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# Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study

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**Abstract**

Since abortion laws were liberalized in Western Europe, conscientious objection (CO) to abortion has become increasingly contentious. We investigated the efficacy and acceptability of laws and policies that permit CO and ensure access to legal abortion services. This is a comparative multiple-case study, which triangulates multiple data sources, including interviews with key stakeholders from all sides of the debate in England, Italy, Norway, and Portugal. While the laws in all four countries have similarities, we found that implementation varied. In this sample, the ingredients that appear necessary for a functional health system that guarantees access to abortion while still permitting CO include clarity about who can object and to which components of care; ready access by mandating referral or establishing direct entry; and assurance of a functioning abortion service through direct provision or by contracting services. Social attitudes toward both objection and abortion, and the prevalence of CO, additionally influence the degree to which CO policies are effectively implemented in these cases. England, Norway, and Portugal illustrate that it is possible to accommodate individuals who object to providing abortion, while still assuring that women have access to legal health care services.

## Introduction

Abortion laws were liberalized in many countries throughout Western Europe from the

1960s onward, with first-trimester abortion becoming functionally available upon a woman's request within varied legal structures and requirements. Out of political compromise or pragmatic necessity, clauses allowing medical practitioners to refuse to perform abortions on grounds of conscience were inserted into many of these laws. Since then, conscientious objection (CO) has become increasingly politically contentious. Some argue that the loss of staff willing to perform abortions—on account of their invoking CO—has effectively limited access for women seeking legal abortions in certain jurisdictions, while others stress the importance of respecting individual conscience.

CO has been defined as "the refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical, or ethical beliefs."[1] Although CO to abortion is reportedly widespread, a limited number of countries have laws or policies that regulate its practice. In 2013, Wendy Chavkin et al. conducted a scan of national laws and policies that regulate CO to abortion, finding that most of those countries with regulations permit CO but circumscribe the practice in order to protect women's access to care.[2] A similar review from 2015 found only 22 countries that explicitly regulate CO to abortion, most of which are in Europe and have legally permissible abortion and national health care systems.[3] Many of these countries stipulate who is eligible to object and restrict the circumstances in which CO is authorized. However, a few countries, primarily in Scandinavia and Eastern Europe, do not discuss CO in their abortion laws, which has been interpreted to mean that providers lack a legal right to object.[4]

We embarked on this exploratory multiple-case study of four countries whose abortion laws contain CO clauses in order to assess the efficacy and acceptability of national policies that regulate CO to abortion—that is, do their regulations effectively permit CO while still ensuring that women have access to abortion care? We restricted our inquiry to those countries that have CO clauses in statute, legally permissible abortion, and publicly funded health care provision in which the state has an obligation to provide an agreed-on bundle of health care services to its citizens. The selection of countries was also based on the feasibility of stakeholder interviews and the extent to which in-person interviews would expand our understanding of a regulation's perceived impact on abortion access. The four countries meeting these requirements are all high-income Western European countries with liberal abortion regimes. Lawmakers seeking to liberalize national abortion policies must consider a wide variety of legal, social, economic, and cultural factors that influence access to abortion, of which CO is only one. We hope that these case studies can inform stakeholders about the varied experiences of countries which purport to

regulate CO in a manner that enables both objection and abortion access.

Each of these four countries has ratified the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the European Convention on Human Rights, and the European Social Charter. Article 18(1) of the International Covenant on Civil and Political Rights guarantees the right to freedom of thought, conscience, and religion, while Article 18(3) explicitly authorizes restrictions on exercise of conscience when necessary to protect public safety, order, health, or morals, or the fundamental rights and freedoms of others. Article 12 of the International Covenant on Economic, Social and Cultural Rights enshrines the right to health, and Articles 16(e) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women affirm the reproductive rights of women and access to family planning care, respectively. International and regional human rights bodies charged with interpreting these treaties and supervising the compliance of states have determined that the freedom to manifest religion or beliefs can be subjected to restrictions. Specific findings by such bodies include the requirements that laws and policies permitting CO must pertain to individuals, not institutions; must require objecting physicians to refer women to alternate accessible and willing providers; and must ensure that sufficient numbers of non-objecting providers are available. The professional ethical guidelines of many countries' medical, nursing, and midwifery societies support the option of CO but require objecting providers to be forthright about their objection, to provide referrals, and to provide treatment in medically urgent situations (see Table 1).

**Table 1. Professional standards of care regarding conscientious objection to abortion**

## Methods

We employed an exploratory, multiple-case study design because it is well suited to analyzing the nuances of complex phenomena and relies on multiple data sources to enhance rigor and strengthen the credibility of the theories generated.[5] Prior to commencing fieldwork, we surveyed each country's health system and legal landscape as they relate to abortion and CO, using research templates to ensure the uniform collection of background information. This included a review, in collaboration with legal colleagues,

of each country's constitution, relevant laws, and regulations. These data, along with other data sources—including medical codes of ethics and professional guidelines, government and regional agency reports, press clippings, scholarly publications, archival documents, and interviews with key stakeholders—were catalogued in online folders shared among the research team.

In each country, we interviewed 11–16 stakeholders from all sides of the debate, including at least one lawmaker, legal expert, health system official, medical association representative, reproductive health advocate, academic, bioethicist, anti-abortion advocate, and religious freedom advocate. In total, 54 stakeholders participated in semi-structured interviews across our four cases. Background research and key informants in each country helped identify relevant participants, and we conducted a preliminary investigation of the public stances of each interviewee in order to ensure that the sample included those with a range of attitudes toward abortion and CO. Most interviews were conducted in English, with some in Italian and Portuguese, which were subsequently translated into English for analysis. Interviews were digitally transcribed. Through an iterative process, the research team agreed on a set of descriptive analytical themes across cases. To increase rigor, case summaries were reviewed by several interviewees from each country.

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**Case summaries**

*England*

In 1967, the UK Parliament passed the Abortion Act, establishing legal exceptions to the Offenses Against the Person Act of 1861 and to the Scots common law offense of abortion. Under the 1967 law, an abortion may be lawfully provided if two physicians concur that the continuance of the pregnancy would involve greater risk to the physical or mental health of the pregnant woman or her existing children than would termination before 24 weeks of gestation, or at any time in the pregnancy if there would be substantial risk of serious disability in the resulting child or serious risk to the life or health of the pregnant woman.[6] The Abortion Act applies in England, Scotland, and Wales, but not in Northern Ireland or the Isle of Man; for the purposes of this study, we analyzed the situation only in England. The National Health Service (NHS) pays for almost all abortions for resident women and contracts with the nongovernmental charitable sector, primarily

Marie Stopes International and the British Pregnancy Advisory Service, to provide the majority (about two-thirds) of these services.[7] As of 2015, medication abortions (also known as medical abortions) accounted for 55% of all abortions provided in England.[8]

Section 4 of the Abortion 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 authorized by this Act to which he has a conscientious objection."[9] There is no formal system for CO declaration. Since the law's passage, two court cases have clarified that conscientious objection to abortion is limited to those directly participating in treatment and that they can object only to services directly related to abortion care.[10] Professional medical organizations consider it important to protect their members' exercise of conscience and to simultaneously emphasize providers' duty of care to patients, as well as their obligation to prevent their private beliefs from impeding patients' access to information and services.[11] Both professional guidance and common law require objectors to refer patients to another provider, locating this responsibility to refer under the rubric of the duty to care.[12] Women can "self-refer," which means bypassing the usual gatekeeper —a general practitioner—by obtaining the two required physician signatures under the Abortion Act at the site providing the abortion.[13] It is permissible for employers to require a willingness to provide abortion services as part of job descriptions.[14] In our interviews with anti-abortion respondents, some found this practice discriminatory and thought it could dissuade medical students from entering into associated specialties; most of the stakeholders we interviewed, however, stressed its functional necessity.

Clinical commissioning groups (CCGs) are responsible for determining the health needs of the local population and commissioning health services accordingly (in this case, for example, from the NHS hospital and/or British Pregnancy Advisory Service or Marie Stopes International).[15] In order to determine met and unmet need, they use established benchmarks for the proportion of women who obtain abortions under 10 weeks, and they require abortion services to be provided within a specified period of time following a request.[16] A CCG monitors compliance with its contracts; if an institution were to fail to provide the procedure, the CCG would deem the institution in breach of contract and would reassign the contract. Respondents reported that budget cuts to the NHS and the devolution of many responsibilities from the NHS to CCGs have led to low reimbursement rates for abortion and to competition between family planning and other locally needed services. They added that this aggravates generalized demoralization among NHS clinicians and makes many reluctant to add abortion (or intrauterine device provision) to an increasingly overburdened workload.

Several interviewees discussed developments since the passage of the law, which they believed had consequences both for CO and for practice. They reported that the advent of medication abortion had lessened the burden for some objectors by making them feel less complicit if the woman self-administers the medications, whereas it confused boundaries for others. Moreover, the relocation of most abortion provision to the independent sector has decreased in-hospital training opportunities and has effectively separated abortion care from mainstream medicine.[17]

Most expressed the view that CO did not significantly impede access to abortion. In addition to the reasons just described, many pointed to the fact that objectors constitute a small minority. While the law does not allow abortion on request, interviewees reported that in practice most women experience ready access and are reportedly unaware that abortion remains in the Criminal Code. Nonetheless, respondents additionally reported that one group of advocates has launched a campaign to remove all criminal restrictions on abortion. Several study participants who favor abortion access disputed the necessity to do so, voicing concern that it might prove politically risky.

While the Church of England is the official state religion, one respondent characterized England as “a country with a very depleted religious tradition.” Other interviewees highlighted that England is a “multi-faith, multi-ethnic, multi-cultural society” committed to honoring diversity while also ensuring that differing views do not intrude on one another.

*Italy*

Enacted in 1978, Italian Law No. 194 “on the social protection of motherhood and the voluntary termination of pregnancy” legalizes abortion during the first 90 days of pregnancy for economic, family, health, or personal reasons, and allows abortion before 24 weeks’ gestation when the pregnancy entails a serious threat to the woman’s life or when fetal abnormalities constitute a serious threat to the woman’s physical or mental health.[18] Women seeking abortion must first undergo an exam and “options counseling” in order to obtain a certificate confirming qualification for the procedure; then they must wait seven days, unless there is urgent need for termination.[19] Law No. 194 emphasizes that the purpose of counseling prior to abortion is to make women aware of available welfare services and to help them “overcome the factors which might lead the woman to have her pregnancy terminated.” Additionally, the law states that the “father of the conceptus”

should be included in counseling, with the woman's permission.[20] In practice, the provision allowing second-trimester abortions to protect the mental health of the woman is rarely utilized, and women seeking services after 12 weeks often travel abroad for care.[21] Italy's national health system, the Servizio Sanitario Nazionale (SSN), is required to fund all abortion services provided in the country, which it does mostly in public hospitals, with a small minority in approved private clinics. Only obstetrician/gynecologists may be certified as abortion providers. As of 2013, 93.5% of abortions in Italy were performed in SSN hospitals as opposed to private clinics, and 86.2% of the procedures were surgical.[22]

Article 9 of the law legalizes and regulates the practice of conscientious objection, which is permitted unless the immediate termination of pregnancy is essential in order to save the pregnant woman's life. While the law requires objectors to submit a declaration of objection to the provincial medical officer, interviewees consistently explained that objectors usually notify just their medical supervisors. Even then, participants noted, a declaration of objection is moot in cases where objectors are employed at a Catholic hospital, work at a hospital where the medical directors are themselves objectors, or work in one of the many hospitals where nobody provides abortions and where there is thus no such service.

Respondents reported that it is the hospital's responsibility to ensure that the patient receives all necessary services. Regional health departments are responsible for monitoring hospital compliance, and they hold an explicit right to move personnel if necessary.[23] However, interviewees misunderstand this and consistently asserted that listing abortion provision in a job posting is considered discriminatory, which limits regional health departments' ability to effectively redistribute the provider workforce. As a result, participants explained, many hospitals are staffed only by objectors and thus offer no functional abortion services. Despite the clarity of the law regarding the scope of permissible objection, many respondents were unaware of the legal requirements relating to who can object and to which components of care. All interviewees opposed to abortion expressed discontent with any constraints on CO.

Unlike in the other countries, CO in Italy is widespread, with estimates of prevalence among gynecologists in Rome and the surrounding region ranging from 81.9% (according to the Department of Health) to 91.3% (according to the Free Association of Italian Gynecologists for the Application of Law 194).[24] Only 60% of Italian hospitals offer abortion services.[25] Several interviewees who favor abortion access explained that Article 9 had made sense when the law was initially passed in 1978, since it would have been

unrealistic to force providers to suddenly comply with a new requirement to provide abortion services. However, in their view, the way the law has been implemented has resulted in an inversion of the initial intent to allow an exception to the norm of providing care. Instead, they explained, objection has become the norm and abortion provision the exception. Interviewees from all sides of the debate noted that abortion providers in Italy experience discrimination, increased workloads, and limited career trajectories. Many said that some clinicians registered as conscientious objectors in order to avoid these burdens, rather than for moral or religious reasons, and referred to this as “convenient” objection.

Article 15 of Law 194 requires that health personnel be trained in and make use of “more modern techniques of pregnancy termination which are physically and mentally less damaging to the woman and are less hazardous,” illustrating impressive foresight on behalf of the drafters, who had anticipated technological developments.[26] However, several interviewees consider the paucity of medication abortion to be in direct contradiction to this provision. Medication abortion accounted for only 13.8% of abortions in Italy in 2013, and access varies dramatically based on regional restrictions.[27]

In 2012, the International Planned Parenthood Federation European Network filed a complaint before the European Committee of Social Rights asserting that access to safe abortion was limited in Italy due to widespread conscientious objection, and a similar complaint was filed a year later by the Italian General Confederation of Labour.[28] The committee issued decisions on these complaints in 2014 and 2016, respectively, finding that women do encounter substantial barriers and discrimination when seeking access to abortion and that affected hospitals do not adequately compensate for service gaps due to CO.[29] The committee held that this violates the right to health and the right to nondiscrimination as enshrined in the European Social Charter.

Interviewees emphasized the social and political influence of the Vatican, despite the fact that only 30% of Italians regularly attend mass.[30] Many publicly funded hospitals are affiliated with the Catholic Church and do not provide abortion services even though some employees may be willing. Interviewees who favor abortion access reported that, in their view, the Catholic Church’s overt opposition to abortion has contributed to the stigma associated with the procedure in Italy.

Notably, interviewees across the board remarked that the law in Italy is well written but not applied. Those opposed to abortion felt that counseling clinics do not adequately

fulfill their duty to dissuade women from having abortions. Conversely, those who favor abortion access described the SSN's inadequate performance in maintaining access to abortion services in the face of widespread individual objection. As one respondent put it, "I really think that the question is not conscientious objection but a well-organized health system, which recognizes abortion as a health procedure."

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*Norway*

Passed in 1975, Norway's Act No. 50 "concerning the termination of pregnancy" allows abortion on request before the 12th week of pregnancy. It also permits abortion through 18 weeks' gestation if a board determines that continuing the pregnancy would put a significant mental or physical strain on the woman, that the resulting child might suffer from severe medical complications, that the woman's pregnancy is the result of rape or incest, or that the woman suffers from a severe mental illness.[31] After the 18th week of pregnancy, terminations are authorized only under exceptional circumstances. As in England, interviewees in Norway explained that the policy in practice enables women to bypass the usual gatekeepers—general practitioners—and self-refer for the procedure. Public hospitals are required by law to provide abortion services; the Norwegian National Health System finances all abortions which take place in public hospitals, with a few pilot programs providing abortions in non-hospital clinics.[32] Often, obstetrician/gynecologist registrars (physicians in specialty training) perform abortions. In 2015, 86.4% of terminations were medication abortions.[33]

The 1975 law allows health care professionals who are directly involved in providing or assisting abortions to object to participating. Clinicians may not invoke CO if the life of the pregnant woman is in danger.[34] While the law specifies that objectors should provide written notification to their administrative chiefs, interviewees held conflicting views regarding whether such a declaration was mandatory; nonetheless, respondents concurred that objectors usually notify their supervisors informally and that this functions well.[35]

Most interviewees, regardless of their stance on abortion, agreed that women should not experience provider disapproval when seeking abortion and that it was the health care authority's responsibility to ensure that women receive legal care. To illustrate fulfillment of this duty, respondents reported instances where physicians had been sanctioned or

dismissed for objecting to providing intrauterine devices. Municipalities are charged with organizing abortion services in such a way that women are able to obtain care even where CO exists, and most interviewees therefore agreed that it would be permissible to include abortion provision as a required duty in job descriptions.[36] Some nurse and midwife interviewees working in hospitals described feeling overburdened when many of their colleagues were objectors and reported sites where it had been necessary to cap the number of objectors and to require willingness to provide abortions as a hiring prerequisite. Most physician interviewees had not experienced such situations. The majority of respondents in Norway did not feel that CO hindered access to abortion services, although some reported that thinly populated and staffed rural areas might experience occasional staff shortages, which could lead to delays.

In 2011, the Norwegian Ministry of Health and Care Services issued a circular clarifying that general practitioners could not object to providing women with referrals to abortion services.[37] However, in 2014, the health minister attempted to widen the scope of conscientious objection by allowing general practitioners to refuse to provide women with abortion referrals. This led to popular protest, with 10,000 people demonstrating against it at the March 8th Women's Day celebration in Oslo. The proposed changes were withdrawn, physicians' obligation to help women seeking abortion was underscored in subsequent regulations, and women were allowed to self-refer for abortion services in addition to prohibiting general practitioners' refusal to refer.[38] Nonetheless, despite this recent debate, interviewees consistently reported that general practitioners who are objectors constitute a very small minority.

While the Evangelical Lutheran Church is the established Church of Norway, the Constitution provides for the free exercise of religion and stipulates that all religious and belief communities shall be supported equally.[39] According to one anti-abortion respondent, this church has no official guidance on CO to abortion, and others reported that most Norwegians are not religiously observant. Almost all Norwegian interviewees, despite their differing views on abortion and on the desirable scope of CO, concurred that the regulation of CO should accommodate the competing interests of stakeholders and that women must be able to readily obtain non-judgmental services. As one interviewee who favors expanding the scope of CO explained, "I think it's important to take care of both sides. We have the law and I can say I don't agree with this law, but that's the democratic minority. I don't agree with abortion but we have the law, and I have to take care of the doctors and nurses who don't want [to perform abortions] in the same way I also have to take care of the women, because they have a right in the law [too]."

*Portugal*

In 1984, Portugal amended its Penal Code to permit abortion in cases of rape and in cases where the pregnancy poses a danger to the health of the woman or fetus.[40] After much social protest that led to a referendum in 2007, another exception was added to the Penal Code whereby abortion is permitted upon a woman's request within the first 10 weeks of pregnancy.[41] Women seeking an abortion must first undergo a physical exam and options counseling in order to obtain a certificate confirming their qualification for the procedure, which is followed by a mandatory three-day waiting period.[42] The Portuguese national health system, Serviço Nacional de Saude (SNS), is obligated to provide free abortion care within five days of a patient's request and provides care largely through its own public hospitals (around two-thirds of abortions), which almost exclusively provide medication abortion.[43] The onus lies on the hospital to ensure access. In areas with provider shortages, the SNS dispatches traveling teams of willing physicians, pays for patients to travel and receive SNS-funded care elsewhere, or contracts with the independent sector. Unlike SNS facilities, independent contractor clinics provide primarily surgical abortion procedures.[44]

Interviewees explained that because advocates who championed the 2007 effort to further decriminalize abortion had been aware that CO would be a point of contention, they did not dispute the inclusion of a CO clause. This clause stipulates that only those involved in the direct provision of abortion may object and that objectors must submit a written declaration to their hospital director. This declaration must affirm that the objector will provide an abortion if necessary to save the health of the pregnant woman, will refer the patient to a willing clinician, will not participate in options counseling, and will identify the specific legal exceptions to which they object.[45] This "partial objection" is unique to Portugal among our cases, and it was endorsed by many anti-abortion interviewees and by some of those in favor of abortion who believe that the declaration process should reflect a nuanced gradation of objection. Those respondents opposed to abortion considered the exclusion of objectors from counseling to be discriminatory, whereas others assumed it provides relief for those uncomfortable with abortion and protects women from negative encounters.

Overall, study participants reported that Portugal's system successfully ensures women's access to abortion. They raised concerns about provider burnout in light of the fact that

clinicians working in areas with provider shortages report an excessive abortion-related workload, and consequently a limited range of practice; they consider budget cuts to the SNS to have exacerbated this problem. Interviewees mentioned that some hospitals reserve certain positions for non-objectors in order to increase women's access to abortion services.

In addition to federal regulations, the Order of Doctors' code of ethics requires doctors to report to the Order of Doctors all services (including those unrelated to abortion) to which one conscientiously objects and to immediately inform patients of their objection.[46] However, many of our clinician respondents, including those from the Order of Doctors, were unaware of these dual reporting requirements. They indicated that few complied with either and that informal adjustments suffice. As in the other cases, this irregular compliance with reporting means that rigorous data on the prevalence of objection are not available.

Several interviewees discussed the impact of Portugal's small size on access to abortion, saying that it is fairly easy for patients in locales with many objectors to travel for services, although this might entail delays. Several respondents reported that while roughly 80% of the population identifies as Catholic, only 20% regularly attend mass, leading one interviewee to characterize Portugal as a "soft Catholic country."[47]

While interviewees in the other countries frequently complained that their laws are outdated, Portuguese informants were less well versed in the intricacies of the country's abortion law, possibly because it is more complex or because it is still in its infancy. Nonetheless, the law has already withstood a challenge by anti-abortion members of Parliament, whose 2015 attempt to impose cost sharing and mandatory psychological counseling on women seeking abortion was later revoked.[48]

**Table 2. National laws and policies related to abortion and conscientious objection**

## Discussion

*Public sector commitment to providing legal care*

While the approaches to regulating CO in all four countries have similarities (see Table 2), stakeholders reported varying degrees of implementation. National health systems in the four countries are obligated to assure the provision of free, timely, and appropriate abortion care, a task for which they rely on regional health authorities and hospital managers. The duty to provide abortion services therefore rests at the organizational level as opposed to an individual one, a distinction which anchors our discussion of the specific ways in which this commitment is carried out in each country—whether by subcontract or by direct provision, with supplementation as necessary. It is worth noting that while opponents of abortion were not at peace with legally permissible abortion, they did not contest the duty of the national health system to provide publicly funded care.

In this sample, the ingredients that appear necessary for a functional health system that permits provider CO and yet assures access to abortion include the following: clarity about who can object and to which components of care; ready access into the system by mandating referrals or establishing direct entry; and assurance of a functioning abortion service through direct provision or by contracting services to other abortion providers. Surprisingly, written declaration by objectors does not appear to be essential. Although all countries but England technically require written declarations from objectors, many interviewees were not aware of this, and it seemed to be often practiced in the breach. Interviewees agreed that supervisors have to know who objects in order to design work schedules and assignments. Many considered informal on-site notification to suffice and referenced instances of cooperation among objectors and abortion providers in order to ensure the delivery of care. Respondents highlighted that this lack of consistent reporting means that there are scant or spotty regional and national data on the prevalence and characteristics of objection, which generally limits the national health system's ability to monitor implementation and intervene as needed. The English system for monitoring the provision of care is linked to contract review—because providers are on contract with the NHS, regional authorities continually review data relating to the provision of abortion in order to ensure contract compliance, a process that doubles as a method for monitoring providers' legal compliance.

All four countries stipulate that only those involved in the direct provision of abortion are eligible for objector status, and that objectors and primary care physicians are obligated to refer women seeking abortion to the appropriate provider. In all four, this has been upheld by national legislation, administrative rule making, and case law. Interestingly, England and Norway have adopted a belt-and-braces approach, allowing women to self-refer by skipping the usually required first stop at the gatekeeper general practitioner and

proceeding directly to the abortion provider. Interviewees in England and Norway reported that CO restrictions were least concerning to obstetrician/gynecologists and most disturbing to general practitioners, nurses, and midwives: the obligation to provide referrals and care prior to the procedure is most likely to affect general practitioners, and the requirement to provide post-procedure care is most likely to disturb objector nurses and midwives, who may have to administer second doses of medications or assist with post-procedure bleeding, pain management, and so forth, especially after a procedure initiated on a previous shift.

Despite the four countries' legal and legislative clarity on the fact that ancillary, managerial, and supervisory tasks fall outside the scope of legal objection, respondents in each country reported that some clinicians had illegally invoked CO to the provision of emergency contraception, intrauterine devices, and post-abortion care. While interviewees in all countries reported instances when clinicians had been sanctioned or prosecuted for failure to comply with the law, they also described uneven and incomplete monitoring of compliance. Participants reported ongoing debate in their respective countries over excluding objectors from counseling, as is done in Portugal. While anti-abortion interviewees in Portugal and Italy saw such exclusion as unfair to both objectors and women, their counterparts in Norway said that they approved of protecting women from exposure to disapproving clinicians.

Whether the national health system provides abortion itself or subcontracts the procedure out to third parties can affect its ability to permit objection and ensure women's access. In Italy, interviewees said that SSN insistence that care be provided at its own facilities despite the lack of willing clinicians has stifled the emergence of an independent sector and constrained access to the procedure. However, in England, where ready access is assured because the independent sector provides the majority of abortions in stand-alone clinics, interviewees said that obstetrician/gynecologist trainees within the NHS often lack sufficient opportunity for training in abortion care. They anticipate that this technical competence gap could prove increasingly problematic, since the need for hospital-based abortion care for women with medical complications may increase if England's obesity and diabetes epidemics persist. Norway avoids this problem by relying on obstetrician/gynecologists-in-training to provide most in-hospital abortions.

In contrast to their counterparts in England, Portugal, and Norway, interviewees in Italy consistently reported that access to abortion is compromised in areas with a high prevalence of objection and that the government has not compensated for the paucity of

willing providers. Interviewees from all four countries queried whether increased salaries or other positive incentives might attract more clinicians to abortion provision and simultaneously reduce stigma. They also reported that clinicians might be more willing to provide medication abortion than surgical abortion. Lastly, they speculated that the health system could increase the pipeline of willing providers by routinely incorporating training on the clinical and legal aspects of reproductive health care. The Norwegian law stipulates only that abortions must be performed by medical practitioners and in facilities approved by the medical officer, which widens the pool of eligible providers and settings.

*Societal attitudes toward objection and abortion*

Interviewees in each country conveyed a range of attitudes toward both objection and abortion that appear to affect the efficacy of policy implementation in that country. Interestingly, the majority of interviewees who are advocates for abortion expressed a widespread acceptance of CO, for various reasons. Many of them justified their perspective on the grounds of respect for self-determination and integrity, which they consider applicable not only to women who decide to terminate pregnancies but also to clinicians who decide that their moral beliefs preclude them from performing abortions. Pragmatically, many in this group also articulated a wish to protect women seeking abortions from disapproval and from receiving care from individuals uncomfortable with providing it. A similar desire to shield women from exposure to those with negative attitudes toward abortion underlay their rejection of requiring proof of sincerity of objection, along with their opinion that doing so would be impracticable and smack of policing. This group of interviewees also pointed to the earlier era of “silent objection”—when some objecting staff would discourage or delay patients—as confirming the utility of permitting CO, since the overt practice can then be subject to regulatory constraints.

However, this type of pragmatism was not uniform. A few interviewees in each country advocated the prohibition of CO altogether, considering it incompatible with clinicians’ duty to patients and arguing that objectors should choose other lines of work if they are unable to fulfill all of their responsibilities. Women’s rights advocates in Portugal, England, and Norway highlighted a refusal to cede ground gained for women’s position over recent decades. On the opposite side of the spectrum, aside from participants in Norway, anti-abortion respondents could not reconcile their opposition to abortion with a toleration of permissive laws, nor with constraints on CO.

Interviewees consistently noted that the stigmatization of both objection and abortion provision complicates policy in practice. Those opposed to abortion access argued that objector stigma is a reason why more providers do not object to providing abortion whereas, conversely, those supportive of abortion linked abortion-provider stigma with provider shortages, burnout, and "convenient" objection. Moreover, while all four countries have mechanisms for patients to complain about health service provision, many interviewees reported that women seeking abortion are unlikely to complain because of shame or stigma associated with the procedure, thus limiting a country's ability to monitor the implementation of CO policies. In fact, because Italian abortion advocates reported that they could not identify a woman willing to step forward with a formal complaint or legal challenge, nongovernmental organizations had to initiate the two complaints brought before the European Committee of Social Rights.

The limitations of our approach preclude us from generalizing our findings. This was an exploratory study of four liberal Western European countries with national health care systems and abortions provided without patient fees. We interviewed a non-representative sample of participants who were chosen because of their organizational roles. We did not systematically investigate the experiences of women seeking abortion nor of practicing clinicians (although many of the physicians, nurses, and midwives interviewed because of their institutional roles were also practitioners and relayed their own observations from the frontlines), and we cannot report whether these groups substantiate the observations here. Therefore, we lack the empirical grounding to make recommendations for countries without specific laws, with less robust health sectors, or with a higher prevalence of CO. Nonetheless, there are strengths in our study approach that support confidence in the findings. The use of multiple cases integrating legal analysis, offical documents, and interviews of experts permits a comparison of patterns across similar countries, the provision of granular detail about the translation of CO policy into practice, and the preliminary identification of factors that enable robust access to abortion by the public sector in the context of CO.

## Conclusion

CO to abortion presents a challenge to governments charged with negotiating competing belief systems. Non-theocratic governments with commitments to pluralism have to resolve tensions between contending rights and obligations, particularly when the

conflicts involve governmental services or requirements. This balancing act becomes especially fraught when the domain is socially contentious and the line between religiously based conscience and political position is blurred. This is certainly the case regarding reproductive health care, where political and religious opposition have been closely allied and often indistinguishable. Legally permissible CO to legally sanctioned health care highlights the competing interests of objectors, willing providers, patients, and societies committed to delivering a democratically agreed-on set of services by a national health care system.

Regional and international human rights bodies concur that states must provide abortion services and can limit the expression of CO in order to do so. According to our interviewees, England, Norway, and Portugal comply with their national laws that permit individuals to exercise CO to abortion, while still fulfilling their obligations to provide and fund access to abortion care. They do so by imposing constraints on objectors and by assuring ready access into a functioning system. These “best case” studies illustrate that it is possible to permit CO to abortion and still ensure that women have access to care.

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