EUROPEAN COMMITTEE OF SOCIAL RIGHTS
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Case Document No. 5

Federation of Catholic Family Associations in Europe (FAFCE) v. Sweden
Complaint No. 99/2013

OBSERVATIONS FROM THE SWEDISH ASSOCIATION FOR SEXUALITY EDUCATION AND THE CENTER FOR REPRODUCTIVE RIGHTS (RFSU)

Registered at the Secretariat on 18 December 2013

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Federation of Catholic Family Associations in Europe (FAFCE) v. Sweden
Third-party intervention by the Swedish Association for Sexuality Education and the Center for Reproductive Rights

1. The following comments are submitted by the Swedish Association for Sexuality Education (RFSU) and the Center for Reproductive Rights pursuant to Rule 32A of the European Social Charter and following the leave granted by the President of the Committee on October 25, 2013.

2. The brief is focused on the issue of conscientious objection in the reproductive health sphere. Drawing on international human rights and medical standards, it discusses the right to conscience of medical providers and how human rights and medical authorities have found that this right must be balanced against women's right to access lawful reproductive health services. Further, the brief describes the organization and regulation of abortion care in Sweden, and elaborates on ways in which medical providers and medical students can claim a right to abstain from participating in abortion provision, should they wish to do so.

3. The Swedish Association for Sexuality Education and the Center for Reproductive Rights urge the Committee to take these comments into consideration in its assessment of the current case.

Interest of RFSU and the Center for Reproductive Rights

4. The Swedish Association for Sexuality Education (RFSU) is a politically and religiously independent, non-governmental organization founded in 1933. Today it is the leading organization in Sweden in the field of sexual and reproductive health and rights. RFSU comprises experts, individual members, local associations and member organizations. It also runs a clinic focusing on reproductive health services, sexual counseling/psychotherapy and supervision.

5. RFSU continues to build upon the foundation it laid down back in the 1930s. Rights to sexual and reproductive health services and sexuality education are key tools in the struggle

for a healthier and more equitable society, as well as critical for the full achievement of gender equality. Ever since its inception, RFSU has regarded abortion as a central issue and a basic human right. RFSU is the key organization in Sweden promoting abortion rights. A woman's right to make her own decision whether or not to have children as well as when to procreate is of fundamental importance to self-determination and her freedom to independently choose how to live her life. RFSU continuously advocates for the increase of investments in contraceptive information/educational measures and for the current Swedish Abortion Act to be upheld. Advocacy is carried out at national, EU, and global levels by means of long-term and continuous political dialogue with target groups identified as critical for driving the agenda forward.

6. The Center for Reproductive Rights (CRR), founded in 1992, is one of the world's leading legal human rights organizations in the field of women's reproductive rights. CRR's mission is to strive for the respect, protection and fulfillment of women's human rights in relation to their reproductive health and reproductive autonomy worldwide. Consisting primarily of human rights lawyers, CRR advocates for rights-promoting reproductive health laws and policies globally, and engages in strategic litigation to advance women's human rights. In this capacity, the organization has brought forth and won several high-profile cases on behalf of women whose reproductive rights have been violated, such as the European Court of Human Rights cases *R.R. v. Poland* (2011) and *P. and S. v. Poland* (2012) and the CEDAW Committee cases *Alyne da Silva Pimentel v. Brazil* (2011) and *L.C. v Peru* (2011). The Center's expertise is also frequently called upon by U.N. human rights bodies such as the U.N. human rights Treaty Monitoring Bodies, the Office of the High Commissioner of Human Rights, and the Human Rights Council.

International human rights and medical standards on conscientious objection on behalf of health providers in the reproductive health sphere

2.1. Conscientious objection as a *manifestation* of the rights to conscience and religion

7. There is no basis in international law for a freestanding right to conscientious objection in the reproductive health field. The International Covenant on Civil and Political Rights (ICCPR), a legally binding human rights instrument signed and ratified by Sweden, does not grant a right to conscientious objection.[1] Rather, the Human Rights Committee (HRC), the body that interprets the provisions and oversees the implementation of the ICCPR,

[1] International Covenant on Civil and Political Rights, *adopted* Dec. 16, 1966, art. 18, para. 1, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) [hereinafter ICCPR].

has expressed that conscientious objection *specifically in the military* can be *inferred* from the right to freedom of thought, conscience, and religion.[2]

8. It is significant that the HRC has distinguished freedom of thought, conscience, and religion from the freedom to *manifest* religion or belief. Conscientious objection is considered to fall under the latter and is therefore subject to limitations. Freedom of thought, conscience, and religion are non-derogable, or absolute, rights.[3] On the other hand, the freedom to manifest religion or belief can be subject to restrictions, if these restrictions are "prescribed by law and . . . necessary to protect public safety, order, health or morals, or the fundamental rights and freedoms of others."[4] Thus, in the context of sexual and reproductive health in particular, conscientious objection as an exercise of the right to manifest religion or belief may be restricted by the right to health of others (in case of abortion care, the right to health of women).

9. This distinction between the absolute right to freedom of conscience and its manifestations, subject to limitations, corresponds well with the approach by the European Court of Human Rights (the Court) in the admissibility decision *Pichon Sajous v. France* in 2001.[5] The applicants were joint owners of a pharmacy who had been summoned to domestic courts and fined because of their refusal to sell contraceptives. The applicants complained to the Court that domestic courts had disregarded their right to freedom of religion under Article 9 of the European Convention on Human Rights (ECHR). The Court noted that the sale of contraceptives was "legal and occur[ed] on medical prescription nowhere other than in a pharmacy."[6] Under those circumstances, "the applicants [could not] give precedence to their religious beliefs and impose them on others as justification for their refusal to sell such products, since they [could] manifest those beliefs in many ways outside the professional sphere."[7] As such, the refusal to sell contraceptives did not fall under the ambit of Article 9 of the ECHR, and the Court therefore found the application manifestly ill-founded. Famously, the Court stated, "Article 9 of the Convention does not always guarantee the right to behave in public in a manner governed by the [relevant belief]. The word 'practice' used in Article 9 § 1 does not denote each and every act or form of behaviour motivated or inspired by a religion or a belief."[8]

10. In no way can *Pichon Sajous v. France* be read to suggest that the Court would have reached a different conclusion had the relevant drug involved abortifacients, as alleged in the FAFCE Complaint. Abortifacients were simply not at issue in this case and the Court did not once discuss such drugs in its decision. The fact that the local French Police Court had

[2] Human Rights Committee, *General Comment No. 22: Right to freedom of thought, conscience and religion (Art. 18)*, (48th Sess., 1993), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 11, U.N. Doc. CCPR/C/21/Rev.1/Add.4 (1993) [hereinafter Human Rights Committee, *Gen. Comment No. 22*].
[3] ICCPR, *supra* note 1, art. 4, para. 2; Human Rights Committee, *Gen. Comment No. 22, supra* note 2, para. 1.
[4] ICCPR, *supra* note 1, art. 18, para. 3; Human Rights Committee, *Gen. Comment No. 22, supra* note 2, para. 8.
[5] Pichon and Sajous v. France, No. 49853/99, Eur. Ct. H.R. (2001).
[6] *Id.*
[7] *Id.*
[8] *Id.*

distinguished contraceptives from abortifacients, mentioned in the background, is wholly irrelevant to the Court's reasoning.

2.2. Calls for regulation of conscientious objection has the purpose of safeguarding women's right to health

11. Too often, the right to health is violated by the non-availability or refusal to make lawful health services available, due to the personal beliefs of health providers. The right to health, including women's rights to access reproductive health services, such as legal abortion services, is a valid, justified, and necessary limitation to health providers' practice of conscientious objection. As such, women's right to health in general, and to sexual and reproductive health in particular, is a legitimate aim to limit health providers' rights to manifest religion or belief. In interpreting the rights to health and freedom of religion and beliefs, the HRC and the Committee on Economic, Social and Cultural Rights (the ESCR Committee) have expressed that protection of health as a restriction or limitation on the freedom to manifest religion or belief can be valid under the following conditions: when it is in accordance with the law; not incompatible with the nature of other human rights; in the interest of legitimate aims; and strictly necessary for the promotion of the general welfare.[9]

12. States, according to the ESCR Committee, should "refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health."[10] The ESCR Committee has also stated that "[t]he realization of women's right to health requires the removal of all barriers interfering with access to health services, education, and information including in the area of sexual and reproductive health."[11] The United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (the SR on the Right to Health) has observed that the laws on, and practice of, conscientious objection act as barriers to women's access to sexual and reproductive health services by "permitting health-care providers and ancillary personnel, such as receptionists and pharmacists, to refuse to provide abortion services, information about procedures and referrals to alternative facilities and providers."[12]

13. Since the practice of conscientious objection is considered a barrier to the right to health, the practice should be interpreted in favor of women's right to health and access to

[9] Human Rights Committee, *Gen. Comment No. 22*, *supra* note 2, para. 8; Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 28 & 29, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*].

[10] ESCR Committee, *Gen. Comment No. 14*, *supra* note 9, para. 34.

[11] *Id.* para. 21.

[12] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Interim rep. of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, transmitted by Note of the Secretary-General*, para. 24, U.N. Doc. A/66/254 (Aug. 3, 2011) (by Anand Grover) [hereinafter SRRH, *Interim Report* (2011)].

health services. As such, recommendations calling for the regulation of conscientious objection must be read in light of the situation in certain countries where the practice of conscientious objection is so widespread that it effectively leads to the deprivation of essential and legal health services for women. The Human Rights Committee has noted, in Concluding Observations to Poland:

> [I]n practice, many women are denied access to reproductive health services, including . . . lawful interruption of pregnancy. [The HRC] notes with concern that procedural safeguards contained in article 39 of the Act of 5 December 1996 on the Medical Profession ("conscience clause") are often inappropriately applied. It also notes with concern that illegal abortions are reportedly very common (with estimates of 150,000 illegal abortions per year), that unsafe abortions have in some cases caused the death of women, and that those aiding or abetting abortions (such as husbands or parents) have been convicted.[13]

14. The HRC concludes that Poland "should introduce regulations *to prohibit the improper use and performance of the 'conscience clause' by the medical profession*."[14] The SR on the Right to Health has recommended that "conscientious objections exemptions [are] well-defined in scope and well-regulated in use *and that referrals and alternative services are available in cases where the objection is raised by a service provider*."[15] The CEDAW Committee, in observations to Poland and Croatia, has expressed that states must ensure that women have access to abortion and that "*access is not limited* by the use of the conscientious objection clause"[16] as it considers the practice of conscientious objection to abortion by hospitals as an "infringement of women's reproductive rights."[17] Clearly, as demonstrated by these quotes, the concern of these different human rights authorities is the unavailability of lawful services, rather than a supposed right to conscientious objection for medical staff. The problem when conscientious objection is unregulated in these situations becomes not that the rights to conscience of health providers is violated, but, rather, that women do not get access to the services to which they are legally entitled, including lawful abortion. This is not a problem in Sweden. As discussed below in this brief, women's right to abortion services in Sweden is guaranteed by other means, such as by Sweden's rights-based abortion law and the obligation of Heads of Medical Departments to ensure that their personnel has the required set of skills needed to perform all medical services.

15. Finally, the FAFCE Complaint refers to international medical standards as a means of supporting their claim that states must introduce regulation to allow conscientious objection in the reproductive health sphere. However, just like the human rights statements related above, the purpose of both the World Health Organization (WHO) and the International Federation of Gynaecology and Obstetrics (FIGO) when calling for regulation of this practice is *to safeguard women's access to services*, not to call for a freestanding right for

[13] Human Rights Committee, *Concluding Observations: Poland*, para. 12, U.N. Doc. CCPR/C/POL/CO/6 (2010).
[14] *Id*. (emphasis added).
[15] SRRH, *Interim Report* (2011), V(m) (emphasis added).
[16] Committee of the Elimination of Discrimination against Women (CEDAW Committee), *Concluding Observations: Poland*, para. 25, U.N. Doc. CEDAW/C/POL/CO/6 (2007) (emphasis added).
[17] CEDAW Committee, *Concluding Observations: Croatia*, para. 109, U.N. Doc. A/53/38 (1998).

health providers to object. The WHO states that the practice of conscientious objection "can delay care for women in need of safe abortion, which increases risks to their health and life" and that "international human rights law . . . stipulates that freedom to manifest one's religion or beliefs might be subject to limitations necessary to protect the fundamental human rights of others. Therefore laws and regulations should not entitle providers and institutions to impede women's access to lawful health services."[18] Similarly, FIGO has expressly declared that the primary commitment of an obstetrician-gynecologist is to serve women's reproductive health and well-being notwithstanding the health provider's personal conscience,[19] and that, "[a]ny conscientious objection to treating a patient is secondary to this primary duty."[20]

16. Thus, the position taken in these important international medical guidelines strongly supports the argument made above, that the main purpose of calling for regulation of conscientious objection in the healthcare field is to ensure that women can access the services to which they are legally entitled. Given that Swedish healthcare regulations already guarantee women access to abortion services and that minimal risks for abuse of the practice of conscientious objection in the health sphere are at hand, no specific regulation is called for in Sweden, as will be elaborated below.

2.3. Jurisprudence of the European Court of Human Rights related to conscientious objection

17. Strikingly, in its discussion on the jurisprudence of the European Court of Human Rights, the FAFCE Complaint fails to refer to the two cases where the Court has specifically addressed the practice of conscientious objection in the abortion field. In these two cases, *R.R. v. Poland*[21] and *P. and S. v. Poland*,[22] the Court addressed two situations in which women had been denied legal reproductive health services due to providers' explicit objection to abortion. The Court found that the failure of Poland to grant access to prenatal testing (in *R.R. v. Poland*) and abortion following rape (in *P. and S. v. Poland*) amounted to violations of the women's right to private life and inhuman and degrading treatment. In line with the above statements from UN human rights bodies, the Court's focus was on women's right to access services, stating: "States are obliged to organise the health services system in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context *does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation*."[23]

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[18] WORLD HEALTH ORGANIZATION (WHO), SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS 96 (2nd ed. 2012) (references omitted).

[19] FIGO COMMITTEE FOR THE ETHICAL ASPECTS OF HUMAN REPRODUCTION AND WOMEN'S HEALTH, ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY 25 (2009) *available at* http://www.figo.org/files/figo-corp/Ethical%20Issues%20-%20English.pdf.

[20] *Id.* at 26.

[21] R.R. v. Poland, No. 27617/04 Eur. Ct. H. R. (2011).

[22] P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R. (2012).

[23] R.R. v. Poland, No. 27617/04 Eur. Ct. H. R., para. 206 (2011), *cited in* P. and S. v. Poland, No. 57375/08 Eur. Ct. H.R., para. 106 (2012) (emphasis added).

18. In Eweida and Others v. the United Kingdom, the Court ruled that the protection of health and safety in a hospital was considered as "inherently of a greater magnitude" than the wearing of a cross as manifestation of one's belief, and that the rights to health and non-discrimination may justify limits on the freedom to manifest one's religion or belief.[24] Similarly, pursuing the policy of equal opportunities and ensuring non-discrimination based on sexual orientation prevails over the conscientious objection to participate in establishing same-sex civil partnerships and provide psycho-sexual counseling to same-sex couples.[25] In the same case, the Court ruled that states parties have a wide margin of appreciation in deciding whether and to what extent interference is necessary and in striking a balance between competing rights guaranteed by the ECHR.[26] The Court recognized that there is no clear delineation between the positive and negative obligations of states under the ECHR but emphasized that under both contexts, "fair balance…has to be struck between the competing interests of the individual and of the community as a whole, subject in any event to the margin of appreciation enjoyed by the State."[27]

19. The lengthiest discussion in the FAFCE Complaint on the Court's case law on conscientious objection relates to circumstances that are simply not comparable to those discussed in the case under consideration. The case *Bayatyan v. Armenia*[28] establishes, as alluded to in the FAFCE Complaint, that there is a freestanding right to conscientious objection, regardless of domestic laws. However, this case—as well as earlier cases from the European Commission of Human Rights on this issue—refers to *conscientious objection in the military*. As such, the Court's finding in *Bayatyan* is simply not relevant to the issue of conscientious objection in the healthcare sphere. The differences are crucial. First, in the healthcare field, other persons' rights are at stake. More specifically, with regard to abortion, women's rights to health (including their right to access lawful reproductive health services), autonomy, and conscience are affected when health providers object to providing lawful services, to an extent that does not have meaningful comparison in the military field. Second, while military service tends to be compulsory, there is nothing obligatory about becoming an obstetrician-gynaecologist or a midwife. Thus, a person trained in medicine with objections to providing abortion services can choose another specialization. The issue in *Bayatyan*, for instance, was precisely that no alternative to performing military service was available. Finally, in *Bayatyan* the applicant suffered significant harm—being sentenced and subjected to a lengthy prison term for his refusal to serve in the military—while, as elaborated below, the FAFCE Complaint has in no place managed to demonstrate harm on behalf of Swedish medical providers due to the lack of an explicit right to refuse abortion care in Swedish law.

2.4. Resolution 1763 of the Parliamentary Assembly of the Council of Europe

[24] Eweida and Others v. The United Kingdom, Nos. 48420/10, 59842/10, 59842/10, 51671/10 & 36516/10 Eur. Ct. H.R., para. 99 (2013).
[25] *Id.* paras. 102-110.
[26] *Id*. paras. 84, 99, 106, & 109.
[27] *Id.* para. 84; R.R. v. Poland, No. 27617/04 Eur. Ct. H. R., para. 189 (2011).
[28] Bayatyan v. Armenia, No. 23459/03 Eur. Ct.H. R. (2011).

20. Resolution 1763 of the Parliamentary Assembly of the Council of Europe (PACE)[29] is not binding on states and cannot be used as a basis to establish a right to conscientious objection for healthcare providers or as an obligation to regulate conscientious objection in Sweden. The Resolution is merely an "[embodiment] of a decision by the Assembly on a question of substance which it is empowered to put into effect, or an expression of view for which it alone is responsible" and does not provide for any binding state obligations.[30]

21. Furthermore, some of the provisions of the Resolution run contrary to established medical and human rights principles, such as the wording in the Resolution suggesting that entire institutions can object to providing abortion care.[31] In an admissibility decision in 1988, the European Commission of Human Rights noted that the right to freedom of conscience is an individual right, by its very nature, and therefore cannot be exercised by an institution.[32] Similarly, in France, in assessing whether heads of public health establishments could refuse to allow the provision of abortion services in their departments, the French Constitutional Court ruled in 2001 that conscientious objection is a right afforded to individuals, not institutions.[33] As one legal and medical scholar has noted, in relation to the internationally protected right to freedom of conscience: "[H]ospital and clinic corporations are artificial legal bodies that have no eternal soul that they may claim an entitlement to protect."[34]

22. Provisions in a non-binding "expression of view" of the PACE that go against established human rights and medical principles clearly cannot impose any obligations on states. Furthermore, similar to the statements from international human rights bodies referred to above, whereas Resolution 1763 recognizes the problem of the unregulated use of conscientious objection, it does so in the context of discussing how the practice may harm women's right to lawful services: "The Assembly is concerned that the unregulated use of conscientious objection *may disproportionately affect women, notably those having low incomes or living in rural areas*."[35] Thus, when the Resolution calls for regulation, it does so *in the interest of patients' access to lawful healthcare services*, which is entirely different from calling for regulation with the purpose that healthcare providers be given a right to object to providing care.

23. It is true that the Resolution "invites Council of Europe member states" to develop comprehensive and clear regulations that, among other things, guarantee a right to

[29] EUR. PARL. ASS. (PACE), Resolution 1763, *adopted* Oct 7, 2010 (35th Sitting).
[30] EUR. PARL. ASS. (PACE), Resolution 1202 (Rules of Procedure of the Assembly), *adopted* Nov. 4, 1999, rule 24.1.b.
[31] EUR. PARL. ASS. (PACE), Resolution 1763, *adopted* Oct 7, 2010 (35th Sitting), para. 1.
[32] Kontakt-information-Therapie and Hagen v. Austria, No. 11921/86 Eur. Com. H.R., para. 1 (1988) ("Moreover, the rights primarily invoked, i.e. the right to freedom of conscience under Article 9 (Art. 9) of the Convention and the right not to be subjected to degrading treatment or punishment (Article 3) (Art. 3), are by their very nature not susceptible of being exercised by a legal person such as a private association").
[33] Conseil constitutionnel [CC] decision No. 2001-446DC, June 27, 2001, Rec. 74, paras. 11-17 (Fr.), *available at* http://www.conseil-constitutionnel.fr/conseil-constitutionnel/root/bank_mm/anglais/a2001446dc.pdf.
[34] B.M. Dickens, *Reproductive Health Services and the Law and Ethics of Conscientious Objection*, 20(2) MedLaw 283, 291 (2001).
[35] EUR. PARL. ASS. (PACE), Resolution 1763, *adopted* Oct 7, 2010 (35th Sitting), para. 2 (emphasis added).

conscientious objection in relation to participation in certain medical procedures.[36] However, to reiterate, this statement does not impose obligations on states. Sweden has, as will be explained below, organized its healthcare system in a way that both ensures that women are entitled to accessing lawful reproductive health services in a manner that upholds their rights and their dignity, *and* that respects the right of conscience of healthcare providers. Given that the claims in the FAFCE Complaint do not present or respond to a real problem, neither for women in need of abortion services, nor for healthcare providers in the reproductive health sphere, there is no reason for Sweden to amend its laws or change its practices in response to Resolution 1763.

Conscientious objection in the Swedish context

24. The FAFCE Complaint alleges that the fact that conscientious objection is not specifically regulated or granted in Swedish law constitutes a violation of Article 11 of the European Social Charter (the Charter), and that Sweden has an obligation to regulate this practice under international human rights law. As has been demonstrated above, no such international obligation exists. Furthermore, the FAFCE Complaint is mistaken about the facts, since there is no evidence that healthcare professionals in the reproductive health sphere in Sweden suffer discrimination or harassment on the basis of their conscience or religion. This part of the brief argues, first, that Swedish law ensures women's right to access abortion services and that this right is properly implemented. As will be shown, there is therefore no need for specific regulation of conscientious objection on behalf of healthcare providers to secure women's access to services. Second, there is no evidence that discrimination or harassment of health professionals in the reproductive health sphere is at hand in Sweden due to conscientious objection to abortion. No data has been presented supporting the claim that healthcare personnel are being forced to partake in abortion care against their will. Similarly, no evidence exists to the effect that students of midwifery or medicine would be discriminated against on grounds of conscientious objection. Thus, regulation of the practice of conscientious objection in healthcare practice or medical training is also not called for on these grounds.

3.1 The Swedish abortion law is rights-based and ensures women's right to access services

25. The FAFCE Complaint focuses on Article 11 of the European Social Charter, the right to the protection of health, which aims to guarantee the people of Europe the right to the best possible healthcare. Article 11 read together with Article E, aiming at non-discrimination, imply that no resident shall be treated in a discriminatory way because of ethnicity, sex, language, religion, political or other opinion, nationality or social origin, health, association with a national minority, birth or other status when seeking healthcare.

[36] *Id*. paras. 4-5.

26. The FAFCE Complaint argues that the failure to regulate conscientious objection in the healthcare field is a violation of health under Article 11 of the Charter. It fails to explain, however, whose health is supposed to be at stake in Sweden on this ground. As will be demonstrated below, the Swedish abortion law is rights-based and women's right to access services is guaranteed in the law itself, which is why specific regulations of conscientious objection on behalf of reproductive healthcare providers are not called for. The right to conscience of healthcare providers—also guaranteed in Sweden, as discussed in the next section of this brief—can hardly be invoked under Article 11 of the Charter.

27. The aim of the Swedish healthcare services is regulated in the Swedish Health Care Act and reads as follows: "[The aim of health services is] to provide best possible health and to give care on equal terms for the entire population. Healthcare shall be provided with respect of equality and for human dignity."[37] This portal clause of the Swedish Health Care Act corresponds well with Article 11 of the European Social Charter.

28. The overall responsibility for ensuring the right of qualified care rests on the local Health Authority. These responsibilities are then delegated to the Head of Department of the respective medical or healthcare facility. As such, the Heads of the various Women's Clinics in Sweden are responsible for ensuring that women have access to the care they are entitled to in their clinics under both the Health Care Act and, in this particular case, the law concerning abortion. It also means that the Head of the Women's Clinic has the responsibility to ensure that abortion-seeking women are, during their entire visit, received and treated by personnel who do not object to abortion.

29. The Swedish healthcare system is consistent with Article 11 of the European Social Charter by guaranteeing that well-educated professionals work in safe environments and by placing the patients' needs at the core of the whole healthcare system. The position of the patient has been strengthened even more in the last years by new regulations in this area.[38]

30. The Swedish Abortion Act from 1974 is one example of this rights-based approach of Swedish healthcare laws and policies.[39] The Abortion Act has a strong focus on the woman seeking care and all its provisions are written with her best interest in mind. For example, the Abortion Act, Section 1, states that a woman who is in need of an abortion before the 18th week shall be given an abortion unless it would impose a serious danger to her life or health.[40] The Abortion Care Regulation, accompanying the Abortion Act, then states that the abortion-seeking woman has an unconditional right to expect a friendly and understanding attitude from all the staff she meets in connection with her abortion procedure.[41] The Abortion Act also provides that the care-seeker always should be offered counseling, should she wish so.

[37] Health Care Act SFS (1982:763), Section 2.
[38] Patient safety act SFS (2010:659) Chapter 4, Section 2.
[39] Law on Abortion SFS (1974:595).
[40] *Id*, Section 2.
[41] The National Board of Health and Welfare, general guidelines and regulations SOSFS (1989:6).

This is the absolute right of the care-seeking woman but counseling should never be imposed on her.[42]

31. The right to health under Article 11 of the European Social Charter shall be interpreted to mean that states are required to bring infant and maternal mortality under control.[43] Significantly, Sweden has one of the lowest maternal and infant mortality rates in the world.[44] The reasoning above illustrates that Sweden has solid and patient-centered reproductive health policies and that women's right to access lawful abortion is ensured by various means, such as a rights-based abortion law and the explicit responsibility of each Health Department to guarantee that healthcare staff is available to provide abortion care.

32. Here it should also be mentioned that representatives of the Swedish medical community strongly advise against an explicit right to conscientious objection on behalf of medical staff, with references to the primary ethical duty of healthcare providers to respond to the needs of their patients. For example, the Swedish Midwifery Association has expressed serious concern over proposals to introduce a conscience clause in reproductive healthcare, based on the "ethical responsibility of medical staff to provide lawful health services and to prioritize the fundamental healthcare needs of patients over their personal values."[45] Similarly, the Swedish Medical Association declares that the introduction of a specific right to conscientious objection would undermine the right to abortion in Sweden, and that healthcare providers have a primary duty to "protect the right of patients to adequate healthcare."[46]

3.2. There is no evidence that healthcare professionals with a conscientious objection to abortion are discriminated against in Sweden

33. The FAFCE Complaint alleges that there is wide-spread discrimination of healthcare providers in the Swedish reproductive health sphere. For example, it claims: "In most cases, the healthcare workers that object to abortions are told that they have chosen the wrong job, the wrong profession or the wrong department" (p. 21), "[h]ealth care workers and healthcare students are reprimanded, repositioned or put at disadvantage for refusing to perform procedures such as abortions," (p. 21) and "[m]edical workers, who are reprimanded, repositioned or put at disadvantage for refusing to perform procedures such as abortions, therefore claim that their rights under international treaties are infringed" (p. 25). However, in no place does the FAFCE Complaint provide sources to these allegations, nor does it offer

[42] Law on Abortion SFS (1974:595), Section 2.
[43] "The right to health and the European Social Charter;" information document prepared by the secretariat of the ESC March 2009. In the note from the secretariat, page 8, it is strongly emphasized that all measures should be taken to obtain a result as close as possible to zero risk.
[44] World bank statistics on child and maternal mortality 2012 *available at* www.worldbank.org; http://data.worldbank.org/indicator/SP.DYN.IMRT.IN, http://data.worldbank.org/indicator/SH.STA.MMRT.
[45] Dagens sjuksköterska, November 10, 2010, "Svenska barnmorskeförbundet är djupt oroliga över Europarådets resolution om "Rätten till samvetsvägran i laglig medicinsk vård," *available at* http://www.dagenssjukskoterska.se/debatt/debatt-samvetsklausul-hotar-abortratten/.
[46] Läkartidningen, November 23, 2010, "Samvetsfrihet på patientens bekostnad,", *available at* http://www.lakartidningen.se/07engine.php?articleId=15473.

concrete examples of cases where this supposed discrimination has occurred. In fact, the only case in which the FAFCE Complaint provides support for its allegations is one where the health provider in question was indeed granted permission to be exempted from participating in abortion care: the case in Norrtälje mentioned on page 21 of the Complaint. Rather than being an exceptional case, as alleged, this is a good example of how the Swedish system accommodates the needs of professionals with conscientious objections to abortion care.

34. In fact, the freedom of religion, the freedom of expression and the prohibition of discrimination are strong values in the Swedish society and important principles in Swedish law. For example, the ECHR is fully incorporated into Swedish law.[47] The Swedish Discrimination Act is another instrument to protect these values, stating: "[T]he law is intended to combat discrimination and in other ways promote equal rights and opportunities regardless of sex, gender identity or expression, ethnicity, religion or other belief, disability, sexual orientation or age."[48]

35. In the Swedish labor market, collective agreements have a key position and labor unions play a central role in safeguarding the rights of employees, *inter alia*, ensuring non-discrimination and decent treatment in the workplace.[49] The role of the collective agreement means that, among other things, the parties on the labor market (i.e. labor unions and employers' organizations), will agree on the conditions of work. The unions are granted the right to negotiate for their members' interests, in cases of dispute, which is a right also clearly regulated in the European Social Charter, Article 6. Thus, if a dispute emerges in the workplace, the local or the central labor union will negotiate with the employer on behalf of the employee. This applies, for example, to instances where the employee claims discrimination for any reason, for example, if he or she feels pressured to perform tasks that go against his or her conscience or finds him- or herself to be treated in a discriminatory way for refusing to do so.[50]

36. If the negotiation ends without the parties agreeing, the labor organization can proceed with the dispute to the special Labor Court.[51] The authors of this brief have examined all court cases decided by the Labor Court since 2003. There is not one single case concerning conscientious objection in the healthcare field, in which an employee claims to have been discriminated against on grounds of conscientious objection. Thus, there is not one case about termination of employment; not one case of discrimination in the workplace; nor of unlawful relocation related to the issue of conscientious objection in the healthcare field. The issue has not at any point been the subject of legal negotiation. The authors of this brief have also been in contact with representatives of the labor unions who organize employees in the healthcare

[47] The Swedish Government webpage on human rights concerning freedom of thought and religion, *available at*: http://www.manskligarattigheter.se/en/human-rights/what-rights-are-there/freedom-of-thought-and-religion.
[48] The Discrimination Act SFS (2008:567).
[49] The system of labor law and collective agreements in Sweden, see a summary *available at*: http://www.almega.se/om-almega/in-english/labour-law-and-collective-agreements.
[50] Employment (Co-Determination in the work place) Act SFS (1976:580), Section 11-16.
[51] The Swedish Labour Court, information *available at*: http://www.arbetsdomstolen.se/pages/page.asp?lngID=7&lngLangID=1.

field, who confirm that to their knowledge, the issue of conscientious objection has not been subject to legal trial or negotiation.

37. As such, the allegation in the FAFCE Complaint that there is widespread discrimination of health providers on the ground that they cannot invoke conscientious objection finds no support in official statistics, nor in relevant Swedish jurisprudence. Clearly, had the problem of healthcare professionals' right to conscientious objection in the reproductive health sphere in Sweden been significant, this would be visible in official data. However, this is not the case, which is also evident from the fact that the FAFCE Complaint does not name one single concrete case of a healthcare professional being discriminated against or harassed because of his or her beliefs concerning abortion.

3.3. There is no evidence that students with a conscientious objection to abortion care are discriminated against in Sweden

38. Under section 6.11 of the FAFCE Complaint, the complainants state that obligatory elements in the practical training of healthcare studies can be discriminatory against students with conscientious objections to abortion. However, the Complaint provides no support for this allegation. Abortion care and contraceptive counseling are vital parts of women's reproductive healthcare. In Sweden, to become a midwife or a gynaecologist it is compulsory to learn to master abortion care and contraceptive counseling, along with other obligatory components of the training. Nevertheless, every student in higher education in Sweden who objects to a certain obligatory part of their studies can ask to be excused from this part of the training. The college or university can accept or deny such an application. If the application is denied, the student can appeal the decision to the Higher Educations Appeals Board.[52] If the allegations in the FAFCE Complaint were true, the Appeals Board would be flooded with appeals from medical students who have been made to learn abortion care against their wishes. But, as will be shown, this is not and has never been the case.

39. The legal framework concerning education is found in the Higher Education Regulation.[53] This applies equally to all programs within Swedish higher education. Decisions that can be appealed to the Higher Educations Appeals Board include instances when students have been denied access to educational program on the grounds that they do not meet entry requirements, when they have been denied exemption from entry requirements, or when they have been denied exemption from compulsory educational components.[54] In other words, students of midwifery or medicine who have been refused exemption from the requirement to learn abortion care can appeal such decisions. Nevertheless, since the introduction of the Higher Education Appeals Board in 1992, no such appeal has been presented. In fact, only one case has been tried that relates to conscientious objection. The case concerned a veterinary student who wanted to avoid participating in trial surgery during his education. This application was refused on the grounds that knowledge of such surgery is

[52] Higher Educations Appeals Board, information *available at*: http://www.onh.se/inenglish.4.880c3ba1194d1b806c800030199.html.
[53] Higher Education Regulation SFS (1993:100).
[54] *Id.* Chapter 12, Section 2

a vital part of the profession after graduation and that alternative means of acquiring these skills were not available. The decision is published on the Appeals Board's website.[55]

40. Some decisions by higher education institutions may also be appealed when the claim is that the decision runs contrary to the Discrimination Act, illustrating the strong standing of the principle of non-discrimination in the Swedish educational context.[56] There have been no appeals related to conscientious objection in higher education under the Discrimination Act either. In conclusion, the fact that during more than 20 years not a single relevant case of appeal has been tried in the Appeals Board shows that the arguments concerning discrimination on conscientious objection grounds in higher education are ill-founded.

41. The question of a right to conscientious objection of medical students has been discussed in connection with the reorganization of the college and university world on different occasions. In the context of higher education reform in the mid-1990s, the matter of conscientious objection was examined in a special investigation appointed by the government. The investigation concluded that an explicit conscientious clause should not be introduced. Instead, the committee was satisfied with the work of the Appeals Board.[57]

42. Finally, here it should be noted that on the general level of medical training for doctors and nurses in Sweden practical training of abortion- or contraceptive care is not required. Therefore, an individual who objects to abortion and who does not wish to partake in such training or practice is granted the full possibility to pursue a healthcare career in other specializations. Thus, whereas abortion care is considered a key component of women's reproductive healthcare and, therefore, a critical element in training for work within the field of women's health, the Swedish model of higher education allows those who object to abortion a wide array of other options, both on the general and specialized level of medicine.

Conclusions

43. The case before the Committee raises numerous issues related to conscientious objection of medical providers in the reproductive health sphere. Whereas the freedom of conscience and religion are absolute and non-derogable rights, their manifestation are subject to limitations necessary to protect, among other grounds, health and the rights and freedoms of others. Objecting to abortion on conscience grounds is a manifestation of the right to conscience and, as such, may be limited in the interest of protecting and guaranteeing women's right to access lawful health services. There is therefore no absolute right to conscientious objection in the reproductive healthcare field, because the rights of healthcare staff to manifest their freedom of conscience must be balanced against the rights of women to health and dignity.

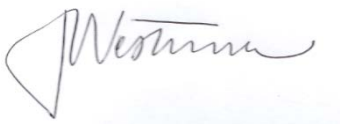
[55] Higher Educations Appeals Board, information *available at*: http://www.onh.se/inenglish.4.880c3ba1194d1b806c800030199.html.
[56] Right of appeal in accordance with the Discrimination Act (2008:567).
[57] Inquiry (U 1993:04) for a conscience clause in higher education.

44. Furthermore, when human rights instances and medical expert bodies call for regulation of the practice of conscientious objection in the abortion field, they do so in the interest of safeguarding women's right to access abortion care. The calls for regulation thus responds to a problem that is acute in some countries: the problem of abortion care being refused or obstructed in spite of its lawful status, when healthcare providers are allowed to object without monitoring or state oversight. In countries where women's access to services is safeguarded by other means, these calls for regulation cannot be interpreted to mean that a specific right to conscientious objection of health care personnel must be introduced.

45. In Sweden, the Abortion Law is rights-based. Women are granted the right to access abortion until week 18 of their pregnancy, and thereafter when certain criteria are met. It is the responsibility of the Head of the respective Women's Clinic to ensure not only that providers are available at all times to provide abortion services, but also that women in need of such services are received and treated respectfully and without condemnation. Abortion care is seen as a critical component of women's reproductive health, which is why learning abortion and contraceptive care is also a compulsory component of training to become a midwife or an obstetrician/gynaecologist. At the same time, there are possibilities both for a medical provider to challenge a decision that he or she must partake in abortion care—through the use of mechanisms set up by law and under collective agreements—and for students who have been denied exemption from compulsory elements of the training on conscience grounds. To date, there are no cases before the Labor Court in which medical providers claim discrimination or harassment related to their conscientious objections to abortion, nor are there any known negotiations between employers and labor unions on behalf of employees claiming discrimination on such grounds. There are also no cases in which students have appealed to the Higher Educations Appeals Board for having been denied exemption from learning abortion care.

46. As such, the allegation that there is widespread discrimination and harassment of medical providers and medical students in Sweden related to their objection to abortion finds no support in facts. The claims presented in the FAFCE Complaint in relation to the lack of specific regulation of conscientious objection in the healthcare field in Sweden do not respond to a real and tangible problem. The many human rights and medical declarations expressing concern over the impact that conscientious objection can have on women's right to health and dignity, in combination with Sweden's carefully constructed organization of its abortion care and its mechanisms to safeguards the rights to non-discrimination of medical providers, all imply that the claims in the FAFCE Complaint are ill-founded. The RFSU and the Center for Reproductive Rights therefore urge the Committee to dismiss the Complaint.

Respectfully submitted:



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