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Medical Conscientious Objection in Latin America 30 Years After Cairo

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Abstract

The 2018 and 2020 debates on abortion legislation in Argentina, the decriminalization rulings by the Mexican Supreme Court, the resistance from physicians in Peru, and Chile's unsuccessful attempt at constitutional reform share a common element: the centrality of conscience clauses. These provisions enable healthcare personnel to invoke conscientious objection (CO), allowing them to refuse participation in medical procedures that conflict with their moral or religious beliefs. This phenomenon gained attention following the 1994 International Conference on Population and Development (ICPD), marking a significant global shift from population control towards a rights-based approach to reproductive health and rights. As this framework became more established, the role of CO in healthcare began to change. It became a way out not only for those with religious convictions but also for health professionals concerned about the stigma surrounding sexual and reproductive health services, particularly abortion. In other words, it turned into a means to navigate new professional obligations, and even a strategy to cope with excessive workloads. However, its most problematic use arises when it becomes a political tool, as conservative groups started to invoke CO as a form of resistance to new sexual and reproductive rights laws and as a symbol of ideological cohesion. As a result of its increasingly broad and strategic use, CO has ultimately limited access to timely and quality sexual and reproductive health services for women, trans people, and adolescents. This has led to systemic disruptions in healthcare provision, directly undermining ICPD's commitment to ensuring universal access to reproductive healthcare. This article focuses on abortion, where most CO regulations and legal disputes have surfaced. We examine conscience clauses of Latin America and their impact on healthcare provision, identifying trends and regulatory innovations that go beyond simply transplanting European or North American models. Among these innovations, we highlight the incorporation of institutional safeguards within conscience clauses in some Latin American countries as a novel strategy to mitigate the negative effects of expanded and misused CO. At the same time, however, we also observe that several courts and legislatures in the region have recognized the right to institutional conscientious objection (ICO), a development that has further exacerbated the harmful consequences of CO by allowing entire

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healthcare institutions to refuse services that conflict with their mission or identity. We argue that the expansion of CO clauses, along with the increasing diversity and impact of their applications, not only calls for new regulatory responses, some of which are already emerging in the region, but also demands an empirically informed reconceptualization. Such a reconceptualization must move beyond the classical definitions of CO inherited from the context of compulsory military service in order to fully grasp the current nature of this phenomenon.

Keywords Conscientious objection · Abortion law · Reproductive rights · Institutional safeguards · Latin America · Health law and policy · International Conference on Population and Development (ICPD) · Institutional conscientious objection

Introduction

It is difficult to know how many of the participants at the 1994 International Conference on Population and Development (ICPD) could have foreseen that conscientious objection (CO) would later emerge as a major obstacle to the universality and accessibility of sexual and reproductive health services—two of the Conference's core principles.

It is true that, at that time, legislation already recognized the right of health professionals to deny services based on moral or religious convictions.[1] Some cases of denial on grounds of conscience within health settings were also known, but they remained relatively limited, under-theorized, and rarely problematized.[2]

[1] For example, in Argentina, regulations on conscientious objection in healthcare began to emerge in the early 1980s and were consolidated in the 1990s, especially through laws of professional competence in nursing and nutrition. These laws recognized conscientious objection as a "right not to act"—that is, the right of health professionals to abstain from providing services that conflicted with their moral or religious beliefs, provided that such refusal did not cause harm to patients. See, in this regard, Agustina Ramón Michel, Sonia Ariza Navarrete, and Agustina Allory, "Allegations and disputes of autonomy. conscientious objection clauses in Argentine health law," in Conscientious objection in the area of health in Latin America, vol. Law, Gender and Sexuality (Bogotá: Siglo Editorial, (Ramón et al. 2024).

[2] In fact, it is during the 1980s and 1990s that the first cases of conscientious objection in health services begin to reach high national courts. For example, in 1981, the House of Lords in England, in the case of the Royal College of *Nursing*, responded to a request from the College of Nursing to protect nurses' right to conscientious objection to abortions, including pre- and post-procedures, concluding that such protection was valid. In 1985, the Constitutional Court of Spain, in the *Judgment No. 53/1985*, recognized this right as constitutional for doctors and health personnel directly involved in abortions, following an appeal of unconstitutionality against the decriminalization of abortion, affirming that conscientious objection existed even without explicit regulation. In Italy, the *Judgment No. 196/1987* arose from a case in which judges questioned the abortion law by not providing for conscientious objection for them; the Court determined that only health personnel could avail themselves of this right due to the differences in their roles. Finally, in Germany, the *Judgment of the Federal Administrative Court of 1991 (BVerwG 7 C 26/90)* addressed a case where a municipality in Bavaria required doctors to be willing to perform abortions to gain access to certain positions. The court considered the measure legitimate, justifying it in the need to guarantee health services within the legal framework. A more extensive collection of court rulings on health conscientious objection can be found at Agustina Ramón Michel and Dana Repka (n.d.), https://www.redaas.org.ar/conscientious-objection-map.

In fact, in the mid-1990s, the very concept of *reproductive health* was only beginning to enter the international human rights arena.[3] It was precisely the ICPD and its Programme of Action (PA-ICPD) that contributed to the understanding of reproductive health as a right of all people.[4] Yet the ICPD did not come forward easily. For decades, mistrust and tension had grown between several countries in the Global North and South. The First Population Conference in 1974, convened by the United Nations in Bucharest, was marked by a concern of the central countries about what they perceived as a "demographic explosion" and the low economic development of third world countries.[5] By contrast, Latin American countries, alongside members of the Non-Aligned Movement,[6] were concerned about just the opposite: declining birth rate and the fear of becoming "empty countries."[7] This clash of interests led many countries in the Global South to push back against reproductive health language, preferring instead family-centered policies.[8] Many of these *pro-natalist policies* included patriotic appeals to increase the population,[9] defend the traditional family, and ban contraceptives.[10]

From the 1960 s to 1980 s, this opposition to family planning was not exclusive to left-wing or populist governments; authoritarian and democratic regimes of various ideological orientations—often supported by the Catholic Church—converged in rejecting reproductive health policies.[11] An example is the decree issued by Isabel Perón's in Argentina banning contraception, which was continued by the military government that overthrew her.[12] However, the most brutal case of anti-natalist policy was the forced sterilizations of poor rural women in Peru, carried out under orders from President Fujimori between 1996 and 2000.[13] These violations underscore the profound challenges of translating the principles of the ICPD into reality.

[3] Mabel Bellucci (2019); (Straw 2017), https://doi.org/10.15366/rjuam2017.35.005.

[4] Jl, F., & Mcintosh, A. (1996). Cairo revisited: some thoughts on the implications of the ICPD. *Health transition review*, 6 (1996); V. Chandra-Mouli et al. "The political, research, programmatic, and social responses to adolescent sexual and reproductive health and rights in the 25 years since the international conference on population and development." *The Journal of adolescent health: official publication of the Society for Adolescent Medicine*, 65 6S (2019): S16-S40. https://doi.org/10.1016/j.jadohealth.2019.09.011.

[5] Karina Alejandra Felitti (2012).

[6] The Non-Aligned Movement emerged in the 1960 s as a coalition of states seeking to maintain their political and economic independence amid Cold War tensions between the superpowers of the USA and the Soviet Union. Composed mainly of developing countries from Asia, Africa, and Latin America, the movement promoted South-South cooperation and an agenda focused on development and sovereignty in the face of pressures from dominant ideological blocs. About the Non-Aligned Movement, see more at (Savio, 2023), 113–22.

[7] Karina Felitti (2008).

[8] (Novick 1999); Felitti, "The 'demographic explosion' and family planning under debate.".

[9] Karina Alejandra Felitti, "The demographic policy of the third peronist government: justifications, repercussions and resistances to birth control restrictions (1973-1976), (Felitti 2004).

[10] Felitti, "The 'demographic explosion' and family planning under debate.".

[11] Pablo Gudiño Bessone (2017): 38–67.

[12] Decree 659, approved by Isabel Perón, later reinforced in 1977 during the military dictatorship by decree 3938. See State Agencies. National Commission for Demographic Policy. Adopt the National Population Objectives and Policies, Decree No. 3938/77 (1977).

[13] To see how these sterilizations worked and the role of health services: (Ballón 2014).

They left a legacy of violence and racism that continues to echo today, as adolescents with intellectual disabilities are still being sterilized without their consent.[14]

Against this backdrop, the ICPD was undoubtedly revolutionary: 179 countries signed the PA-ICPD, recognizing that it is each person—not the state, nor an elite, nor a political leader—who should have control over their own body, including their reproductive choices.[15] The PA-ICPD also classified unsafe abortion as a public health issue and urged governments to commit to reducing its incidence.[16] This was a tectonic shift in the global discourse, even if it may seem modest today. By 1994, no Latin American country allowed abortion at a woman's request, and the prevailing approach was one of criminalization and stigma, not public health.

In the aftermath of Cairo, the principles and commitments adopted began to reorient sexual and reproductive health strategies and initiatives at both national and international levels.[17] In Latin America, during the First Meeting of the Regional Conference on Population and Development in Latin America and the Caribbean in 2013, States adopted the Montevideo Consensus,[18] endorsing their commitment to the PA-ICPD and prioritizing the elimination of unsafe abortion.[19]

From this trajectory, CO in healthcare—particularly in abortion services—has come out as a complex issue with far-reaching implications, posing serious risks to the fulfillment of the commitments made at Cairo.

Normatively, CO is framed as a legal entitlement that allows professionals to abstain from fulfilling certain legal, administrative, or institutional obligations on the grounds of conscience or religious beliefs. Originally linked to military service, this legal construct was designed to protect individuals from state demands that conflict with their moral integrity.[20] However, in practice, both its uses and effects have expanded significantly.

This expansion is also evident in law. Today, conscience clauses are increasingly common in abortion laws,[21] sexual and reproductive health laws, professional laws,

[14] (Sen, et al., 2019): 319—322.https://doi.org/10.1080/26410397.2019.1676534.; (Frohmader 2014); María Fernanda Téllez Girón García (2021); Colombia: Constitutional Court, Fourth Chamber of Review, Judgment T-1019 of 2006. Constitutional Court, Sixth Chamber of Review, Judgment T-492, 2006. Constitutional Court, Fourth Chamber of Review, Judgment T-063 of 2012. Argentina: The Daily Day (2022), sec. General information, https://www.eldia.com/nota/2022-1-2-2-44-47-esterilizaciones-forzadas-un-capitulo-de-horror-que-toca-su-fin-informacion-general; Chile: (Yupanqui-Concha et al. 2021): 58–75.

[15] United Nations Population Fund (1994).

[16] United Nations Population Fund, "Programme of action, adopted at the International Conference on Population and Development." See more at (Shah et al. 2014)): S39–48.

[17] Willard Cates Jr and Baker Maggwa (2014): S14–21.

[18] Economic Commission for Latin America and the Caribbean (ECLAC) (2013).

[19] Some countries in Latin America have used postabortion care as an entry point to increase access to abortion. In Argentina, for example, health professionals adapted the global model of postabortion care to expand safe access to abortion in certain medical facilities, using practices that defy national bans on abortion and resist state surveillance. See in this regard: Siri Suh and Julia McReynolds-Pérez (2023): 395–421, https://doi.org/10.1086/722315.

[20] María Ayelén Gaitán Zamora and Miguel Hernán Vicco (2019): 528–34.

[21] Wendy Chavkin et al. (2013): S41-56, https://doi.org/10.1016/S0020-7292(13)60002-8.

and, in general, in laws on health services.[22] Recent history in Latin America is testimony to this regulatory impetus around CO, which is especially prominent in abortion.

Based on extensive documentary research spanning 180 countries and a corpus of over 400 norms,[23] we explore Latin American regulations on CO in abortion care in light of global developments. We aim to identify patterns and innovations, confront normative realities with everyday practice, and reflect on the underlying conceptions of CO that shape these regulations.

Conscience Clauses in Latin America

In December 2020, Argentina took a significant step by legalizing the voluntary interruption of pregnancy, following a year shadowed by the pandemic's challenges and sociopolitical tensions. This marked a departure from the legislative stalemate of 2018, in large part due to the strategic regulation of CO. This regulation struck a balance between recognizing abortion rights, addressing the medical community's hesitations, and navigating political negotiations necessary to secure the necessary votes.[24]

One year later, Mexico's Supreme Court of Justice invalidated a provision regulating CO in healthcare, potentially drawing inspiration from Colombia's Constitutional Court decisions. The court highlighted the lack of clear limitations on the exercise of conscientious objection, prompting discussions on the need for fresh legislative frameworks.[25]

In Ecuador, the decriminalization of abortion in rape cases, accompanied by an extensive conscience clause recognizing institutional CO, stirred significant controversy, including within the feminist movement, and led to its provisional suspension by the Constitutional Court.[26]

[22] Agustina Ramón Michel and Dana Repka (2024). In press; Agustina Ramón Michel and Dana Repka (2021), https://redaas.org.ar/objecion-de-conciencia/mapa-global-sobre-objecion-de-conciencia/; Ramón Michel et al. (2024), in press.

[23] Ramón Michel y Repka, "Conscientious objection clauses in abortion: a comparative analysis.".

[24] Agostina Mileo et al. (2023), sec. Bless you https://ecofeminita.com/aborto-2023/. "The senate approved the legalization of abortion: the key points of the law," (Checked 2020), https://chequeado.com/hilando-fino/el-senado-aprobo-la-legalizacion-del-aborto-los-puntos-claves-de-la-norma/; Ayzaguer (2023), https://www.lanacion.com.ar/sociedad/aborto-que-dice-ley-objecion-conciencia-medicos-nid2556162/.

[25] Santana (2021), sec. Latin America, https://www.france24.com/es/am%C3%A9rica-latina/20210921-mexico-corte-suprema-objecion-conciencia; (Barragán 2021), sec. Mexico https://elpais.com/mexico/2021-09-21/la-suprema-corte-determina-que-la-objecion-de-conciencia-no-interfiera-con-los-derechos-reproductivos-de-las-mujeres.html.

[26] "Constitutional Court suspends conscientious objection in abortion due to rape," *Firstfruits*, December (Scoops. 2022), sec. Society, https://www.primicias.ec/noticias/sociedad/constitucional-elimina-objecion-conciencia-aborto/.

In Chile, the Constitutional Council proposed elevating CO, both individual and institutional, to the status of a fundamental right.[27] However, this initiative lost traction following the victory of the "no" vote in the 2023 referendum.[28]

These episodes underscore the regional narrative, from Buenos Aires to Santiago, of legal and political battles aimed at reconciling deeply rooted differences. Here, CO is not merely a regulatory aspect; it is pivotal in the political negotiations fostering advancements in sexual and reproductive rights, impacting both patients and the internal dynamics of healthcare teams.[29]

The institutionalization of CO in abortion began in the Global North between 1970 and 1990 but saw renewed momentum in Latin America in the mid-2000s.[30] Colombia spearheaded this movement in 2006, liberalizing abortion regulations while affirming medical professionals' right to CO.[31] Mexico followed in 2007, decriminalizing first-trimester abortions and incorporating a CO clause.[32]

These episodes set a pattern across Latin America where advancements in abortion rights often accompany legal provisions for medical CO. Currently, 16 out of 33 countries in the region (Argentina,[33] Barbados,[34] Belize,[35] Bolivia,[36] Brazil,[37] Chile,[38] Colombia,[39] Costa Rica,[40] Cuba,[41] Ecuador,[42] Guyana,[43]

[27] (Suárez 2023), https://www.procesoconstitucional.cl/aprueban-como-derecho-la-objecion-de-conciencia-individual-e-institucional/.

[28] (Montes 2023), https://elpais.com/chile/2023-12-18/chile-rechaza-la-propuesta-de-las-derechas-y-se-queda-con-la-constitucion-nacida-en-la-dictadura-de-pinochet.html.

[29] (Davis, et al., 2022): 2190–2205, https://doi.org/10.1080/17441692.2021.2020318; (Shanawani 2016): 384–93, https://doi.org/10.1007/s10943-016-0200-4; (Bertolè 2021): 1–13; (Autorino, et al., 2020): 102403, https://doi.org/10.1016/j.ssresearch.2020.102403; Morrell and Chavkin (2015): 333–38, https://doi.org/10.1097/GCO.0000000000000196.

[30] Ramón Michel y Repka, "Conscientious objection clauses in abortion: a comparative analysis.".

[31] Constitutional Court of Colombia. Judgment C-355/06 of May 10, 2006 (Plenary Chamber), sec. 10.1.

[32] There is a precedent to this reform in December 2004. See LAMAS, Marta. The decriminalization of abortion in Mexico. Nueva sociedad, 2009, vol. 220, no. 1, p. 166.

[33] See Articles 10 and 11, Law 27,610 on Access to Voluntary Termination of Pregnancy, 2020; Sect. 6, Protocol for the comprehensive care of people with the right to voluntary and legal interruption of pregnancy, 2021.

[34] See Article 10, Medical Termination of Pregnancy Act, 1985.

[35] See Sect. 113, Belize Penal Code, 1980.

[36] See Article 11, Law No. 3131 on the Medical Professional Practice, 2008; Page 12, Route of interinstitutional action against gender violence of the Public Ministry of Bolivia, 2023; Article 28, Code of Medical Ethics and Deontology, approved by Ministerial Resolution No. 622, 2008.

[37] See Pages 21 and 22, Technical standard for humanitarian attention to abortion, 2014; Article 20, Code of Ethics of the Medical College of Chile, 2008.

[38] See Article 119 Ter, Sanitary Code, 2017.

[39] See Articles 15 and 16, Resolution 051 of 2023 of the Ministry of Health and Social Protection.

[40] See Article 119 Ter, Sanitary Code, 2017.

[41] See Sect. 12, Guidelines and methodologies for the implementation of all types of voluntary termination of pregnancy of the Ministry of Public Health of the Republic of Cuba, 2011.

[42] See Article 9, Organic Law that regulates the voluntary interruption of pregnancy for girls, adolescents and women in case of rape, published in the Official Gazette Second Supplement No. 53 of April 29, 2022.

[43] See Article 11, Medical Termination of Pregnancy Act No. 7, 1995.

Mexico,[44] Paraguay,[45] Peru,[46] Uruguay,[47] and Venezuela[48]) recognize some form of legal abortion alongside CO clauses written into decriminalization or legalization statutes. These clauses range in scope, driven by the need to reconcile competing interests or mitigate pressures from conservative sectors.[49]

Latin American CO clauses differ in their conceptualization from those in Europe and the USA. While the latter focused on allowing healthcare providers to refuse service, Latin American frameworks typically frame CO as a "right," paralleling the legal discourse on abortion itself. However, consensus lacks on CO's practical implications, allowing for potential misuse. In other words, there is no consensus in the region on *what CO means in practice*, which opens the door to improper or excessive uses of this legal figure. For instance, in Colombia, CO is limited to "duly substantiated religious convictions,"[50] while in Chile, any refusal based on "ethical, moral, religious, *professional* or other relevant reasons"[51] is protected, opening the door to technical objections, which could include refusals based solely on a provider's personal judgment.[52]

Disagreement persists regarding who may claim CO. In some countries, eligibility is determined based on the individual's professional role (a subjective criterion), while in others, it depends on the type of involvement in the abortion procedure (an objective criterion).[53] In the first group, which includes eight countries, Cuba

[44] See Articles 6.4.2.7 and 6.4.2.8, NOM-046-SSA2-2005 on Family, sexual and violence against women. Criteria for Prevention and Care, modified, with respect to the relevant article on CO in the face of abortion, in 2009; and Action of unconstitutionality 54/2018, promoted by the National Human Rights Commission, demanding the invalidity of Articles 10 Bis, Second and Third Transitory of the General Health Law, published in the Official Gazette of the Federation on May 11, 2018, which annuls the sanitary CO clause that was in force until that moment: Article 10 bis of the General Health Law of Mexico of 2017.

[45] See Article 37, Constitution of Paraguay, 1992; and Page 31, Standards of humanized post-abortion care in force as of Resolution SG 146 of the Ministry of Public Health and Social Welfare, 2012.

[46] See Article XII, General Health Law No. 26842, 1997; Article 4, Law No. 29635 on Religious Freedom, 2010; Article 8, Regulation No. 006-2016-JUS of Law No. 29635, Religious Freedom Law, 2016.

[47] See Articles 11 and 12, Law 18987 on voluntary interruption of pregnancy, 2012; and Articles 21, 22, 25, 26, 27, 28 and 29. Decree No. 375/2012 regulating the law on Termination of Pregnancy, 2012.

[48] See Article 61, Constitution of Venezuela, 1999; and Article 58, Code of Medical Deontology created by the Venezuelan Medical Federation, 2004.

[49] Agustina Ramón Michel et al. (2020): 271–83.

[50] This is how its Constitutional Court defines it on at least five occasions. See Constitutional Court of Colombia (Ninth Chamber of Review). Judgment T-209/08 of February 28, 2008; Constitutional Court of Colombia (Third Chamber of Review). Judgment T-946/08 of October 2, 2008; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-388/09 of May 28, 2009; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-841/11 of November 3, 2011; Constitutional Court of Colombia. Judgment C-274/16 of May 25, 2016; Constitutional Court of Colombia. Judgment C-055/22 of 21 February 2021.

[51] Constitutional Court of Chile. Judgment No. 3729 of August 28, 2017, cons. One hundred and twenty-first. The highlight belongs to us.

[52] Undurraga, Verónica and Michelle Sadler (Undurraga, et al., 2019): 17–19.

[53] Ramón Michel y Repka, "Conscientious objection clauses in abortion: a comparative analysis.".

only authorizes CO for obstetrician-gynecologists; Bolivia and Brazil limit it to physicians without specifying the specialty.[54] By contrast, Colombia limits CO to those who actually "perform" the abortion, while Argentina and Ecuador restrict it to those who "directly participate" in the procedure. Belize, Chile, Costa Rica, and Guyana employ broader or more ambiguous terms to define involvement.[55] Mexico is the only country where both criteria might be applied simultaneously, in line with the Supreme Court's recommendation that Congress recognize the right exclusively for "medical and nursing personnel" (subjective criterion) who "directly participate in the required health procedure" (objective criterion).[56]

Further distinguishing these clauses is the involvement of a wide range of institutional actors in their interpretation and application. Beyond legislatures and courts, health authorities have often played a critical role by issuing protocols, regulatory decrees, or ethical guidelines that operationalize the legal framework and clarify how CO should be applied in practice. In 12 of the 16 countries with CO clauses on abortion, Ministries of Health have issued such instruments,[57] helping to define the scope and boundaries of this legal figure.[58] Additionally, in six countries, 11

[54] For example, Uruguay's CO clause, which arises from its law on the interruption of pregnancy, refers to "gynecologists and health personnel" as the subjects entitled to object; and, along the same lines, the regulatory decree targets "medical and technical personnel" who intervene in abortion. See Article 11, Law 18987 on voluntary interruption of pregnancy, 2012 and Article 29, Decree No. 375/2012 regulating the law on Termination of Pregnancy, 2012. However, the regulatory decree added a limitation, recognizing CO only to "medical and technical personnel who must intervene directly in an interruption of pregnancy" (that is, adding a limitation by type of intervention). However, in 2015, the Contentious Administrative Court of Uruguay considered such a limitation to be illegitimate with erga omnes effect, as it considered that the CO recognized by law that it included all the stages of the procedure for the termination of pregnancy, both the preparatory actions (for example, preparation of the instruments) and the subsequent actions (for example, disposal of the remains) that are necessary for its conclusion. See Administrative Court of Uruguay. Alonso, Justo and Others with Executive Power. Action for Nullity. File No. 430/13, of August 11, 2015 (main proceedings).

[55] For example, Chile's clause authorizes objections not only to the "surgeon required to terminate the pregnancy" but also to all the "rest of the personnel who are responsible for carrying out their functions inside the surgical ward during the intervention," which results in a particularly broad CO depending on the role played in the practice of abortion. Article 119 ter first paragraph, Health Code, 2017.

[56] This has been established in recitals 505 and 507, in the judgment in which it resolved action of unconstitutionality 54/2018 in 2021.

[57] This is the case of Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Mexico, Paraguay, Peru, Uruguay, and Venezuela.

[58] Ecuador and Venezuela are the two countries in the region that recognize CO at the constitutional level, complemented by laws and regulations.

judicial cases on CO have been filed[59] alongside a broader process of abortion law liberalization.[60]

The result is not only a proliferation of CO clauses but also a shift towards more defined limitations, contrasting the early European minimalist approach. These contemporary clauses are expansive, encompassing duties such as referral and informational obligations for those invoking CO, illustrating a robust regulatory evolution in Latin America.

The Forms and Impact of Medical Denials

In healthcare services, CO is often invoked by professionals to sidestep fears, evade the stigma of providing certain services, or even cope with work overload. Reactionary groups have leveraged CO as a tool to resist laws challenging traditional norms surrounding sexuality and reproduction, expanding its use beyond the liberal intentions that originally justified its legal recognition.[61]

This diversification in how CO is used has generated innumerable problems.

Firstly, invoking CO undermines the accessibility and availability of health services for users.[62] In regions with high numbers of objecting professionals, women

[59] Constitutional Court of Colombia (Ninth Chamber of Review). Judgment T-209/08 of February 28, 2008; Constitutional Court of Colombia (Third Chamber of Review). Judgment T-946/08 of October 2, 2008; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-388/09 of May 28, 2009; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-841/11 of November 3, 2011; Constitutional Court of Colombia. Judgment C-274/16 of May 25, 2016; Constitutional Court of Colombia. Judgment C-055/22 of February 21, 2021; Administrative Court of Uruguay. Alonso, Justo and Others with Executive Power. Action for Nullity. File No. 430/13, of August 11, 2015 (main proceedings); Constitutional Court of Chile. Judgment No. 3729 of August 28, 2017; Constitutional Court of Chile. Judgments Rol No. 5572-18 and 5650-19 dated November 19, 2018, and January 18, 2019, respectively, which were joined in a single case; Supreme Court of Justice of Mexico. Action of unconstitutionality 54/2018, promoted by the National Human Rights Commission, demanding the invalidity of the Second and Third Transitory Articles 10 Bis of the General Health Law, of September 21, 2021; Constitutional Court of Ecuador. Case No. 93-22-In "Public action of unconstitutionality" of November 16, 2022.

[60] Thus, the first rulings of the Constitutional Court of Colombia on CO were issued in the first years after the ruling that partially decriminalized abortion; the Uruguayan Contentious Administrative Court issued an erga omnes ruling that expanded the scope of CO to three years after the abortion law; the two rulings of the Constitutional Court of Chile that led to a legal recognition of institutional CO arose as a result of the law of causes, in 2017 and 2019; the Mexican ruling that declared the unconstitutionality of the sanitary CO clause for being excessively vague was issued during the same week in which the Supreme Court resolved two other rulings liberalizing abortion; and, finally, the decision of the Constitutional Court of Ecuador, which also declared the unconstitutionality of its CO in abortion for reasons similar to the Mexican one, was issued in the same year as the law decriminalizing abortion for rape, from which the country's CO clause emerged. No other region currently registers this level of judicial dynamism around CO regulations in abortion.

[61] (Nejaime, and Siegel, 2014); Agustina Ramón Michel and Sonia Ariza Navarrete (2021), 531–72, https://dialnet.unirioja.es/servlet/articulo?codigo=8079960.

[62] See Davis, Haining, and Keogh, "A narrative literature review of the impact of conscientious objection by health professionals on women's access to abortion worldwide 2013-2021.".

seeking abortions face long delays, longer distances, and additional costs.[63] A striking example is Chile, where a recent study by Corporación Humanas revealed that nearly half of the professionals approved to perform abortions in the public system are conscientious objectors, a proportion that in some regions of the country rises to 80% of the authorized practitioners. In certain hospitals, 100% of the staff refuse to perform abortions.[64]

These denials disproportionately affect individuals living in remote areas and those with limited resources.[65] The situation worsens in places where legislation is new or ambiguous about who can invoke CO and its scope, where CO is poorly regulated, or where objecting professionals refuse referrals, provide biased counseling, or spread misinformation to dissuade women from obtaining abortions.[66]

CO's negative impact extends beyond patients. It causes internal strife within healthcare teams, increasing pressure and workload on professionals who do provide services. These individuals frequently deal with heavy workloads[67] and may face discrimination from colleagues or supervisors, hindering their career advancement.[68] This has been recognized by the WHO:

> If the regulation and legal framework for conscientious objection is unclear, unenforced, or non-existent, this can place a burden on health workers, including when dealing with issues related to their conscience or ethics and leading to conflicts in the workplace.[69]

When the exercise of conscience goes beyond simple refusal to perform an abortion, it often turns into efforts to prevent it altogether—through deterrence, misinformation, delays, and, sometimes, abuse. Such practices not only breach professional ethics but also disrupt organizational models for abortion care, leading to mismanagement within services.[70]

A striking example of this mismanagement arises with *institutional denials*, where entire facilities refuse to provide abortion services, whether or not the law permits it.[71] In Argentina, despite laws prohibiting institutional CO by public hospitals and mandating private institutions ensure access to willing providers, institutional

[63] Ramón Michel et al., (Ramón 2024)"Study on conscientious objection in abortion in Argentina: the misuses.".

[64] Corporación Humanas (2023); Corporación Humanas, "National map of conscientious objector obstetricians in public health establishments: Chile 2019-2020," 2020, https://www.humanas.cl/monitoreo-implementacion-ley-no-21-030-sobre-aborto-en-tres-causales-en-relacion-a-la-objecion-de-conciencia-de-funcionarios-as-publicos-as-de-salud/.

[65] See (Harris, et al., 2016); Autorino, Mattioli, and Mencarini, "The impact of gynecologists' conscientious objection on abortion access.".

[66] World Health Organization (2022).

[67] de Londras et al. (2023): 104716, https://doi.org/10.1016/j.healthpol.2023.104716.

[68] Ramón Michel et al., "Regulating conscientious objection to legal abortion in Argentina.".

[69] World Health Organization, Abortion Care Guideline.

[70] de Londras et al. 2022): 95, https://doi.org/10.1186/s12978-022-01405-x.

[71] (Merner, et al., 2023): 17455057231152373.

refusals persist. This forces many women, particularly in rural or remote areas, to travel over 200 km to access abortion services years after the law's enactment.[72]

These denials often lead to legal challenges. In Colombia, despite ICO being prohibited, reports of refusals by public and private facilities have reached the Constitutional Court.[73] Similarly, in Argentina, despite CO being limited to individual health professionals, at least 85 cases of institutional denials have been documented between the enactment of the abortion law and December 2023.[74]

Individual CO clauses are sometimes manipulated to create de facto institutional CO, pressuring health professionals to declare themselves objectors.[75] This phenomenon led Argentina's Supreme Court, in the F.A.L. case, to mandate that health institutions employ non-objecting personnel to uphold the rights of women and pregnant individuals.[76] Likewise, Mexico's Supreme Court has emphasized that CO should never result in denying health services or delay care when it risks health deterioration, thereby mandating sufficient non-objecting medical and nursing staff across all government levels to ensure medical care.[77]

These instances illustrate that while CO clauses aim to delineate the bounds of care refusal, their actual impact can be far from benign.

Divergent Legal Innovations in Latin America

Academia and various actors hold divergent views on medical CO. Some defend it as a fundamental right rooted primarily in freedom of conscience and religion.[78] Others argue that the personal beliefs of providers should not hinder patients' rights, emphasizing that allowing CO in such cases risks turning access to health services into a matter of chance.[79] Between these positions lie more pragmatic and balanced approaches that advocate for limited and clearly defined recognition of CO.[80]

[72] Ramón Michel et al. (2024)"Study on conscientious objection in abortion in Argentina: the misuses.".

[73] These are the cases of the Constitutional Court of Colombia (Ninth Chamber of Review). Judgment T-209/08 of February 28, 2008, and Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-388/09 of May 28, 2009; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-841/11 of November 3, 2011.

[74] Ramón Michel et al. (forthcoming 2026)"Study on conscientious objection in abortion in Argentina: the misuses.".

[75] Merner et al., "Institutional objection to abortion: a mixed-methods narrative review.".

[76] Supreme Court of Justice of the Nation (2012). Case "F.A.L. s/Self-satisfying measure," judgment of March 13, 2012.

[77] Supreme Court of Justice of Mexico. Action of unconstitutionality 54/2018, promoted by the National Human Rights Commission, demanding the invalidity of articles 10 Bis, Second and Third Transitory of the General Health Law, of September 21, 2021, cons. 428 and 429.

[78] See, for example (Martínez et al. 2000); Javier Martínez Torrón and Rafael Navarro-Valls "Protecting conscientious objection as a fundamental right. Considerations on the draft agreements of the Slovak Republic with the Catholic Church and with other registered Churches," *General Journal of Canon and Ecclesiastical Law of the State* 12 (2006): 1–28.

[79] See (Fiala, et al. 2016); (Fiala, and Arthur, 2017); (Schuklenk, 2019); (Savulescu, et al., 2017).

[80] See, in this sense, (Navarrete, and Ramón Michel, 2018): (Maxwell, et al., 2022); Maxwell, Ramsayer, and Fleming.

In comparative law, a stance of moderate permissibility tends to predominate. Analyzing existing standards, we find that among the 90 countries regulating CO, nearly all—87—acknowledge it as a right, though with specific limitations. Only three countries prohibit CO outright, and none of these is in Latin America.[81] Countries in the region with relevant regulations explicitly recognize CO in line with this global trend. Nonetheless, within this framework, two notable regulatory innovations have emerged: institutional safeguards and institutional conscientious objection (ICO).

Institutional Safeguards

Over the past two decades, institutional safeguards have been integrated into conscience clauses. These safeguards assign particular responsibilities to the State and healthcare institutions. They include establishing referral mechanisms in cases of CO,[82] ensuring the availability of professionals willing to perform abortions, creating registries of objectors,[83] and outlining procedures for evaluating and sanctioning objections.[84] Some regulations also incorporate broader obligations, such as requiring hospitals or health authorities to prevent CO from becoming an obstacle to care.[85]

[81] Ramón Michel y Repka, (2019)"Conscientious objection clauses in abortion: a comparative analysis.".

[82] In the field of LAC, the mechanism of imposing on health institutions, the obligation to refer users as an institutional guarantee is explicitly contemplated in the following countries: in Argentina, through Article 11 of Law No. 27610 on Access to Voluntary Termination of Pregnancy of 2020 and Sect. 6 dedicated to Conscientious Objection of the Protocol for the comprehensive care of people with the right to termination voluntary and legal pregnancy updated in 2022; In Brazil, through its Technical Standard for Humanitarian Abortion Care of the Ministry of Health, 2014; in Chile, through Article 119 Ter of its 2017 Health Code; in Colombia, based on Section D. of the Protocol for the Health Sector for the Prevention of Unsafe Abortion in Colombia, issued by the Ministry of Health and Social Protection; in Costa Rica, through Sect. 9 of Executive Decree No. 42113-S on the "Officialization of the 'Technical Standard for the Medical Procedure Linked to Article 121 of the Criminal Code' of 2019. And in Mexico, although it has not yet crystallized into a legal or regulatory norm, it has been contemplated by the Supreme Court of Justice of Mexico, when resolving the action of unconstitutionality 54/2018 in 2021.

[83] This guarantee is recognized in the Protocol for the Health Sector for the Prevention of Unsafe Abortion in Colombia of the Ministry of Health and Social Protection of Colombia of 2014 and in the Technical Standard for Humanitarian Abortion Care of Brazil of 2014. In addition, it was also contemplated by the Supreme Court of Justice of Mexico, when resolving the action of unconstitutionality 54/2018 in 2021.

[84] Only Colombia's CO clause contemplates this requirement, which has been specially confirmed by its Constitutional Court each time it had the opportunity to rule on the scope of CO. See Constitutional Court of Colombia (Ninth Chamber of Review). Judgment T-209/08 of February 28, 2008; Constitutional Court of Colombia (Third Chamber of Review). Judgment T-946/08 of October 2, 2008; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-388/09 of May 28, 2009; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-841/11 of November 3, 2011; Constitutional Court of Colombia. Judgment C-274/16 of May 25, 2016; Constitutional Court of Colombia. Judgment C-055/22 of 21 February 2021.

[85] See for example Article 9, Organic Law of Ecuador that regulates the voluntary interruption of pregnancy for girls, adolescents, and women in case of rape, published in the Official Gazette Second Supplement No. 53 of April 29, 2022.

The goal of these safeguards is to guarantee access to abortion services by mitigating the negative effects of CO on patients. They function as a regulatory policy aligned with the principles of universal access to sexual and reproductive health services.[86] Notably, the PA-CIDP had already called for countries to establish referral systems for reproductive healthcare[87]—an obligation that only began to materialize in conscience clauses during the 2000 s, precisely to prevent service denial due to CO from obstructing access.[88]

Currently, institutional safeguards are in place in only 20 countries worldwide, including eight in Latin America. This emerging trend signifies a shift away from traditional clauses, which primarily addressed the duties and limits of individual objectors.[89] Instead, these safeguards adopt a more empirical and structural perspective, recognizing the need not only to restrict individual conduct but also to ensure service continuity and uphold patients' rights.

Some Latin American courts have notably contributed to establishing these institutional safeguards and their constitutional justifications. Colombia stands out, having recognized institutional safeguards in at least four rulings and affirmed that these guarantees are not mere recommendations but binding obligations for health institutions and the State, aimed at realizing women's human rights and fulfilling international commitments.[90] The Court has grounded these safeguards in rights to life, health, and personal integrity, viewing them as measures to prevent harm and protect dignity.[91] It also cites the right to equality and non-discrimination, highlighting the disproportionate impact of deregulated CO on women, girls, and adolescents living in rural or underserved areas.[92]

Most innovatively, Colombia's Constitutional Court introduced an original constitutional argument: the right to freedom of conscience for women. The Court reasons that this right, as a highly personal and non-transferable one, protects all decisions related to reproductive autonomy, including the choice to carry a pregnancy to term or not. This perspective opens the door for legal and doctrinal development, suggesting that considerations of freedom of conscience could underpin both individual

[86] International Conference on Population and Development, Programme of Action of the International Conference on Population and Development. (New York: United Nations 1994), principle 8.

[87] Ibid., Measure 7.6.

[88] Only four countries in the world, none of them in Latin America, had institutional guarantees in their health awareness clauses before the ICPD (Belarus, Denmark, France and Italy). All the rest of the 18 countries that have CO clauses, including Latin American countries, began to recognize them from the new century: six during the 2000 s and ten in the last decade.

[89] Ramón Michel et al., (2020) "Regulating conscientious objection to legal abortion in Argentina.".

[90] See Constitutional Court of Colombia (Ninth Chamber of Review). Judgment T-209/08 of February 28, 2008; Constitutional Court of Colombia (Third Chamber of Review). Judgment T-946/08 of October 2, 2008; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-388/09 of May 28, 2009; Constitutional Court of Colombia (Eighth Chamber of Review). Judgment T-841/11 of November 3, 2011.

[91] Constitutional Court of Colombia (Ninth Chamber of Review). Judgment T-209/08 of February 28, 2008, para. 4.9.

[92] Constitutional Court of Ecuador. Case No. 93-22-In "Public action of unconstitutionality" of November 16, 2022, cons. 29.1.

and institutional safeguards—acknowledging that health professionals who provide abortion care also have conscience rights threatened by widespread invocation of CO, which can impose additional burdens, ostracism, and mistreatment on these "professional guarantors of rights."[93]

Institutional Conscientious Objection

ICO, which gained prominence during the debates on the legalization of abortion, allows hospitals and clinics to refuse to offer services that conflict with their mission and identity.[94] It remains a controversial and relatively uncommon concept globally. In the four countries recognizing it—Chile, Uruguay, France, and the USA—its exercise is typically limited to private institutions, subject to strict conditions.[95] In Uruguay, to counter the perception that ICO is strictly an individual matter, the term "ideology objection" was adopted, emphasizing that institutions, guided by their principles, operate under a set of values that justify ICO.[96] However, even in Uruguay, private clinics invoking ICO are obliged to perform procedures prior to abortion and refer patients to another provider.[97]

By contrast, the Chilean conscience clause recognizes a stronger and broader OCI without associated duties. This provision emerged through a series of back-and-forth between Congress, the national Ministry of Health, and the Constitutional Court, which originated from the 2017 law that decriminalized abortion on three grounds, initially contemplating only individual CO and explicitly prohibiting its invocation by institutions.[98] Only a few months later, in the same year, the Constitutional Court of Chile modified the law to include ICO through its ruling Rol No. 3729, effectively establishing it through judicial interpretation and requiring its incorporation into the

[93] Expression used in Argentina to identify professionals who provide care for the legal and voluntary termination of pregnancy.

[94] Thus, in Chile, it was the debate and subsequent approval of Law No. 21,030 that ended up decriminalizing abortion on three grounds in 2016 that motivated a group of deputies and senators to appeal to the Constitutional Court "in defense of an institutional CO," which gave rise to sentence No. 3729.

Similarly in Argentina, although implementing their claim outside the judicial headquarters, ten clinics from different parts of the country issued a joint statement questioning the prohibition of institutional CO established by the debated project, and advocating for its recognition to ensure respect for "the freedom to think and to believe, to associate and to work, to care and to cure, to save and to heal, without running the risk of imprisonment, disqualification or closure for acting according to their own conscience and ideology." Finally, in Uruguay, pressure from some health institutions led to the inclusion of the figure of "objection of ideology" in the decree regulating the law.

[95] Ramón Michel y Repka, (2021) "Conscientious objection clauses in abortion: a comparative analysis.".

[96] Miguel Angel Quiroga Vizcarra (2020); (Aramberri 2021).

[97] Article 27, Decree No. 375/2012 regulating the Law on Termination of Pregnancy, 2012.

[98] Law No. 21,030, which regulates the decriminalization of the voluntary interruption of pregnancy on three grounds and which contemplated the CO clause in article 119 Ter of the Chilean Health Code (2017). In that article, it was contemplated that "conscientious objection is of a personal nature and in no case may it be invoked by an institution.".

Health Code.[99] This decision allowed private health institutions to invoke the OIC without being subject to any derivative obligations. The constitutionality of the ICO was reaffirmed by the Court 2 years later, when a group of legislators challenged the validity of the conscientious clause set out in the new "Regulations for Exercising Conscientious Objection as Provided for in Article 119 Ter of the Health Code." This regulation prohibited invoking private health institutions that had agreements with the Ministry of Health and that offered obstetrics services that involved care in the ward from invoking CO.[100]

However, in resolving this challenge, the Court confirmed that any private health institution could invoke the ICO.[101] As a result, at present, only public institutions are barred from invoking ICO.[102]

The Chilean Court's arguments are not merely dogmatic assertions; rather, they present reasoning that could resonate elsewhere. First, the Court argued that health institutions, as legal persons, are capable of collective moral judgment and pursue common objectives.[103] From this perspective, they deserve the right to maintain their own beliefs, in a similar way to natural persons. Thus, the Court declared that health institutions, in their capacity as legal persons, are holders of fundamental rights.[104]

The second argument, tied to the assertion that institutions are holders of fundamental rights, is based on freedom of association. The Court argued that the ICO is an extension of the fundamental right to freedom of association of institutions, granting them autonomy to manage their affairs in accordance with their mission and institutional ideology. In this sense, banning the ICO could compromise this autonomy and legally deny convictions that underpin certain associations.[105] Based on this right, the Court concluded that each health provider, public or private, has full freedom to define "in which areas and what benefits it provides to its patients," without there being a constitutional or legal regulation that obliges it to offer certain services.

[99] In fact, after its Ruling Rol No. 3729 of 2017, Article 119 Ter of the Chilean Health Code began to contain the confusing expression: "conscientious objection is of a personal nature and may be invoked by an institution.".

[100] This was provided for in Article 13, second paragraph of Supreme Decree No. 67 of the Ministry of Health, dated October 23, 2018, which established: "Private health establishments, which have signed agreements governed by the provisions of Decree with the force of law No. 36, of 1980, of the Ministry of Health, may not be conscientious objectors when they contemplate obstetrics and gynecology services that by their nature include care in pavilion.".

[101] Constitutional Court of Chile. Judgments Rol No. 5572-18 and 5650-18 dated November 19, 2018, and January 18, 2019.

[102] This prohibition arises from article 13, first paragraph of Supreme Decree No. 67 cited above, which establishes tha: "Public health establishments may not invoke conscientious objection." On the CO regime currently in force in Chile, see (Montero, et al., 2017); Danitza Karinn Pérez Cáceres 2019; (Casas, and Vivaldi, 2014).

[103] Constitutional Court of Chile. Judgment Rol No. 3729 of August 28, 2017, cons. one hundred and thirty-fifth; Constitutional Court of Chile. Judgment Rol No. 3729 of August 28, 2017, cons. ninth.

[104] Constitutional Court of Chile. Judgment Rol No. 3729 of August 28, 2017, cons. one hundred and thirty-sixth.

[105] (Muñoz Cordal, 2020): 267–87., 271-272.

In short, the Chilean Court affirmed that the exercise of the ICO does not cause "any diminishment" in the right to life and physical integrity of the woman involved,[106] ignoring the existing evidence about the negative impact and serious problems of access to abortion. In contrast to this position, other Latin American high courts have adopted *more weighted approaches*, emphasized the individual nature of CO and rejected ICO, placing limits on denials through a series of duties and safeguards.[107]

What these cases reflect is a dynamic and legally complex field of regulatory development. In diverse, and at times contradictory ways, these developments respond to a broader context of vindicating legal and safe abortion and to a growing awareness of the harms caused by the misuse and abuse of CO.

Conclusion

Thirty years after the 1994 International Conference on Population and Development (ICPD), which established sexual and reproductive health as a fundamental human right, healthcare systems continue to grapple with the challenge of fulfilling their commitments to ensure universal and inclusive access.

Since at least 2005, the process of decriminalization and liberalization of abortion across Latin America has accelerated, leading an increasing number of countries to adopt conscience clauses in healthcare. As previously explained, this regional trend aligns with a global pattern that favors the admissibility of CO, based on the premise that professionals should be allowed to refrain from providing care if doing so would entail a profound moral conflict that makes providing care untenable and threatens their personal integrity.

In practice, however, the use of CO in health services has often diverged significantly from the liberal frameworks that initially justified it. Its application has become more diverse and, often, more problematic, resulting in harm rather than the intended protection of moral conscience.

In response to this reality, some Latin American countries have begun integrating institutional safeguards into their conscience clauses. These safeguards impose specific responsibilities and obligations on states and healthcare providers that go

[106] Constitutional Court of Chile. Judgments Rol No. 5572-18 and 5650-18 dated November 19, 2018, and January 18, 2019, cons. 15th.

[107] The prohibition of institutional CO appears in the following rulings: Constitutional Court of Colombia. Judgment C-355/06 of May 10, 2006; Constitutional Court of Colombia. Judgment T-209/08 of February 28, 2008; Constitutional Court of Colombia. Judgment T-946/08 of October 2, 2008; Constitutional Court of Colombia. Judgment T-388/09 of May 28, 2009; Constitutional Court of Colombia. Judgment T-841/11 of November 3, 2011. Constitutional Court of Colombia. Judgment C-274/16 of May 25, 2016. Constitutional Court of Ecuador. Case No. 93-22-In "Public Action of Unconstitutionality" of November 16, 2022; Supreme Court of Justice of Mexico. Action of unconstitutionality 54/2018, promoted by the National Human Rights Commission, demanding the invalidity of the Second and Third Transitory Articles 10 Bis, of the General Health Law, of September 21, 2021. In this way, it has been upheld by the Constitutional Court of Colombia, the Supreme Court of Justice of Mexico and the Constitutional Court of Ecuador.

beyond the individual duties of objectors. Currently present in eight countries, this regulatory innovation signals a shift towards a new approach to CO—one that exceeds merely defining individual limits and duties and instead recognizes the need for institutional mechanisms to protect patients' rights and provide options within public abortion policy. More grounded in empirical evidence and structural considerations than traditional models, this approach aligns more closely with the original spirit of the ICPD.

However, institutional safeguards are not the only notable development in the Latin American legal landscape. The concept of ICO introduces a more conservative paradigm often described as a "revolution," which has been adopted by two countries in the region. This phenomenon was notably supported by the Chilean Constitutional Court, which employed and relied on a novel set of legal arguments to legitimize ICO as a counterpoint to the safeguards.

Unlike the safeguards, ICO reflects a classical liberal conception, framing institutions and health professionals as morally autonomous entities that, in good faith, refuse to provide services conflicting with their moral identity. They are viewed as morally independent subjects, invoking their own conscience to justify non-provision of care that they deem incompatible with their values.

These two innovations—one evidence-based and institutionally grounded, the other rooted in traditional liberal thought—embody contrasting visions of CO. They yield markedly different implications for the realization of sexual and reproductive rights and exemplify the ongoing tensions and trade-offs that characterize Latin America's complex interplay of law, medicine, public policy, and human rights as the region carves its unique post-ICPD trajectory.

Declarations

Competing Interests The authors declare no competing interests.

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