child, General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24). UN Doc. CRC/C/GC/15 (2013).

44 Committee on Economic, Social and Cultural Rights, General Comment 22 on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights), UN Doc. E/C.12/GC/22, ¶ 43 (2016).

45 *Id.*

46 *Id.* at ¶ 14.

47 UN Special Rapporteur on the Right to Health, Interim Report, UN Doc. A/66/254 (2011).

48 UN Special Rapporteur on Freedom of Religion or Belief, Gender-based violence and discrimination in the name of religion or belief, UN Doc. A/HRC/43/48, ¶ 43 (2020).

49 *Id.*

50 *Id.* at ¶ 76 (f).

51 Working Group on discrimination against women and girls, Conscientious objection to abortion: key considerations, UN Doc. A/HRC/WG.11/41/1 (2024).

52 *Id.*

53 R.R. v. Poland, App. No. 27617/04, Eur. Ct., H.R, (2011); FAFCE v. Sweden, Compl. No. 99/2013, Eur. Comm. Soc. R (2013).

54 African Commission on Human and People's Rights, General Comment No. 2 on Article 14 of the Maputo Protocol on the Rights of Women in Africa (2014) ¶ 48.

55 *Id.*

56 Inter-American Commission of Human Rights, Access to Information on Reproductive Health from a Human Rights Perspective, OEA/Ser.L/V/II. Doc. 61, (2011), http://www.oas.org/en/iachr/women/docs/pdf/access%20to%20information%20women.pdf.

57 *Id.*

58 Working Group on discrimination against women and girls, *supra* note 51.

59 UN Special Rapporteur on Right to Health, *supra* note 47, at ¶ 24.

60 *Id.*

61 42 U.S.C. § 300a-7.

62 HHS, Protecting Statutory Conscience Rights in Health Care; Delegations of Authority. May 21, 2019, https://www.federalregister.gov/documents/2019/05/21/2019-09667/protecting-statutory-conscience-rights-in-health-care-delegations-of-authority

63 National Women's Law Center, "Trump's Refusal of Care Rule: We Took Him to Court, Here's What You Need to Know, October 2019, https://nwlc.org/trumps-refusal-of-care-rule-we-took-him-to-court-now-what/.

64 Protecting Statutory Conscience Rights in Health Care; Delegations of Authority, 89 Fed. Reg. 2166 (Jan. 11, 2024) (to be codified at 45 C.F.R. pt. 88).

65 LawAtlas, *supra* note 31.

66 Working Group on discrimination against women and girls, *supra* note 51.

67 Ley No. 27.610, *Acceso a la Interrupción Voluntaria del Embarazo y a la Atención Postaborto*, B.O. 15/01/2021 (Arg.).

68 Corte Constitucional [C.C.] [Constitutional Court], Sentencia C-355/06, 2006 (Col.).

69 Corte Constitucional [C.C.] [Constitutional Court], Sentencia T-209/08, 2008 (Col.).

70 Corte Constitucional [C.C.] [Constitutional Court], Sentencia T-946/08, 2008 (Col.).

71 Corte Constitucional [C.C.] [Constitutional Court], Sentencia T-388/09, 2009 (Col.).

72 *Id.*

73 *Id.*

74 *Id.*

75 *See,* Resolución No. 444 de 2006, Diario Oficial [D.O.] 46.450 (13 de diciembre de 2006) (Col.); Resolución No. 051 de 2023, Diario Oficial [D.O.] 52.254 (12 de enero de 2023) (Col.); Protocolo para la Prevención del Aborto Inseguro en Colombia (2014); Orientación y Asesoría para la Interrupción Voluntaria del Embarazo (IVE): Documento Técnico para Prestadores de Servicios de Salud (2014).

76 Inter-American Commission of Human Rights, *supra* note 56.

77 *Id.* at 98.

78 Ley General de Salud [LGS], art. 10 Bis, Diario Oficial de la Federación [DOF], 7 de febrero de 1984 (Mex.).

79 Acción de Inconstitucionalidad 54/2018 [AI 54/2018], Suprema Corte de Justicia de la Nación [SCJN] 21 de Septiembre de 2021 ¶ 446 (Mex.).

80 *Id.* at ¶¶ 454, 455, 480.

81 *Id.*

82 *Id.* at ¶ 507.

83 Tribunal Constitucional [T.C.] [Constitutional Court], Sentencia 44/2023, de 9 de mayo de 2023, BOE núm. 139, 12 de junio de 2023, 83714 (Spain).

84 *Id* at 83753.

85 Código Sanitario, Decreto con Fuerza de Ley No. 725, Diario Oficial de la República de Chile, 31 de enero de 1968 (Chile).

86 *Id.*

87 42 U.S.C. § 238n.

88 U.S. Dep't of Health & Hum. Servs., Your Protections Against Discrimination Based on Conscience and Religion, https://www.hhs.gov/conscience/your-protections-against-discrimination-based-on-conscience-and-religion/index.html#:~:text=The%20Church%20Amendments,health%20services%20or%20research%20activities.

89 LawAtlas, s*upra* note 31.

90 Rachana Pradhan & Hannah Recht, The Powerful Constraints on Medical Care in Catholic Hospitals Across America, KFF Health News (Feb. 17, 2024), https://kffhealthnews.org/news/article/catholic-hospitals-affiliates-ethical-religious-directives-reproductive-care/.

91 *Id.*

92 Columbia Law School, The Law, Rights & Religion Project. The Southern Hospitals Report: Faith, Culture, and Abortion Bans in the U.S. South, (2021), https://lawrightsreligion.org/our-work/southern-hospitals-report.

93 Dana Repka, *UN Advises Against Institutional Conscientious Objection to Abortion*, Health & Hum. Rts. J. (Feb. 2, 2025), https://www.hhrjournal.org/2025/02/02/un-advises-against-institutional-conscientious-objection-to-abortion/.

94 Working Group on discrimination against women and girls, *supra* note 51.

95 African Commission on Human and Peoples Rights, *supra* note 54.

96 Inter-American Commission on Human Rights, *supra* note 56, at ¶ 97.

97 Confederazione Generale Italiana del Lavoro (CGIL) v. Italy, Complaint No. 91/2013, Eur. Comm. Soc. Rts., Decision on the Merits (Oct. 12, 2015).

98 Agustina Ramón Michel & Dana Repka, *supra* note 24.

99 Resolución 1535/2021, Protocolo para la Atención Integral de las Personas con Derecho a la Interrupción Voluntaria y Legal del Embarazo, Anexo I (May 27, 2021) (Arg.), https://bancos.salud.gob.ar/recurso/protocolo-para-la-atencion-integral-de-las-personas-con-derecho-la-interrupcion-voluntaria

100 *Id.*

101 Corte Constitucional, *supra* note 69; Corte Constitucional, *supra* note 71.

102 Acción de Inconstitucionalidad 54/2018, *supra* note 79.

103 Decreto N.º 375/012, Reglamentación de la Ley sobre Interrupción Voluntaria del Embarazo, 22 de noviembre de 2012 (Uru.).

104 *Id.*

105 Committee on the Elimination of Discrimination against Women, Concluding observations on the tenth periodic report of Uruguay, UN Doc. CEDAW/C/URY/CO/10 (2023).

106 Ley N.º 21.030, Regula la despenalización de la interrupción voluntaria del embarazo en tres causales, 23 de septiembre de 2017 (Chile).

107 Tribunal Constitucional de Chile, Sentencia Rol N° 3725-17-CPT, 28 de agosto de 2017 (Chile).

108 Tribunal Constitucional de Chile, Sentencia Rol N.º 5572-18-CDS / 5650-18-CDS (acumuladas), 18 de enero de 2019 (Chile).

109 Working Group on discrimination against women and girls, *supra* note 51.

110 *Id.*

111 *Id.*

112 LawAtlas, s*upra* note 31.

113 *Id.*

114 Rachel Kogan, Katherine L. Kraschel & Claudia E. Haupt, *Which Legal Approaches Help Limit Harms to Patients From Clinicians' Conscience-Based Refusals?*, 22 AMA J. Ethics E209 (2020), https://journalofethics.ama-assn.org/article/which-legal-approaches-help-limit-harms-patients-clinicians-conscience-based-refusals/2020-03.

115 Office of the Attorney Gen. of Idaho, *AG Labrador Announces Dismissal of EMTALA Challenge to Idaho Defense of Life Act*, Idaho Att'y Gen. Newsroom (Mar. 5, 2025), https://www.ag.idaho.gov/newsroom/ag-labrador-announces-dismissal-of-emtala-challenge-to-idaho-defense-of-life-act/.

116 "Together, AHM and Moyle mark a dramatic shift in so-called conscience protection at the federal level. EMTALA—and patients' interests in life and health—had long been understood to prevail over providers' religious objections. The sponsors of various conscience-related laws and budget riders made explicit that religious and moral beliefs would not relieve providers of duties of emergency care. Multiple times, Congress considered but rejected conscience carve-outs to EMTALA. And when the Trump administration issued a rule in 2019 authorizing denial of care where a patient was experiencing ectopic pregnancy, miscarrying, or otherwise in need of emergency care, multiple federal courts vacated the rule as not in accordance with EMTALA." Elizabeth Sepper, *The Ever-Expanding Right to Refuse to Provide Healthcare*, Bill of Health, Petrie-Flom Center, Health Law Policy, Biotechnology, and Bioethics at Harvard Law School. September 23, 2024. https://petrieflom.law.harvard.edu/2024/09/23/the-ever-expanding-right-to-refuse-to-provide-healthcare/.

117 *St. Luke's Health System, Ltd. v. Labrador*, No. 1:25-cv-00015-BLW (D. Idaho filed Jan. 14, 2025), https://litigationtracker.law.georgetown.edu/litigation/st-lukes-health-system-ltd-v-labrador/.

118 Human Rights Committee, General Comment 36, Article 6 (Right to life). UN Doc CCPR /C/GC/36 (2019).

119 *Id.*

120 Human Rights Committee, *supra* note 38, at ¶ 43.

121 African Commission on Human and Peoples Rights, *supra* note 54.

122 Working Group on discrimination against women and girls, *supra* note 51.

123 *Id.*

124 Agustina Ramón Michel & Dana Repka, *supra* note 24.

125 Working Group on discrimination against women and girls, *supra* note 51.

126 Termination of Pregnancy Act, ch. 304 (Zam.).

127 *Id.*

128 Decreto Ejecutivo N.º 42113-S, *Oficializa la Norma Técnica para el Procedimiento Médico Vinculado con el Artículo 121 del Código Penal*, 12 de diciembre de 2019 (Costa Rica).

129 Protocolo para la Prevención del Aborto Inseguro en Colombia, *supra* note 75.

130 Acción de Inconstitucionalidad 54/2018, *supra* note 79.

131 *Id.*

132 Melissa Upreti & Jihan Jacob, *The Philippines Rolls Back Advancements in the Postabortion Care Policy*, 142 Int'l J. Gynecol. & Obstet. 255 (2018).

133 Trybunał Konstytucyjny [Constitutional Tribunal] (Pol.), Judgment of Oct. 7, 2015, K 12/14, OTK ZU 9A/2015, item 143.

134 Julia Kapelańska-Pręgowska, The Scales of the European Court of Human Rights: Abortion Restriction in Poland, the European Consensus, and the State's Margin of Appreciation, 23(2) Health Hum Rights 213 (2021).

135 Committee on the Elimination of Discrimination against Women, Inquiry concerning Poland conducted under article 8 of the Optional Protocol to the Convention, ¶¶ 108g, 108k, UN Doc. CEDAW/C/POL/IR/1 (2024).

136 Working Group on discrimination against women and girls, *supra* note 51.

137 LawAtlas, s*upra* note 31.

138 *Id.*

139 Alexandra Brown et al., *supra* note 3, at 359-360.

140 Melanie Zurek & Jenny O'Donnell. "Abortion referral-making in the United States: findings and recommendations from the abortion referrals learning community." 100(5) Contraception 360 (2019), https://pubmed.ncbi.nlm.nih.gov/31376380/.

141 Human Rights Committee, *supra* note 38. ¶ 43.

142 Working Group on discrimination against women and girls, *supra* note 51.

143 *Id.*

144 UN Special Rapporteur on Right to Health, *supra* note 47, at ¶ 24.

145 Working Group on discrimination against women and girls, *supra* note 51.

146 *P. and S. v. Poland*, App No. 57375/08, Eur. Ct. H.R, (2012).

147 Inter-American Commission of Human Rights, *supra* note 56, at 95.

148 *Id.* at 99.

149 Agustina Ramón Michel & Dana Repka, *supra* note 24.

150 Resolución 1535/2021, *supra* note 99.

151 Corte Constitucional, *supra* note 69, at ¶ 4.6 (citing Constitutional Court of Colombia, Judgment No. C-355/06 (2006)).

152 Inter-American Commission of Human Rights, *supra* note 56.

153 Acción de Inconstitucionalidad 54/2018, *supra* note 79.

154 *Id.*

155 New Zealand Health Professionals Alliance Inc v Attorney-General, [2021] NZHC 2510, CIV-2020-485-178 (Sept. 23, 2021) (N.Z.), https://www.law.utoronto.ca/sites/default/files/documents/reprohealth/nz_2021_hpa_v_attorney-general.pdf.

156 *Id.*

157 *Id.*

158 *Id.*

159 *Id.*

160 *Id.*

161 Human Rights Council, Report of the Working Group on the issue of discrimination against women in law and in practice, Visit to Poland, UN Doc. A/HRC/41/33/Add.2 (2019).

162 *Id.*

163 LawAtlas, s*upra* note 31.

164 *Id*.

165 *Id.*

166 Working Group on discrimination against women and girls, *supra* note 51.

167 Committee on the Elimination of Discrimination against Women, Concluding observations on the combined eighth and ninth periodic reports of Uruguay, ¶ 35 (b), UN Doc. CEDAW/C/URY/CO/8-9 (2016).

168 *P. and S. v. Poland*, *supra* note 146.

169 Inter-American Commission of Human Rights, *supra* note 56.

170 Agustina Ramón Michel & Dana Repka, *supra* note 24.

171 Corte Constitucional, *supra* note 69; Corte Constitucional, *supra* note 71.

172 *Id.*

173 Organic Law 1/2023, February 28, 2023, which amends Organic Law 2/2010 on sexual and reproductive health and the voluntary interruption of pregnancy, (B.O.E. 2023, 5364) (Spain).

174 *Id.*

175 Tribunal Constitucional, *supra* note 83, at 70745.

176 *Id.*

177 R.R. V. Poland, *supra* note 53.

178 Andres Constantin, Religious Lawfare: Conscience-Based Claims in Liberal Democracies. Global Health, Human Rights, and Social Justice. 122-123. (Brill Nijhoff 2025).

179 International Planned Parenthood Federation – European Network (IPPF EN) v. Italy, Complaint No. 87/2012, European Committee of Social Rights (2013).

180 Agustina Ramón Michel & Dana Repka, *supra* note 24.

181 Working Group on discrimination against women and girls, *supra* note 51, at ¶ 31.

182 Resolución 1535/2021, *supra* note 99.

183 Acción de Inconstitucionalidad 54/2018, *supra* note 79.

184 Corte Constitucional, *supra* note 69.

185 UN Special Rapporteur on Extrajudicial, Summary or Arbitrary Executions, Report on a Gender-Sensitive Approach to Arbitrary Killings, ¶ 95, UN Doc. A/HRC/35/23 (2017).