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The Impact of 'conscientious objection' on abortion-related outcomes: A synthesis of legal and health evidence

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ABSTRACT

The World Health Organization (WHO) and international human rights bodies have long urged states to take steps to ensure that 'conscientious objection' does not undermine access to abortion in practice. This review uses an established methodology to identify and integrate evidence of the health and human rights impacts of the practice of conscientious objection/refusal. The evidence identified in this review suggests strongly that conscientious objection negatively affects the rights of abortion seekers and has negative implications for the rights of non-objecting health workers. This is exacerbated in situations where an exercise of 'conscience' goes beyond 'opting out' of providing care and extends into seeking to prevent abortion through dissuasion, misinformation, misdirection, delay, and sometimes abuse. The insights from this review suggest that states must take better and further action to centre abortion seekers in the regulation of conscientious objection, and to prevent and ensure accountability for rights-limiting manifestations of conscience that go beyond opting out of direct provision of abortion care in non-emergency settings.

1. Introduction

Conscientious objection, also known as conscientious refusal, is the practice of health-care providers refusing to provide abortion care based on their objection to the services sought. In some cases, such objection is based on health workers' religious or ethical objections to abortion [1] and in many settings conscientious objection is accommodated within health systems in response to a perceived need to preserve individual health workers' moral and ethical integrity. However, it is not always the case that refusal of services under the banner of 'conscientious objection' reflects profound personal belief. Instead, it can be attributable to factors as varied as moral judgement of the sexual activity of individual women who seek abortion, attempts at individual workload management, the avoidance of judgement or ostracization by colleagues or professional superiors, or attempts to divert abortion seekers into private, for-payment healthcare settings where the same health workers do provide abortion care in return for remuneration. In other words, as well as being a mode of preserving moral integrity for some health workers, assertions of conscientious objection can also operate as a 'safety valve' or 'shield' [2] for health professionals seeking to avoid the practical burdens of abortion provision.

Many countries that regulate abortion through law make express provision for conscientious objection based on the proposition that, as moral agents, health workers should be able to object to providing abortion care [3,4]. However, as those seeking abortion care have human rights and are themselves also moral agents, the ability to refuse care is usually limited and subject to obligations that purport to ensure abortion seekers can access the care they seek [5,6]. Although highly prevalent in some settings [6], conscientious objection is an aberration from the usual principle that health professionals may not refuse to

AL and FdL developed the PICO and search strategies. AF and MF did the initial searches. AL, AC, MR and FdL reviewed and finalized data extraction and quality. FdL did the initial manuscript draft. AC prepared the tables and figures. All authors reviewed, finalized and approved the submitted text.

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provide care based on personal objection to it. The WHO has long recognized conscientious objection as a barrier to quality abortion and recommended its effective regulation [7].

International human rights bodies also recognize that conscientious objection can operate as a barrier to accessing abortion that can operate to undermine women's human rights. They have repeatedly stressed states' obligations to ensure provider refusal is not an obstacle to accessing abortion [8, paras 14; 43,9, paras 11;13], and to take effective steps to prevent third parties (such as health-care facilities or providers) undermining the right to the highest attainable standard of sexual and reproductive health [8, para 59]. International human rights law requires states to ensure that the regulation of abortion does not jeopardize the lives of pregnant women; subject them to physical or mental pain or suffering constituting torture, cruel, inhuman, or degrading treatment or punishment; discriminate against them; or interfere arbitrarily with their privacy [10, para 8]. Human rights-based abortion law and policy is evidence-based (i.e., not arbitrary) and proportionate. [11, para 18]. An evidence base ensures that laws are not arbitrary, while proportionality implicates that any law or policy intervention would be provided by law, necessary for the achievement of a legitimate objective, rationally connected to the achievement of this objective, and minimally intrusive by reference to protected rights. As a matter of international human rights law, states are required to ensure that its regulatory choices—including how it regulates conscientious objection—do not force women to resort to unsafe abortion and must, if necessary, review, reform and liberalize applicable laws to achieve this [8, para 28]. Nevertheless, conscientious objection remains prevalent, continues to erect significant barriers to accessing abortion care, and tends to be un- or under-regulated [4].

The aim of this review is to address knowledge gaps directly or indirectly related to the health and non-health outcomes of conscientious objection or refusal in abortion provision. This review was conducted as part of the evidence base for the WHO *Abortion Care Guideline* (2022) [12]. It is one of seven evidence reviews undertaken by the research team following a methodological approach that has been published elsewhere [13].

Throughout this review we use the terms conscientious objection, objection/refusal, and refusal on the basis of conscience interchangeably to refer to the broad practice of health workers declining to engage in the provision of abortion care on the basis of their purported objection. In line with the approach taken in the *Abortion Care Guideline* [12], the terms women, girls, pregnant women [and girls], pregnant people, and people are used interchangeably to include all those who can become pregnant.

2. Methods

2.1. Identification of studies and data extraction

This review examined the impact of the intervention 'conscientious objection' on (i) people seeking abortion, and (ii) health professionals. The search strategy, which included the key words 'abortion AND conscientious objection', 'abortion AND conscience', 'abortion AND conscientious refusal' was developed collaboratively by AL and FdL drawing on the fields of law, policy, and human rights. We (FdL, MF, and AF) searched the databases PubMed, HeinOnline, and JStor, and the search engine Google Scholar, reflecting our interest in health and non-health outcomes. As the WHO's Safe Abortion: technical and policy guidance for health systems (2nd edition) [7] included information up to 2010, we limited our search to papers published in English since 2010. Quantitative, qualitative and mixed-methods comparative and non-comparative studies, reports, PhD theses, and economic or legal analyses that undertook original data collection or analysis related to our outcomes of interest were included, while reviews, doctrinal legal analyses, and works that did not contain original data were excluded.

Based on a separate, preliminary review of the literature [14] we identified health and non-health outcomes of interest that could be linked to the effects of conscientious objection. Our outcomes of interest linked to people seeking abortion were delayed abortion, continuation of pregnancy, opportunity costs, self-managed abortion, and referral to another provider. Outcomes of interest linked to health workers were workload implications, perceived imposition on personal conscience or ethics, perceived impact on the provider-patient relationship, stigmatization, and system costs.

An initial screening of the literature was undertaken by MF and AF. Using the Covidence® tool, titles and abstracts were screened for eligibility, following which full texts were reviewed. A third reviewer (FdL) confirmed these studies met inclusion criteria. FdL and AC extracted data, with any discrepancies being reviewed and discussed with AL and MR to ensure that all studies were suited to the study design. Any discrepancies were resolved through consensus.

To understand fully the implications of the findings for abortion law and policy, we applied human rights standards to the data extracted from the included studies. In accordance with the methodological approach for this review [13], appliable human rights law standards were identified through a review of international human rights law. Regional and national human rights laws were not included. By considering applicable international human rights law standards together with the evidence from the included manuscripts we identified (a) which human rights standards are engaged by conscientious objection, (b) whether the evidence from included studies suggests that conscientious objection has positive or negative effects on the enjoyment of rights, and (c) whether human rights law provides evidence that can elucidate the impacts and effects of conscientious objection even if no data on impacts on an outcome of interest are identified in the included studies.

2.2. Analysis

Extracted data from included studies and applicable human rights standards were matched to the outcomes of interest, an overall conclusion synthesizing these findings relative to the outcome of interest was reached, and these were presented in evidence tables designed according to our established methodology [13]. We used a previously designed approach to incorporate a visual representation (symbol) of the effect direction in order to summarize the effect of conscientious objection across all study designs [15]. Where the evidence suggested an increase in the outcome this was indicated by the symbol ▲. A suggested decrease in the outcome was indicated by the symbol ▽. A suggestion of no change in the outcome was indicated by the symbol ○. Symbols did not indicate the magnitude of the suggested effect [13].

3. Results

The search generated 26,698 citations after duplicates were removed. We screened the titles and abstracts and conducted a full text screening of 904 manuscripts. After applying our exclusion criteria, 31 manuscripts were included in the final analysis (Fig. 1. Prisma flow diagram).

Manuscripts described data from the following settings: Argentina [16], Australia [17,18], Brazil [19,20], Colombia [21–23], Croatia [24], Ghana, [23,25–27], Italy [28–31], Mexico [32], Nigeria [33], Norway [31,34], Slovakia [35], South Africa [36], Switzerland [37], Tunisia [38], the United Kingdom [31,39,40], the United States of America [41–44] and Zambia [45]. Some studies were multi-jurisdictional [23, 31] and one was regional (Sub-Saharan Africa) [46]. The characteristics of included studies are outlined in Table 1.

For the analysis of the impact of conscientious objection on abortion related outcomes 30 studies were identified addressing the following outcomes: delayed abortion ($n = 14$) [16,17,22,26,28,29,30,31,32,33, 36,42,45,46], continuation of pregnancy ($n = 3$) [18,22,42], opportunity costs ($n = 22$) [17,18,19,20,21,22,23,24,25,27,28,29,31,32,33,34,

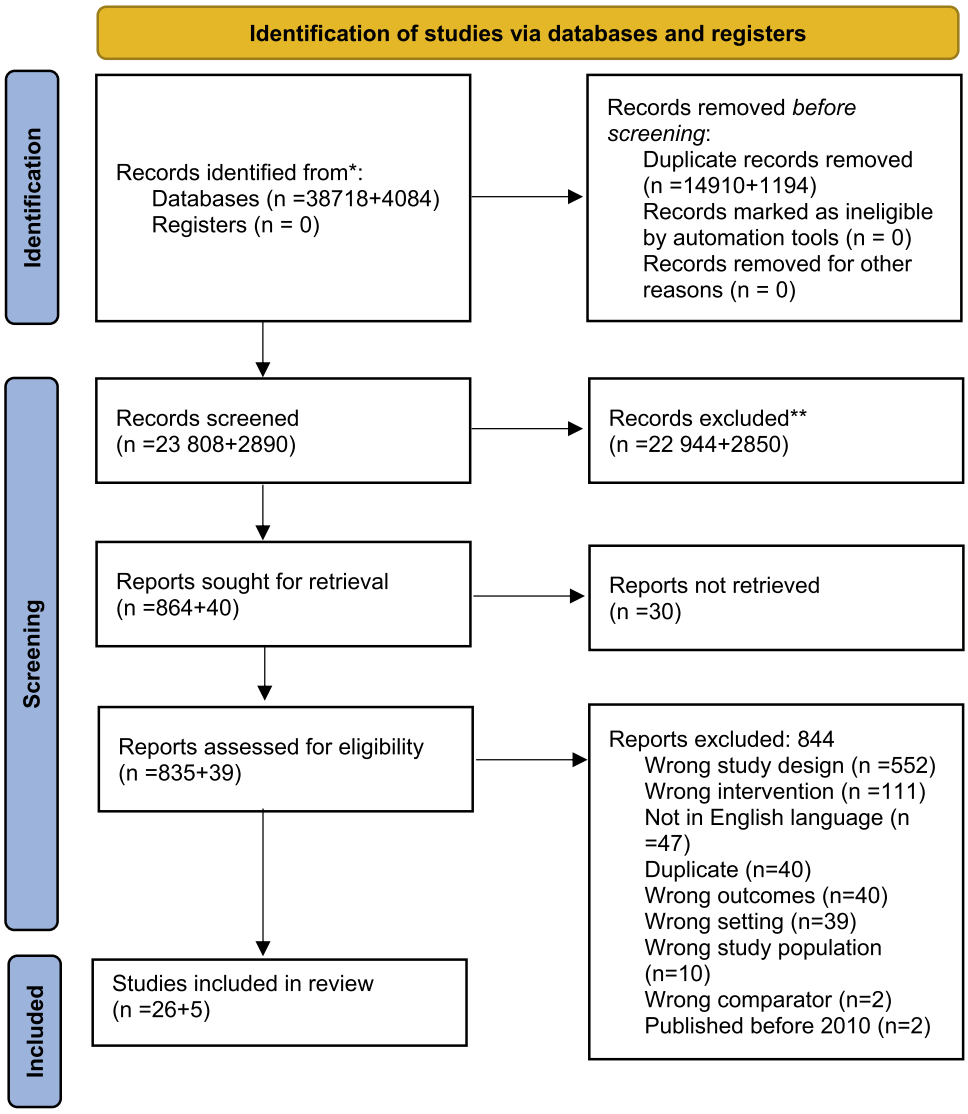

Fig. 1. Prisma flow diagram. *Consider, if feasible to do so, reporting the number of records identified from each database or register searched (rather than the total number across all databases/registers).
**If automation tools were used, indicate how many records were excluded by a human and how many were excluded by automation tools.
From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.

35,36,38,39,42,45], unlawful abortion ($n = 1$) [45], referral to another provider ($n = 12$) [17,18,19,22,23,25,26,27,34,42,43,45] workload implications ($n = 15$) [16,27,28,29,30,31,32,33,34,36,37,40,41,43,44], perceived imposition on conscience or ethics ($n = 5$) [34,37,40,41,44], perceived impact on relationship with patient ($n = 2$) [18,34], stigmatization of healthcare providers ($n = 7$) [16,20,27,31,32,34,45], and system costs ($n = 4$) [32,36,33,46]. No studies were identified that encompassed information related to the outcome self-managed abortion.

3.1. Impact on the intervention on abortion seekers

A summary of the health and human rights impacts of conscientious objection on people seeking abortion is presented in Table 2. Evidence identified per study and outcome is presented in Supplementary Table 1.

Findings from 14 studies indicate that conscientious objection is associated with delays in accessing comprehensive abortion care [16,17,22,26,28,29,30,31,32,33,36,42,45,46]; indeed, in one study 220 of 269 stakeholders interviewed indicated that in their view the main observed effect of conscientious objection is delays in accessing abortion care [16]. 4 of the included studies suggest that a high prevalence of conscientious objection is associated with longer waiting times for abortion [26,28,29,30], while another study found that where providers refuse to participate in any abortion care, including post-abortion care, this can delay access to timely care [33]. One study particularly points to the impact of a high prevalence of conscientious objection within professional cadres that are already few in number, such as physicians [26], while two studies point to how refusals to refer or intentional provision of inaccurate information in the attempt to dissuade or obstruct the abortion seeker can result in delay [22,42]. This calls to mind states' obligations to ensure the organization of health services and goods in a way that makes them accessible and available, even where conscientious objection is prevalent. This may be especially prescient with respect to rural healthcare provision, with two studies suggesting that women in rural areas may experience abortion delays due to conscientious objection [17,31]. As well as having a general obligation to ensure the availability and accessibility of sexual and reproductive health care, states are required to identify and address inadequate rights protection for women living in rural areas [8,9].

Unclear policies on objection and referral contribute to delays (including in the immediate aftermath of legal change [32]), as does a failure to regulate conscientious objection at all [36], or the inconsistent application of, or non-adherence to, regulation [42]. Requirements to refer are a source of delay both because the act of referral itself may cause delay by requiring someone to return another day when a non-objecting provider is available [45] or, as one included study suggests, by failing to provide referrals to health workers who do provide abortion [42].

Table 1
Characteristics of included studies.

Author/year	Country	Methods	Participants
Amado 2010	Colombia.	Case series design ($n = 46$). Review of the circumstances of women who had been denied a legal abortion.	N/A.
Aniteye 2013.	Accra, Ghana.	Qualitative individual in-depth interviews ($n = 43$).	Healthcare providers (managers, obstetricians and midwives) aged 38–70, at three hospitals in Accra; a teaching hospital, a regional hospital and a district hospital.
Autorino 2018.	Italy.	Panel data analysis (n=not reported); data on CO and utilization of abortion services.	N/A.
Autorino 2020.	Italy.	Panel data analysis (n=not reported); data on CO and on all abortions taking place in healthcare facilities in Italy, between 2006 and 2016	Abortion data from the Italian National Statistical Office (Istat) and CO data from the Italian Institute for Health.
Awooner-Williams 2018.	Ghana.	Cross sectional study ($n = 213$).	Healthcare providers (physicians, midwives, nurses, physician assistants) trained in abortion provision and working in hospital facilities in northern Ghana.
Awoonor-Williams 2020.	Ghana.	Qualitative individual in-depth interviews ($n = 8$) and focus group discussions ($n = 4$)	Obstetrician-gynecologists ($n = 14$) and midwives trained in abortion provision ($n = 20$) in healthcare facilities in the Eastern and Volta Regions.
Blaho 2016	Slovakia	Qualitative individual semi-structured interviews ($n = 11$)	Healthcare providers (physicians and nurses) aged 28–61 working in "paediatric oncology and haematology, pathological and operative obstetrics and geriatrics".
Bo 2015.	Italy.	Time series design ($n = 101{,}522$); data on CO and its correlation with workload in 13 regions in Italy.	N/A.
Chavkin 2017.	England (United Kingdom), Italy, Norway and Portugal	Interviews with key stakeholders ($n = 54$) and a review of each country's constitution, laws and regulations, medical codes of ethics, professional guidelines, government reports, press clippings, scholarly publications and archival documents.	Key stakeholders in England, Italy, Norway and Portugal.
Contreras 2011.	Mexico.	Qualitative individual semi-structured interviews ($n = 64$).	Healthcare providers (physicians, nurses, psychologists, anesthesiologists), health managers and receptionists working in 12 public hospitals and one health centre. In addition, decision-makers from the Ministry of Health were interviewed.
Czarnecki 2019.	Michigan, United States of America.	Qualitative individual semi-structured interviews ($n = 50$).	Healthcare providers (physicians, nurses and one nurse-midwife) working in the labour and delivery unit of a large teaching hospital.
de Oliveira Branco 2020	Brazil	Qualitative individual semi-structured interviews ($n = 20$)	Health workers ($n = 15$) of which 2 were abortion providers, managers, social service workers, lawyers) with at least six months experience being involved in the provision of care to women who experience sexual violence.
Diniz 2014.	Brazil.	Cross sectional survey ($n = 1690$) and in-depth interviews ($n = 50$) with participants who responded to the survey.	Obstetrician-gynecologists aged 25–84 years affiliated with the Brazilian Federation of Obstetrics and gynaecology. In-depth interviews were conducted with physicians who had provided abortions for women and girls who had been raped.
Doran 2016.	New South Wales, Australia.	Qualitative individual in-depth interviews ($n = 13$).	Women 18–46 years with experience of abortion whilst living in a rural area of New South Wales.
Fink 2016.	Colombia.	Qualitative individual in-depth interviews ($n = 28$), snowball sampling.	Key informants (bioethicists, activists, nonprofit leaders, attorneys, a professor, a government official) and healthcare providers (physicians and one medical student) who were qualified to provide abortion care but who conscientiously objected in some or all cases.
Fleming 2019.	Scotland, United Kingdom.	Qualitative individual in-depth interviews ($n = 8$).	Midwives ($n = 2$), lawyers ($n = 4$) and priests ($n = 2$).
Freedman 2010	United States.	Qualitative individual in-depth interviews ($n = 30$).	Physicians who had graduated from an Ob-gyn residency training program in which routine opt-out abortion training was offered
Freeman 2019.	Zambia.	Qualitative individual in-depth interviews ($n = 51$).	Healthcare providers (clinical officers, community health workers, medical officers, physicians, nurses and midwives) practicing in rural and urban areas at different levels of the health system.

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Table 1 (*continued*)

Author/year	Country	Methods	Participants
Gerdts 2016.	England, United Kingdom.	Cross sectional study ($n = 58$).	Non-UK residents aged 14–46, seeking abortions at three British Pregnancy Advisory Services (BPAS) abortion clinics in London and Liverpool.
Håkansson 2021.	Croatia.	Qualitative in-depth individual interviews ($n = 7$).	Women aged 18–45 with experience of unwanted pregnancy and/or abortion in Croatia.
Harries 2014.	South Africa.	Qualitative individual in-depth interviews ($n = 48$).	Healthcare providers (physicians and nurses), health managers and policy influentials.
Harris 2016.	Colombia and Ghana.	Literature review, qualitative individual in-depth interviews ($n = 13$) and piloting of cross-sectional survey ($n = 9$).	Key stakeholders i.e., conscientious objectors, abortion providers, psychiatrists, activists, health administrators and legal experts.
Homaifar 2017.	Nebraska, United States of America.	Cross-sectional survey ($n = 431$).	Physicians and advanced-practice clinicians in family medicine and obstetrics-gynaecology.
Keogh 2019.	Victoria, Australia.	Qualitative individual semi-structured interviews ($n = 19$).	General practitioners, medical practitioners, nurses, obstetric-gynecologists, service managers, a psychologist and a sexual health physician.
Lamina 2013.	Ogun State, Nigeria.	Qualitative individual in-depth interviews ($n = 36$) and focus group discussions ($n = 1$).	Healthcare providers (nurses, nurse-midwives, physicians, counsellors, healthcare managers, community health extension workers) in 16 public and private health facilities at different level of the health system.
Lema 2012.	Sub-Saharan Africa.	Case reports (n cases=5).	N/A.
Nordberg 2014.	Norway.	Qualitative individual interviews ($n = 7$).	General practitioners, aged 30 to 55, identifying as conscientious objectors.
Perrin 2012.	Switzerland.	Qualitative individual in-depth interviews ($n = 77$).	Healthcare providers, aged 32 to 71 (physicians, nurses and reproductive health social workers), practicing in 22 healthcare facilities across 16 cities and towns.
Raifman 2018.	Tunisia.	Qualitative individual in-depth interviews ($n = 23$).	Healthcare providers (physicians, midwives, nurse) and gate keepers (counsellors and front office staff) in six healthcare facilities.
Ramón Michel 2020.	Argentina.	Mixed methods ($n = 280$): review of literature and law, cross-sectional survey ($n = 269$), individual semi-structured interviews ($n = 11$).	Healthcare providers and other stakeholders from public and private sector, including provincial managers of health programs, heads of departments, social workers, psychologist and administrative personnel. 259/280 were abortion providers.
Stulberg 2016.	United States of America.	Qualitative individual semi-structured interviews ($n = 27$).	Obstetrician-gynecologists with experience of working in Catholic hospitals, residing in 15 states throughout the country.

The included studies thus suggest a negative relationship between conscientious objection and the rights of people who seek abortion. States' human rights obligations include the obligation to take steps to reduce maternal mortality and morbidity to fulfil the rights to life and to the highest attainable standard of physical and mental health [8,10], which can clearly be implicated by delays in accessing sexual and reproductive care. Furthermore, the obligation to ensure equality and non-discrimination, including in sexual and reproductive healthcare, is manifestly engaged by measures whose impacts are unevenly distributed across different categories of women, including rural women.

Findings from three studies suggest that conscientious objection is associated with the continuation of pregnancy where objecting health workers provide inaccurate information or referrals [18,22,42]. In one study the proportion of objecting health workers providing misleading referrals to abortion seekers was as high as 15% [42], while another study found that some objectors engage in lengthy conversations aimed at convincing women to continue with pregnancy, sometimes using harsh or abusive language if their initial attempts are unsuccessful [22]. These findings once more point towards the human rights implications of conscientious objection. States should ensure that abortion regulation is evidence-based and proportionate and, where it is lawful, that abortion is safe and accessible [8–11]. These studies suggest that conscientious objection is exercised in a way that undermines women's rights to information, to the highest attainable standard of physical and mental health, and to decide the number and spacing of their children. International human rights bodies have recognized this risk and sought to minimize the negative impact by imposing an obligation on states to ensure that provider refusal does not undermine access to abortion [8,9,11]. However, these studies suggest that this is the impact of conscientious objection where it is exercised in a manner that (purposefully or inadvertently) frustrates a woman's preference to end her pregnancy.

22 studies related to the outcome opportunity costs [17,18,19,20,21,22,23,24,25,27,28,29,31,32,33,34,35,36,38,39,42,45]. In many cases the opportunity costs associated with conscientious objection in these studies are related to the apparent inclination of some objecting heath workers to go beyond not providing abortion care themselves, but to seek to deter woman from having an abortion [18,38]. Direct opportunity costs include travel [28,31,39] (which more women may need to undertake if a high proportion of health workers object to providing abortion care [28,29]), additional and unnecessary administrative burdens [23] (including where an objector refers to another general practitioner who must then refer to a provider, rather than referring directly to the provider [34]), financial burdens (including in some cases where health workers abandon their objections in return for financial compensation [33,36]), difficulty in navigating the health system, identifying providing and non-judgmental health workers [24], and costs in time. While seven studies indicated that women experience an indirect opportunity cost in the form of uncertainty [18,19,25,36,38,45] and health workers making decisions on a case-by-case basis depending on the reasons women give for seeking abortion [27,45].

The variation in how conscientious objection is exercised creates uncertainty in women about the kinds of obstacles they may encounter, which has material, psychological and physical consequences, and

Table 2
Overall impact of conscientious objection on abortion seekers.

Outcome	Overall conclusion of evidence	Application of HR standards	Conclusion evidence + HR
Delayed abortion	Overall, findings from 14 studies support that CO may delay timely access to abortion and post-abortion care. CO may delay access to abortion care by further decreasing limited resources such as healthcare providers and facilities, and requiring abortion seekers to travel further to obtain care. CO may disproportionately affect vulnerable subgroups: women living in rural areas and immigrants appear to experience the greatest delays in care due to CO. The effects of CO on delayed access to care are greatest where: CO is prevalent; where CO policies and referral practices are unclear; where CO policies are implemented inconsistently; and where CO regulations are not followed.	Conscientious objection engages states' obligations to respect, protect and fulfil the rights to life and health (by taking steps to reduce maternal mortality and morbidity), and to equality and non-discrimination (because of disproportionate impact on vulnerable groups).	Failure to regulate conscientious objection and arrange the system of abortion care provision so that objection does not result in delays that increase risks of maternal mortality or morbidity, has negative implications for rights.
Continuation of pregnancy	Overall, findings from three studies suggest that objecting healthcare providers may provide inaccurate information on referrals, intentionally or otherwise, that contribute to continuation of pregnancy.	Conscientious objection engages states' obligations to protect, respect and fulfil the right to health (by ensuring abortion regulation is evidence-based and proportionate, that where it is lawful abortion is safe and accessible, and that provider refusal does not undermine access to abortion), and the right to decide on the number and spacing of children,. It can also result in violation of the state's obligation to ensure abortion is available where the life and health of the pregnant person is at risk, or where carrying a pregnancy to term would cause her substantial pain or suffering, including where the pregnancy is the result of rape or incest or where the pregnancy is not viable.	Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by healthcare providers does not undermine or hinder a pregnant person's ability safely to access abortion, does not have a disproportionately negative effect on health and physical and mental integrity, does not prevent a woman from access to abortion in cases of sexual violence including rape or incest, and does result in denial of therapeutic abortion, has negative implications for rights.
Opportunity costs	Overall, evidence from 22 studies describe the direct or indirect relationship that CO may have with diverse opportunity costs to abortion seekers. Opportunity costs include direct costs such as increased travel, financial burdens, and time. A pervasive indirect opportunity cost associated with CO is uncertainty of options. Significant variation in how and when CO is implemented creates uncertainty in the obstacles and options abortion seekers will have. This uncertainty has both psychological and physical consequences, and associated opportunity costs. Healthcare providers who claim CO and who attempt to prevent the abortion by providing misleading information may also stigmatize the abortion seeker in the process. Some providers will claim CO on a case-by-case basis, which leaves access to abortion care unpredictable and contributes to opportunity costs.	Conscientious objection engages states' obligations to protect, respect and fulfil the right to health (by ensuring abortion regulation is evidence-based and proportionate, that where it is lawful abortion is safe and accessible, that provider refusal does not undermine access to abortion, that post-abortion care is available in all circumstances, and the right to information.	Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by healthcare providers does not have a disproportionately negative effect on health and physical and mental integrity, does not expose abortion seekers to harm, does not result in non-provision of post-abortion care, and does not result in provision of inaccurate or misleading information, has negative implications for rights.
Unlawful abortion	Overall, evidence from one study suggests that healthcare providers who conscientiously object to abortion, may still provide referrals specifically to reduce unsafe, illegal abortion.	Conscientious objection engages states' obligations to respect, protect and fulfil the rights to life and health (by taking steps to reduce maternal mortality and morbidity, and by protecting people from the physical	Regulation of conscientious objection that ensures referral in situations of non-provision may prevent recourse to unlawful abortion and thus, where unlawful abortion is unsafe, reduce maternal mortality and morbidity.

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Table 2 (*continued*)

Outcome	Overall conclusion of evidence	Application of HR standards	Conclusion evidence + HR
		and mental health risks associated with unsafe abortions).	
Self managed abortions	No evidence identified.	Conscientious objection engages states' obligations to respect, protect and fulfil the rights to life and health (by taking steps to reduce maternal mortality and morbidity, and by protecting people from the physical and mental health risks associated with unsafe abortions).	Regulation of conscientious objection that ensures referral in situations of non-provision may prevent recourse to self-managed abortion and thus, where self-managed abortion is unsafe, reduce maternal mortality and morbidity.
Referral to another provider	Overall, evidence from 12 papers suggests that objecting healthcare providers implement the referral requirements for CO differently. This results in a net decrease of timely and appropriate referrals. Only two of 12 papers reported that "most" healthcare providers were willing to refer. The vast majority of evidence speaks to an inconsistent and fragmented approach to abortion referrals, when CO is invoked.	Conscientious objection engages states' obligations to protect, respect and fulfil the right to health (by ensuring that where it is lawful abortion is safe and accessible, and that provider refusal does not undermine access to abortion).	Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by healthcare providers does not have a disproportionately negative effect on the provision of abortion care (including through diversion to paid-for services), does not undermine or hinder access to abortion, and does not hinder a pregnant person's ability safely to access abortion, has negative implications for rights.

associated opportunity costs. Two studies show that when it is unclear whether a health worker provides abortion care, women may experience opportunity costs if they schedule an appointment with an objecting heath worker and must then seek another appointment with a providing health worker [21,35]. This variation in practice includes inconsistency in practice, even by individual practitioners. Three studies indicate that providers claim conscientious objection on a case-by-case basis [19,38,45], creating uncertainty in abortion seekers about whether, in their case, the health worker will refuse abortion based on such an objection or not, and what their options and care pathways might be [18,19,25,27,32,33,36,38,45]. Furthermore, even where the law provides for abortion where a pregnancy has resulted from rape conscientious objection can operate as a barrier, with two studies suggesting that women may experience stigmatization in such circumstances [20], and that objecting physicians will not provide care if they do not believe the woman's claim that a rape has occurred [19]. However, another indicates that some objectors provide abortion care where they have failed to dissuade the woman from ending the pregnancy due to concern that she would otherwise avail of unsafe abortion [23]. A further study shows that conscientious objection can result in a lack of abortion specific information, although objectors may provide what they describe as 'counseling' on options including continuing with pregnancy [25]. One study shows that such 'counseling' sometimes makes direct reference or allusion to religious teachings in the attempt to deter the woman from proceeding with an abortion [45], while another shows that for some health workers providing biased counselling is a mode of expressing conscience [23]. One study suggests that heath workers who claim religious affiliations frequently limit the information they provide [19], while another suggests that some objecting health workers provide misleading legal or medical information including informing pregnant people—inaccurately—that their circumstances did not fall into the legal grounds for access to abortion [22].

Some conscientious objectors seek to prevent the woman from accessing abortion by providing misleading information, stigmatizing her in the process and thus contributing to opportunity costs, or by providing referrals to facilities that do not provide abortion care [42]. Even where objecting health workers provide referrals, evidence from one study suggests that women experience opportunity costs in the form of multiple pre-referral scans and appointments, and another shows that objecting health workers do not reassure women of their legal entitlements [45]. It is clear, thus, that the studies considered for this review present evidence that conscientious objection results in women's right to accurate information, to access to abortion where continuation with pregnancy poses a risk to her health or life or would cause her significant pain and suffering, and to the highest attainable standard of physical and mental health being undermined. Human rights bodies have repeatedly made clear that if states permit conscientious objection, they must do so in a manner that protects the rights of pregnant people and does not undermine access abortion, [8–11] however the evidence relating to the outcome opportunity costs suggests a lack of (effective) regulation of this kind. These studies suggest that such regulatory frameworks are either not in place or, if they are, are ineffective in ensuring that provider refusal does not operate as a barrier to accessing quality care.

One study points to the complex relationship between conscientious objection and unlawful abortion by suggesting that even health workers who conscientiously object to abortion may provide referrals for abortion care to reduce unsafe, illegal abortion which they otherwise apprehend the pregnant person seeking to access [45]. However, as the 12 studies that addressed the outcome 'referral to another provider' suggest, referral practices are highly variable with individual objectors implementing referrals differently [17,18,19,22,23,25,26,27,34,42,43,45]. Only one of these twelve studies indicated that 'most' objecting health workers were willing to refer [18], while most of the evidence pointed to an inconsistent and fragmented approach to referrals where conscientious objection is invoked. As a matter of international human rights law, referral must be required in cases of conscientious objection. This requirement is intended to ensure that conscientious objection does not undermine access to abortion, however these studies suggest that such requirements are either not present, not complied with, or not effectively enforced.

3.2. *Impact of conscientious objection on health professionals*

A summary of the health and human rights impacts of conscientious objection on health professionals is presented in Table 3. Evidence identified per study and outcome is presented in Supplementary Table 2.

15 of the included studies contained data related to the outcome 'workload implications' [16,27,28,29,30,31,32,33,34,36,37,40,41,43,45]. These indicate that the workload implications of conscientious objection can be physical, logistical, psychological or a combination of these. Objecting providers are aware that their objection has workload implications for their colleagues without whose willingness to provide they themselves may not be able to practice where they are currently working [34]. Some health workers claim conscientious objection to avoid additional workloads and stigmatization in settings where objection is the norm [16] and others develop practices (of referral or partial participation) to try to navigate institutional objection [43]. Workload implications associated with conscientious objection include difficulties

Table 3
Overall impact of conscientious objection on healthcare providers.

Outcome	Overall conclusion of evidence	Application of HR standards	Conclusion evidence + HR
Workload implications	Overall, evidence from 15 studies indicate that CO has workload implications. Workload implications may have physical, logistical, psychological or mixed components. The effects of CO on workload implications are increased when CO is implemented inconsistently or without clear, guiding rules. CO may contribute to workload implications such as difficulties in organizing staffing, increased workload for staff that provide abortion care, workplace conflicts and frustration. In some cases, objecting healthcare providers feel pressure to participate in abortion care with resulting emotional workload implications. Unclear or inadequate regulation of CO may contribute to these negative workload implications. Organizational changes such as formation of teams of like-minded personnel who provide abortion care, and increased clarity on who can object, to what and when, may reduce negative workload implications.	Conscientious objection engages states' obligations to protect, respect and fulfil the right to health (by ensuring that provider refusal does not undermine access to abortion, and by protecting healthcare professionals providing abortion care).	Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by healthcare providers does undermine or hinder access to abortion, has negative implications for rights. Workload implications arising from regulation of conscientious objection may place significant burdens on healthcare professionals providing abortion care, with negative implications for both their rights and the rights of persons seeking to access abortion.
Perceived imposition on personal conscience or ethics	Overall, evidence from five studies reported on CO with a perceived imposition on providers personal conscience or ethics. Four studies described that CO, when implemented inconsistently, contributes to a perceived imposition on personal conscience or ethics amongst health care providers. This perceived imposition may cause providers to refuse any kind of participation or to consider changing workplace.	Conscientious objection engages states' obligations to protect, respect and fulfil the right to health (by ensuring that provider refusal does not undermine access to abortion, and by protecting healthcare professionals providing abortion care).	Failure to regulate conscientious objection so that, e.g., workloads, staffing levels, or lack of regulatory clarity, may impact negatively on the exercise of rights to freedom of conscience and belief by healthcare providers who are either total or partial objectors. In the case of partial objectors this may necessitate changes in the workplace or a full opt-out from abortion care provision in order to minimise imposition on personal conscience or ethics. Regulation of conscientious objection or lack thereof, including around issues related to workload and staffing or where regulatory clarity does not exist, may lead partial objectors to fully opt out of service provision. This reduces the number of possible providers and undermines or hinders access to abortion, thus having negative implications for rights.
Perceived impact on the provider-patient relationship	Overall, evidence from two studies reported on CO with a perceived impact on patient relationships with mixed findings. Evidence from 1 study described that objecting healthcare providers thought CO might make women feel guilty, thus impacting the relationship. Another study found no concern for negative impact on the provider patient relationship.	Conscientious objection engages states' obligations to protect, respect and fulfil the right to health (by protecting people seeking abortion).	Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by healthcare providers does not expose abortion seekers to a negatively impacted relationship with their healthcare provider, has negative implications for rights.
Stigmatization	Overall, evidence from seven studies report on the effect CO may have on stigmatization of health care providers. Six papers report that when CO is prevalent, non-objecting health care providers face stigmatization and limits career trajectory. One paper found no relationship between CO and stigmatization of abortion providers.	Conscientious objection engages states' obligations to protect, respect and fulfil the right to health (by protecting healthcare professionals providing abortion care),	Decisions about whether to provide abortion care can have stigmatiszng and career limiting effects where senior colleagues or managers are conscientious objectors, or where conscientious objection is the norm. Failure to regulate conscientious objection in order to avoid this may have negative effects on professionals providing abortion care or result in those willing to provide, acting as conscientious

(*continued on next page*)

Table 3 (*continued*)

Outcome	Overall conclusion of evidence	Application of HR standards	Conclusion evidence + HR
			objectors in practice, with negative implications for both their rights and the rights of persons seeking to access abortion.
System costs	Overall, evidence from five papers suggests that CO contributes to broad health system and social costs. In some cases, it may contribute to direct out of pocket payments by the abortion seeker. CO appears to disproportionately affect women seeking care in public hospitals. CO contributes to costs at the individual, provider and systems level. In some cases, objecting healthcare providers will offer abortion services in the private sector for informal or formal payment, but will object to providing uncompensated care in the public sector. Differentially restricting access to abortion amongst women with public insurance, may deter finances away from the public system and may also increase public costs through payment for unwanted births. It may also increase abortion related morbidity and mortality.	Conscientious objection engages states' obligations to protect, respect and fulfil the right to health (by ensuring that where it is lawful abortion is safe and accessible, and that regulation of abortion is evidence-based and proportionate).	Failure to regulate conscientious objection, so that the exercise of rights to freedom of conscience and belief by healthcare providers does not have a disproportionately negative effect on the provision abortion care (including through diversion to paid-for services), has negative implications for rights.

in organizing staffing, increased workload for workers who provide abortion care including provision resulting from abortion travel related to conscientious objection [28,29] and from referral by objecting health workers [27], and workplace conflicts [37,40]. Included studies suggest that workload implications increase when conscientious objection is exercised inconsistently, in respect of services that do not constitute direct provision of abortion [36], or without clear, guiding rules [30,33,41], while several studies indicate that organizational initiatives like forming teams of willing providers [32] and making it clearer who may object, to what and when, may reduce or mitigate the identified negative workload implications of conscientious objection. In some cases, the studies indicate that objecting healthcare providers feel pressure to participate in abortion care which itself creates psychological workload implications for them [40,45]. States' obligation to respect, protect and fulfil the right to the highest attainable standard of physical health entails ensuring that sexual and reproductive healthcare is available, accessible, acceptable, and of a good quality. The evidence from these studies suggests that failures in regulating conscientious objection undermine the right to health by imposing workload burdens on individual health workers and facilities, failing to protect health professionals involved in providing abortion care, and thus potentially undermining access to abortion.

This is further suggested by evidence from five studies, which spoke to perceived impositions on personal conscience or ethics in respect of conscientious objection [34,37,40,41,44]. Evidence from one included study indicated that some general practitioners considered the ability to refuse abortion care to be about protecting themselves and their integrity, more than about abortion per se [34], suggesting the importance for some health workers of an ability to opt out of provision. These studies again suggest the importance of clarity in respect of conscientious objection, with one study suggesting that inconsistent implementation of conscientious objection contributes to a perceived imposition on personal conscience or ethics [37]. One study suggested that objecting health workers sometimes participate in pre- and post-abortion care even though it causes conflicting feelings in them [41], while evidence from two studies indicated that health workers may participate in care with which they are not comfortable in busy or high workload settings in which people feel a pressure to provide some aspects of care [40,45]. Indeed, one study suggested that this perception can cause people to make decisions about where they will work as they seek to avoid such situations arising in the future [40].

Seven of the included studies related to the relationship between conscientious objection and the stigmatization of health workers [16,20,27,31,32,34,45]. Although data from one study suggests that conscientious objectors experience respect and understanding from their colleagues [34], four studies include data suggesting that non-objecting health workers encounter stigma and judgement, and sometimes limitations on their career trajectories [16,20,31,32]. Data from one study suggests that some health workers use conscientious objection to avoid stigma [16]. Data from two studies indicate that junior physicians may be discouraged [27] or even prevented [45] from providing abortion care because, inter alia, of apprehended stigma where senior physicians or management oppose abortion. This points to the ways in which conscientious objection can operate as a barrier to abortion not only because of non-provision by objectors but also because of its broader implication within a facility or setting which, in turn, reinforces the importance of ensuring that states comply with their international human rights law obligation effectively to regulate conscientious objection and protect the right to the highest attainable standard of physical and mental health including through ensuring the availability and accessibility of sexual and reproductive healthcare.

Overall evidence from two studies reported on the outcome perceived impact on provider-patient relationships [18,34]. While evidence from one study described that objecting healthcare providers thought their expression of conscientious objection might make women feel guilty or judged [18], thus impacting the relationship between provider and abortion seeker, this was not shared by all participants in the other included study, some of whom considered that there were no damage to the relationship in the majority of cases [34]. Finally, evidence from four studies suggests that conscientious objection contributes to broad health system and social costs [32,33,36,46]. Evidence from three studies suggests that some providers who refuse abortion provision without additional compensation in public settings provide abortion for formal or informal payment in private settings, suggesting that purported conscientious objection operates to divert people from public to profit-making private settings [32,33,36,46]. Evidence from a further study suggests that conscientious objection contributes to increased abortion-related morbidity and mortality [46], calling to mind states' obligation to take steps to reduce maternal mortality and morbidity including where that is related to the regulation of abortion.

3.3. Discussion

This review demonstrates that conscientious objection continues to operate as a significant barrier to access to quality abortion care. Even where someone succeeds in accessing quality abortion following such a refusal, the experience of encountering and managing conscientious objection can be harmful. For those who seek to end their pregnancies it poses the challenges of stigma, judgement, refusal, inaccessibility, and unforeseeability about the availability of care that the studies considered in this review make clear. As health systems are themselves social institutions [47,48] shaped, in part, by interpersonal power dynamics, health workers' values, identities and personal ethics are inescapably embedded within them. Conscientious objection thus poses challenges to individual health workers, varying from managing the workload implications of colleagues' preference not to engage with the provision of abortion care to seeking to maintain personal ethics and conscience while providing health care. From a regulatory perspective, however, the challenge is especially acute.

To ensure quality of care and health systems, those who determine law and policy relevant to abortion provision must seek to both provide health care in accordance with the preferences and human rights of those who seek it and to ensure equal, non-discriminatory, and person-centred care while respecting the values, ethics, and employment entitlements of those who work within the health system. This is a challenge with which both international and national systems continue to grapple. The legal regulation of conscientious objection varies widely across systems, including the systems that are reflected in the studies included in this evidence synthesis. Variations include who can claim objection (individual health workers v. institutions, those directly involved in the provision of abortion v. anyone in any way involved with the provision or management of abortion care), when abortion care may be refused and when it may not, and whether, how quickly, and through what process there is an obligation to refer an abortion seeker to someone who is willing to provide care. In some countries the formal law provides for conscientious objection but fails to specify who may claim it, how, and in what circumstances [4]. It is extremely rare for a country expressly to prohibit conscientious objection to abortion [4]. No international human rights bodies have to date characterized conscientious objection *per se* as a violation of women's rights, but many have recognized that it can result in such violations and thus made clear states' obligations of effective regulation. In many cases, however, domestic law and policy continues to be silent or ambiguous about exercises of 'conscience' that are incompatible with the obligations outlined in international human rights law and professional codes of practice [49]. Similarly, international human rights law does not *require* states to permit conscientious objection and while the right to *hold* conscience or belief is unlimited, the right to manifest one's conscience or belief is not [50]. As a matter of international human rights law, states are both entitled and obliged to regulate health workers' manifestation of conscience or belief to ensure that it does not undermine or hinder pregnant people's access to lawful abortion [8, paras 14;43,9, paras 11;13,11, para 65(m),51, paras 30; 31(d),52, para 37(b)-(c),53, para 33(c),54, paras 41(d); 42(d),55, paras 11–12].

Studies attest to the complexity of health workers' personal conscience and ethics in respect of abortion [22]. Many health workers are neither absolute objectors nor absolute providers, but rather are better described as partial objectors, i.e., people who have a relatively clear sense of what they are comfortable with providing and what they consider unethical healthcare which they would not provide. Importantly, the profundity, sincerity, or basis of the decision to refuse care does not materially change the individual and system effects of conscientious refusal of abortion care: regardless of the grounding for the refusal, conscientious objection operates to erect barriers to, and interrupt continuity of, abortion care, with significant implications for pregnant people's human rights.

Given the regulatory difficulties that it poses, it is perhaps to be expected that in many countries the law is either silent on conscientious objection or reflects what Brock calls the 'conventional compromise' of allowing conscientious objection to abortion but seeking to regulate or limit it in a way that purports to minimize its impacts on women's health and human rights, albeit often in unclear or under-specified terms [56]. This compromise involves an understanding of issues such as who may refuse (usually limited to those involved in the direct provision of care), what must be provided where there is a refusal of care (usually comprising a referral obligation), and when refusal is not permitted on the basis of conscience (usually in emergency situations), although these factors are not always expressly articulated in the law and, as the studies considered here have shown, where they are they are not always complied with. Professional bodies tend also to endorse such a compromise, especially by making clear that health workers must inform women that abortion is available and refer them to another professional who can provide the abortion care sought [57,58]. The compromise may also be further operationalized by informal rules like 'practical norms' that shape everyday professional behaviors but may not always be compatible with formal rules and laws [59,60], hence colleagues finding practical ways to accommodate conscientious objection by even where it *is de jure* prohibited. Such a compromise is also reflected in international human rights bodies' treatment of conscientious objection. While states may permit conscientious objection, they are required to guarantee an adequate number of willing providers and their appropriate geographic distribution [8], to prohibit institutional conscientious objection [61, para 33(c),51, paras 30–31] [62, para 41(f)], to establish effective referral systems [8 para, 43] [11, para 65(m)], [9, para 11,61, para 33(c),62, para 43] [63,64, para 28], to impose clear limits on who may object and in what situations [8, para 43], and to ensure adequate monitoring and enforcement of laws and policies on conscientious objection [51, paras 30–31,62, para 41(f),23, para 37(b)].

However, neither the prohibition on conscientious objection, permission with limitations and referral requirements, or regulatory silence alone address what the studies considered in this review suggest is a critical difficulty, namely cases in which health workers who object to abortion care go beyond merely opting out of provision of that care and engage instead in efforts to prevent or obstruct access to abortion. This reinforces the argument of Keogh et al. that practices of objectors seeking to delay or deter women from access abortion are "clearly contrary to the 'conventional compromise'…[which seeks] to preserve the integrity of the objector by not making them complicit in what they believe is wrong" [18]. Such behaviors go beyond the mere holding of a particular belief or ethical position and constitute manifestation of such belief or ethical position in a way that has negative effects on the rights and well-being of others. As a result, any claimed right to freedom of conscience or belief cannot properly ground a claim that the state cannot act to limit such purported conscientious objection to abortion care provision.

3.4. Limitations

This review has limitations. While the studies are geographically diverse, some regions are un- or under-represented including the Middle East, Eastern Europe, and parts of Africa. In addition, the legal and health systems are highly divergent across the settings, as are cultural and demographic dynamics which may have relevance for the prevalence and impacts of conscientious objection in abortion care. We did not relate the studies included here to other studies on, for example, prevalence of objection within the specific settings and such a further study might reveal further nuances relevant to understanding the health and non-health impacts of conscientious objection.

3.5. Only studies published in English were included

Understanding the rights-related implications and impacts of interventions in abortion law and policy does not lend itself easily to study

designs such as randomized control trials or comparative observational studies. This is reflected in the mixture of study types contained in this review as outlined in Table 1. While the range of study types included might be considered a limitation in a conventional systematic review, it is consistent with approaches adopted in human rights law research and analysis and does not limit the review's usefulness in identifying rights-related implications of law and policy interventions as is the objective of this review. Similarly, as we have previously explained [13], standard tools used for assessing risk of bias or questions of quality such as GRADE [65] are not suited to this range of studies and the broad objective of ensuring the full integration of human rights law in the review.

Finally, as mentioned above and explained elsewhere [13], we limited our engagement with rights standards to international human rights law and did not consider regional or domestic legal standards which vary across settings depending on factors such as ratification of international treaties and the status of international instruments in domestic law [12, p. 7].

4. Conclusion

Some scholars have expressed the view that conscientious objection is irredeemably flawed and should no longer be permitted [66–68], while others argue that it has sufficient value to health workers and to health systems that more effective modes of managing it (ranging from quotas where there is evidence that conscientious objection is impeding access to abortion [69], to increased clarity in laws, policies, and training [2]) to ensure that it does not undermine access to abortion should be pursued. The latter approach is consistent with calls from the World Health Organization and UN human rights bodies for states to take steps to ensure that conscientious objection does not undermine access to abortion in practice. The evidence considered in this study suggests strongly that current approaches to the exercise of conscientious objection are insufficient to achieve this. It is thus clear that, if permitting conscientious objection to abortion care is to be maintained, better and further action to centre abortion seekers in the regulation of conscientious objection and to prevent and ensure accountability for manifestations of conscience that go beyond opting out of direct provision of abortion care in non-emergency settings are needed.

CRediT authorship contribution statement

Fiona de Londras: Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Writing – original draft. **Amanda Cleeve:** Data curation, Formal analysis, Investigation, Methodology, Visualization, Writing – review & editing. **Maria I. Rodriguez:** Formal analysis, Methodology, Writing – review & editing. **Alana Farrell:** Data curation, Investigation, Writing – review & editing. **Magdalena Furgalska:** Data curation, Investigation, Writing – review & editing. **Antonella F. Lavelanet:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Methodology, Project administration, Resources, Validation, Writing – review & editing.

Declaration of Competing Interest

There are no conflicts of interest to declare.

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Supplementary materials

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Corrigendum

Corrigendum to 'The Impact of 'Conscientious Objection' on Abortion-Related Outcomes: a synthesis of legal and health evidence'

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The authors regret that this paper erroneously included a duplicate study reviewed in different formats (working paper and published article). The study 'Autorino 2018', reference 28, should not have been included. The total number of included manuscripts should be 30 (rather than 31), with 3 studies relating to Italy (rather than 4). The number of studies relating to the following outcomes of interest should be adjusted to (a) 13 for delayed abortion; (b) 21 for opportunity costs; and (c) 14 for workload implications. Table 1 should be adjusted to remove 'Autorino 2018'. In addition, information on Autorino 2020 (ref. 29) in Table 1 should be adjusted in respect of Methods (which should read 'Panel data analysis (n=>1 million observations at individual level observations, between 240 and 268 observations at regional level); data on CO and on all abortions taking place in healthcare facilities in Italy, between 2002 to 2016') and Participants (which should read 'Abortion data from the Italian National Statistical Office (Istat) and CO data from the Italian Institute for Health'). These corrections do not change the overall outcomes, discussion, or conclusions outlined in the paper.

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