## *Recognising a Human Right to Abortion*

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# Recognising a Human Right to Abortion

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# Abstract

This thesis presents an argument for the recognition of a human right to abortion in the international human rights framework. Firstly, I identify the key conceptual issues with the current human rights system; its approach to gender-based rights, issues with cross-cultural traction, and the relative lack of protection afforded to economic, social, and cultural rights. I go on to consider the specific limitations of the international human rights framework in relation to abortion, in light of worldwide variations in access to abortion and recent backsliding. The remainder of my thesis seeks to address these issues, by adopting Alan Gewirth's Principle of Generic Consistency (PGC) and applied in conjunction with feminist values as the foundation for a genuinely universal human rights framework. I argue that the PGC establishes a moral right to abortion which must be recognised as a human right and set out a framework for the progressive realisation of the right to abortion capable of responding to the socio-economic, political, religious, and cultural variation in how abortion is currently addressed. I also consider specific barriers to accessing abortion which must be addressed in order for the right to abortion to be effective. Finally, given the limited enforcement mechanisms available to human rights bodies and the ongoing contested nature of abortion, I consider how the right to abortion could be realised indirectly, through legal change achieved through local social movements, national courts, and regional human rights bodies. My thesis demonstrates an original contribution to knowledge by applying the PGC as a feminist-adjacent theory capable of addressing the key issues with the international human rights approach to abortion.

# Statement of Copyright

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# Introduction

In this thesis, I argue that an explicit human right to abortion must be recognised in the international human rights framework. Highlighting the limitations of the current framework and human rights standards on abortion, I argue that a feminist transformation of human rights is necessary, which must take Alan Gewirth's Principle of Generic Consistency (PGC) as its foundation. I establish that there is a moral right to abortion under the PGC which must be recognised in the international human rights system, and I set out a framework for the progressive realisation of this right. I conclude by addressing the potential avenues for realising this right at the domestic level.

Much has been written on international human rights standards on abortion. This scholarship can be loosely grouped under four themes: tracking the evolving nature of these standards and their limitations;[1] recognising the ways that these standards can be expansively interpreted;[2] arguing that certain rights should be expanded to include abortion;[3] and looking at human rights and abortion in specific contexts.[4] Increasingly, the language of reproductive justice has overtaken that of reproductive rights, and

[1] See, for example, Rebecca J. Cook and Bernard M. Dickens, 'Human Rights Dynamics of Abortion Law Reform' (2003) 1 *Hum. Rts. Q.* 1; Christina Zampas and Jaime M. Gher, 'Abortion as a Human Right – International and Regional Standards' (2008) 8(2) *Hum. Rts. Law Rev.* 249; Rachel Rebouché, 'Abortion Rights as Human Rights' (2016) 25(6) *Soc. Leg. Stud.* 765.

[2] See, for example, Joanna N. Erdman, 'Harm reduction, human rights, and access to information on safe abortion' (2012) 118(1) *Int. J. Gynecol. Obstet.* 83; Lucía Berro Pizzarossa and Patty Skuster, 'Towards Human Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion' (2021) 23(1) *Health Hum. Rts. J.* 199.

[3] See, for example, Ronli Sifris, *Reproductive Freedom, Torture, and International Human Rights* (Routledge, 2013).

[4] See, for example, Louise Finer and Johanna B. Fine, 'Abortion Law Around the World: Progress and Pushback' (2013) 103(4) *Am. J. Public Health* 585; Ronli Sifris and Suzanne Belton, 'Australia: Abortion and Human Rights' (2017) 19(1) *Health Hum. Rts. J.* 209; Lucía Berro Pizzarossa, 'Legal barriers to access abortion services through a human rights lens: the Uruguayan experience' (2018) 26(52) *Reprod. Health Matters* 151.

reproductive justice scholars have been critical of the individualised liberal human rights frame while also adopting human rights language in the articulation of their goals.[5] Key to the reproductive justice framing has been the recognition of intersectionality and the specific barriers to accessing reproductive healthcare faced by already marginalised groups. However, within this wealth of literature, there has been little scholarship advocating for the inclusion of a standalone right to abortion within the international human rights framework.

There is also a school of scholarship which has been heavily critical of human rights and international law. Feminist and postcolonial scholars have pointed out the ways in which gender-based and intersectional issues have been absent from human rights law, and how the implementation of human rights has had imperialist overtones.[6] Further, the ideological split between civil and political (CP) and economic, social, and cultural (ESC) rights has been critiqued for leading to the relatively weaker protection afforded to ESC rights. Beyond these critiques, critical legal scholarship has showed a greater scepticism towards human rights – arguing that human rights are inherently ineffective and problematic.[7] Though some critical legal scholars avoid rejecting the concept of human rights completely, there is a tendency within this scholarship to reject

[5] Zayika Luna and Kristin Luker, 'Reproductive Justice' (2013) 9 *Annu. Rev. of Law Soc. Sci.* 327; Loretta J. Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (University of California Press, 2017).
[6] See, for example, Hilary Charlesworth, Christine Chinkin, and Shelley Wright, 'Feminist Approaches to International Law' (1991) 85(4) *AJIL* 613; Charlotte Bunch, 'Women's Rights as Human Rights: Toward a Re-Vision of Human Rights' (1990) 12(4) *Hum. Rts. Q.* 486; Makau Mutua, 'Savages, Victims, and Saviors: The Metaphor of Human Rights' (2001) 42 *Harv. Int'l. L. J.* 201.
[7] See, for example, David Kennedy, 'International Human Rights Movement: Part of the Problem?' (2002) 15 *Harv. Hum. Rts. J.* 101; Ratna Kapur, 'Human Rights in the 21st Century: Take a Walk on the Dark Side' (2006) 28 *Sydney L. Rev.* 665.

the idea of a traditional moral foundation for human rights in favour of constructivist or discourse-based models of recognising rights.[8]

My thesis seeks to address the current gaps in the literature on human rights and abortion – and gaps within human rights standards on abortion themselves – by setting out the key critiques of these standards and resolving them through my framework for recognising an explicit right to abortion. I situate this within the broader conceptual critiques of the international human rights system, which can be addressed by transforming the framework in line with the PGC. I reject the non-foundationalist arguments around human rights and morality, addressing the critiques made here by highlighting how the PGC can incorporate relationalist approaches in its application, thereby becoming a feminist-compatible theory. I seek to make an original contribution to knowledge in three ways: by bringing together overarching conceptual critiques of the international human rights framework with specific issues around abortion; setting out the PGC as a rationalist theory capable of supporting relational feminist values; and applying this to abortion within the human rights system. In Chapters 4 and 5, I include my own proposed text for the right to abortion and recommendations on specific accessibility issues, with provisions for progressive realisation.

In the context of the ongoing contested nature of abortion, and recent notable rollbacks on access to abortion such as the overturning of the constitutional right to abortion in the US, I argue that abortion is a moral right and one which must be included in the international human rights framework. Current human rights standards do not adequately protect access to abortion, and as human rights discourse has become

[8] See, for example, Sumi Madhok, *Vernacular Rights Cultures* (Cambridge University Press, 2021); Shaimaa Abdelkarim, 'Subaltern subjectivity and embodiment in human rights practices' (2022) 10(2) *Lond. Rev. Int. Law* 243.

increasingly adopted by feminist movements pushing for abortion law reform, the inclusion of an explicit human right to abortion would provide necessary support to these movements. I conclude that recognising a human right to abortion will be an important part of guaranteeing comprehensive access to abortion services worldwide.

## *Thesis Structure*

In Chapter 1, I address three key conceptual issues with the international human rights framework: its inadequate approach to gender-based human rights issues; issues with the cross-cultural traction of human rights; and the relatively weaker protection afforded to ESC rights. In relation to gender-based rights, I set out feminist critiques of the international human rights framework and introduce Charlotte Bunch's concept of a feminist transformation of human rights. Building on this concept, I argue that a feminist transformation must take an intersectional approach to gender-based rights, recognising the variable experiences of differently positioned women and inclusive of trans, non-binary, and gender-expansive people. While rejecting cultural relativism, I consider the critiques made around the Western bias of the human rights framework and argue that a feminist transformation must ensure cross-cultural traction. Finally, I highlight the ways in which ESC rights have been afforded relatively weaker protection than CP rights in the international framework. I argue that a feminist transformation must afford stronger protection for ESC rights in order to achieve genuine universality, as these rights are important aspects of gender-based rights and cross-cultural traction.

Following from these broader critiques, in Chapter 2 I address the specific issues with how international human rights bodies have approached abortion. I focus on the

development of human rights standards by the Human Rights Committee, Committee on Social, Cultural, and Economic Rights, Committee on the Elimination of Discrimination Against Women, and two Special Rapporteurs for the right to health. While international human rights standards on abortion have evolved over time, there remain limitations with each treaty body's approach. There is no explicit human right to abortion, and I identify three key overarching issues with how abortion is approached by the international human rights framework: that the legalisation or decriminalisation of abortion is recommended in circumstances only where a certain threshold of harm has been reached; the fragmentation of standards on abortion which leaves gaps; and the lack of enforcement and follow-up mechanisms. To emphasise the problems with this, I then look at the landscape of access to abortion worldwide, the prevalence of unsafe abortion, and recent restrictions on abortion in Poland and the US. I conclude this chapter by introducing the reproductive justice framework as a critique of current reproductive rights, and the broader literature on advancing abortion as a human right.

Chapter 3 sets out the PGC as the foundation for a feminist transformation of human rights capable of addressing the issues set out in Chapter 1. In the first part of this chapter, I explain each stage of the argument to the PGC before defending it against key objections that have been advanced. Secondly, I indirectly apply the PGC as the foundation of the international human rights framework and consider the issues of cross-cultural traction and ESC rights. While the PGC requires conceptual universality, it does also provide some scope for cultural pluralism and minority rights insofar as this does not violate the rights set out by the PGC. The PGC also requires protection for positive rights, which would translate into stronger state obligations – including obligations for higher-income states to assist those states unable to guarantee the realisation of ESC

rights unaided. Before I explore how the PGC can better support gender-based rights, I address feminist objections to rationalist moral theories including those from the care ethics perspective. I argue that feminist values of care and relationality can be incorporated in the application of the PGC and can therefore support an intersectional and contextual approach to gender-based rights as advocated for in Chapter 1.

Chapter 4 then applies the theory to abortion specifically. I apply the PGC in conjunction with feminist perspectives on abortion to establish the morality of abortion, balancing the generic rights of pregnant people with precaution for the foetus.[9] I then set out four policy presumptions around early abortion, the development of the foetus, abortion in the later stages of pregnancy, and the context in which abortion decisions are made. These presumptions are then applied in the human rights context, from which I develop a framework for the progressive realisation of the right to abortion. As the right to abortion incorporates both CP and ESC elements, progressive realisation is important given the worldwide variation in the legalisation of abortion and resources that can be directed towards these services. However, the framework sets out a minimum core content that all states must meet, progressing in tiers up to full compliance. In doing so, this framework offers a solution to the current limitations with abortion in the international human rights framework highlighted in Chapter 2.

Having established this framework, Chapter 5 goes into more detail on specific issues with the availability and accessibility of abortion: conscientious objection, medically unnecessary restrictions on abortion service provision, telemedicine for early medical abortion, and self-managed abortion. While there are more accessibility issues

[9] I use the terms 'pregnant person' or 'pregnant people' to be inclusive of trans, non-binary, and gender expansive people who are capable of becoming pregnant and may therefore require access to abortion.

that may be explored, the scope of this chapter is limited to those which the international human rights framework has thus far insufficiently addressed. I argue that the international human rights framework's current reliance on mandatory referral mechanisms to regulate conscientious objection is insufficient and set out a framework of recommendations as to how states should respond to conscientious objection. I then set out recommendations for the removal of medically unnecessary regulations such as mandatory waiting periods, mandatory counselling, restrictions on abortion providers, and in-person clinic attendance requirements. I also make recommendations around the provision of telemedicine for early medical abortion, or the enabling of self-managed abortion where this is not possible, in order to minimise barriers to access in line with the requirements of the framework for the right to abortion set out in Chapter 4.

Chapter 6 addresses the issue that the recognition of a human right to abortion would not automatically lead to compliance, given international treaty bodies' lack of enforcement and follow-up mechanisms. Addressing this issue and the claims made by some scholars that human rights are ineffective, I argue that the right to abortion can be indirectly realised in domestic contexts. Through processes of vernacularization, feminist movements translate human rights concepts into ways that resonate in local contexts and put pressure on governments to comply with human rights standards. I look at the examples of Argentina, Ireland, and Northern Ireland where human rights formed part of these recent movements for abortion law reform. In addition, domestic courts can be influential in abortion law reform and in ensuring access to abortion where it is already legalised, as I demonstrate by looking at the Colombian and Argentine courts. Further, the three regional human rights systems (Inter-American, European, and African) can also support the implementation of abortion rights. Thus, the right to abortion could be

realised through these alternative avenues – and would be significant in bolstering the claims made by abortion law reform movements where there is political resistance.

# 1

# Towards a Feminist Transformation of Human Rights

## *Introduction*

In this chapter, I explore the three primary conceptual issues with the international human rights framework: 1) its inadequate approach to gender-based human rights issues; 2) issues with the cross-cultural traction of human rights; and 3) the relatively weaker protection afforded to economic, social, and cultural rights. While these three issues have been identified by a range of other scholars, they are often addressed individually rather than as interconnected. Feminist scholars have, for example, often focused on the problems around gender-based human rights issues to the exclusion of the latter two problems. I argue that all three of these issues undermine the current human rights framework's claim to universality, and that a genuinely universal human rights system must therefore be responsive to gender-based issues, cross-cultural difference, and socio-economic inequalities.

I adopt Charlotte Bunch's concept of a 'feminist transformation of human rights' to argue that the international human rights framework must be transformed to work towards substantive equality and address the three primary conceptual issues.[1] I first address the limitations with traditional feminist approaches to human rights, namely in

[1] Charlotte Bunch, 'Women's Rights as Human Rights: Toward a Re-Vision of Human Rights' (1990) 12(4) *Hum. Rts. Q.* 486, 496.

relation to the homogenisation of the category of 'woman' which ignores intersectional and cross-cultural differences and excludes trans, non-binary, and gender expansive people. In relation to cross-cultural traction, I reject the arguments around cultural relativism while acknowledging that the international human rights framework has reflected Western understandings of rights and has often been imposed as an imperialist discourse in non-Western states, particularly where gender-based issues are concerned. A feminist transformation of human rights must therefore retain its commitment to the conceptual universality of rights, while providing the space for culturally specific interpretations and (limited) pluralism. Finally, I consider the differential treatment of civil and political (CP) and economic, social, and cultural (ESC) rights and the influence of neoliberalism on the human rights framework. As the realisation of ESC rights is fundamental for gender equality and cross-cultural traction, strengthening protections for this category of rights must be another core aspect of a feminist transformation of human rights. As I will explore in later chapters, addressing each of these three issues will be particularly important for the realisation of a human right to abortion.

# *1. Gender and Human Rights*

## *1.1. Feminist Critiques of Human Rights*

Feminist scholars have long articulated the way that law and human rights have excluded women's concerns, portraying androcentric norms as universal and gender-neutral.[2]

[2] Hilary Charlesworth, Christine Chinkin, and Shelley Wright, 'Feminist Approaches to International Law' (1991) 85(4) *AJIL* 613, 644.

Susan Millns, for example, pointed out that it was not enough to grant women the same (purportedly universal) rights already afforded to men, as this ignored the fact that the 'injuries suffered by women may be different to those inflicted upon men'.[3] Further, feminist scholars highlighted that the public/private dichotomy institutionalised by the human rights framework prevented the recognition of issues such as gender-based violence as human rights violations, as this was perpetrated within the home by a private actor rather than by the state.[4] While gender-based issues have been increasingly incorporated into the international human rights framework, there remain issues that feminist approaches to human rights have not fully addressed. Charlotte Bunch identifies four feminist approaches to human rights, although they generally overlap in practice, and views the first three as important but inadequate.[5] I will adopt Bunch's model for the purpose of critique, and the fourth approach, which Bunch refers to as the feminist transformation of human rights, will inform the remainder of this chapter.

The first and second approaches focus on taking women's needs into consideration in relation to civil and political rights and the recognition of the 'economic subordination' of women.[6] Feminists sought the recognition that civil and political (CP) rights and economic, social, and cultural (ESC) rights applied to women generally, but also sought 'to show how violations of women, like rape, battery and sexual slavery, were manifestations of the abuse of already accepted human rights principles' and how women were particularly affected by poverty.[7] Feminist human rights campaigners thus aimed

[3] Susan Millns, ''Bringing Rights Home': Feminism and the Human Rights Act 1998' in Susan Millns and Noel Whitty (Eds.) *Feminist Perspectives on Public Law* (Cavendish Publishing, 1999) p.185.
[4] See: Gayle Binion, 'Human Rights: A Feminist Perspective' (1995) 17(3) *Hum. Rts. Q.* 509, 516; Celina Romany, 'Women as Aliens: A Feminist Critique of the Public/Private Distinction in International Human Rights Law' (1993) 6 *Harv. Hum. Rts. J.* 87, 87.
[5] Bunch (n1) 493.
[6] *Ibid* 493-495.
[7] Charlotte Bunch, 'Looking Back, Looking Forward: Women's Human Rights in Global Perspective' (2017) 38(3-4) *Women's Rts. L. Rep.* 333, 334; Bunch (n1) 494.

to realign the liberal underpinnings of the human rights framework in order to meet 'feminist standards of justice' by seeking the reinterpretation of existing rights to include a gender-based dimension.[8] This has largely been achieved - for example, it has been recognised that the family rights contained in Article 10 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) require the protection of, and remedies for, victims of domestic abuse.[9] Further, the right to life contained in Article 6 of the International Covenant on Civil and Political Rights (ICCPR) requires states to implement measures to reduce maternal and infant mortality.[10]

The third approach focused on making legal and political institutions work for women, such as through creation of the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW).[11] CEDAW contains both CP rights, such as rights to public participation (Article 7) and equality before the law (Article 15), and ESC rights, such as the rights to education (Article 10) and healthcare (Article 12).[12] CEDAW requires states to 'condemn discrimination against women in all its forms' and 'modify or abolish existing laws, regulations, customs and practices which constitute discrimination' which includes gender stereotypes.[13] CEDAW thus takes a substantive approach to gender equality and represents an important milestone in recognising gender-based human rights. In addition to CEDAW, the four World Conferences on Women (Mexico City

[8] Eileen Hunt Botting, *Wollstonecraft, Mill, and Women's Human Rights* (Yale University Press, 2016) p.9; Rebecca J. Cook, 'Women's International Human Rights Law: The Way Forward' in Rebecca J. Cook (Ed.), *Human Rights of Women* (University of Pennsylvania Press, 1994) p.10.
[9] UN General Assembly, *International Covenant on Economic, Social, and Cultural Rights* (16 December 1966, entered into force 3 January 1976) 993 UNTS 3; Committee on Economic, Social, and Cultural Rights, 'General Comment No. 16: The Equal Right of Men and Women to the Enjoyment of all Economic, Social, and Cultural Rights (Art. 3)' (11 August 2005) UN Doc. E/C.12/2005/4, para. 27.
[10] UN General Assembly, *International Covenant on Civil and Political Rights* (16 December 1966) 999 UNTS 171; Human Rights Committee, 'General Comment No. 36 on Article 6: Right to Life' (30 September 2019) UN Doc. CCPR/C/GC/36, para. 26.
[11] Bunch (n1) 495.
[12] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women* (18 December 1979, entered into force 3 September 1981) 1249 UNTS 13.
[13] *Ibid* Article 2.

1975, Copenhagen 1980, Nairobi 1985, and Beijing 1995) organised by the United Nations were significant to the development of the women's rights agenda.[14] The Beijing Declaration and the Platform for Action affirmed that 'women's rights are human rights' and set out a range of commitments aimed at empowering women and girls and addressing areas of critical concern, including violence against women and economic inequalities.[15] The Vienna Declaration, adopted following the 1993 UN World Conference on Human Rights, sought to ensure the inclusion of women's rights in mainstream human rights work, emphasising that the eradication of discrimination against women was a priority objective for the international community.[16] However, there are concerns over whether the promise of CEDAW and the Beijing and Vienna Declarations with respect to gender-based rights has been fulfilled. Bunch, for example, indicates that the effectiveness of CEDAW is limited by the fact that it is regarded as a 'convention without teeth' and not taken seriously by many governments.[17]

While one study has shown that CEDAW has had a statistically significant (albeit varied) positive effect on the advancement of women's rights, these initial three approaches to gender-based rights has not translated into substantive gender equality.[18] Niamh Reilly argues that despite the belief that there have been 'genuine improvements in women's legal, economic and social status' that individual women can benefit from, there are continuing 'structural forces at work worldwide that disadvantage women and

[14] UN Women, 'World Conferences on Women' <https://www.unwomen.org/en/how-we-work/intergovernmental-support/world-conferences-on-women> accessed 14 January 2023.
[15] UN, *Beijing Declaration and Platform for Action, adopted at the Fourth World Conference on Women 15 September 1995* (27 October 1995) UN Doc. A/CONF.177/20.
[16] UN World Conference on Human Rights, 'Vienna Declaration and Programme of Action' (12 July 1993) UN Doc. A/CONF.157/23, para. 18.
[17] Bunch (n1) 496.
[18] Neil A. Englehart and Melissa K. Miller, 'The CEDAW Effect: International Law's Impact on Women's Rights' (2014) 13(1) *J. Hum. Rts.* 22.

girls in gender-specific ways.'[19] This will be highlighted in relation to abortion in Chapter 2. The three approaches explored in this section have taken a limited challenge to the status quo; there has been limited recognition of new rights and underlying human rights standards; and some scholars have argued that feminist claims have been obscured or de-radicalised under the UN system.[20] Rosa Ehrenreich Brooks, for example, has criticised CEDAW for its failure to identify anything 'fundamentally wrong, or even questionable, in the way social and political relations and structures are organized within the state' which results in an approach amounting to 'just let the women in, and that's that'.[21] Others have questioned whether assimilation into the current international human rights framework is possible, concluding that a change to the foundation structure is required for real inclusion.[22] This leads into the fourth approach of Bunch's model.

### *1.2. A Feminist Transformation of Human Rights*

Bunch argues that a 'feminist transformation of human rights' is an ongoing process which requires feminists to question what is 'considered a "legitimate" human rights issue' and ask how the human rights framework can become more responsive to women, through a focus on issues such as reproductive rights and gender-based abuse.[23] Bunch leaves this concept somewhat vague, noting that the 'practical applications of

[19] Niamh Reilly, *Women's Human Rights* (Polity Press, 2009) p.160-161.
[20] Dianne Otto, 'Rethinking Universals: Opening Transformative Possibilities in International Human Rights Law' (1997) 18 *Aust. YBIL* 1, 26; Anne Orford, 'Feminism, Imperialism, and the Mission of International Law' 71 *Nord. J. Int'l L.* 275, 281; Hilary Charlesworth, 'Not Waving but Drowning: Gender Mainstreaming and Human Rights in the United Nations' (2005) 18 *Harv. Hum. Rts. J.* 1, 2.
[21] Rosa Ehrenreich Brooks, 'Feminism and International Law: An Opportunity for Transformation' (2002) 14 *Yale J. L. & Feminism* 345, 351.
[22] Karen Engle, 'International Human Rights and Feminism: When Discourses Meet' (1992) 13 *Mich. J. Int'l L.* 517, 523; Eva Brems, 'Enemies or Allies? Feminism and Cultural Relativism as Dissident Voices in Discourse' (1997) 19(1) *Hum. Rts. Q.* 136, 138.
[23] Bunch (n1) 496-497.

transforming the human rights concept from feminist perspectives need to be explored further.'[24] However, the idea of a feminist transformation of human rights has been expanded upon by other commentators, who have suggested that such a transformation would involve more than 'simply refining or reforming existing law' – such as the creation of international regimes focusing on structural abuse, the revision of notions of state responsibility, and challenges to the centrality of the state in international law.[25] I adopt an understanding of this concept by building on the work of Niamh Reilly and Eileen Hunt Botting, in order to argue that a feminist transformation of human rights must reform the existing human rights framework in order to address the three primary conceptual issues and recognise rights not yet included in the framework, such as a human right to abortion.

Niamh Reilly argues that a feminist transformation of human rights can be achieved through the reinterpretation of human rights in a way which challenges their current biases, all while retaining a commitment to universal human rights principles such as equality and non-discrimination.[26] This in turn, Reilly argues, requires a 'radical critique' of certain modes hierarchical thinking - including the public/private divide within international law, the prioritisation of civil and political rights, which uncritically accepts neoliberal economics, and the tension between Western hegemony and cultural relativism.[27] Eileen Hunt Botting similarly addresses the combined need for both confronting male bias and tackling cultural bias in the conception of women's rights, arguing that there is a need to examine 'how gender and other cultural differences affect the differential and unjust treatment of women within and across societies.'[28] Hunt

[24] *Ibid* 497.
[25] Charlesworth, Chinkin, and Wright (n2) 644.
[26] Reilly (n19) p.10, 18.
[27] *Ibid* p.10, 30.
[28] Hunt Botting (n8) p.11-12.

Botting argues that this interrogation of injustice can then pave the way for aspirational claims of human rights, to allege new rights which have not yet been recognised.[29] A feminist transformation of human rights requires a much more extensive reform of the current human rights framework than the previous approaches.

The remainder of this chapter builds on this concept of feminist transformation, and I argue that this requires a revision of the international human rights framework towards one that is responsive to gender-based issues, has cross-cultural traction, and substantively protects ESC rights – thus reflecting genuinely universal moral rights. In terms of how a transformed framework should respond to gender-based human rights issues, I will first consider how feminist theory has often adopted the assumption that all women share experiences of gender inequality and therefore have the same needs and interests. This sets up men and women as two homogenous groups in opposition and fails to appreciate that inequalities are experienced along intersectional lines rather than on the basis of gender alone. An additional shortcoming of this limited construction of 'women's rights' is the exclusion of trans, non-binary, and gender-expansive people who may experience the same or similar rights violations. For the international human rights framework to comprehensively respond to gender-based issues, it must adopt a broad and intersectional understanding of gender-based inequalities.

[29] *Ibid* p.12.

## *1.3. From 'Women's Rights' to Gender-Based Rights*

### i. An Intersectional Approach to Gender-Based Rights

The concept and terminology of 'women's rights' has been criticised for suggesting that there exists the single universal category of 'women' which is set in opposition to the single universal category of 'men'. This risks assuming that all women, irrespective of any other factors, experience inequality, powerlessness, and human rights violations in the same way, and that all men are similarly positioned in terms of having power. These 'meta-stereotypes' claim that all women share experiences of oppression, and that these experiences are always different from men.[30] Further, they suggest that a person's gender is the primary aspect of their identity, rather than their links to other communities.[31] For example, Adetoun Ilumoka looks at the economic position of African women, and argues that for the majority of women in Africa 'whose struggles for basic needs and subsistence *alongside men* prevents them from changing their lives for the better, addressing the problem of poverty is a priority human rights issue'.[32] Further, in critiquing the exclusion of solidarity between women and men within feminist struggles, bell hooks highlights how the shared struggles of Black women and men has been key to anti-racist efforts.[33]

[30] Upendra Baxi, *The Future of Human Rights* (Oxford University Press, 2006, 3rd Edn.) p.157; Tracy E. Higgins, 'Anti-Essentialism, Relativism, and Human Rights' (1996) 19 *Harv. Women's Law J.* 89, 100.
[31] Inderpal Grewal, ''Women's rights as human rights': Feminist practices, global feminism, and human rights in transnationality' (1999) 3(3) *Citizenship Stud.* 337, 341.
[32] Adetoun O. Ilumoka, 'African Women's Economic, Social, and Cultural Rights – Towards a Relevant Theory and Practice' in Rebecca J. Cook (Ed.), *Human Rights of Women* (University of Pennsylvania Press, 1994) p.321 [emphasis added].
[33] bell hooks, *Feminist Theory: From Margin to Center* (first published 1984, Routledge, 2015) p.71.

Intersectionality, a framework developed by Kimberlé Crenshaw, understands characteristics such as race, gender, class, sexuality, disability etc. as interconnected.[34] Experiences of discrimination differ across intersectional lines, so that not all women experience oppression in the same way. Crenshaw demonstrated this through considering the experiences of Black women which differ to those of both white women and Black men as their experience isn't exclusively or predominantly race *or* gender based.[35] Crenshaw highlights that, for example, race and gender compound rather than being merely additive – and Patricia Hill Collins has alternatively described the interconnectedness of oppression based on different characteristics as a 'matrix of domination'. [36] Intersectionality is important for understanding how gender-based human rights issues, including discrimination, are experienced differently.

However, feminist scholars and human rights bodies have often ignored or inadequately addressed the ways in which women will experience inequalities differently along intersectional lines. The assumption of heterosexuality, for example, has been evident in feminist discourse through sweeping generalisations such as Susan Moller Okin's claim that 'a woman's most dangerous environment is the home she lives in.'[37] Another example is CEDAW's requirement that state parties 'take all appropriate measures *to eliminate discrimination against women* in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services'.[38] The focus on discrimination against *women* and equality between men and women ignores the disparities in healthcare access with the category of 'women'. For example, Aboriginal

[34] Kimberlé Crenshaw, 'Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics' (1989) 1 *U. Chi. Legal. F.* 139.
[35] *Ibid* 149.
[36] Patricia Hill Collins, *Black Feminist Thought* (Routledge, 1990).
[37] Susan Moller Okin, 'Feminism, Women's Human Rights, and Cultural Differences' (1998) 13(2) *Hypatia* 32, 36.
[38] CEDAW (n12) Article 12(2) [emphasis added].

and Torres Strait Islander women are less likely than white Australian women to access reproductive healthcare services due to cultural insensitivity and persistent stereotypes about Aboriginal Peoples; *Dalit* women in India face significant discrimination when attempting to access healthcare services; and in the UK, people with disabilities, particularly disabled women, are more likely to have an unmet need for healthcare services than able-bodied people.[39]

Adopting an intersectional understanding of gender-based human rights issues is also important for cross-cultural traction. The concept of a universal category of women can also be criticised for ignoring differences in experiences across and within different cultures. In presenting women as a homogenous group with universal needs and interests, cultural variation is masked by the assumption that the issues that exist in a small number of states can be generalised to the global system.[40] Judith Butler argues that as gender issues intersect with race, class, ethnicity, and sexuality, they cannot be separated out from their historical, political, and cultural contexts.[41] Butler thus questions the 'assumption that there must be a universal basis for feminism, one which must be found in an identity assumed to exist cross-culturally'.[42] Black feminist scholars have similarly rejected the idea of a universal feminist identity. bell hooks, for example, rejected the notion that biological similarity and common oppression could forge a common bond between women, arguing instead that feminism must 'call attention to the

[39] Lisa Morgan and Joey Lynn Wabie, 'Aboriginal Women's Access and Acceptance of Reproductive Health Care' (2012) 10(3) *Pimatisiwin* 312; Nidhi Sadana Sabharwal and Wandana Sonalkar, 'Dalit Women in India: At the Crossroads of Gender, Class, and Caste' (2015) 8(1) *Global Justice: TPR* 44; Dikaios Sakellariou and Elena S. Rotarou, 'Access to healthcare for men and women with disabilities in the UK: secondary analysis of cross-sectional data' (2017) 7(8) *BMJ Open* 1.
[40] Cyra Akila Choudhury, 'Beyond Culture: Human Rights Universalism versus Religious and Cultural Relativism in the Activism for Gender Justice' (2015) 30(2) *Berkeley J. Gender L. & Just.* 226, 250, 261.
[41] Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (Routledge, 1999, 10th Anniversary Edn.) p.6.
[42] *Ibid.*

diversity of women's social and political reality'.[43] Mohanty argues in favour of recognition of an 'imagined community' in relation to Third World struggles, which would avoid similar pitfalls through forging 'political rather than biological or cultural bases for alliance'.[44] A similar approach is necessary for feminism, recognising shared values and goals rather than claims to universal experiences.

In the international human rights framework, treaties have sought to address the particular needs of individual groups – such as CEDAW, the Convention on the Rights of Persons with Disabilities (CRPD), and the International Convention on the Elimination of Racial Discrimination (ICERD).[45] CEDAW and CERD do not explicitly recognise intersectionality in the text, which can be contrasted with CRPD's explicit recognition of the need to include a gender perspective, acknowledging the specific gender-based abuse that women with disabilities may face and the need for gender-sensitive health services.[46] International human rights bodies have increasingly adopted an intersectional approach in expanding on Convention rights (which will be covered in relation to abortion in the next chapter).[47] For example, the CEDAW Committee highlighted in its General Recommendation 33 that discrimination against women is compounded by intersecting factors such as

> 'ethnicity/race, indigenous or minority status, colour, socioeconomic status and/or caste, language, religion or belief, political opinion, national origin, marital

[43] hooks (n33) p.4-6, 27.
[44] Chandra Talpade Mohanty, *Feminism Without Borders* (Duke University Press, 2006) p.46.
[45] CEDAW (n12); UN General Assembly, *Convention on the Rights of Persons with Disabilities* (13 December 2006, entered into force 3 May 2008) 2515 UNTS 3; UN General Assembly, *International Convention on the Elimination of All Forms of Racial Discrimination* (21 December 1965, entered into force 4 January 1969) 195 UNTS 660.
[46] CRPD (n45) Preamble, Article 16, Article 25.
[47] See, for analysis on intersectionality in human rights documents: Gauthier de Beco, 'Protecting the Invisible: An Intersectional Approach to International Human Rights Law' (2017) 17(4) *Hum. Rts. Law Rev.* 633, 636-640; Pok Yin S. Chow, 'Has Intersectionality Reached its Limits? Intersectionality in the UN Human Rights Treaty Body Practice and the Issue of Ambivalence' (2016) 16(3) *Hum. Rts. Law Rev.* 453, 462-467.

and/or maternal status, age, urban/rural location, health status, disability, property ownership and identity as a lesbian, bisexual or transgender woman or intersex person.'[48]

However, Holtmaat and Post have argued that this recognition of intersectionality by CEDAW has been gratuitous, ad hoc, and erratic.[49] Part of a feminist transformation of human rights would require a strengthened intersectional approach by all treaty bodies, which would allow human rights abuses to be examined in a more nuanced way and account for people who face disadvantages across multiple characteristics.[50] Scholars have recognised that a comprehensive intersectional approach will require changes to the way that international treaty bodies approach human rights violations, as this has generally been done in a compartmentalised way.[51] Intersectionality must be integrated into the conceptual basis of human rights in order to be fully effective.

### ii. Gender-Based Rights Beyond Women

Recent years have seen the mainstreaming of a particular brand of feminism which is hostile to trans, non-binary, and gender expansive people, and trans women in particular. Self-described 'gender critical' feminists (who are often referred to by others as 'TERFs' – an abbreviation of 'trans-exclusionary radical feminists') reject the inclusion of trans

[48] CEDAW, 'General Recommendation No. 33 on Women's Access to Justice' (23 July 2015) UN Doc. CEDAW/C/GC/33, para. 8.
[49] Rikki Holtmaat and Paul Post, 'Enhancing LGBTI Rights by Changing the Interpretation of Convention on the Elimination of All Forms of Discrimination Against Women' (2015) 33(4) *Nord. J. Hum. Rts.* 319, 328-330.
[50] Johanna E. Bond, 'Intersecting Identities and Human Rights: The Example of Romani Women's Reproductive Rights' (2004) 5(3) *Geo. J. Gender & L.* 897, 902, 908; de Beco (n47) 662-663.
[51] Joanna Bond, *Global Intersectionality and Contemporary Human Rights* (Oxford University Press, 2021) p.5; de Beco (n47) 663.

women into the category of 'women' which they see as biologically determined and seek to exclude trans women from women-only spaces. One of the main claims made by gender critical feminists is that trans rights (such as to self-identify one's gender and use gender-appropriate facilities) encroach upon the rights of non-trans women.[52] In Britain, gender critical feminism has garnered prominence with support from high-profile figures, journalists, and politicians and the so-called 'trans debate' frequently features in the mainstream media.[53] The case of *Bell v Tavistock* saw a legal challenge to the prescribing of gender affirmation treatment for under 18s, and the cases of *Forstater v CGD Europe* and *Bailey v Stonewall* were brought by gender critical women who had been dismissed from their employment for transphobia, arguing that this contravened the Equality Act.[54] While hostility towards trans women in feminist scholarship is not new, this tension between trans-inclusive and trans-exclusionary feminism has now become a core issue in contemporary feminism.[55] In this section, I will therefore address the two key arguments (biological sex and safety) made for the exclusion of trans people from feminist discourse, concluding that the human rights framework must recognise trans, non-binary, and gender expansive people for realisation of gender-based rights.

Gender critical feminists view women's rights as being attached to biological sex, and moreover argue that one cannot change their sex. Alessandra Asteriti and Rebecca

[52] Sally Hines, 'Trans and feminist rights have been falsely cast in opposition' (*The Economist*, 13 July 2018) <https://www.economist.com/open-future/2018/07/13/trans-and-feminist-rights-have-been-falsely-cast-in-opposition> accessed 14 January 2023.
[53] Juliet Jacques, 'Transphobia is Everywhere in Britain' (*The New York Times*, 10 March 2020) < https://www.nytimes.com/2020/03/09/opinion/britain-transphobia-labour-party.html> accessed 14 January 2023; Sophie Lewis, 'How British Feminism Became Anti-Trans' (*The New York Times*, 7 February 2019) <https://www.nytimes.com/2019/02/07/opinion/terf-trans-women-britain.html> accessed 14 January 2023.
[54] *Bell and another v The Tavistock and Portman NHS Foundation Trust* [2021] EWCA Civ 1363; *Forstater v CGD Europe and others* (2021) ET/22200909/2019; *Bailey v Stonewall Equality Ltd and others* (2022) ET/2202172/2020.
[55] See, for example: Janice Raymond, *The Transsexual Empire* (The Women's Press, 1979); Mary Daly, *Gyn/Ecologyy* (The Women's Press, 1979); Germaine Greer, *The Whole Woman* (Black Swan, 1999).

Bull, for example, refer to the process of legally changing one's gender as a 'legal fiction with no bearing on biological status' and make repeated references to women as a 'biological sex class'.[56] Similarly, in a piece written for *The Guardian*, Suzanne Moore argued that sex is a material fact, which she views as an important fact given that women's 'oppression is innately connected to our ability to reproduce'.[57] Other feminist theorists have, however, sought to move away from this model of biological determinism, distinguishing between sex as biology or nature, and gender as the social categories or roles applied to sexed people.[58] Along this line of argument, while it would not be possible to change one's sex, one could change their gender. However, some theorists also reject the idea of sex as a biologically immutable binary. Darren Rosenblum views sex as a continuum, arguing that there is no clear divide between 'men' and 'women' as sex/gender is formed through biological *and* cultural factors; chromosomes, gonads, hormones, internal reproductive organs, external genitalia, secondary sexual characteristics, and, importantly, self-identity, are all taken as relevant.[59] Intersex people are born with a variation of what are typically understood as 'male' and 'female' sex characteristics, and are thus outside of the binary. Additionally, it is possible to change a number of these characteristics – external genitalia, hormones, and secondary sexual characteristics can all be altered through gender affirmation surgery and hormonal treatment.

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[56] Alessandra Asteriti and Rebecca Bull, 'Gender Self-Declaration and Women's Rights: How Self-Identification Undermines Women's Rights and Will Lead to an Increase in Harms: A Reply to Alex Sharpe' (*Modern Law Review Forum,* 22 July 2020) <https://www.modernlawreview.co.uk/asteriti-bull-sharpe/> accessed 14 January 2023.

[57] Suzanne Moore, 'Women must have the right to organise. We will not be silenced' (*The Guardian,* 2 March 2020) <https://www.theguardian.com/society/commentisfree/2020/mar/02/women-must-have-the-right-to-organise-we-will-not-be-silenced> accessed 14 January 2023.

[58] Sally Hines, 'The feminist frontier: On trans and feminism' in Tasha Oren and Andrea L. Press (Eds), *The Routledge Handbook of Contemporary Feminism* (Routledge, 2019) p.97; Butler (n41) p.9.

[59] Darren Rosenblum, 'Unsex CEDAW, or What's Wrong with Women's Rights?' (2011) 20(2) *Colum. J. Gender & L.* 98, 135.

The label 'gender critical' refers to the rejection of the concept of gender in favour of sex, viewing gender identity as merely appealing to harmful gender-based stereotypes. Gender critical feminists have also expressed concerns over the 'unverifiable' and 'subjective' nature of gender identity.[60] This is, however, a simplified understanding of gender and gender identity. Joan Scott views gender as a much more complex category of analysis than the sex/gender distinction argument.[61] Scott argues that gender is a constitutive element of social relationships based on *perceived* differences between the sexes.[62] Scott identifies four interrelated elements to gender: culturally available symbols (such as women represented by Eve and the Virgin Mary in Christian traditions); the interpretation of those symbols which repress any alternative possibilities (typically asserting the binary distinction between male/female and masculine/feminine); social institutions (such as the family) and the organisation of society through segregated labour markets and education; and subjective identity in terms of how gendered identities are substantively constructed with reference to social organisations and historically specific cultural representations.[63] Further, Finn Mackay argues that our interpretations of an individual's sex, insofar as we do not see the majority of people's genitals, is an interpretation of gender through making assumptions based on socio-cultural indicators or stereotypes.[64] This understanding of gender can also be supported by recognising the way in which our current gender/sex categories were imposed through colonialism.[65] I adopt this approach to gender identity, understanding gender identity as a negotiation with societal constructions of how gender should map onto sex.

[60] Asteriti and Bull (n56).
[61] Joan Scott, 'Gender: A Useful Category of Historical Analysis' (1986) 91(5) *Am. Hist. Rev.* 1053.
[62] *Ibid* 1067.
[63] *Ibid* 1067-1069.
[64] Finn Mackay, *Female Masculinities and the Gender Wars: The Politics of Sex* (I.B. Tauris, 2021) p.30.
[65] María Lugones, 'Toward a Decolonial Feminism' (2010) 25(4) *Hypatia* 742.

This more complex recognition of the relationship between gender and sex provides a more comprehensive means of addressing gender-based human rights issues. Hunt Botting argues that the distinction between biological sex and socially constructed gender promotes a more rigorous analysis of gender but does not expand upon this claim.[66] As Sally Hines argues, reducing 'womanhood to reproductive capacity and role undoes decades of feminist work that has sought to upturn conservative thought that relegates gender role to sex' and the positioning of sex as the source of women's oppression precludes any intersectional analysis.[67] Thus, in contrast with Moore's argument that women's oppression is sex-based as it is connected with reproductive capacity, an understanding of gender-based oppression from Scott's perspective would understand reproductive roles as being socio-culturally imposed. Challenging the perceived sex/gender binary is important for feminism as 'leaving traditional biology intact tightens rather than loosens the hold of a gender system on our bodies.'[68] Thus for feminism, and particularly for an intersectional approach to feminism, rejecting the idea of biological sex as the primary signifier of women's oppression is fundamental.

Gender critical feminists also seek to retain women-only spaces as sex-segregated spaces which would exclude trans women, on the basis of protecting non-trans women from harm as trans women might commit violence against non-trans women. In relation to the first claim, Alex Sharpe argues that the fear of violence from trans women is problematic as it assumes 'the equivalence of non-trans men and trans women and therefore of their respective offending patterns'.[69] Sharpe argues that this assumption is

[66] Hunt Botting (n8) p.134.
[67] Sally Hines, 'Sex wars and (trans) gender panics: Identity and body politics in contemporary UK feminism' (2020) 68(4) *Soc. Rev. Monographs* 25, 34.
[68] Sara Ahmed, 'An Affinity of Hammers' (2016) 3(1-2) *Transgender Stud. Q.* 22, 30.
[69] Alex Sharpe, 'Will Gender Self-Declaration Undermine Women's Rights and Lead to an Increase in Harms?' (2020) 83(3) *MLR* 539, 547.

without merit, as it places emphasis on the 'apparent relevance of gendered forms of socialisation and/or biological drives.'[70] Feminist scholarship has sought to explain gender-based violence as linked to hegemonic masculinity and the stereotypes that are imposed on men and boys around physical strength and heterosexual dominance, rather than a biological trait inherent to people of the male sex.[71] Further, Aleardo Zanghellini highlights that the assumption that people of the male sex are prone to violence is extended to trans women as a class, arguing that this relies on the absence of evidence of difference.[72] Above, I reject biological sex as primarily important for feminist theory and instead understand gender identity as a complex negotiation with socio-cultural stereotypes around the differences between the sexes. Aligning trans women with hegemonic masculinity is problematic, as this argument reverts back to biological determinism.

Sharpe accepts that there are exceedingly rare cases of violence against cisgender women by trans women but argues that 'the exclusion of a whole class of women from women-only spaces is not justified in public policy terms by a handful of cases'.[73] Zaghellini similarly argues that a blanket policy of excluding trans women from women-only spaces would be disproportionate to the aim of protecting non-trans women, particularly in the absence of evidence that this would improve non-trans women's safety.[74] Zaghellini makes the following analogy:

[70] *Ibid* 541.
[71] Raewyn W. Connell and James W. Messerschmidt, 'Hegemonic Masculinity: Rethinking the Concept' (2005) 19(6) *Gender and Society* 829; Rachel Jewkes and others, 'Hegemonic masculinity: combining theory and practice in gender interventions' (2015) 17 *Culture, Health & Sexuality* 112.
[72] Aleardo Zanghellini, 'Philosophical Problems With the Gender-Critical Feminist Argument Against Trans Inclusion' (2020) 10(2) *Sage Open* 1, 5.
[73] Sharpe (n69) 547.
[74] Zanghellini (n72) 7.

> '[W]e know that some men who come into contact with children in their work will offend against them. Yet we do not exclude all men from working with children, even if using gender as a watershed would prevent those offenses. Why does the good of minimizing child sexual abuse not lead us inexorably to the conclusion that we must outlaw all male teachers and coaches?'[75]

Further, in considering the use of women-only spaces such as public toilets as being about protection from violence, this discussion must also consider the potential harms resulting from the exclusion of trans women from these spaces. Sharpe argues that we must recognise 'the vulnerability of trans women as a class to male violence, and therefore their need to access women-only spaces.'[76] Where a trans woman has to choose between using women's or men's bathrooms, forcing them to use the men's bathroom may put them at risk of violence from non-trans men given the prevalence of violence against trans people generally.[77] Trans participants in a recent study highlighted their experiences of harm in gender-segregated toilets as a result of transphobia and the portrayal of trans women as dangerous.[78]

Further, these arguments ignore importance of access to services such as sexual and reproductive healthcare and sexual violence support. Trans men and some non-binary and gender-expansive people face difficulties when accessing women-oriented reproductive health services, such as cervical cancer screenings and abortion services.[79]

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[75] *Ibid* 6.
[76] Sharpe (n69) 19.
[77] Karel Blondeel and others, 'Violence motivated by perception of sexual orientation and gender identity: a systematic review' (2018) 96 *Bull. World Health Organ.* 29.
[78] Charlotte Jones and Jen Slater, 'The toilet debate: Stalling trans possibilities and defending 'women's protected spaces'' (2020) 68(4) *Soc. Rev. Monographs* 834, 847.
[79] Aimee Linfield, 'Reducing cervical screening inequalities for trans people' (Public Health England Screening, 10 April 2019) <https://phescreening.blog.gov.uk/2019/04/10/reducing-cervical-screening-inequalities-for-trans-people/> accessed 14 January 2023; Heidi Moseson and others, 'Abortion experiences and preferences of transgender, nonbinary and gender-expansive people in the United States' (2021) 224(4) *Am. J. Obstet. Gynecol.* 376.e1.

Trans women also need to access to rape crisis and domestic violence services.[80] As argued above, an intersectional perspective on gender-based rights requires the recognition of varied experiences of disempowerment and oppression, including the experiences of trans, non-binary, and gender-expansive people. In conceptualising feminism as based on shared goals and values rather than universal experiences, I argue that gender-based rights discourse must therefore include trans, non-binary, and gender-expansive people in addition to non-trans women. This is all the more important in the context of the connections between restrictions on gender-based rights and trans rights. For example, Texas Governor Greg Abbott has been responsible for signing into law both restrictions on abortion and a bill to prevent children from receiving gender affirmative healthcare.[81] Protecting the human rights of women and trans people are not mutually exclusive but must be recognised as interconnected – and this shared ground for gender-based rights is important within a transformed international human rights framework.

[80] Shon Faye, 'Trans women need access to rape and domestic violence services. Here's why' (*The Guardian,* 21 November 2017) <https://www.theguardian.com/commentisfree/2017/nov/21/trans-women-rape-domestic-violence-dangers> accessed 14 January 2023.

[81] Sneda Dey and Karen Brooks Harper, 'Transgender Texas kids are terrified after governor orders that parents be investigated for child abuse' (*The Texas Tribune,* 28 February 2022) <https://www.texastribune.org/2022/02/28/texas-transgender-child-abuse/> accessed 14 January 2023; Shannon Najmabadi, 'Gov. Greg Abbott signs into law one of the nation's strictest abortion measures, banning procedure as early as six weeks into pregnancy' (*The Texas Tribune*, 19 May 2021) <https://www.texastribune.org/2021/05/18/texas-heartbeat-bill-abortions-law/> accessed 14 January 2023.

# 2. Cross-Cultural Traction

## 2.1. The Cultural Relativism vs. Universalism Debate

Cultural relativists call into question what they perceive as the superiority of Western conceptions of morality and reject claims as to the rightness or wrongness of differing cultural values. The relativist challenge to human rights has been simplified as follows: 'norms of morality are relative to a given society; the ethical basis for international human rights is Western; therefore international norms should not be the basis of value judgments in other cultural contexts.' [82] Alison Dundes Renteln argues that the presumption of universality presupposes 'that individuals stripped of their cultural and political heritage would be pure rational beings and would thus dutifully select liberal democratic principles of justice.'[83] She views the 'root of the problem' as the underlying 'belief that all peoples think in a similar fashion.'[84]

J. Oloka-Onyango and Sylvia Tamale distinguish between two broad arguments relating to cultural relativism. They identify the first as emanating from non-Western politicians and scholars, asserting that universal human rights norms are an imperialist interference with religious and cultural beliefs and practices.[85] The second argument comes from Western scholars, who 'evoke the culturalist dimension as both explanation and excuse for inaction or wrong action'.[86] The issue coming from this second argument

[82] Annie Bunting, 'Theorizing Women's Cultural Diversity in Feminist International Human Rights Strategies' (1993) 20(1) *J. L. & Soc.* 6, 8.
[83] Alison Dundes Renteln, *International Human Rights: Universalism Versus Relativism* (Sage, 1990) p.50.
[84] *Ibid*.
[85] J. Oloka-Onyango and Sylvia Tamale, '"The Personal is Political," or Why Women's Rights Are Indeed Human Rights: An African Perspective on International Feminism' (1995) 17(4) *Hum. Rts. Q.* 691, 706.
[86] *Ibid*.

is that the chief 'defenders of cultural relativism are not from nondominant cultures but are white male intellectuals' who fail to engage with postcolonial concerns.[87] The problems with cultural relativist arguments in this second sense will be explored, highlighting the problems with how culture is presented as absent from power and with the assumptions that human rights are specifically Western. While the cultural relativist challenge can be rejected on this basis, there is nonetheless a need for a feminist transformation of human rights to engage with the postcolonial concerns that human rights mirror imperialist discourses and view cultural difference negatively. The human rights framework can again be viewed as falsely universal as it is biased towards Western liberalism and fails to be inclusive of values that differ to this model. Achieving genuine universality therefore requires us to retain a commitment to the conceptual universality of human rights, while ensuring that the framework is freed from its current cultural bias, becomes more sensitive to different cultural values, and allows contextual interpretations and cultural accommodations.

Cultural relativism presents a simplistic view of culture. Theorists have observed how relativists perceive cultures as 'unchanging givens' and ignore the competing assertions of norms or the fact that culture is subject to change and struggle.[88] The term 'culture' is also used to refer to values spanning religion, language, ethnicity, nationality, and race.[89] Uma Narayan thus argues that we should reject the idea that anything can be uncontroversially defined as "Indian culture" or "Western culture" or "African culture".[90]

[87] Bronwyn Winter, 'Women, the Law, and Cultural Relativism in France: The Case of Excision' (1994) 19(4) *Signs* 939, 959.
[88] Uma Narayan, 'Essence of Culture and a Sense of History: A Feminist Critique of Cultural Essentialism' (1998) 13(2) *Hypatia* 86, 94; Bunting (n82) 8-9; Jack Donnelly, 'The Relative Universality of Human Rights' (2007) 29(2) *Hum. Rts. Q.* 281, 296.
[89] Sarah Song, 'Feminists Rethink Multiculturalism: Resisting Essentialism and Cross-Cultural Hypocrisy' in Margaret Davies and Vanessa E. Munro (Eds.), *The Ashgate Research Companion to Feminist Legal Theory* (Ashgate, 2013) p.140.
[90] Narayan (n88) 102.

Cultural values vary not only across nations but within them, and it cannot be assumed that the interests of the dominant group represent the interests of everyone. What are perceived as commonly accepted cultural values depend on the group(s) with power who decide which cultural values and norms are prioritised. As Jack Donnelly notes, relativism ignores the influence of politics, or conflates politics with culture, thus confusing 'what a people have been forced to tolerate with what it values.'[91] There is an 'interpretative privilege in cultural formation' and this issue is particularly relevant to feminist theorists who argue that culture often represents the interests of men so 'how and what women choose to accept or reject as part of their culture is often ignored or suppressed'.[92]

Cultural relativism is therefore often blind to gender issues by focusing on the cultural significance of traditional practices rather than the potential harms caused by them.[93] Feminist scholars have thus sought to highlight the ways that cultural relativism can operate to justify gender inequality. Okin argues that 'the sanctity of "cultural practices" is most often claimed when issues of sexuality, marriage, reproduction, inheritance, and power over children are concerned'.[94] Cultural relativism would support practices such as female genital mutilation (FGM) as being a traditional rite of passage for girls.[95] In addition to actively supporting misogynistic practices, another issue is that cultural relativism can be used as an excuse for states to avoid reform on gender issues, masking political beliefs on the rights of people in a society rather than relating to genuine concern over preserving cultural practices.[96] For example, Islam is often

[91] Donnelly (n88) 296.
[92] Arati Rao, 'The Politics of Gender and Culture in International Human Rights Discourse' in Julie Peters and Andrea Wolper (Eds.), *Women's Rights Human Rights* (Routledge, 1995) p.173; Nancy Kim, 'Toward a Feminist Theory of Human Rights: Straddling the Fence between Western Imperialism and Uncritical Absolutism' (1993) 25 *Colum. Hum. Rts. L. Rev.* 49, 90.
[93] Bunting (n82) 9; Kim (n92) 87.
[94] Okin (n37) 36.
[95] *Ibid* 37; Kim (n92) 61.
[96] Choudhury (n40) 230.

presented as incompatible with gender equality, but scholars note that the varying interpretations which are elevated and formalised across different states cannot be explained by 'culture' but are shaped by socioeconomic and political developments and, importantly, the exploitation of cultural identities by those in power.[97] Cultural relativism can thus be used as an attempt to justify the inequality of marginalised groups under the guise of preserving cultural values.

Cultural relativists additionally argue that human rights are uniquely Western, imposed as a purportedly superior value system on non-Western cultures. Some scholars have, however, rejected this argument. Upendra Baxi, for example, points to anti-colonial struggles in which people claimed the individual and collective rights that had previously been denied to them.[98] Baxi argues that no culture is 'devoid of notions about human rights' given that all cultures contain 'beliefs, sentiments, symbols that impart sense to the notion of being human'.[99] In contrast, Jack Donnelly argues that human rights are not to be confused with 'values such as justice, fairness, and humanity' emanating from non-Western cultures.[100] However, such arguments tend to have racist overtones by implying that human rights violations are 'culturally endemic' to non-Western states.[101] In another article, Donnelly writes that 'most non-Western cultural and political traditions lack not only the practice of human rights but the very concept' and that people 'in these countries may even have the greatest difficulty comprehending what is meant by human rights'.[102] This argument also works vice versa, to imply that human rights protection is innate to

[97] *Ibid* 238; Farida Shaheed, 'Controlled or Autonomous: Identity and the Experience of the Network, Women Living under Muslim Laws' (1994) 19(4) *Signs* 997, 1001.
[98] Baxi (n30) p.212-214.
[99] *Ibid* p.25.
[100] Donnelly (n88) 284.
[101] Oloka-Onyango and Tamale (n85) 706.
[102] Jack Donnelly, 'Human Rights and Human Dignity: An Analytic Critique of Non-Western Conceptions of Human Rights' (1982) 76(2) *Am. Pol. Sci. Rev.* 303, 303, 313.

certain countries, and Narayan highlights the problem with equating human rights with the West in light of 'the historical reality that Western doctrines of equality and rights coexisted for decades with support for slavery and colonialism'.[103] The cultural relativist argument thus makes problematic assumptions about the human rights compatibility of Western and non-Western populations.

### *2.2. Human Rights Imperialism*

A distinction can be drawn between the claim that rights are inherently Western, and that it happened to be in the West that human rights 'came to fruition in the particular sense of becoming *an important part of the legal and cultural fabric and of having real political consequences*.'[104] The concept of human rights is not specifically Western, and many outside of the West have endorsed the ethical basis for human rights.[105] The international human rights framework, as a legal and political institution, has Western liberalism as its foundation and therefore promotes 'a Eurocentric ideal' as universally applicable.[106] This relates back to Oloka-Onyango and Tamale's definition of cultural relativism in the first sense, concerning the imposition of Western understandings of rights as an imperialist intervention. This is often the case in relation to gender-based rights issues, as feminist critiques of cultural relativism often take the position that culture always undermines

[103] Narayan (n88) 97.
[104] Stephen Hopgood, 'Human Rights on the Road to Nowhere' in Stephen Hopgood, Jack Snyder, and Leslie Vinjamuri (Eds) *Human Rights Futures* (Cambridge University Press, 2017) p.286.
[105] Bunting (n82) 9.
[106] Makau Mutua, 'Savages, Victims, and Saviors: The Metaphor of Human Rights' (2001) 42 *Harv.Int'l. L.J.* 201, 205.

human rights.[107] Consequently, these critiques also assume that rights-violating cultures are usually non-Western. Riane Eisler, for example, wrote that *'in many regions of the developing world* (ironically often those with the highest poverty and, correlatively, birth rates), women have no right to reproductive freedom and are defined by both law and custom as literally male controlled mechanisms of reproduction' – ignoring reproductive rights restrictions in higher income countries.[108]

Returning to the example of FGM, the language of 'barbaric torture' used to condemn this practice is markedly different to that used in relation to gender issues in the West.[109] Peggy Levitt and Sally Engle Merry observe that FGM is seen as a harmful tradition whereas 'other forms of surgical bodily modification such as plastic surgery has never been considered a human rights violation.'[110] It is important to emphasise here that this is not to condone harmful practices. Bronwyn Winter argues that it is spurious to use the example of patriarchal oppression in one society to justify patriarchal oppression in another:

> 'It is true that Western society generally condemns excision, polygamy, and other non-Western misogynistic practices while condoning more culturally palatable forms of woman hating (such as pornography, marital rape, or the exploitation and deformation of women's bodies and psyches in advertising, the arts, and fashion). It seems a little paradoxical, however, to use the fact that patriarchy is the dominant form of social organization, and thus a common denominator of

[107] Peggy Levitt and Sally Engle Merry, 'Making Women's Human Rights in the Vernacular: Navigating the Culture/Rights Divide' in Dorothy L. Hodgson (Ed.) *Gender and Culture at the Limit of Rights* (University of Pennsylvania Press, 2011) p.81.
[108] Riane Eisler, 'Human Rights: Toward an Integrated Theory for Action' (1987) 9(3) *Hum.Rts.Q.* 287, 294. [emphasis added].
[109] *Ibid* 294-295.
[110] Levitt and Engle Merry (n107) p.85.

sociosexual relations in most societies, as a justification for tolerating "different" expressions of male domination in "other" cultures.'[111]

However, identifying how non-Western examples of gender inequality are portrayed is nevertheless important to highlight these inconsistencies as a key conceptual issue in the international human rights framework. Issues such as FGM, female infanticide, coercive sterilisation, and sex-selective abortion are often portrayed in ways which reflect imperialist discourse, presenting women as weak and in need of protection from outside influence, a key excuse for the civilising mission in the colonial era.[112] Makau Mutua looks at the word 'mutilation' in FGM as implying 'the wilful, sadistic infliction of pain on a hapless victim, and stigmatizes the practitioners and their cultures as barbaric savages' which reflects colonial discourses.[113] Levitt and Engle Merry similarly argue that this narrative is the 'familiar colonial trope of the backward traditional society coercing the innocent young woman.'[114] Others have observed how this idea of "saving women" from dangerous men has been used to justify military invasions in Afghanistan and Iraq and has become a resuscitated narrative within the context of the "War on Terror".[115] In this context, Muslim women are subjected to gendered Islamophobia which sustains 'Orientalist tropes and representations of backward, oppressed and politically immature women' in the context of portrayals of Islam as anti-democratic, anti-liberal, and oppressive.[116] The French ban on wearing the *hijab* in schools and face-covering veils in public is an example of this, the assumption

[111] Winter (n87) 958.
[112] Kapur (n**Error! Bookmark not defined.**) 678.
[113] Mutua (106) 225.
[114] Levitt and Engle Merry (n107) p.86.
[115] Niamh Reilly, 'Doing transnational feminism, transforming human rights: the emancipatory possibilities revisited' (2011) 19(2) *Irish J. Sociology* 60, 65; Choudhury (n96) 231; Sara R. Farris, *In The Name of Women's Rights* (Duke University Press, 2017).
[116] Jasmin Zine, 'Between Orientalism and Fundamentalism: The Politics of Muslim Women's Feminist Engagement' (2006) 3(1) *Muslim World J. Hum. Rts.* 1, 1-2.

being that these coverings are always manifestations of fundamentalist patriarchal control rather than being a means of religious identification that a Muslim woman might choose.[117] While I reject the cultural relativist arguments in the second sense in Oloka-Onyango and Tamale's definition, the imperialist nature of human rights narratives is a key conceptual issue with the international human rights framework that must be addressed as part of a feminist transformation.

### *2.3. Conceptual Universality and Cultural Accommodation*

A feminist transformation of human rights must retain its commitment to universality, while also ensuring that human rights have traction cross-culturally. Feminism must be wary of accepting cultural norms without question given how dominant constructions of culture can perpetuate gender inequality.[118] However, as highlighted above, it cannot be assumed that gendered interests are the same cross-culturally, and so cultural difference must be accommodated in the human rights framework to ensure that universal human rights norms are applicable and effective in different cultural contexts. Abdullahi Ahmed An-Na'im argues that the universality of human rights must be realised through deliberate strategies to address existing tensions within different cultural settings.[119] He argues that cultural sensitivity and an understanding of the rationale behind cultural values is necessary in order to persuade people that changing religious and customary

[117] *Ibid* 10.
[118] Anne Phillips, 'Multiculturalism, Universalism, and the Claims of Democracy' in Maxine Molyneux and Shahra Razavi (Eds.), *Gender Justice, Development, and Rights* (Oxford University Press, 2002) p.117.
[119] Abdullahi Ahmed An-Na'im, 'Islam and Human Rights: Beyond the Universality Debate' (2000) 94 *ASIL Proceedings* 95, 100.

laws in line with human rights standards is valid and acceptable.[120] This approach looks to the reinterpretation of existing values to correspond with human rights standards through internal, or local, dialogue.[121] As an insight into how this might manifest, we can consider the work of Muslim feminists.[122] Muslim feminists commit 'to the feminist goals of combating patriarchy and transforming the oppressive ideological and material conditions that sustain the subordination of women' while viewing these goals as compatible with their religion.[123] Accepting that Islamic texts are subject to contestable interpretations, Muslim feminists seek to challenge how dominant patriarchal interpretations are presented as the only possible understandings and instead invoke 'gender positive' readings.[124]

This approach does not assume that universality already exists, instead ensuring that universal concepts are applied contextually. This will require some translation in settings where there is resistance to the concept or language of human rights, as An-Na'im argues. Ilumoka points out that 'freedom and justice has more resonance amongst the "masses"' in Africa whereas the language of rights tends to be used primarily among the political elite.[125] Carolyn Heitmeyer and Maya Unnithan similarly highlight that women in India rarely frame the ability to control their own fertility in the language of reproductive rights.[126] Engle Merry introduced the concept of vernacularisation to

[120] Abdullahi Ahmed An-Na'im, 'State Responsibility Under International Human Rights Law to Change Religious and Customary Laws' in Rebecca J. Cook (Ed.), *Human Rights of Women* (University of Pennsylvania Press, 1994) p.177.
[121] *Ibid* p.179.
[122] There are many different Muslim feminisms, which is sometimes referred to as Islamic feminism. I am using this term to refer to Muslim feminists who are committed to both their religion and feminism, and view the two as compatible, to be distinguished from some secular Muslim feminists who do not.
[123] Zine (n116) 15.
[124] *Ibid* 15-16.
[125] Ilumoka (n32) p.319.
[126] Carolyn Heitmeyer and Maya Unnithan, 'Bodily rights and collective claims: the work of legal activists in interpreting reproductive and maternal rights in India' (2015) 21 *J. R. Anthropol. Inst.* 374, 375.

explain how civil society organisations translate human rights ideas into the local language in order to realise human rights in a way that resonates.[127] I will return to this concept in Chapter 6 in discussing how abortion rights movements can translate a human right to abortion into specific socio-cultural contexts. contextually. Joanna Bond adopts 'qualified universalism' as favouring 'universal application of human rights to all but would recognize that individuals do not experience human rights violations in the same ways'.[128] Recognising universal concepts which can be applied contextually would also support the intersectional approach to gender-based rights as outlined above.

In addition, the balance between universal human rights and cultural sensitivity may also require specific cultural accommodations to be made. Michel Rosenfeld argues that comprehensive pluralism can bridge the gap between universalism and cultural relativism.[129] However, absolutist relativism holds that all moral views are equally valid, so no moral view can be held as superior; as cultural relativism is thus oppositional to universalism, this is not so much a gap that can be bridged but universalism can nevertheless be understood in a way which is sensitive to differing cultural values. This middle ground, Rosenfeld's understanding of comprehensive pluralism, holds one conception of good above all others but also seeks to accommodate other conceptions.[130] Accommodating different cultural values within a transformed human rights framework would mean that human rights norms would continue to be understood as universal, while also providing scope for certain minority or group rights. The cultural accommodations which may be accepted under this form of pluralism may include

[127] Sally Engle Merry, *Human Rights and Gender Violence* (The University of Chicago Press, 2006) p.5.
[128] Bond (n50) 155.
[129] Michel Rosenfeld, 'Can Human Rights Bridge the Gap between Universalism and Cultural Relativism – A Pluralist Assessment Based on the Rights of Minorities' (1999) 30(2) *Colum. Hum. Rts. L. Rev.* 249.
[130] *Ibid* 267.

exemptions from generally applicable laws, assistance to do things that the majority can do unassisted, representation of minorities in government bodies, recognition of traditional legal codes by the dominant legal system, or limited self-government rights.[131]

Rosenfeld ranks the fundamental norms of comprehensive pluralism (such as tolerance) as 'second-order norms' and norms emanating from remaining conceptions of good as 'first -order norms'.[132] First-order norms would only be accommodated to the extent that they are compatible with second-order norms; comprehensive pluralism thus 'grants priority to second-order norms over first-order norms, such priority only comes into play in the context of an actual conflict among first-order norms.'[133] Rosenfeld considers the protection of Aboriginal rights under the Canadian Constitution as an example of a pluralistic approach to minority rights,[134] and within the international human rights framework, the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) already ascribes rights to Indigenous Peoples to exercise self-determination and self-governance in relation to their internal and local affairs.[135] Allowing cultural accommodations should be context-dependent, going back to feminist concerns that unquestioningly accepting cultural norms can perpetuate the inequality of marginalised groups. Sarah Song argues that group-specific rights should not be accommodated where they threaten the agency of individual members of minority cultural groups.[136] Multicultural accommodations should enhance the rights of members of minority groups, which requires a careful balance between group rights and the rights of the individual. Ensuring the balance between cultural sensitivity and universal human rights would

[131] Song (n89) p.140.
[132] Rosenfeld (n129) 270.
[133] *Ibid* 270; 279.
[134] *Ibid* 276.
[135] UN General Assembly, *United Nations Declaration on the Rights of Indigenous Peoples* (2 October 2007) UN Doc. A/RES/61/295, Articles 3-4.
[136] Song (n89) p.149.

therefore require that the potential harms to minority groups be scrutinised. The recognition of universal human rights, while providing the scope for contextual application and some cultural accommodations, will ensure the genuine universality of the international human rights framework, thus addressing the current conceptual issues with cross-cultural traction.

# *3. Economic, Social, and Cultural Rights*

## *3.1. The Current Position of Economic, Social, and Cultural Rights*

The international human rights framework has generally prioritised civil and political (CP) rights over economic, social, and cultural (ESC) rights. While there is overlap between these categories and many human rights can be considered to be both, this divide has been entrenched within international and regional human rights systems. The European Convention on Human Rights (ECHR) contains only CP rights, and the European Social Charter, a counterpart to the ECHR containing socio-economic rights, was passed by the Council of Europe over 10 years after the ECHR.[137] The Universal Declaration of Human Rights (UDHR) contains both categories of rights, but the majority of rights (Articles 3-21) are CP rights whereas ESC rights make up only six of the rights covered (Articles 22-27).[138] During the process to transform the UDHR into binding obligations, ideological disputes arose between the West and the East. The international human rights framework had largely developed along the lines of Western liberalism

[137] Council of Europe, *European Convention for the Protection of Human Rights and Fundamental Freedoms* (4 November 1950, entered into force 3 September 1953) ETS 5; Council of Europe, *European Social Charter* (18 October 1961, entered into force 26 February 1965) ETS 35.
[138] UN General Assembly, *Universal Declaration of Human Rights* (10 December 1948) Resolution 217 A (III).

which prioritised CP rights, whereas the communist Eastern Soviet states prioritised the protection of ESC rights. The tensions between the East and West in the wake of the Cold War prevented the creation of one unified Covenant, so the UDHR was split into two treaties, the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).

Differences in the protection afforded to CP and ESC rights are evident in the varying obligations placed on states under the ICCPR and ICESCR. The ICCPR requires that each State Party 'undertakes to *respect and to ensure to all individuals* within its territory and subject to its jurisdiction the rights recognized in the present Covenant' including an obligation to take the necessary steps 'to adopt such laws or other measures as may be necessary to give effect to' the rights contained in the Covenant.[139] However, the ICESCR contains a weaker obligation, requiring that each State Party '*undertakes to take steps*, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to *achieving progressively the full realization of the rights* recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.'[140] Whereas the ICCPR requires that states commit to the realisation of all of the rights contained in the Covenant, the ICESCR only requires states to commit to taking steps towards protecting ESC rights.

Further, the ICCPR states that the rights contained in the convention must be ensured to all 'without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.'[141] The

[139] ICCPR (n10) Article 2(1)-(2) [emphasis added].
[140] ICESCR (n9)Article 2(1) [emphasis added].
[141] ICCPR (n10) Article 2(1).

ICESCR contains the same statement on non-discrimination, but is followed by a limitation: 'Developing countries, with due regard to human rights and their national economy, may determine *to what extent they would guarantee the economic rights* recognized in the present Covenant *to non-nationals.*'[142] This might be explained in terms of the resources required to ensure each set of rights; where CP rights can be framed as negative rights in the sense that they require state non-interference, ESC rights are positive rights as their realisation requires states to take substantive measures.[143] ESC rights are, therefore, seen as expensive rights to guarantee. For example, the right to health (Article 12 ICESCR) requires the infrastructure, equipment, and personnel to provide healthcare for every member of the population, and additionally requires healthcare to be accessible, affordable, and culturally appropriate. Low- and middle-income states may not have the resources available to guarantee every right contained in the ICESCR, and the distinction made between the two categories of rights may be necessary to ensure that states are not held at fault for failing to protect human rights in circumstances where they are financially unable to.

However, aside from the provision in relation to non-nationals, the ICESCR makes no other clear distinction between low, lower-middle, upper-middle, and high-income states.[144] States with the financial capacity to guarantee all (or most) of the contained rights are not subject to a stronger obligation, nor does the ICESCR require states to ensure that an appropriate proportion of their resources are directed towards the

[142] ICESCR (n9) Article 2(2)-(3) [emphasis added].
[143] Where the infrastructure does not already exist, civil and political rights do also require positive measures. The right to a fair trial under Article 14 ICCPR, for example, would require the existence of an independent judiciary, an appeals system, and access to the courts, amongst other things.
[144] The World Bank classifies economies into these four groups, determined by gross national income per capita. These groupings are imperfect but are useful in relation to this discussion on resource-distribution. See: World Bank Data Team, 'New World Bank country classifications by income level: 2022-2023' (*World Bank Blogs,* 1 July 2022) <https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2022-2023> accessed 14 January 2023.

protection of ESC rights. The obligation that states progressively realise ESC rights to the maximum of their *available* resources leaves it to states to decide how much of their resources they want to make available, with the result that ESC rights are granted weak protection even in high-income states with the resource capacity to fully comply. While the Committee on Economic, Social, and Cultural Rights has elaborated in General Comments on the obligations on states to progressively realise ESC rights, including the implementation of national strategies for accountability and cost-effective resource allocation, these documents are not legally binding.[145]

In November 2018, the UN Special Rapporteur on extreme poverty and human rights, Phillip Alston, visited the UK and found that, despite residing in the world's fifth largest economy, 14 million people (amounting to one fifth of the population) live in poverty.[146] Alston observed increasing child and pensioner poverty, homelessness and housing insecurity, a falling life expectancy for certain groups, cuts to welfare provision for people with disabilities, and reductions to social services including mental health care.[147] Poverty in the UK had disproportionately affected 'women, racial and ethnic minorities, children, single parents, persons with disabilities and members of other historically marginalized groups'.[148] Alston linked this increasing level of poverty to the welfare reforms and austerity measures put in place by the Conservative Party since entering into Government in 2010, which 'deliberately gutted local authorities and thereby effectively eliminated many social services' despite the fact that the UK had a

[145] See, for example, CESCR, 'General Comment No. 9 on the Domestic Application of the Covenant' (3 December 1998) UN Doc. E/C.12/1998/24; CESCR, 'General Comment No. 12 on the Right to Adequate Food (Article 11)' (12 May 1999) UN Doc. E/C.12/1999/5, paras. 21-28.
[146] HRC, 'Visit to the United Kingdom of Great Britain and Northern Ireland: Report of the Special Rapporteur on extreme poverty and human rights' (23 April 2019) UN Doc. A/HRC/41/39/Add.1, para. 3.
[147] *Ibid* paras. 3-4.
[148] *Ibid* para. 67.

'booming economy'.[149] The COVID-19 pandemic and the current 'cost of living crisis' have exacerbated this situation in the few years following Alston's assessment.[150]

Alston also reported on extreme poverty in the United States in 2018, observing that the US is 'one of the world's wealthiest societies' but with 40 million people living in poverty, 18.5 million in extreme poverty, and 5.3 million in absolute poverty, the state's 'immense wealth and expertise stand in shocking contrast with the conditions in which vast numbers of its citizens live'.[151] Here, poverty refers to people living below the US's poverty threshold which varies for different types of household – for a family of four, poverty would be an annual income of under $25,000.[152] Extreme poverty refers to an annual income of below half of the poverty threshold, so under $12,500 for a family of four, and absolute poverty is measured as $4 per day.[153] Alston expressed serious concerns over the welfare of Indigenous Peoples, who disproportionately suffer from poverty and poor health.[154] Although the US has not ratified the ICESCR, Alston stated that:

> 'denial does not eliminate responsibility, nor does it negate obligations. International human rights law recognizes a right to education, a right to health care, a right to social protection for those in need and a right to an adequate standard of living.'[155]

[149] *Ibid* paras. 5, 95.
[150] See, for example, Sophie Boobis and Francesca Albanese, 'The impact of COVID-19 on people facing homelessness and service provision across Great Britain' (*Crisis*, 19 November 2020); Charlie Berry and Mike Thompson, 'Shelter Briefing: Cost of Living Crisis and the Housing Emergency' (*Shelter*, 7 September 2022).
[151] HRC, 'Report of the Special Rapporteur on extreme poverty and human rights on his mission to the United States of America' (4 May 2018) UN Doc. A/HRC/38/33/Add.1, para. 4.
[152] *Ibid.*
[153] *Ibid*.
[154] *Ibid* paras. 61-62.
[155] *Ibid* para. 12.

In highlighting the impact of criminalisation on the homeless, Alston argued that homelessness 'on this scale is far from inevitable and reflects political choices to see the solution as law enforcement rather than adequate and accessible low-cost housing, medical treatment, psychological counselling and job training.'[156] Alston's reports on poverty in the US and the UK both highlight that each state has made political and economic choices resulting in the infringement of ESC rights, despite having the resource capacity to do otherwise.

ESC rights have relatively recently garnered more protection within the international human rights framework. The splitting of the UDHR into two Covenants was on the understanding that ESC rights would remain judicially unenforceable.[157] However, in 2013, the Optional Protocol (OP) to the ICESCR came into force, allowing individuals and groups to bring communications on violations to the CESCR, as has been the case under the ICCPR since its inception.[158] Further, the 1993 Vienna Declaration stressed that all human rights are 'universal, indivisible, and interdependent and interrelated' and that they must be treated by the international community 'in a fair and equal manner, on the same footing, and with the same emphasis.'[159] Ioana Cismas therefore views the distinction between these categories of rights as an arbitrary 'wall of separation' which must fall, given the their intersecting nature.[160] However, despite this important

[156] *Ibid* para. 45.
[157] Eibe Riedel, Gilles Giacca, and Christophe Golay, 'The Development of Economic, Social, and Cultural Rights in International Law' in Eibe Riedel, Gilles Giacca, and Christophe Golay (Eds.), *Economic, Social, and Cultural Rights in International Law* (Oxford University Press, 2014) p.7.
[158] UN General Assembly, *Optional Protocol to the International Covenant on Economic, Social, and Cultural Rights* (5 March 2009, entered into force 5 May 2013) A/RES/63/117; UN General Assembly, *Optional Protocol to the International Covenant on Civil and Political Rights* (19 December 1966, entered into force 23 March 1976) 999 UNTS 171.
[159] UN World Conference on Human Rights (n16) para. 5.
[160] Ioana Cismas, 'The Intersection of Economic, Social, and Cultural Rights and Civil and Political Rights' in Eibe Riedel, Gilles Giacca, and Christophe Golay (Eds.), *Economic, Social, and Cultural Rights In International Law* (Oxford University Press, 2014) p.472.

recognition of indivisibility, this separation continues in the protection afforded to each category. While the ICCPR and ICESCR have almost equal numbers of State Parties (173 and 171 respectively), the OP to the ICESCR, which is required for the substantive protection of rights by allowing violations to be addressed, has just 26 State Parties compared with 116 State Parties to the equivalent OP to the ICCPR.[161] The position of ESC rights in the international human rights framework therefore remains relatively weaker.

### *3.2. Socio-Economic Rights and Neoliberalism*

Several commentators have linked the historical development of the international human rights framework to the rise of neoliberalism.[162] Where liberalism supported free-market capitalism and state non-interference, neoliberalism modified this economic agenda to view the role of the state as one of facilitator in the operation and expansion of global capitalism.[163] Jessica Whyte argues that neoliberalism and human rights converged as neoliberal thinkers 'mobilised and developed the language associated with [human rights] for their own ends.'[164] Thus, human rights were not 'simply shaped by an underlying economic reality' but were actually a central component of neoliberalism.[165] Whyte argues that neoliberals saw the international human rights framework as a threat to market expansion, and in response sought to redefine human rights to exclude social

[161] Office of the UN High Commissioner for Human Rights, 'Status of Ratification' <https://indicators.ohchr.org/> accessed 14 January 2022.
[162] See, for example, Jessica Whyte, *The Morals of the Market* (Verso, 2019); Susan Marks, 'Four human rights myths' in David Kinley, Wojciech Sadurski, and Kevin Walton (Eds), *Human Rights: Old Problems, New Possibilities* (Edward Elgar, 2013); Naomi Klein, *The Shock Doctrine: The Rise of Disaster Capitalism* (Henry Holt, 2007).
[163] Paul O'Connell, 'On Reconciling Irreconcilables: Neo-liberal Globalisation and Human Rights' (2007) 7(3) *Hum. Rts. Law Rev.* 483, 492.
[164] Whyte (n162) p.5.
[165] *Ibid* p.21.

protections.[166] Paul O'Connell highlights that the rights contained in the UDHR are 'anathema to neo-liberal orthodoxy' given that neoliberals do not view basic needs such as healthcare, housing, or food as human rights.[167] Under neoliberalism, it is the individual – not the state – who is responsible for meeting their own needs, so, where 'one might argue that the denial of adequate health care to a particular group emanated from a structural denial of human rights, neoliberals see failures by individual consumers to make adequate provision for their own health-care needs'.[168] This line of thinking was observed by Phillip Alston on his visit to the US, where the poor are demonised, stereotyped as lazy and dishonest, and racially profiled, and internalise these narratives to 'proudly resist applying for benefits to which they are entitled and struggle valiantly to survive against the odds.'[169] In this context, scholars claim that socio-economic rights have been recast as market-friendly, minimalist living standards which are compatible with neoliberalism, standing in opposition to substantive material entitlements.[170]

However, Samuel Moyn rejects the argument that human rights have supported or otherwise complied with neoliberalism, instead arguing that human rights have failed to offer resistance to neoliberalism through their failure to meaningfully tackle material inequality.[171] Despite the incompatibility of socio-economic rights with neoliberal economic systems, the CESCR claims a neutral position, stating in its General Comment 3 that 'in terms of political and economic systems the Covenant is neutral and *its principles*

[166] *Ibid* p.40.
[167] O'Connell (n163) 498.
[168] *Ibid* 497.
[169] Philip Alston, 'Statement on Visit to the USA, by Professor Phillip Alston, United Nations Special Rapporteur on extreme poverty and human rights' (15 December 2017) <https://www.ohchr.org/en/statements/2017/12/statement-visit-usa-professor-philip-alston-united-nations-special-rapporteur?LangID=E&NewsID=22533> accessed 14 January 2023, para. 37.
[170] Whyte (n162) p.99-101; Paul O'Connell, 'The Death of Socio-Economic Rights' (2011) 74(4) *MLR* 532, 533.
[171] Samuel Moyn, *Not Enough: Human Rights in an Unequal World* (Harvard University Press, 2018) p.175-176.

*cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or a capitalist system,* or a mixed, centrally planned, or laisser-faire economy, or upon any other particular approach.'[172] While David Kennedy has argued that the human rights framework insulates the economy and hides background political conditions, the issue is not that human rights bodies *support* a neoliberal economic agenda but that they have insufficiently addressed the inequalities resulting from it.[173] Moyn argues that it could be theoretically possible for human rights to offer resistance to neoliberal policies, but the current legal human rights project has been powerless to do so.[174] Thus, I argue that strengthened protections for ESC rights under a transformed international human rights framework could address these issues and work towards substantive equality.

### *3.3. Universality and Economic, Social, and Cultural Rights*

The relatively weaker protection afforded to ESC rights undermines the claim to universality of the current international human rights framework. These rights are arguably of greater importance to many people, as many human rights violations experienced worldwide relate to socio-economic disadvantage. As Stephen Hopgood argues, socio-economic rights 'will always be more attractive for those currently without

[172] CESCR, 'General Comment No.3: The Nature of States Parties' Obligations (Art. 2, para. 1 of the Covenant)' (14 December 1990) UN Doc. E/1991/23, para. 8 [emphasis added].
[173] David Kennedy, 'International Human Rights Movement: Part of the Problem?' (2002) 15 *Harv. Hum. Rts. J.* 101, 109-110.
[174] Moyn (n171) p.176.

capital'.[175] Eibe Riedel, Gilles Giacca, and Christophe Golay have explained the importance of ESC rights as follows:

> 'Without minimum claim rights in working life, health protection, and education systems, and without the guarantee of an adequate standard of living, flowing from human dignity, guaranteeing a "survival kit" that sets a minimum existence protection standard, the overall picture of human rights would be incomplete, missing out crucial dimensions of protection for the most needy, in particular marginalized and disadvantaged persons and groups of persons. Thus, freedom of opinion alone makes no sense to a starving person.'[176]

In addition, as human rights are indivisible, interdependent, and interrelated, many CP rights cannot be fully realised without their ESC counterparts. James Nickels argues that without sufficient 'protections for subsistence, basic health care and basic education, people in severe poverty will frequently be marginal rightsholders. They will be unlikely to know what rights they have or what they can do to protect them, and their extreme need and vulnerability will make them hard to protect through social political action.'[177] For example, the right to vote and participate in the governance of one's country (Article 21 UDHR) is limited by the powerlessness, exclusion, and deprivation of choice that can be experienced by people living in extreme poverty.

In addition, feminist scholars have highlighted the importance of ESC rights in addressing gender-based human rights issues, given that major forms of gender

[175] Hopgood (n104) p.286
[176] Riedel, Giacca, and Golay (n157) p.6.
[177] James W. Nickels, 'Poverty and Rights' (2005) 55 *Philos. Q.* 385, 395.

inequality operate within the economic, social, and cultural spheres.[178] Reilly, for example, argues that:

> 'In most societies women are still expected to carry the responsibility of caring for dependent family members (children, elderly, people with disabilities, etc.) and accessing basic goods and services on behalf of the family, including food, water, accommodation, healthcare, education etc. The privatization of basic goods and services makes them unaffordable to many and increases the pressures on women to work longer hours in order to earn more income and/or absorb a greater burden of unpaid social care. Further, reduced public and social spending exacerbates female poverty and makes girls and women particularly vulnerable to forced migration, forced prostitution, trafficking and a wide range of related abuses.'[179]

This is a broad generalisation, and these socio-economic inequalities will not be experienced by all women, but inequalities are deepened by the intersection of gender and socio-economic disadvantage or class. Frances Raday therefore argues that the neoliberal rejection of the redistributive character of ESC rights works to undermine gender equality efforts, by creating 'market conditions which make women's equal opportunity in economic and labor markets in theory axiomatic but in practice unattainable'.[180] The strengthening of protection for ESC rights is therefore of significant importance for the realisation of gender-based rights and must be central to a feminist transformation of the international human rights framework.

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[178] Charlesworth, Chinkin, and Wright (n2) 635; Bunch (n1) 488.
[179] Reilly (n19) p.32
[180] Frances Raday, 'Gender and democratic citizenship: the impact of CEDAW' (2012) 10(2) *ICON* 512, 516, 525.

Finally, addressing these disparities in protection for CP and ESC rights is necessary if the international human rights framework is to be genuinely universal and have cross-cultural traction. Scholars have linked the prioritisation of CP rights to the Western liberal foundation of the human rights framework. Adamantia Pollis and Peter Schwab argue that the 'cultural patterns, ideological underpinnings, and developmental goals of non-Western and socialist states are markedly at variance' with the portrayal of rights in the UDHR.[181] For former colonised states, experiences of economic exploitation and political authoritarianism have influenced the subsequent development of human rights values; Pollis highlights that the individual liberties of CP rights were 'hardly the values which the colonialists transmitted to the peoples over whom they ruled'.[182] In these states, ESC rights tend to be given precedence as, in this historical context, human dignity has become linked to welfare supports, freedom from starvation, and the rights of all people to benefit from economic growth. [183] Western influence over the international human rights framework has also meant that issues such as refugee rights, Indigenous rights, and support for low-income or underdeveloped states have been side-lined. The Declaration on the Rights of Indigenous Peoples, while importantly recognising the collective rights of Indigenous communities, is not a legally binding document and the four states that voted against the Declaration – the US, Canada, Australia, and New Zealand – were all Western settler states with Indigenous populations. The Declaration on the Right to Development similarly lacks force and was resisted by a number of Western states including the US and the UK, with a key concern around the duties it would

[181] Adamantia Pollis and Peter Schwab, 'Human Rights: A Western Construct with Limited Applicability' in Adamantia Pollis and Peter Schwab (Eds.), *Human Rights: Cultural and Ideological Perspectives* (Praeger, 1979) p.14.
[182] Adamantia Pollis, 'Human Rights, Third World Socialism and Cuba' (1981) 9(9/10) *World Dev.* 1005, 1007.
[183] *Ibid* 1013.

place on higher-income states to provide sustained international assistance.[184] Ensuring the universality of a transformed international human rights framework will thus also require addressing questions of ESC rights protection across significant worldwide socio-economic inequalities.

## *Conclusion*

Throughout this chapter, I have set out the three key conceptual issues with the international human rights framework, around gender-based human rights, cross-cultural traction, and the protection of ESC rights, which undermine its claim to universality. I addressed each of these issues by adopting and expanding upon Charlotte Bunch's concept of a feminist transformation of human rights. Firstly, I argued that a feminist transformation of human rights must employ an intersectional approach which recognises gender inequalities as contextual, lending itself to the recognition of gender-based human rights which are inclusive of all women, trans, non-binary, and gender-expansive people. Secondly, while rejecting cultural relativist claims against universalism, I argued that a feminist transformation of human rights must also address issues of cross-cultural traction. Human rights can remain conceptually universal, while their application is sensitive to cultural difference and inclusive of (some) cultural accommodations. Finally, I argued that a feminist transformation of human rights must also strengthen the protection that is afforded to ESC rights, as these rights are indivisible

[184] UN General Assembly, *Declaration on the Right to Development* (4 December 1986) A/RES/41/128; R.N. Kiwanuka, 'Developing Rights: The UN Declaration on the Right to Development' (1988) 35(3) *NILR* 257, 265-266.

from CP rights in terms of their importance, are a fundamental part of gender-based rights, and are necessary for cross-cultural traction. The remainder of this thesis will consider how a feminist transformation of human rights should look in the context of abortion, addressing these three broad conceptual issues and the limitations of current international human rights standards on abortion, which will be explored in the following chapter.

# 2

# Abortion as a Human Rights Issue

## *Introduction*

Following on from the last chapter, which set out the key conceptual issues with the current international human rights framework, this chapter will address how international human rights bodies have inadequately approached abortion thus far. The first section explores the trajectory of the recognition of abortion as a human rights issue by UN human rights bodies, starting with the initial recognition of reproductive rights at the 1994 International Conference on Population and Development (ICPD). This is followed by an assessment of the approaches of the three most prominent human rights bodies to address abortion, the Human Rights Committee (HRC), Committee on Economic, Social, and Cultural Rights (CESCR), and Committee on the Elimination of Discrimination Against Women (CEDAW), and the comments of two Special Rapporteurs.

I will set out the specific limitations of each respective body's approach, before arguing that the approach of the international human rights framework is limited as a whole for three overarching reasons. Firstly, there is a relatively high threshold of harm that must be reached for a human rights violation to be found. Secondly, the current approach to abortion has developed in a piecemeal manner, leaving gaps in protection, and thus applies insufficient pressure on states to provide comprehensive access to

abortion. Thirdly, the broader limitations of human rights bodies' implementation mechanisms have meant that standards on abortion have been ineffective.

In the second section, I support these arguments by highlighting the significant disparities in abortion provision worldwide and the impacts of the criminalisation or lack of access to safe abortion services. I also consider further restrictions on abortion which have been recently implemented in the United States and Poland. This second section thus also underlines the importance of recognising abortion as a human right as part of the feminist transformation of human rights. The third and final section considers the reproductive justice framework, developed in response to and as a critique of the definition of reproductive rights advanced at the ICPD, which can inform the structuring of abortion as a human right in a way that responds to some of the issues set out in this chapter and Chapter 1. In this third section, I also critique the existing literature on advancing abortion as a human right which proposes the expansion of existing rights or the recognition of new rights which would broadly incorporate a right to abortion. These proposals carry similar limitations to the current human rights approach with respect to setting out insufficient obligations around abortion.

## *1. Abortion in the International Human Rights Framework*

### *1.1. Recognising Reproductive Rights*

As already explored in Chapter 1, feminist scholars and activists sought the inclusion of gender-based rights issues within existing human rights structures and through dedicated institutions such as CEDAW. The recognition of reproductive rights was a core

aspect of this movement towards viewing women's rights as human rights. The ICPD which took place in Cairo in 1994, and the Fourth World Conference on Women which took place in Beijing in 1995 (henceforth referred to as the 'Beijing Women's Conference'), were landmarks in the development of reproductive rights. The ICPD Programme of Action was the first international human rights document to explicitly recognise reproductive rights as already encompassed within existing human rights and set out objectives for the realisation of these rights.[1] The Programme of Action adopted a broad definition of reproductive health, and defined reproductive healthcare as 'the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.'[2] This required all countries to provide family planning services, comprehensive pregnancy-related healthcare, infertility treatment, sexual health services (including the treatment of sexually transmitted infections), and, although qualified, abortion.[3] The Programme highlighted the importance of education, information, and choice around sexuality, reproductive health, and parenting, and highlighted that reproductive health services should be accessible, affordable, acceptable, and convenient.[4] The Programme is also somewhat intersectional in areas, recognising the additional barriers to reproductive health faced by migrants and adolescents.[5]

However, the Programme's approach to abortion was much less progressive. Abortion was primarily raised as an issue in relation to sex-selective abortion, unsafe abortion as linked to maternal mortality, and the 'current reliance on abortion for fertility

[1] UN, *Programme of Action of the International Conference on Population and Development* (5-13 September 1994) UN Doc. A/CONF.171/13 (Annex), Chapter VII.
[2] *Ibid* para. 7.2.
[3] *Ibid* para. 7.6.
[4] *Ibid* paras. 7.5-7.6.
[5] *Ibid* para 7.11.

regulation' in some countries.[6] Rather than supporting access to abortion as a fundamental aspect of reproductive healthcare, the Programme instead recommended that governments take steps to 'help women avoid abortion'.[7] The key paragraph concerning abortion (8.25) again emphasised that in 'no case should abortion be promoted as a method of family planning' and that 'every attempt should be made to eliminate the need for abortion.'[8] Recognising unsafe abortion as a public health concern, the Programme encourages governments to expand and improve family planning services in order to prevent unwanted pregnancies and thus reduce recourse to abortion.[9] It is widely recognised that the criminalisation of abortion pushes pregnant people towards unsafe abortion practices, but the ICPD did not recognise the legalisation of abortion as a key step towards reducing maternal mortality and morbidity associated with unsafe abortion. The ICPD assumed that abortion could be eradicated by ensuring access to contraception and addressing high-risk sexual behaviour, ignoring the broad and complex reasons why a pregnant person might require an abortion.[10] Instead, the Programme's only support for the provision of safe abortion services was where abortion was already legalised.[11]

The ICPD therefore failed to recognise the impact of the lack of safe, legal, and accessible abortion services, despite the fact that abortion would fit within the Programme's definition of reproductive health and is necessary for the reduction of maternal mortality and morbidity. As Marge Berer has argued, the above statements on abortion 'wash their hands of responsibility for the harm that results from unsafe and

[6] *Ibid* paras. 4.15, 7.44, 8.19, 7.10.
[7] *Ibid* para. 7.24.
[8] *Ibid* para. 8.25.
[9] *Ibid*.
[10] *Ibid* paras. 8.25, 8.27.
[11] *Ibid* para. 8.25.

illegal abortion'.[12] Instead, the ICPD entrenched the stigmatisation of abortion by adopting an approach which construed abortion as not only undesirable, but as a practice that governments could and should stamp out. This ignored the reality of abortion decisions and the importance of abortion as part of reproductive decision-making for gender equality. This qualified approach to abortion – referred to by some scholars as the 'Cairo compromise' – resulted from the Catholic Church's opposition to obligations which would have required governments to commit to the legalisation and provision of abortion.[13] The Holy See (the seat of the Vatican) had opposed the inclusion of abortion as a method of family planning, supported by a number of other governments.[14] Malta, for example, opposed any terms in the Programme which could be interpreted as conflicting with its domestic legislation criminalising abortion.[15] Udi Sommer and Aliza Forman-Rabinovici read the qualifications on abortion as an effort to 'placate both those who called for expanded women's reproductive rights and autonomy on the one hand and forces that opposed abortion on the other' and note the significance of moving abortion 'out of the realm of moral policy and into the realm of public health'.[16] However, I argue that approaching abortion as an undesirable practice to be eliminated failed at moving it out of the realm of morality, and instead the ICPD implicitly adopted the assumption that abortion was unjustifiable. Sommer and Forman-Rabinovici themselves acknowledge that a more critical reading of the Programme points to an effort to

[12] Marge Berer, 'The Cairo "Compromise" on Abortion and Its Consequences for Making Abortion Safe and Legal' in Laura Reichenbach and Mindy Jane Roseman (Eds), *Reproductive Health and Human Rights* (University of Pennsylvania Press, 2011) p.153-154.
[13] Joanna N. Erdman, 'Abortion in International Human Rights Law' in Sam Rowlands (Ed), *Abortion Care* (Cambridge University Press, 2014) p.245; Berer (n12).
[14] UN General Assembly, 'Overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development' (2 July 1999) 9th Plenary Meeting, UN Doc. A/S-21/PV.9, p.18-19, 41-42.
[15] *Ibid* p.9.
[16] Udi Sommer and Aliza Forman-Rabinovici, *Producing Reproductive Rights* (Cambridge University Press, 2019) p.173, 180.

delegitimise abortion as a reproductive right.[17] The starting point for the recognition of reproductive rights in the international human rights framework largely excluded abortion from its remit.

Taking place the following year, the Beijing Women's Conference reaffirmed and built upon the recognition of reproductive rights at the ICPD.[18] The Beijing Platform for Action highlighted that the 'right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment.'[19] The Beijing Platform again highlighted the need to 'recognize and deal with the health impact of unsafe abortion as a major public health concern' but added to the text of paragraph 8.25 of the ICPD Programme that governments should 'consider reviewing laws containing punitive measures against women who have undergone illegal abortions'.[20] This addition is significant in light of the failure of the ICPD to recognise criminalisation as a factor of unsafe abortion, but the Beijing Platform again provided a limited impetus for governments to legalise and provide abortion services.

This qualified approach has meant that abortion has not been fully recognised as a human right with clear obligations on governments to ensure access to safe, legal services. The starting point for recognising abortion within the international human rights framework was an understanding of abortion as a negative, rather than as a fundamental aspect of reproductive rights and gender equality. This has inevitably influenced the development of international human rights standards on abortion, which has slowly progressed through incremental and piecemeal comments from various treaty

[17] *Ibid* 180.
[18] UN, *Beijing Declaration and Platform for Action, adopted at the Fourth World Conference on Women* (4-15 September 1995) UN Doc. A/CONF.177/20/Rev.1.
[19] *Ibid* para. 92.
[20] *Ibid* paras. 106(j)-(k).

bodies. In the following subsections, I will expand upon the development of human rights standards on abortion by UN treaty bodies – with a focus on the HRC, CESCR, and CEDAW – and argue that these standards, while evolving, remain insufficient at addressing the lack of comprehensive access to safe, legal abortion services worldwide.

### *1.2. Human Rights Committee*

The HRC, the treaty body monitoring the implementation of the International Covenant on Civil and Political Rights (ICCPR), has increasingly recognised that restrictions on abortion may violate the rights to equality of rights between men and women (Article 3), life (Article 6), freedom from torture and cruel, inhuman, and degrading treatment (Article 7), privacy (Article 17) and non-discrimination (Article 26). The HRC's first significant acknowledgment of abortion was in 2000, in its General Comment 28 on equality between men and women.[21] The HRC set out an obligation under Article 6 to ensure that women do not undergo life-threatening clandestine abortion, recommended under Article 7 that abortion should be provided where a pregnancy results from rape, and expressed concerns over compliance with Article 17 where states impose a duty on medical professionals to report women who have undergone abortions.[22]

In 2005, the HRC heard the first abortion case brought at the UN level. *K.L. v Peru* concerned a KL, 17-year-old girl, who became pregnant and later found out that she was carrying an anencephalic foetus.[23] Anencephaly is an embryonic development disorder

[21] HRC, 'General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)' (29 March 2000) UN Doc. CCPR/C/21/Rev.1/Add.10.
[22] *Ibid* paras. 10-11, 20.
[23] *K.L. v Peru* (2005) UN Doc. CCPR/C/85/D/1153/2003, para. 2.1.

which results in the absence of part of the brain, skull, and scalp. KL was informed that the foetal impairment was fatal and would also put her own life at risk, so she attempted to obtain an abortion.[24] Under the Peruvian Criminal Code, therapeutic abortion was permitted only where terminating the pregnancy was the only way to save the life of the pregnant women or to avoid serious and permanent damage to their health.[25] However, despite the risk to her life, KL was told that an abortion would be unlawful and she was forced to continue the pregnancy to term, giving birth to a baby girl who lived for just four days.[26] As a result, KL's mental health was seriously affected.[27]

The HRC noted that KL was forced to endure the 'distress of seeing her daughter's marked deformities and knowing that she would die very soon'.[28] The resulting mental suffering experienced by KL, as a result of the refusal by healthcare professionals to carry out a therapeutic abortion, amounted to cruel, inhuman, and degrading treatment in violation of Article 7.[29] In addition, the HRC found a violation of Article 17, as KL should have been lawfully entitled to a therapeutic abortion under the Criminal Code and the refusal was thus unjustified.[30] In light of these findings, the HRC did not find it necessary to make a determination on Article 6.[31] However, in a dissenting opinion, Hipólito Solari-Yrigoyen stated that this case also revealed a violation of Article 6 as KL's life was placed in grave danger as a result of being refused an abortion.[32] Christina Zampas and Jaime Gher argued that this case was a landmark as it represented 'the first time a UN human rights body held a government accountable for failing to ensure access to abortion

[24] *Ibid* para. 2.2.
[25] *Ibid* para. 2.3.
[26] *Ibid* paras. 2.3-2.6.
[27] *Ibid* paras. 2.5-2.6.
[28] *Ibid.*
[29] *Ibid* para. 6.3.
[30] *Ibid* para. 6.4.
[31] *Ibid* para. 6.3.
[32] *Ibid* Appendix.

services to an individual.'[33] In addition to requiring the Peruvian government to provide an effective remedy for KL, including compensation, the HRC also stated that the government should take steps to avoid similar violations in future.[34]

In 2011, the HRC reaffirmed this approach in *L.M.R. v Argentina.*[35] This case concerned a young woman with a mental disability who had become pregnant from rape and was prevented from having an abortion despite meeting the legal grounds for one.[36] The Supreme Court of Buenos Aires had ruled that an abortion could go ahead, but the hospital refused to provide it and LMR eventually had an abortion illegally.[37] The HRC found violations of Articles 3, 7, and 17.[38] *K.L.* and *L.M.R.* concerned procedural access to abortion on grounds which were already legal domestically, so the non-repetition remedies required by the HRC did not necessarily require the legalisation of abortion on broader grounds but rather the implementation of processes to ensure accessibility. However, in two later cases concerning Ireland's restrictive abortion regime, the HRC demonstrated its willingness to direct states to change their abortion law.

*Mellet v Ireland* and *Whelan v Ireland* both concerned women who had to travel to England for abortions in cases of fatal foetal impairments.[39] Amanda Mellet and Siobhán Whelan were found to be carrying foetuses with fatal impairments in the 21st and 20th week of their pregnancies, respectively, and were informed that the foetuses would most likely die in utero or shortly after birth.[40] Both women travelled to Liverpool for

[33] Christina Zampas and Jaime M. Gher, 'Abortion as a Human Right – International and Regional Standards' (2008) 8(2) *Hum. Rts Law Rev.* 249, 271.
[34] *K.L. v Peru* (n23) para. 8.
[35] *L.M.R. v Argentina* (2011) UN Doc. CCPR/C/101/D/1608/2007.
[36] *Ibid* paras. 2.1-2.4.
[37] *Ibid* paras. 2.6-2.8.
[38] *Ibid* paras. 9.2-9.4.
[39] *Mellet v Ireland* (2016) UN Doc. CCPR/C/116/D/2324/2013; *Whelan v Ireland* (2017) UN Doc. CCPR/C/119/D/2425/2014.
[40] *Mellet* (n39) paras. 2.1-2.2; *Whelan* (n39) para. 2.1.

abortions, at a cost of around €3000.[41] Both women were unable to access aftercare and bereavement counselling upon their return to Ireland, which they would have received had they carried on with their pregnancies.[42] In *Mellet*, the HRC stated that the applicant's physical and mental distress had been exacerbated by a number of factors such as being unable to continue receiving medical care and health insurance coverage for her treatment in Ireland, the shame and stigma associated with the criminalisation of abortion, and having to 'choose between continuing her non-viable pregnancy or travelling to another country while carrying a dying fetus, at her personal expense'.[43] The HRC noted that much of this suffering could have been avoided if Amanda Mellet had not been prohibited from undergoing an abortion in her own country under the care of medical professionals she already knew and trusted, thus finding a violation of Article 7.[44] This reasoning and finding was repeated in *Whelan*.[45]

The HRC additionally found a violation of Article 17, stating that the interference with Amanda Mellet's decision as to how best to cope with her non-viable pregnancy was unreasonable and arbitrary.[46] In *Whelan*, this reasoning was modified slightly; the HRC found a violation of Article 17 as 'preventing the author from terminating her pregnancy in Ireland caused her mental anguish and constituted an intrusive interference in her decision as to how best to cope with her pregnancy, *notwithstanding the non-viability of the fetus*.'[47] This suggests that restrictive abortion laws may violate Article 17 even where the viability of the foetus is not an issue. Another point of significance is the finding of a violation of Article 26 in both cases. The HRC considered the position of those who

[41] *Mellet* (n39) paras. 2.3-2.4; *Whelan* (n39) paras. 2.3-2.5.
[42] *Mellet* (n39) para. 2.5; *Whelan* (n39) para. 2.6.
[43] *Mellet* (n39) para. 7.4.
[44] *Ibid* paras. 7.4-7.6.
[45] *Whelan* (n39) paras. 7.5-7.7.
[46] *Mellet* (n39) para. 7.8
[47] *Whelan* (n39) para. 7.9 [emphasis added].

decided to carry a foetus with a fatal impairment to term, who would receive treatment covered by Ireland's healthcare system and their health insurance, including aftercare and bereavement support following a miscarriage or stillbirth.[48] This was contrasted with the position of those who decide to terminate a non-viable pregnancy, and would have to do so outside of Ireland's healthcare system, incurring financial and psychological burdens, and are then unable to receive post-termination aftercare.[49] The HRC felt that this differential treatment failed to take into the medical needs and socioeconomic circumstances of the applicants, and was not reasonable, objective, or legitimate.[50] As the applicant's claims under Article 26 in *K.L. v Peru* were declared inadmissible, this finding of a violation in *Mellet* and *Whelan* highlights progression in the HRC's approach to abortion. Further, the HRC's approach to Article 17 in *K.L.* and *L.M.R.* has been viewed as primarily an exercise in fulfilling procedural equality, in guaranteeing what the legislature had already permitted.[51] In *Mellet* and *Whelan*, the HRC was willing to direct the state to guarantee access to abortion on a ground not already legalised.

The HRC's expanding approach to abortion was set out most clearly in 2019, in a paragraph in its General Comment 36 on the right to life.[52] The HRC stated that measures regulating abortion must not result in a violation of the right to life, subject those seeking abortion to physical or mental pain or suffering, or arbitrarily interfere with their right to privacy. The HRC additionally clarified the minimum circumstances in which states must provide safe, legal, and effective access to abortion: where the life and health of the pregnant person is at risk and where carrying the pregnancy to term would cause the

[48] *Mellet* (n39) para. 7.10; *Whelan* (n39) para. 7.11.
[49] *Ibid.*
[50] *Mellet* (n39) para. 7.11; *Whelan* (n39) para. 7.12.
[51] Charles Ngwena, 'Access to Safe Abortion as a Human Right in the African Region: Lessons from Emerging Jurisprudence of UN Treaty Monitoring Bodies (2013) 29(2) *S. Afr. J. Hum. Rights* 399, 421.
[52] HRC, 'General Comment No. 36: Article 6 (Right to Life)' (3 September 2019) UN Doc. CCPR/C/GC/36, para. 8.

pregnant person substantial pain or suffering, notably where the pregnancy is the result of rape or where the pregnancy is not viable. More broadly, states must also ensure that pregnant people do not resort to unsafe abortions by removing criminal sanctions. Beyond the question of abortion legality, the HRC also expanded on the accessibility of abortion services in practice, setting out requirements that states remove barriers to access, including those arising from conscientious objection. States must also ensure access to evidence-based sexual and reproductive health education and information, including information on affordable contraceptive methods. Finally, states should prevent the stigmatization of those who undergo abortion and ensure the availability of, and effective access to, quality and confidential prenatal and post-abortion health care.

The HRC's recent Concluding Observations highlight the increasing willingness of this treaty body to direct states over a lack of compliance with these standards. For example, the HRC has made recommendations in relation to: El Salvador's total prohibition on abortion which imposes disproportionate criminal penalties; the impacts of conscientious objection and breaches of doctor-patient confidentiality where healthcare professionals have reported pregnant people for abortion offences in Bolivia; and Germany's three-day mandatory waiting period which may act as a barrier to access.[53] *Mellet* and *Whelan*, General Comments 36, and recent Concluding Observations demonstrate the recognition by the HRC of the importance of access to safe, legal abortion services – significant progress since the HRC's first recognition of abortion in 2000.

[53] HRC, 'Concluding observations on the seventh periodic report of El Salvador' (9 May 2018) UN Doc. CCPR/C/SLV/CO/7, paras. 15-16; HRC, 'Concluding observations on the fourth periodic report of the Plurinational State of Bolivia' (2 June 2022) UN Doc. CCPR/C/BOL/CO/4, paras. 16-17; HRC, 'Concluding observations on the seventh periodic report of Germany' (30 November 2021) UN Doc. CCPR/C/DEU/CO/7, paras. 18-19.

However, there remain some pressing limitations with the HRC's approach. Firstly, the HRC has avoided commenting on broader circumstances where abortion should be made legal and accessible, such as on request or for socio-economic reasons, and has not considered issues such as restrictive gestational time limits. The legalisation of abortion to protect the life or health of the pregnant person, where the pregnancy resulted from rape, or in cases of fatal foetal impairment is required as a minimum, and the HRC's broader comments on decriminalisation and preventing unsafe abortion would suggest that states should provide access on broader grounds. However, as this is not explicit, there is insufficient pressure on states to do so. Secondly, the HRC has not explicitly commented upon access to abortion as important for gender equality and reproductive autonomy. In *Mellet*, the applicant claimed under Article 26 that the criminalisation of abortion had subjected her to a gender-based stereotype around motherhood as her primary role.[54] While the HRC did find a violation of Article 26, this finding was not on the basis of gender discrimination – which Sarah Cleveland challenged in her dissenting opinion.[55] In a recent Concluding Observation on Armenia, the HRC expressed general concerns over gender stereotypes around the role of women in the family and recognised intersectional inequalities around access to abortion for women living in rural areas, those in poverty, women with disabilities, and women from ethnic or religious minorities.[56] However, acknowledgment of the gendered and intersectional inequalities around access to abortion has not been a consistent feature of previous comments by the HRC. Without clear recognition of these structural issues, the HRC's ability to effectively address the harms of restrictions on abortion is limited.

[54] *Mellet* (n39) para. 3.19.
[55] *Mellet* (n39) Annex II.
[56] HRC, 'Concluding observations on the third periodic report of Armenia' (25 November 2021) UN Doc. CCPR/C/ARM/CO/3, paras. 13(a), 17(b).

### *1.3. Committee on Economic, Social, and Cultural Rights*

Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) affirms the right to the 'highest attainable standard of physical and mental health'. Article 12(2)(a) refers to infant mortality and the health of the child, but there is no explicit reference to maternal or reproductive health. However, the ICESCR's treaty monitoring body, CESCR, adopted General Comment 14 on Article 12 in 2000, highlighting that Article 12(2)(a) was to be understood as requiring measures to improve maternal health as well as child health, including sexual and reproductive health services, such as family planning, and access to information and resources in order to access those services.[57] The CESCR also noted the importance of confidential sexual and reproductive health services for adolescents, and the need to ensure an adequate number of hospitals providing sexual and reproductive health services, particularly in rural areas, with doctors adequately trained to provide those services.[58] However, the Committee made no explicit mention of abortion in this document. In General Comment 16 on the Article 3 right to the equality of rights enjoyment between men and women, issued in 2005, CESCR also stated that Article 12 required 'the removal of legal restrictions on reproductive health provisions'.[59] This implied that the criminalisation of abortion would violate Article 12, but, again, abortion was not explicitly mentioned.

However, in 2016, CESCR issued General Comment 22 which was specifically dedicated to expanding on state obligations around the right to sexual and reproductive

[57] CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the ICESCR)' (11 August 2000) UN Doc. E/C.12/2000/4, para. 14.
[58] *Ibid* paras. 23, 36.
[59] CESCR, 'General Comment No. 16: The Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural rights (Art. 3 of the ICESCR)' (11 August 2005) UN Doc. E/C.12/2005/4, para. 29.

health as enshrined in Article 12.[60] CESCR highlighted that there are numerous legal, procedural, practical, and social barriers to the realisation of the right to sexual and reproductive health.[61] In relation to social barriers, CESCR acknowledged intersectional discrimination in this area as in particular affecting socio-economically disadvantaged women, ethnic minorities and Indigenous populations, migrants, LGBT+ people, and people with disabilities.[62] CESCR further noted that gender-based stereotypes around motherhood affect the enjoyment of this right.[63] Addressing intersectional and gender-based discrimination was therefore highlighted as key to the full realisation of sexual and reproductive rights.

In relation to abortion, CESCR has generally avoided outlining the specific circumstances in which states should legalise abortion. Instead, CESCR recommended in this General Comment that states 'repeal or eliminate' laws that criminalize access to reproductive health services, ensure access to those services, and take measures to prevent unsafe abortions.[64] While CESCR viewed the prevention of unsafe abortions as a means of lowering maternal mortality and morbidity rates, the Committee also did go on to recognise abortion as integral to gender equality, stating that restrictive abortion laws and the criminalisation of abortion undermines women's 'autonomy and right to equality and non-discrimination in the full enjoyment of the right to sexual and reproductive health'.[65] Thus, CESCR set out requirements that states 'to adopt legal and policy measures to guarantee all individuals access to affordable, safe and effective contraceptives and comprehensive sexuality education, including for adolescents; to

[60] CESCR, 'General Comment No. 22 on the Right to Sexual and Reproductive Health (Article 12 of the ICESCR)' (2 May 2016) UN Doc. E/C.12/GC/22.
[61] *Ibid* para. 2.
[62] *Ibid* para. 30.
[63] *Ibid* para. 27.
[64] *Ibid* para. 49(a).
[65] *Ibid* paras. 28, 34.

liberalize restrictive abortion laws; to guarantee women and girls access to safe abortion services and quality post-abortion care, including by training health-care providers; and to respect the right of women to make autonomous decisions about their sexual and reproductive health.'[66]

CESCR has emphasised the need for accessible, available, affordable and acceptable sexual and reproductive health services.[67] CESCR's accessibility standards require the removal of barriers and positive measures to ensure substantive equality, such as ensuring that provisions for conscientious objection do not obstruct access.[68] CESCR requires states to ensure access to the medications on the World Health Organization's Model List of Essential Medicines, which includes mifepristone and misoprostol, two medications used to induce abortions in the early stages of pregnancy.[69] In addition, CESCR's General Comment 25 on science and ESC rights in 2020 highlighted the importance of ensuring access to safe and modern methods of abortion, including the above abortion medications, and highlighted that attention should be paid to advancements in best practice for abortion care.[70] Elsewhere I have argued that these standards, when taken together, can be interpreted to support telemedical and self-managed abortion (issues which will be discussed in more detail in Chapter 5).[71]

Where the HRC has set out the minimum circumstances in which abortion should be legalised, CESCR has avoided doing so. CESCR has expressed particular concerns over

[66] *Ibid* para. 28.
[67] *Ibid* paras. 12-21.
[68] See, for example, CESCR, 'Concluding observations on the initial report of South Africa' (29 November 2018) UN Doc. E/C.12/ZAF/COF/1, paras. 65-66; CESCR, 'Concluding observations on the sixth periodic report of Spain' (25 April 2018) UN Doc. E/C.12/ESP/CO/6, paras. 43-44.
[69] CESCR (n60) para. 13.
[70] CESCR, 'General Comment No. 25 on Science and Economic, Social and Cultural Rights' (30 April 2020) UN Doc. E/C.12/GC/25, para. 33.
[71] Zoe L. Tongue, 'Telemedical and Self-Managed Abortion: A Human Rights Imperative?' (2022) *Eur. J. Health Law* [online ahead of print].

the criminalisation of abortion in some circumstances, such as abortion in cases of rape.[72] However, elsewhere the Committee has set out broader recommendations; for example, in its 2015 comment on Uganda, CESCR recommended 'that the State party revise its abortion legislation, including by considering decriminalizing abortion and providing for exceptions to the general prohibition on abortion *in certain cases*.'[73] While this lack of specificity on the grounds for abortion that should be legalised may limit the interpretation of these standards by some states, this can also be construed as a positive approach in light of CESCR's more recent comments. In a number of Concluding Observations issued in 2021 and 2022, CESCR has shown a willingness to direct states to legalise abortion beyond the minimum circumstances indicated by the HRC.[74] For example, CESCR recommended that the Bolivian state 'expand the circumstances in which abortion is legally permitted and eliminate restrictive requirements limiting access to abortion.'[75] This is significant for implying the need for access to abortion beyond the exceptional circumstances of risk to life or health, rape, and fatal foetal impairment more overtly than other treaty bodies.

CESCR's approach to abortion is progressive, particularly in relation to accessibility and legalisation, but there remain some limitations. CESCR does not explicitly state the extent to which expansion on the circumstances for legal abortion is required, so as I argued in relation to the HRC, this places insufficient pressure on states

[72] See, for example, CESCR, 'Concluding observations on the fourth periodic report of Ecuador' (14 November 2019) UN Doc. E/C.12/ECU/CO/4, paras. 51-52; CESCR, 'Concluding observations on the initial report of Bahrain' (4 August 2022) UN Doc. E/C.12/BHR/CO/1, paras. 44-45.
[73] CESCR, 'Concluding observations on the initial report of Uganda' (8 July 2015) UN Doc. E/C.12/UGA/CO/1, para. 35 [emphasis added].
[74] CESCR (n72, 2022) para. 45(a); CESCR, 'Concluding observations on the sixth periodic report of the Democratic Republic of the Congo' (28 March 2022) UN Doc. E/C.12/COD/CO/6, para. 57(a); CESCR, 'Concluding observations on the fifth periodic report of Nicaragua' (11 November 2021) UN Doc. E/C.12/NIC/CO/5, para. 45(a).
[75] CESCR, 'Concluding observations on the third periodic report of the Plurinational State of Bolivia' (5 November 2021) UN Doc. E/C.12/BOL/CO/3, para. 55(a).

to provide comprehensive access to abortion. Further, the relatively limited protection afforded to ESC rights, as explored in Chapter 1, acts as a barrier to the implementation of these standards. As Optional Protocol to the ICESCR has been ratified by fewer states than the ICCPR's counterpart, there is a smaller pool of people able to bring claims of violations of these standards. CESCR is yet to hear a case relating to reproductive health. Of course, even if a successful complaint were to be brought to CESCR, it may be of limited value given the non-binding nature of the resulting recommendations.

### *1.4. Committee on the Elimination of Discrimination Against Women*

CEDAW has, unsurprisingly, gone further than other treaty bodies in connecting restrictions on abortion to gender inequality, stereotypes, and discrimination. The Convention itself does not contain any explicit mention of abortion, and there are only limited references to other reproductive rights issues within the treaty. However, there are a number of rights contained in CEDAW that are relevant to abortion. Article 12 places obligations on states to eliminate discrimination against women in the field of healthcare, to ensure equal access with men to healthcare services including family planning, and to ensure access to 'appropriate services in connection with pregnancy'. Article 16(e), in the context of equality in marriage and family relations, contains the equal right to 'decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights'. The general rights contained in Part I of the Convention are also relevant to abortion and reproductive rights, in particular Article 5 which mandates the elimination of social and cultural gender roles, stereotypes, and prejudices.

In 1999, CEDAW adopted General Recommendation 24 on the Article 12 right to health.[76] The Committee stated that where possible, 'legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.'[77] There was no explicit recommendation that states liberalise their abortion laws and this statement had been critiqued for failing to issue an 'urgent call to action'.[78] However, the document did contain numerous statements on the provision and accessibility of reproductive health services which could also be applied to abortion. For example, CEDAW noted that it is 'discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women' and that alternatives should be provided where healthcare professionals refuse to perform certain services based on conscientious objection. [79] CEDAW made a number of recommendations around the gender-sensitive delivery of healthcare services, requirements that healthcare services are consistent with rights to 'autonomy, privacy, confidentiality, informed consent and choice', and requirements around the removal of barriers to education, information, and access.[80] In particular, CEDAW emphasised the importance of timely access to sexual and reproductive health services.[81]

In 2011, CEDAW handed down its decision in its first and only case concerning abortion under the Optional Protocol. *L.C. v Peru* concerned a girl who had been sexually abused for some years before she became pregnant at the age of 13.[82] As a result of the pregnancy, L.C. became depressed and attempted suicide by jumping from a building and

[76] CEDAW, 'General Recommendation No. 24: Article 12 of the Convention (Women and Health)' (1999) UN Doc. A/54/38/Rev.1.
[77] *Ibid* para. 31(c).
[78] Tatyana A. Margolin, 'Abortion as a Human Right' (2007) 29(2) *Women's Rts. L. Rep.* 77, 90.
[79] CEDAW (n76) para. 11.
[80] *Ibid* para. 31.
[81] *Ibid* para. 31(c).
[82] *L.C. v Peru* (2011) UN Doc. CEDAW/C/50/D/22/2009, para. 2.1.

she suffered damage to her spinal column, which cause paraplegia of her limbs.[83] She was at risk of permanent disability if she did not receive emergency surgery, but this surgery was postponed as doctors were concerned that it would affect L.C.'s pregnancy.[84] L.C. and her mother requested an abortion, which was denied as her life was not in danger as a result of the pregnancy, despite the risks to her mental and physical health and the fact that therapeutic abortion was permitted under the Penal Code.[85] L.C. miscarried and waited three months before she eventually received surgery for her spinal injuries, but she was left with a permanent disability and requiring constant care and assistance.[86]

Finding a violation of Article 12, CEDAW noted that L.C. should have been entitled to an abortion to avoid serious and permanent harm to her health.[87] The denial of an abortion and the delay to her surgery meant that L.C. did not have access to effective and accessible medical services, which was all the more serious as she was a minor and a victim of sexual abuse.[88] CEDAW additionally found a violation of Article 5, as the decision to refuse L.C. therapeutic surgery due to her pregnancy was influenced by gender stereotypes around motherhood which places the protection of the foetus above the health of the pregnant girl.[89] Violations of Article 2(c), requiring equal legal protection of the rights of women, and 2(f), requiring the modification of existing laws which constitute discrimination of women, were also found on the basis that the law allowed individual

[83] *Ibid* paras. 2.1-2.2.
[84] *Ibid* paras. 2.3-2.4.
[85] *Ibid* para. 2.5.
[86] *Ibid* paras. 2.10-2.11.
[87] *Ibid* para. 8.14.
[88] *Ibid* para. 8.15.
[89] *Ibid*.

hospitals to arbitrarily decide whether to allow or deny a therapeutic abortion.[90] In light of these findings, CEDAW felt it unnecessary to make a ruling on Article 16.[91]

As Peru had already legalised therapeutic abortion, the Committee stated that it must establish an appropriate framework enabling women to access abortion, recommending that the state review the law to create a mechanism for effective access to prevent future violations.[92] Given that the denial of a therapeutic abortion and the delay to L.C.'s surgery were decisions taken by hospital staff, CEDAW emphasised that the state must enforce General Recommendation 24 with a view of changing attitudes of healthcare providers towards women seeking reproductive health services through education programmes.[93] In addition to ensuring access to abortion on the grounds already legalised, CEDAW went further and recommended that Peru review the law 'with a view to decriminalizing abortion when the pregnancy results from rape or sexual abuse'.[94] This decision was significant as it was the first time a human rights body explicitly recommended the decriminalisation of abortion on the grounds of rape.

In 2018, CEDAW significantly advanced its approach to abortion in a lengthy report on Northern Ireland.[95] CEDAW found that the UK government had committed grave and systematic rights violations as a result of deliberate criminalisation of abortion in Northern Ireland, which compelled women to carry pregnancies to full term, travel outside Northern Ireland in order to access safe, legal abortions, or obtain abortion medication illegally.[96] In addition, CEDAW stated that compelling women to continue

[90] *Ibid* paras. 8.16-8.17.
[91] *Ibid* para. 8.15.
[92] *Ibid* paras. 8.17; 9.2(a).
[93] *Ibid* para. 9.2(b).
[94] *Ibid* para. 9.2(c).
[95] CEDAW, 'Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to CEDAW' (6 March 2018) UN Doc. CEDAW/C/OP.8/GBR/1.
[96] *Ibid* para. 83(b).

their pregnancies to full term in situations of rape or fatal foetal impairment caused mental and physical anguish amounting to gender-based violence.[97] As in *L.C. v Peru*, the Committee considered the gender stereotypes that inform restrictive abortion laws, finding that Northern Ireland's regime portrayed women's primary role as one of motherhood and created negative stereotypes which stigmatised those who had abortions.[98] CEDAW thus recommended that the state decriminalise abortion in all cases and provide access to legal abortion services at least in cases of a risk to the pregnant person's life or health, rape and incest, and severe foetal impairment.[99]

Similar recommendations have also been made in subsequent Concluding Observations.[100] In addition, CEDAW has expanded on socio-economic issues and the accessibility of abortion services. For example, in its Concluding Observations on Ethiopia in 2019, CEDAW commented upon the shortage of medical staff qualified to perform abortions and recommended that the state improve access to low cost health services and equip doctors to provide accessible health care for women, including abortions, through the allocation of sufficient budgetary resources.[101] Thus, the approach of CEDAW to abortion largely mirrors the combined approaches of the HRC and CESCR in terms of obligations around the minimum circumstances for the legalisation of abortion and standards of accessibility.

[97] *Ibid* para. 83(a).
[98] *Ibid* para. 73.
[99] *Ibid* para. 85.
[100] See, for example, CEDAW, 'Concluding observations on the combined third and fourth periodic reports of Saudi Arabia' (14 March 2018) UN Doc. CEDAW/C/SAU/CO/3-4, para. 48(b); CEDAW, 'Concluding observations on the fourth periodic report on Andorra' (13 November 2019) UN Doc. CEDAW/C/AND/CO/4, para. 36(a); CEDAW, 'Concluding observations on the sixth periodic report of Namibia' (12 July 2022) UN Doc. CEDAW/C/NAM/CO/6, para. 42(a).
[101] CEDAW, 'Concluding observations on the eighth periodic report of Ethiopia' (14 March 2019) UN Doc. CEDAW/C/ETH/CO/8, paras. 37-38.

However, where CEDAW goes further than the other treaty bodies is in relation to the gender-based aspects of abortion, as can be seen in the comments already set out in this section. Notably, in 2017, CEDAW adopted General Comment No. 35 on gender-based violence, and stated that:

> 'Violations of women's sexual and reproductive health and rights, such as forced sterilization, forced abortion, forced pregnancy, criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.'[102]

The recognition that the forced continuation of pregnancy and the denial of safe abortion can amount to gender-based violence is significant. Scholars had previously commended CEDAW for showing a greater willingness than other bodies to recognise reproductive rights, and especially abortion, as requiring affirmative state support.[103] While this omission has been largely corrected in the more recent comments of the HRC and CESCR, this nonetheless remains true in relation to this gendered dimension. As part of this, CEDAW has also taken an increasingly intersectional approach, for example in recognition of the barrier faced in accessing sexual and reproductive healthcare services by women with disabilities, Indigenous women, Black women, and migrant women.[104]

[102] CEDAW, 'General Recommendation No. 35 on Gender-Based Violence Against Women, updating General Recommendation No. 19' (26 July 2017) UN Doc. CEDAW/C/GC/35, para. 18.
[103] Zampas and Gher (n33) 251; Barbara Stark, 'The Women's Convention, Reproductive Rights, and the Reproduction of Gender' (2011) 18(2) *Duke J. Law & Policy* 261, 271.
[104] See, for example, CEDAW, 'Concluding observations on the seventh periodic report of Gabon' (1 March 2022) UN Doc. CEDAW/C/GAB/CO/7, para. 31(c); CEDAW, 'Concluding observations on the eighth periodic report of Panama' (1 March 2022) UN Doc. CEDAW/C/PAN/CO/8, para. 38(c); CEDAW, 'Concluding

CEDAW has addressed abortion in the majority of its Concluding Observations issued in 2022, such that this treaty body now has a significant body of documents setting out state obligations to decriminalise abortion, legalise abortion in the minimum circumstances, and ensure access on those grounds. In its Concluding Observations on Morocco, however, CEDAW went further and recommended that the state consider decriminalisation 'when it is necessary to protect the woman's health, including her physical, mental and social well-being' in accordance with the World Health Organisation's definition.[105] This is notable, in suggesting that social grounds for abortion are encompassed within the right to health. However, while this may be expanded upon by CEDAW in future comments, it is currently an outlier in the Committee's approach to abortion. Further, as with CESCR's suggestions that abortion should be legalised broadly, this comment is not explicit enough to set out clear obligations that the state ensure access to abortion for social reasons. Thus, while CEDAW's approach has been, in some ways, more progressive than the other treaty bodies, it carries similar limitations in terms of the pressure it puts on states to ensure comprehensive access to abortion, to be discussed in more detail below.

### *1.5. Broader Human Rights Comments on Abortion*

Two of the Special Rapporteurs for the right to health have written progressive statements on sexual and reproductive rights, including abortion, which have generally

observations on the eighth report of the Dominican Republic' (1 March 2022) UN Doc. CEDAW/C/DOM/C/8, para. 36(c).

[105] CEDAW, 'Concluding observations on the combined fifth and sixth periodic reports of Morocco' (12 July 2022) UN Doc. CEDAW/C/MAR/CO/5-6, para. 36(c).

gone beyond those of CESCR. In 2011, five years prior to CESCR's General Recommendation on the issue, Special Rapporteur Anand Grover addressed the right to sexual and reproductive health as a fundamental aspect of the right to health, with a specific focus on abortion.[106] Grover viewed criminal restrictions on abortion as 'impermissible barriers to the realization of women's right to health' which infringed the dignity and autonomy of women by restricting their reproductive decision-making, in addition to generating poor physical and mental health outcomes and thrusting women into the criminal justice system.[107] Grover noted that safe abortion would not immediately result from decriminalisation.[108] States must also create the conditions for accessible services, such as the provision of clinics staffed by trained providers, comprehensive sexual and reproductive health education, and the absence of additional barriers such as mandatory waiting periods.[109] Grover also considered broader issues such as the impact of financially inaccessible abortion services on poor and marginalised women, the additional barriers some women face as a result of discrimination, and the wider criminalisation of conduct during pregnancy (for example, for drug exposure).[110] Grover made a number of recommendations, including the decriminalisation of abortion, ensuring safe, quality abortion services, and the provision of information and post-abortion care even where abortion is prohibited.[111] The Special Rapporteur's statement was one of the first UN documents to advocate for the decriminalisation of abortion, not just in order to prevent unsafe abortion but to support reproductive autonomy.

[106] Anand Grover, 'Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' (3 August 2011) UN Doc. A/66/254.
[107] *Ibid* para. 21.
[108] *Ibid* para. 29.
[109] *Ibid* paras. 24, 56.
[110] *Ibid* paras. 31-34, 37-43.
[111] *Ibid* para. 65.

The current Special Rapporteur, Dr Tlaleng Mofokeng, has considered abortion in a number of thematic statements. In a report on sexual and reproductive health amid the COVID-19 pandemic, Mofokeng highlighted that the right to sexual and reproductive health 'guarantees all persons capable of becoming pregnant meaningful control over whether or not to reproduce.'[112] Mofokeng thus recognised access to safe, legal abortion as 'a necessary component of comprehensive health services.'[113] In a subsequent report on violence and the right to health, Mofokeng set out the criminalisation of abortion and denial of abortion services as examples of gender-based violence.[114] The report emphasised the link between criminalisation and unsafe abortion, particularly in regions such as Africa and Latin America where a relatively large percentage of maternal deaths are attributed to unsafe abortion practices.[115] Mofokeng has also reported on the impact of racism on the right to health, and in recognition of how the criminalisation of abortion impacts already marginalised people in particular, recommended the removal of all punitive abortion laws.[116] In addition, Mofokeng highlighted that grounds-based laws and laws with strict gestational time limits act as barriers to safe, quality abortion care.[117] This comment is particularly progressive as, while CESCR has avoided taking a grounds-based approach, the HRC and CEDAW have focused on minimum grounds for legalisation, and none of these three bodies have yet commented on gestational time limits as barriers.

[112] Tlaleng Mofokeng, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health – sexual and reproductive health rights: challenges and opportunities during the COVID-19 pandemic' (16 July 2021) UN Doc. A/76/172, para. 40.
[113] *Ibid*.
[114] Tlaleng Mofokeng, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health – violence and its impact on the right to health' (14 April 2022) UN Doc. A/HRC/50/28, paras. 49, 70.
[115] *Ibid* para. 50.
[116] Tlaleng Mofokeng, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health – racism and the right to health' (20 July 2022) UN Doc. A/77/197, paras. 36, 92.
[117] *Ibid* para. 92.

Mofokeng's overtly intersectional approach, and in particular the use of gender-inclusive language when discussing sexual and reproductive rights, also stands out as significant.

### *1.6. Limitations*

International human rights standards on abortion have progressively evolved over time, as I have highlighted in the above sections. The recent comments of CESCR, CEDAW, and the current Special Rapporteur for the right to health demonstrate the recognition of access to abortion as a fundamental requirement of gender-equitable healthcare. However, despite this continual evolution of standards, there are a number of overarching limitations with the current international human rights approach to abortion. Firstly, there is a tendency, particularly by the HRC, to find that restrictions on abortion violate certain rights based on a relatively high threshold of harm. Lisa Kelly has identified the 'innocent suffering' narrative which tends to arise in abortion rights cases, in which 'an adolescent girl, figured often as a child, is raped, becomes pregnant, and with the support of her parents seeks to terminate the pregnancy' and when this termination is denied, the state is framed as a shameful antagonist.[118] Kelly argues against using such narratives, which reinforce conceptions of good versus bad abortions and leave out the majority of abortion experiences, such as 'the experiences of women who desire nonprocreative sex, who have no access to claims of extreme suffering, who seek multiple abortions, who terminate for economic reasons'.[119]

[118] Lisa M. Kelly, 'Reckoning with Narratives of Innocent Suffering in Transnational Abortion Litigation' in Rebecca J. Cook, Joanna N. Erdman, and Bernard M. Dickens, *Abortion Law in Transnational Perspective* (University of Pennsylvania Press, 2014) p.304.
[119] *Ibid* p.305.

In the context of international human rights, a focus on significant suffering can be found in the cases discussed above, which have all concerned minors, rape, or fatal foetal impairments. While the evolution of international human rights standards has led to a departure from this to some extent, the HRC and CEDAW continue to reference minimum circumstances for the legalisation of abortion, which again sets out a threshold of harm recognising only a number of exceptional grounds for abortion as legitimate. Further, there remains a tendency by human rights bodies to require decriminalisation or access to abortion services by reference to the prevention of unsafe abortion and maternal mortality. Charles Ngwena has criticised the approaches of treaty bodies for failing to draw 'their main impulse from women's right to reproductive autonomy'.[120] In the absence of a human right to abortion, prohibitions on abortion only violate human rights where the threshold of harm for another right is reached – restrictions on reproductive autonomy are not recognised as a sufficient harm in itself.

Secondly, as international human rights standards have evolved gradually, and abortion is not explicitly mentioned within any of the aforementioned treaties, the approaches of the HRC, CESCR, and CEDAW are spread across numerous General Comments, Concluding Observations, and cases. Alice Miller and Mindy Roseman have critiqued this fragmentation which results in issues stretched across multiple bodies and falling under different rights approaches, creating uncertainty and a 'chill' with contentious areas such as sexual and reproductive health.[121] While the HRC and CESCR have summarised their approaches to abortion in relatively recent General Recommendations, much of CEDAW's approach has been developed through state-

[120] Ngwena (n51) 422.
[121] Alice M. Miller and Mindy J. Roseman, 'Sexual and reproductive rights at the United Nations: frustration or fulfilment?' (2011) 19(38) *Reprod. Health Matters* 102, 104.

specific documents. While there are, of course, advantages to this in terms of specificity and responsiveness to contextual issues, there are further problems with the inaccessibility of human rights standards when developed in this way. Inaccessibility means that it becomes harder for civil society groups to hold governments accountable for breaching or failing to protect human rights which require access to abortion. As Mofokeng identified in one of her reports, civil society involvement acts as a guarantee for the effective realisation of the right to health by acting as a mechanism for accountability.[122] The importance of civil society groups for the realisation of human rights, and particularly in relation to contested issues such as abortion, will be explored more expansively in Chapter 6.

The lack of explicit direction to ensure that abortion services are comprehensively accessible and variation between treaty bodies creates gaps in standards that may excuse inaction or efforts to restrict access by states opposed to legalising abortion. Magdalena Furgalska and Fiona de Londras have argued that the Polish Constitutional Tribunal's recent decision to prohibit abortion for foetal impairments was an example of the court taking advantage of the gaps in current international and European human rights standards on abortion.[123] Where these gaps and uncertainties exist, states can claim that restrictive abortion laws nonetheless meet international human rights standards; the Polish Constitutional Tribunal selectively referenced human rights documents in the decision in order to suggest compliance.[124] In the absence of clear obligations on states to provide access to abortion, international human rights bodies risk providing

[122] Mofokeng (n112) para. 89.
[123] Magdalena Furgalska and Fiona de Londras, 'Rights, Lawfare and Reproduction: Reflections on the Polish Constitutional Tribunal's Abortion Decision' (2022) 55(3) *Isr. Law Rev.* 285, 287.
[124] *Ibid* 294-295; Marta Bucholc, 'Abortion Law and Human Rights in Poland: The Closing of the Jurisprudential Horizon' (2022) 14 *Hague J. Rule Law* 73, 90.

legitimacy to states seeking to maintain or impose restrictions.[125] Despite the progressive evolution of international human rights standards on abortion, particularly recently, these gaps remain.

Thirdly, there are issues with implementation as a result of the broader limitations of the international human rights framework. The UN human rights bodies lack strong follow-up and enforcement mechanisms, in part due to a lack of capacity and resources.[126] The primary means of assessing compliance with human rights standards is through state reporting, but there is a significant backlog of overdue state party reports and consequential delays in the review process.[127] In relation to reproductive rights, and abortion specifically, there are limitations as a result of the reservations of some states to certain rights contained in CEDAW. Malta and the Principality of Monaco specifically entered reservations to the Article 16(e) right to decide on the number and spacing of one's children insofar as this contained an obligation to legalise abortion.[128]

The lack of clear obligations on states to ensure comprehensive access to abortion, coupled with the lack of effective enforcement mechanisms, means that the direct effect of current human rights standards on abortion is arguably insubstantial. For example, in the cases of *K.L. v Peru* and *L.C. v Peru* the HRC and CEDAW directed the Peruvian

[125] Furgalska and de Londras (n123) 301.
[126] Alicia Ely Yamin, *When Misfortune Becomes Injustice* (Stanford University Press, 2020) p.149. For treaty body follow-up methods, see: HRC, 'Note by the Human Rights Committee on the procedure for follow-up to concluding observations' (23 December 2021) UN Doc. CCPR/C/161; CEDAW, 'Assessment of the follow-up procedure under Article 18 of the CEDAW Convention' (6 November 2019); CESCR, 'Working methods concerning the Committee's follow-up to Views under the Optional Protocol to the International Covenant on Economic, Social, and Cultural Rights' (2017) UN Doc. E/C.12/62/4.
[127] UNHR Office of the High Commissioner, 'Human Rights Committee Holds Twelfth Informal Meeting with States Parties, Discusses Challenges Relating to the Work of the Committee' (18 July 2022) <https://www.ohchr.org/en/press-releases/2022/07/human-rights-committee-holds-twelfth-informal-meeting-states-parties> accessed 14 January 2023.
[128] CEDAW, 'Declarations, reservations, objections and notifications of withdrawal of reservations relating to the Convention on the Elimination of All Forms of Discrimination against Women' (10 April 2006) UN Doc. CEDAW/SP/2006/2, p.20-21.

government, respectively, to ensure access to therapeutic abortion and decriminalise abortion in cases of rape. However, Peru's abortion law has not been reformed and the barriers to accessing therapeutic abortions remain.[129] Further, Alicia Ely Yamin highlights that CEDAW considered Brazil's compliance with recommendations made in the maternal health case *Pimentel v Brazil* complete, before the state had fully implemented them.[130] This is not to suggest that international human rights standards on abortion are wholly ineffective, but rather that their direct impact is limited by the approaches of treaty bodies to abortion and broader issues with the framework. The indirect impact of international human rights standards on abortion, in the context of national courts, civil society groups, and other localised methods of accountability, will be highlighted in Chapter 6. However, for human rights to have a significant indirect impact on access to abortion worldwide will require clearer obligations.

## *2. Access to Abortion Worldwide*

There are significant worldwide disparities in access to safe, legal abortion services. In Canada, abortion has been decriminalised since 1988 when the Supreme Court held that the sections of the criminal code imposing restrictions on abortion were unconstitutional.[131] As of 2022, abortion has been decriminalised in all jurisdictions of

[129] La Prensa Latina, 'Big gap between ideal and reality for therapeutic abortion in Peru' (19 January 2022) <https://www.laprensalatina.com/big-gap-between-ideal-and-reality-for-therapeutic-abortion-in-peru/> accessed 14 January 2023.
[130] Yamin (n126) p.149; *Alyne da Silva Pimentel v Brazil* (2011) UN Doc. CEDAW/C/49/D/17/2008.
[131] *R v Morgentaler* [1988] 1 SCR 30.

Australia.[132] In recent years, the trend towards decriminalisation has somewhat grown, with abortion now no longer a criminal offence in Argentina, Northern Ireland, and New Zealand.[133] In the majority of Europe while abortion remains a criminal offence, it is also permitted on relatively broad grounds. Numerous European states provide for abortion on request up to 12 weeks' gestation, and others up to 14 (e.g., Spain), 16 (France), or 18 weeks (Sweden).[134] Malta and Andorra are the only states in Europe where abortion is entirely prohibited, without exceptions even to save the life of the pregnant person.[135]

Across Africa, the majority of states limit access to abortion to where the pregnant person's life or health is at risk, where the pregnancy resulted from rape or incest, and in cases of foetal impairment.[136] Some states (e.g., Mauritania and Congo) prohibit abortion entirely, while others permit abortion on request (e.g., South Africa and Mozambique) or on broader grounds (e.g., Zambia and Ethiopia).[137] The legal landscape for abortion similarly varies dramatically in Latin America. While a number of states (e.g., Argentina and Colombia) have recently legalised abortion on request, others either only permit abortion in exceptional circumstances or prohibit it entirely.[138] In El Salvador, the total criminalisation of abortion has been applied to the extent that women who experience involuntary miscarriage or stillbirths have been prosecuted.[139] In July 2022, a woman

[132] Abortion is regulated at the state level in Australia. South Australia was the last to decriminalise abortion with the Termination of Pregnancy Act 2021.
[133] *Ley de Interrupción Voluntaria del Embarazo* No. 27.610 2020 (Argentina); Northern Ireland (Executive Formation etc) Act 2019 s.9 (UK); Abortion Legislation Act 2020 (New Zealand).
[134] Center for Reproductive Rights, 'The World's Abortion Laws' <https://reproductiverights.org/maps/worlds-abortion-laws/> accessed 14 January 2023.
[135] *Ibid*.
[136] *Ibid*.
[137] *Ibid*.
[138] *Ibid.*
[139] Elisabeth Malkin, 'They Were Jailed for Miscarriages. Now, Campaign Aims to End Abortion Ban.' (*The New York Times,* 9 April 2018) <https://www.nytimes.com/2018/04/09/world/americas/el-salvador-abortion.html> accessed 14 January 2023.

was sentenced to 50 years in prison for aggravated homicide following an obstetric emergency which led to the death of her baby.[140]

There are also a number of recent examples of countries backsliding on abortion rights. Poland prohibits abortion except where there is a risk to the pregnant person's life or health or where the pregnancy resulted from rape.[141] Abortion in cases of foetal impairment was previously also permitted, but this was declared unconstitutional by the Polish Constitutional Tribunal in 2020.[142] The right-wing Catholic government, the Law and Justice Party (*Prawo i Sprawiedliwość*), had attempted to pass a Bill to completely prohibit abortion in 2016, and again in 2018 and 2020 to prohibit abortion for foetal impairments, but had been met with widespread protests on each occasion.[143] Changes made to the governing of the Constitutional Tribunal since 2015 have resulted in a breakdown of the separation of powers, as the court has become an 'enabler of government politics'.[144] The majority of judges elected to the Tribunal were selected by the Law and Justice Party, including the current Chief Justice Julia Przyłębska.[145] The ruling came into effect in January 2021, and abortion is now only legal in Poland to save the pregnant person's life or health and in cases of rape. However, as explored in the previous chapter, issues of widespread conscientious objection and the division between

[140] Reuters, 'El Salvador woman's 50-year jail sentence outrages abortion rights group' (4 July 2022) <https://www.reuters.com/world/americas/el-salvador-womans-50-year-jail-sentence-outrages-abortion-rights-group-2022-07-04/> accessed 14 January 2023.
[141] The Family Planning, Human Embryo Protection and Conditions of Permissibility of Abortion Act of 7 January 1993 Article 4a.
[142] Polish Constitutional Tribunal Case K 1/20 (22 October 2020).
[143] Christian Davies, 'Poland's abortion ban proposal collapse after mass protests' (*The Guardian*, 5 October 2016) <https://www.theguardian.com/world/2016/oct/05/polish-government-performs-u-turn-on-total-abortion-ban> accessed 14 January 2023; Marc Santora and Joanna Berendt, 'Polish Women Protest Proposed Abortion Ban (Again)' (*New York Times*, 23 March 2018) <https://www.nytimes.com/2018/03/23/world/europe/poland-abortion-women-protest.html> accessed 14 January 2023; Shaun Walker, 'Concerns over Polish government tightening laws during Covid-19 crisis' (*The Guardian,* 14 April 2020) <https://www.theguardian.com/world/2020/apr/14/concerns-over-polish-government-tightening-abortion-laws-during-covid-19-crisis> accessed 14 January 2023.
[144] Bucholc (n124) 85.
[145] *Ibid*.

private and public healthcare means that abortion is very difficult to access even on those grounds. In the first few months of 2022, it was reported that two Polish women had died after being denied abortions.[146]

In June 2022, the US Supreme Court handed down its judgment in *Dobbs v. Jackson*, holding that there was no constitutional right to abortion, thus overturning the constitutional protection for pre-viability abortion established in *Roe v. Wade* and the 'undue burden' threshold for abortion regulation in *Planned Parenthood v. Casey*.[147] The *Dobbs* case concerned Mississippi's Gestational Age Act, which prohibited abortion beyond 15 weeks gestation in contravention of *Roe v. Wade*. In other states, the result of *Dobbs* is to allow significantly more onerous restrictions. In Texas, for example, abortion is illegal once the foetal heartbeat is detected (around six weeks' gestation) and Louisiana has made abortion illegal except to save the pregnant person's life.[148] 13 states had 'trigger laws' in place to restrict abortion as soon as *Roe v. Wade* was overturned, and more are expected to follow suit.[149] In the two months following *Dobbs*, the estimated number of legal abortions across the US fell by 10,000.[150]

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[146] Courtney Blackington, 'Two Polish women died after being refused timely abortions. Many Poles are outraged – and protesting.' (*The Washington Post,* 18 February 2022) <https://www.washingtonpost.com/politics/2022/02/18/poland-abortion-protest/> accessed 14 January 2023.

[147] *Dobbs v. Jackson Women's Health* 597 U.S. ___ (2022); *Roe v. Wade* 410 U.S. 113 (1973); *Planned Parenthood v. Casey* 505 U.S. 833 (1992).

[148] S.B. 8 (Texas); R.S. 40: 1061 (Louisiana).

[149] Elizabeth Nash and Isabel Guarnieri, '13 States Have Abortion Trigger Bans – Here's What Happens When Roe Is Overturned' (*Guttmacher Institute,* 6 June 2022) <https://www.guttmacher.org/article/2022/06/13-states-have-abortion-trigger-bans-heres-what-happens-when-roe-overturned> accessed 14 January 2023; Elizabeth Nash and Lauren Cross, '26 States Are Certain or Likely to Ban Abortion Without Roe: Here's Which Ones and Why' (*Guttmacher Institute*, 28 October 2021) <https://www.guttmacher.org/article/2021/10/26-states-are-certain-or-likely-ban-abortion-without-roe-heres-which-ones-and-why> accessed 14 January 2023.

[150] Maggie Koerth and Amelia Thomson-DeVeaux, 'Overturning Roe Has Meant At Least 10,000 Fewer Legal Abortions' (*FiveThirtyEight*, 30 October 2022) <https://fivethirtyeight.com/features/overturning-roe-has-meant-at-least-10000-fewer-legal-abortions/> accessed 14 January 2023.

Even where abortion has been legalised or decriminalised, abortion is not always accessible. Geographical, physical, and socio-economic barriers disproportionately affect already marginalised groups, and issues such as conscientious objection, a shortage of trained abortion providers, and the inadequate funding of public healthcare services can also obstruct access. Some states also impose medically unnecessary requirements such as waiting periods, mandatory counselling, and in-person requirements for early medical abortions which also operate as barriers. In India and South Africa, for example, despite having relatively liberal abortion laws, a significant proportion of abortions are performed outside of medical institutions due to the inaccessibility of services.[151]

Where abortion is prohibited or inaccessible, pregnant people will resort to clandestine abortion. Not all clandestine abortions are unsafe; safe self-managed early medical abortions using mifepristone and misoprostol will be discussed in Chapter 5. However, it has been estimated that around 25 million unsafe abortions – amounting to almost one third of all abortions – occur each year, but it is important to note that the actual number is likely to be higher as abortion is underreported due to stigma and fear of criminalisation.[152] Unsafe abortions are much more prevalent in lower-income states due to compounding inequalities and a lack of available resources directed towards healthcare provision.[153] Further, in 2014 researchers estimated that 7.9% of maternal deaths worldwide are abortion-related, though again this may be an underestimation.[154] The greatest percentage of maternal mortality associated with abortion was found in

[151] Susheela Singh and others, 'The incidence of abortion and unintended pregnancy in India, 2015' (2018) 6(1) *Lancet Glob. Health* e111; Mary Favier, Jamie M.S. Greenberg, and Marion Stevens, 'Safe abortion in South Africa: "We have wonderful laws but we don't have people to implement those laws' (2018) 143(S4) *Int. J. Gynaecol. Obstet.* 38.
[152] Bela Ganatra and others, 'Global, regional, and subregional classification of abortions by safety, 2010-2014: estimates from a Bayesian hierarchical model' (2017) 390 *Lancet* 2372, 2377, 2379.
[153] *Ibid* 2377.
[154] Lale Say and others, 'Global causes of maternal death: a WHO systematic analysis' (2014) *Lancet Glob. Health* e323, e331.

Latin America and Sub-Saharan Africa (9.9% and 9.6% respectively) – lower-income regions where abortion is generally more restricted.[155]

This comes in the context of broader disparities in the provision of sexual and reproductive healthcare and autonomy, including access to education and information, sexual health services, an unmet need for modern contraceptive methods, contraceptive coercion and forced sterilisation, maternal mortality rates, obstetric violence, and broader gender-based and intersectional inequalities. Access to sexual and reproductive healthcare services, including contraception and abortion, was affected in many countries by periods of national lockdowns during the COVID-19 pandemic.[156] The current international human rights framework does not adequately respond to the significant global issues with access to abortion. There is a pressing need for clear obligations to be imposed on states to ensure comprehensive access to abortion services, alongside the realisation of broader sexual and reproductive rights, in order to tackle these disparities. A feminist transformation of international human rights must adopt an approach to abortion which addresses the limitations with the current framework.

[155] *Ibid* e326.
[156] Manisha Kumar and others, 'Now is the time: a call for increased access to contraception and safe abortion care during the COVID-19 pandemic' (2020) 5 *BMJ Glob. Health* 1.

# *3. Reproductive Rights and Reproductive Justice*

## *3.1. The Reproductive Justice Framework*

A delegation of African American women attending the ICPD in Cairo, where the definition of reproductive rights was first formally adopted, recognised the gaps in this conception of rights and theorised the reproductive justice framework as an alternative.[157] The SisterSong Women of Colour Reproductive Justice Collective was founded in the US in 1997, and defines reproductive justice as 'the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.'[158] Zakiya Luna and Kristin Luker view reproductive justice requiring both 'a negative right of freedom from undue government interference and a positive right to government action in creating conditions of social justice and human flourishing'.[159] This stands in contrast to the conception of reproductive rights which, particularly at the time of the ICPD, was restricted to the four key elements of choice, privacy, freedom from governmental interference, and personal autonomy which gives rise to individualised negative rights.[160] The reproductive justice framework retains a human rights foundation which emphasises universality but takes a broader approach to state obligations to remove the barriers to accessing reproductive healthcare and provide comprehensive services. The framework also identifies how

[157] Kimala Price, 'What is Reproductive Justice?: How Women of Color Activists Are Redefining the Pro-Choice Paradigm' (2010) 10(2) *Meridians* 42, 56.
[158] SisterSong, 'What is Reproductive Justice?' <https://www.sistersong.net/reproductive-justice> accessed 14 January 2023.
[159] Zayika Luna and Kristin Luker, 'Reproductive Justice' (2013) 9 *Annu. Rev. of Law Soc. Sci.* 327, 328.
[160] Angela Hooton, 'A Broader Vision of the Reproductive Rights Movement: Fusing Mainstream and Latina Feminism' (2005) 13(1) *J. Gender Soc. Pol. & Law* 59, 63.

broader socio-economic contexts, including culture and environmental factors, also affect people's reproductive lives.[161] Beyond access to abortion, contraception, and safe parenthood, reproductive justice addresses a range of issues such as gender-based and sexual violence, the provision of healthcare for sexually transmitted infections, control over partner selection and family planning decisions, infertility, and culturally appropriate birthing experiences.[162] These issues are viewed as interconnected with broader conditions such as access to housing, food, water, safe working conditions, a healthy environment, and substantive equality across socio-political spheres.

A focus on intersectional oppression and the barriers faced by already marginalised groups is central to the reproductive justice framework. Particular attention is thus afforded to the barriers faced by Black, Indigenous, and People of Colour, people with disabilities, LGBTQ+ people, homeless people, migrants, refugees, and asylum seekers. Reproductive justice scholars have also emphasised the importance of including trans, non-binary, and gender expansive people in demanding 'sexual autonomy and gender freedom for every human being'.[163] Scholars have highlighted the reproductive injustices often faced by Black, Indigenous, and ethnic minority women, such as coercion into using contraception or having abortions, forced sterilisation, and the removal of children.[164] The ability to have and raise one's children safely is thus

[161] Loretta J. Ross and Rickie Solinger, *Reproductive Justice: An Introduction* (University of California Press, 2017) p.69.
[162] *Ibid*.
[163] *Ibid* p.9.
[164] See, for example, Loretta J. Ross, 'African-American Women and Abortion: A Neglected History' (1992) 3(2) *J. Health Care Poor Underserved* 274, 275; Leonardo Pegoraro, 'Second-rate victims: the forced sterilization of Indigenous peoples in the USA and Canada' (2015) 5(2) *Settl. Colon. Stud.* 161; Christina Zampas and Adriana Lamačová, 'Forced and coerced sterilization of women in Europe' (2011) 114 *Int. J. Gynaecol. Obstet.* 163.

connected to the issues of access to abortion and contraception under the framing of reproductive self-determination.

In relation to abortion, reproductive justice scholars and activists have sought to move beyond the 'pro-choice' framing that has been popular in abortion rights movements. Joan Chrisler has pointed out that social, economic, and political conditions frame the choices available to different people.[165] However, the choice framing assumes that all people capable of becoming pregnant can decide for themselves whether or not to have children, that they all have the resources to pay for sexual and reproductive healthcare, and that they are all afforded control over their bodies, health, and relationships.[166] People capable of becoming pregnant are also unable to exercise true choice 'whenever their livelihood is endangered, public health and education systems are inadequate, and cultural diversity is not respected.'[167] For example, in the absence of widespread access to temporary contraception, abortion has operated as a remedial measure within China's population control programme, currently a two-child policy.[168] Within this context, coupled with the stigma on premarital sex and motherhood outside of marriage, abortion is relatively common amongst young, unmarried women as it is presented as the only option.[169] Further, a study of the reasons given by people deciding to have an abortion across 14 different countries highlighted that socio-economic concerns were among the most frequently cited. [170] From a reproductive justice perspective, these issues are examples of constraints on reproductive self-determination

[165] Joan C. Chrisler (Ed.) *Reproductive Justice: A Global Concern* (Praeger, 2012) p.53.
[166] *Ibid* p.1.
[167] Sonia Corrêa, *Population and Reproductive Rights* (Zed Books, 2002) p.85.
[168] Kailing Xie, 'Premarital Abortion – What is the Harm? The Responsibilisation of Women's Pregnancy Among China's "Privileged" Daughters' (2019) 8(1) *Brit. J. Chinese Stud.* 1.
[169] *Ibid*.
[170] Sophia Chae and others, 'Reasons Why Women Have Induced Abortions: A Synthesis of Findings from 14 Countries' (2017) 96(4) *Contraception* 233, 237.

requiring addressing alongside simply ensuring access to abortion. At the same time, adopting a reproductive justice framing also highlights the intersectional barriers to access to abortion, in terms of the lack of provision of physical and financially accessible, comprehensive, quality abortion services for many people, impacting people from already marginalised groups in particular.

### *3.2. Advancing a Right to Abortion*

In the literature on advancing abortion as a human right, two approaches can be identified: first, the expansion or interpretation of existing rights to encompass abortion; and second, the development of new distinct rights. Tatyana A. Margolin argued, prior to much of the recent development of human rights standards on abortion, that establishing 'the right to abortion as a human right is essential' to protect pregnant people either through incorporation into an existing article contained in CEDAW or as a free-standing clause.[171] The first approach maps onto the first two approaches outlined in Charlotte Bunch's model as explained in Chapter 1, which focused on the reinterpretation of rights to include gender-based issues. For example, scholars have argued that the denial of abortion should be recognised as cruel, inhuman, and degrading treatment, pointing to the masculine character of human rights as to why gender-based suffering is not uniformly addressed by treaty bodies.[172] While international human rights bodies have recognised that prohibitions on abortion can amount to cruel, inhuman, and degrading

[171] Margolin (n78) 96, 90.
[172] Isabella Moore, 'Indignity in unwanted pregnancy: denial of abortion as cruel, inhuman and degrading treatment' (2019) 23(6) *Int. J. Hum. Rights* 1010; Ronli Sifris, *Reproductive Freedom, Torture, and International Human Rights* (Routledge, 2013).

treatment, this tends to be restricted to exceptional circumstances, such as the cases explored above concerning fatal foetal impairment and rape, rather than for prohibitions on abortion more broadly.

Other scholars have considered the evolution of international human rights standards on abortion as evidence of an emerging right to abortion. For example, Ronli Sifris argued in 2010, prior to CESCR's more recent comments on the right to sexual and reproductive health, that that the right to health included a right to abortion.[173] In addition, Erdman and Cook noted more recently that human rights standards on abortion have been 'evolving from an exclusive focus on saving women from unsafe abortion to recognizing the broader social effects of criminalization that endanger them'.[174] They argue that 'human rights standards therefore require affirmative legal and policy measures to protect against arbitrary denials of lawful care and to ensure access to services under legal grounds.'[175] The international human rights framework can be interpreted as requiring a procedural right to abortion with substantive elements, both positive and negative, in terms of accessibility and decriminalisation. Thus, de Londras et al have argued first, that international human rights bodies, while specifying the minimum grounds for the legalisation of abortion, do not specify that a grounds-based approach is to be adopted to meet this requirement; and second, that grounds-based approaches are therefore insufficient to meet human rights obligations.[176] However, as I have argued above, the expansion of existing human rights to cover abortion and the recently progressive approaches of international human rights bodies have been

[173] Ronli Sifris, 'Restrictive Regulation of Abortion and the Right to Health' (2010) 18 *Med. Law Rev.* 185.
[174] Joanna N. Erdman and Rebecca J. Cook, 'Decriminalization of abortion – A human rights imperative' (2020) 62 *Best Pract. Res. Clin. Obstet. Gynaecol.* 11, 18.
[175] *Ibid* p.16.
[176] Fiona de Londras, Amanda Cleeve, Maria I. Rodriguez, and Antonella F. Lavelanet, 'The impact of 'grounds' on abortion-related outcomes: a synthesis of legal and health evidence' (2022) 22(1) *BMC Pub. Health* 936.

insufficient in terms of setting out clear obligations to provide comprehensive access to abortion services. Further, as argued in Chapter 1, the mere expansion or reinterpretation of existing rights has had a relatively limited impact when it comes to realising gender-based rights.

A feminist transformation of human rights requires the development and recognition of new rights which substantively cover gender-based (and intersectional) issues. In relation to reproductive rights, Melanie M. Lee argued in favour of the recognition of a human right to reproductive self-determination, and Ricardo Pereira has advanced similar arguments in favour of recognising reproductive self-determination as a sub-category of Indigenous rights, recognising the reproductive autonomy of Indigenous Peoples and the financial, geographic and cultural barriers to healthcare they often face.[177] Kathryn McNeilly has proposed a broad 'right to gender flourishing' which would encompass reproductive and sexual health alongside freedom from gender-based violence, equality and non-discrimination, sexual expression, poverty, and education, among other issues.[178] While McNeilly's proposal responds to a number of feminist critiques of human rights, this 'umbrella right' does not substantively go beyond the gender-based rights set out in CEDAW, except for its moving beyond women to include all 'gendered subjects'.[179] In relation to abortion, non-specificity has been a core limitation of the current international human rights approach, which places relatively weak obligations on states to ensure access to abortion services. In addition, abortion was initially largely excluded from the remit of reproductive rights and, as the reservations to

[177] Melanie M. Lee, 'Defining the Agenda: A New Struggle for African-American Women in the Fight for Reproductive Self-Determination' (2000) 6 *Wash. Lee Race & Ethnic Anc. J.* 87, 96; Ricardo Pereira, 'Government-Sponsored Population Policies and Indigenous Peoples: Challenges for International Human Rights Law' (2015) 33(4) *Neth. Q. Hum. Rights* 437, 457.
[178] Kathryn McNeilly, *Human Rights and Radical Social Transformation* (Routledge, 2018) p.145.
[179] *Ibid* p.146.

CEDAW highlight, a number of states are willing to uphold reproductive rights except when it comes to abortion. Thus, the recognition of broader rights to reproductive self-determination or health would similarly place insufficient pressure on states to legalise and guarantee access to abortion. In contrast, the recognition of a specific human right to abortion would place clearer obligations on states in the face of governmental objections to abortion.

In setting out the scope of a human right to abortion as part of a feminist transformation of the international human rights framework, the following chapters will be implicitly informed by key issues arising from the reproductive justice framing, namely in relation to the broader context of reproductive decision-making, intersectionality, and the additional barriers faced by already marginalised groups. I will not explicitly adopt the reproductive justice framework as the foundation of the right to abortion as this framing goes far beyond this one issue, and as Rachel Rebouché identifies, presents a radical agenda for social justice which may be undermined or weakened by its translation into the legal mechanisms of the international human rights framework.[180] The values and aims of the reproductive justice movement will, however, be encompassed in my application of the Principle of Generic Consistency to the issue of abortion and the foundation of international human rights in general, and will be reflected in the framework for a human right to abortion set out in Chapters 4 and 5. In doing so, I seek to address both the conceptual limitations with the international human rights framework in general and the limitations with the current international human rights approach to abortion.

[180] Rachel Rebouché, 'Reproducing Rights: The Intersection of Reproductive Justice and Human Rights' (2017) 7(3) *UC Irvine L. Rev.* 579, 581, 598.

## *Conclusion*

This chapter has addressed the limitations of the current international human rights approach to abortion. The recognition of reproductive rights at the ICPD largely excluded abortion, and early comments by the HRC and CEDAW on abortion were restricted to concerns over unsafe abortion and criminalisation. Since then, the standards on abortion set out by the HRC, CESCR, and CEDAW have evolved to recognise, to varying degrees, minimum circumstances requiring the legalisation of abortion, the need for decriminalisation, the gendered dimensions of abortion restrictions, and requirements for accessibility in practice. Two Special Rapporteurs for the right to health, previously Anand Grover and now Tlaleng Mofokeng, have expanded on these standards to set out progressive approaches relative to the three human rights bodies at each time. However, issues with the human rights approach to abortion remain.

The current approach inadequately responds to the significant problems with access to abortion worldwide, with abortion completely criminalised in some states and legal but inaccessible in others. The piecemeal and fragmented approach of the human rights framework leaves gaps in standards and places insufficient pressure on states to ensure access to abortion. There are also broader issues with implementation and follow-up mechanisms which limit the direct impact of current human rights standards on abortion. The remainder of this thesis will seek to address these problems, as well as the broader conceptual issues set out in the previous chapter, by setting out a feminist transformation of human rights using Alan Gewirth's Principle of Generic Consistency as the foundation, in conjunction with feminist values.

# 3

# Alan Gewirth's Principle of Generic Consistency as the Foundation of Human Rights

## *Introduction*

As set out in Chapters 1 and 2, a feminist transformation of human rights is required to address the current conceptual issues with the international human rights framework and how abortion has been recognised within it. In this chapter, I introduce Alan Gewirth's Principle of Generic Consistency as the foundation for moral rights that should be recognised as universal human rights – thus also providing a foundation for the international human rights framework. This would address the three key conceptual issues raised in Chapter 1 around feminist critiques, cross-cultural traction, and economic, social, and cultural (ESC) rights. In supporting feminist values in its application and the recognition of gender-based rights, the PGC provides the basis for a feminist transformation of human rights.

Firstly, I will set out and expand upon each of the three stages of the argument to the PGC before defending it against key objections that have been made to each stage. I address the direct and indirect application of the PGC, arguing that the PGC can be indirectly applied through the international human rights framework. An international human rights framework grounded by the PGC would require the affirmation of universal

norms, and thus the rejection of cultural relativism, while also supporting the contextual application of those norms in a way which can account for cultural pluralism to some extent. The PGC also establishes a clear foundation for the recognition of ESC rights which would impose stronger obligations on states to realise those rights than the current framework. In the final section, before considering how the PGC would support substantive gender-based rights, I will address key feminist objections to rationalist moral theories (such as the PGC) including the arguments made around care ethics and relationality. I argue that the PGC can encompass these values in its application, therefore offering a feminist-compatible approach which can supply the foundation for a feminist transformation of the international human rights framework.

## *1. Argument to the PGC*

In *Reason and Morality*, Gewirth argued that every agent, through engaging in action, is logically committed to accept a series of judgments and ultimately a supreme moral principle, the PGC, which requires that she respect the necessary conditions of action of other agents.[1] The argument is 'dialectically necessary' as it proceeds from the internal viewpoint of the agent in relation to how she views her own agency, which leads to conclusions that must be accepted by every agent on pain of self-contradiction.[2] Below I present the argument based on a revision of Gewirth's initial argument which is split into three stages.[3] Each stage will be set out in skeletal form and then followed by an

[1] Alan Gewirth, *Reason and Morality* (University of Chicago Press, 1978) p.x.
[2] Deryck Beyleveld, *The Dialectical Necessity of Morality* (University of Chicago Press, 1991) p.15.
[3] *Ibid* p.14; Shaun D. Pattinson, *Influencing Traits After Birth* (Ashgate, 2002) p.4-5; Patrick Capps and Shaun D. Pattinson (Eds.) *Ethical Rationalism and the Law* (Hart, 2017) p.4-5; Shaun D. Pattinson, *Law at the Frontiers of Biomedicine: Creating, Enhancing and Extending Human Life* (Hart, 2023) Ch. 2.

explanation, using characters from *Alice in Wonderland* to expand on the key aspects of the argument. The reader must follow the argument from Alice's internal viewpoint as an agent and, for the purposes of this chapter, assume that Wonderland and the characters within it exist in reality rather than as a figment of Alice's imagination.

## Stage I

As an agent, I claim (by definition) that –

(1) I voluntarily act (or intend to act) for a purpose.

This entails –

(2) My purpose is good,

And –

(3) My freedom and wellbeing are generically necessary conditions of my agency (as I need my freedom and wellbeing in order to pursue any purposes). These are the generic conditions of agency.

I therefore must accept that –

(4) Having the generic conditions of agency is good for my pursuit of any purposes, as the generic conditions are necessary for action.

This entails –

(5) I ought to pursue and defend my possession of the generic conditions.

Alice, an agent, upon seeing a White Rabbit pull a pocket-watch from his waistcoat pocket, decides to follow him down a rabbit hole. She must value her purpose as good, in the sense that there was some positive value which motivated her to voluntarily follow the White Rabbit.[4] As Alice values her purposes as good, she must also value the conditions required for her to pursue those purposes. Upon finding herself in Wonderland, Alice comes across a door the size of a mouse-hole that she wishes to pass through to get into the garden on the other side. To achieve this purpose, she must obtain the key that unlocks the door and, because she is much too tall to get through it, a bottle containing a liquid which will shrink her to the correct size. The 'Principle of Hypothetical Imperatives' (PHI) requires that if Alice values her purpose, she must also equally value the necessary means of achieving her purpose and thus ought to be motivated to pursue those means, or she must abandon her purpose.[5]

There are conditions which Alice requires in order to pursue any purposes, freedom and wellbeing, which are the generically necessary conditions of action. As Alice values as good her purposes and the means to attain them, she must logically also value as good the conditions that are instrumentally necessary for her to achieve any purpose. Alice thus ought to pursue or defend the generic conditions as necessary goods for action,

[4] Deryck Beyleveld, 'The Principle of Generic Consistency as the Supreme Principle of Human Rights' (2012) 13 *Hum. Rights Rev.* 1, 4.
[5] Beyleveld (n4) 4; Pattinson and Capps (n3) p.5.

unless she is willing to compromise her ability to act.[6] It is dialectically necessary for Alice to accept this on pain of self-contradiction; she would deny an understanding of what it is to be an agent if she did not accept that she ought to pursue the conditions required to achieve any purposes.[7]

## Stage II

Following from Stage I, this entails –

(6) I must claim rights to the generic conditions; other agents ought not to interfere with my having the generic conditions against my will, and, if I wish them to, ought to aid me to secure them when I am unable to do so unaided.

Therefore –

(7) I have negative and positive rights to the generic conditions (the generic rights).

As the generic conditions of agency are instrumentally necessary for any purpose, Alice must claim rights to those conditions. Hohfeld distinguishes between rights as liberties, as the freedom to do things, and rights as claims to have certain things or conditions.[8] Only the latter, claim-rights, entail correlative duties.[9] The generic rights are

[6] Beyleveld (n4) 4.
[7] Shaun D. Pattinson, *Revisiting Cases in Medical Law* (Routledge, 2018) p.14.
[8] Wesley Newcomb Hohfeld, 'Fundamental Legal Conceptions as Applied in Judicial Reasoning' (1917) 26(8) *Yale L. J.* 710.
[9] *Ibid*.

claim-rights which align with the will-theory of rights, in that the correlative duties attached to those rights can be waived. This is distinguished from the interest-theory of rights, which recognises certain rights as indispensable and therefore the benefits of those rights are non-waivable. The generic rights are inalienable, and cannot be given up by the Alice, but it is possible for her to waive the benefit of the rights. Alice must therefore hold that other agents ought not to interfere with those conditions without her consent; Alice must hold, for example, that the Queen of Hearts ought not to threaten to cut off her head. In addition to these negative rights, Alice must also hold that she has positive rights to the generic conditions of agency. If Alice is unable to secure the generic conditions for herself unaided, she must hold that other agents ought to assist her in securing the generic conditions where they are able, and if she wishes them to. So, if Alice, while stuck in Wonderland, is unable to find food for herself, she must hold that the Mad Hatter and the March Hare, with plenty of food to spare, thus ought to invite Alice to their tea party. The negative and positive rights to the generic conditions of agency claimed by Alice are the generic rights.

## Stage III

Following from Stage II, this entails –

(8) I have the generic rights because I am an agent.

Following the logical principle of universalisability, this entails –

(9) Every other agent has the generic rights because they are an agent; all agents thus have the generic rights.

Which leads to the PGC –

(10) From every agent's internal viewpoint as an agent, it is dialectically necessary to accept that all agents have the generic rights.

Alice must hold that she has the generic rights because she is an agent. Gewirth refers to this as the 'Argument from the Sufficiency of Agency' (ASA), which provides that the justifying reason for claiming rights to freedom and well-being is that they are the necessary conditions of agency.[10] Agency is both necessary for the rights-claim, as a non-agent could not claim the generic rights, and sufficient, as any agent that fulfils the description of agency must claim the generic rights, regardless of any other characteristics.[11] The introduction of any restrictive qualifying characteristics would contradict the premise of the argument: that the generic rights are linked to action for purposes the agent values.[12] For example, if Alice were to claim that she has the generic rights because she has blonde hair, she would be denying that she understands what it means for her to be an agent. Alice must therefore hold that she must claim the generic rights even if she did not have blonde hair, as this is not a sufficient reason for claiming the generic rights.[13]

[10] Gewirth (n1) p.109.
[11] *Ibid*.
[12] *Ibid* p.110.
[13] *Ibid.*

Following from the ASA, the logical principle of universalisability requires Alice to accept that if her possession of agency is a sufficient reason to hold that she has the generic rights, then the possession of agency by the White Rabbit provides her with a sufficient reason to hold that he too has the generic rights.[14] Alice must also accept that every other agent has the generic rights because they are agents, just as she has the generic rights because she is an agent. Alice must thus accept that all agents can equally claim the generic rights, otherwise she would be denying the basis of her own claim to those rights. This leads to the Principle of Generic Consistency: it is dialectically necessary for every agent to accept that all agents have the generic rights equally.

## *2. Objections to the Argument*

Before expanding on the application of the theory and how this provides the foundation for human rights, it is necessary to defend the argument against objections. Most objections to the PGC have already been refuted by Gewirth himself and by Deryck Beyleveld, so I will address only a small number of key objections at each stage of the argument. Objections relating to the abstract nature of the argument and the application of it will be addressed in Section 5 this chapter, in the context of feminist critiques.

[14] Pattinson (n7) p.15; Pattinson (n3) p.7.

### *2.1. Objections to Stage I*

The key objection to Stage I is raised in relation to step (2), that the agent must hold that her purposes are good. As explained above, this simply means that the agent has attached some positive value to the action which motivated her to do it. Some scholars have objected to this on the basis that not all actions are done for a valued purpose, and that not all purposes are valued. Virginia Held gives examples of what she takes to be purposeless actions with no intrinsic value: a person repetitively tapping a pencil, a voluntary action as they could refrain from it, but continue to do for no apparent purpose; or a person sitting, doing nothing, when they have tasks to complete.[15] These are not, as Held suggests, examples of purposeless and valueless action. The agent need not ascribe intrinsic value to their purposes or actions, but there has to be a positive value which has led them to choose that action over another. So, the tapping of a pencil may be somewhat pleasurable, and the person sitting down must have valued that action over doing anything else, even if the agent would not value those actions on other criteria. The agent may be acting on mere inclination, but where she has voluntary control over the inclination or her acting on it, meaning that she could choose to do otherwise, and voluntarily chooses to act on the inclination, she is therefore acting for a purpose she must value as good.[16] This would not apply to involuntary inclinations.

The similar objection raised is that not all purposes can be valued as good, as the agent might prefer to act in a different way. Held thus argues that a person might prefer that she does not smoke, but chooses to smoke a cigarette anyway (voluntarily, without

[15] Virginia Held, 'The Normative Import of Action' in Michael Boylan (Ed.), *Gewirth: Critical Essays on Action, Rationality, and Community* (Rowman & Littlefield, 1998) p.14-16.
[16] Edward J. Bond, 'Reply to Gewirth' (1980) 11(1) *Metaphilosophy* 70, 72; Beyleveld (n2) p.71.

being driven by compulsion) even though she does not value this action.[17] Edward Bond similarly raises the objection that a desire can exist without the agent valuing the object of that desire.[18] It is not merely having a desire or preference for a purpose that must lead the agent to value it, but in voluntarily choosing to act on that desire or preference. In addition, the agent's purposes need not correspond with their desires, wants, or preferences as to how she thinks she *should* act for her to value them as good. An agent may decide that smoking is bad on various grounds, but she must nevertheless value the action of smoking the cigarette if she voluntary undertakes that action. All voluntary action must therefore be valued as good, as the agent would have otherwise chosen to act for a different purpose.

### *2.2. Objections to Stage II*

The key objection to Stage II that I will address is in relation to the 'ought' statement generated in step (6). Objections to this step question how a prudential 'ought' (one which is justified by the self-interest of the agent, as opposed to a moral 'ought') can require other agents to comply with it. Matthew Kramer and Nigel Simmonds argue that the statement that an agent (*A*) must prescribe to all other agents (*B*) that they ought not to interfere with *A*'s freedom and wellbeing suggests that *B* have reasons for not interfering with *A*'s freedom and wellbeing.[19] They then argue that, as this statement is based entirely on *A*'s needs, it can offer no reason as to why *B* should avoid interfering

[17] Held (n15) p.17.
[18] Edward J. Bond, 'Gewirth on Reason and Morality' (1980) 11(1) *Metaphilosophy* 36, 44.
[19] Matthew H. Kramer and Nigel E. Simmonds, 'Reasons Without Reasons: A Critique of Alan Gewirth's Moral Philosophy' (1996) 34(3) *South J. Philos.* 301, 303.

with *A*'s needs, as prudential prescriptions cannot translate into prudential or moral reasons for *B*'s non-interference.[20] Their conclusion is thus that Stage II is invalid, as they argue that *A* cannot hold that *B* ought not to interfere with their freedom and wellbeing, while admitting that *B* has no reason to avoid interfering.[21] Applying this objection to the *Alice* example, Kramer and Simmonds would argue that Alice cannot hold that the Queen of Hearts ought not to interfere with her freedom and well-being by threatening to cut off her head, as the Queen of Hearts has no prudential or moral reasons to comply with this 'ought' statement. While it is true that the Queen of Hearts has no reason to avoid interfering with Alice's freedom and wellbeing at this stage, this does not invalidate Stage II. This and similar objections have been addressed by both Gewirth and Beyleveld, their responses relating to the fact that, in Stage II, the agent need only be concerned with defending her own needs on prudential criteria, so the 'ought' statement need not be valid on the criteria of other agents.[22] It is thus irrelevant, at this stage, whether the 'ought' statement made by Alice would be accepted by other agents.

In one of his responses to Kramer and Simmonds, Gewirth argues that the reason for non-interference given by *A* does provide *B* with a reason (though neither prudential or moral) for *B* to comply. From *A*'s perspective, *B* has reasons to comply with the 'ought' statement.[23] This, however, complicates the argument as it makes no difference to the validity of Stage II whether or not *B* has a reason to comply. In other words, Stage II does not require the Queen of Hearts to have a reason not to interfere with Alice's freedom and wellbeing. As the argument proceeds from the internal viewpoint of Alice, all that Stage

[20] *Ibid* 303-304.
[21] *Ibid* 304.
[22] Alan Gewirth, 'The Agent Prescriber's "Ought"' (1998) 36(1) *South J. Philos.* 141, 141-142; Beyleveld (n2) p.221; 277.
[23] Alan Gewirth, '"Ought" and Reasons for Action' (1997) 35(2) *South J. Philos.* 171, 174-175.

II requires is that Alice has a reason for holding that other agents ought not to interfere with her freedom and wellbeing; she must defend her possession of the necessary conditions of agency to avoid denying an understanding of her own agency. Likewise, the argument proceeding from the Queen of Hearts' internal viewpoint would not require her to avoid interference with Alice's freedom and wellbeing at this stage, as she is concerned only with her own needs. The moral reasons for respecting the generic rights of other agents are then established in Stage III.

However, Kramer and Simmonds' argument that Stage II is invalid leads to the conclusion that Stage III is also invalid, as there is no reason to respect the rights of *A* that can be universalised. Kramer and Simmonds thus argue that Gewirth has failed to establish a supreme moral principle, as the PGC requires that:

> 'With regard to any agent, all other agents ought to abstain from interfering with the essential conditions of that agent's purposiveness, solely because such abstention is crucially beneficial to that agent.'[24]

This, however, is a misreading of what the argument requires. The Queen of Hearts is not required to avoid interfering with Alice's generic rights solely because this would be beneficial to Alice. The argument must be followed from the internal viewpoint of each agent, so Stage III requires that the Queen of Hearts avoid interfering with Alice's generic rights in order to avoid self-contradiction. The Queen of Hearts must accept that she has the generic rights because she is an agent, following the ASA, and this universalises to establish that all agents have the generic rights (which includes non-interference and assistance). If the Queen of Hearts were to interfere with Alice's generic rights, she would

[24] Matthew H. Kramer and Nigel E. Simmonds, 'No Better Reasons: A Reply to Alan Gewirth' (1998) 36(1) *South J. Philos.* 131, 135.

be denying an understanding of her own agency. Non-interference is thus not solely about benefitting Alice but is required by all agents following from their understanding of what it means to be an agent. Kramer and Simmonds' objection to the 'ought' statement generated in Stage II thus does not invalidate either Stage II or III.

### *2.3. Objections to Stage III*

The objections to Stage III that I will address here relate to the universalising of the prudential rights establishing in Stage II into moral rights, and how the PGC can compel agents to respect the generic rights of other agents. Ari Kohen objects to the theory in relation to self-contradiction, arguing that the theory assumes that all agents have a 'meta-desire' to avoid self-contradiction and that self-contradiction would be painful enough to prevent agents from violating human rights.[25] He argues that Gewirth fails to establish why self-contradiction would be 'impossibly problematic' for any agent.[26] Concluding that self-contradiction is not necessarily painful for agents, Kohen thus asks what reason an agent would have not to engage in self-contradiction?[27] However, Gewirth's argument does not assume that all agents have a desire to avoid self-contradiction, nor that it is impossible or 'painful' to engage in self-contradiction. The argument establishes that an agent who rejects the PGC contradicts her own claim that she understands that she is an agent. The logical principle of non-contradiction thus provides a categorical reason for agents to accept the PGC, but as Gewirth has highlighted,

[25] Ari Kohen, 'The Possibility of Secular Human Rights: Alan Gewirth and the Principle of Generic Consistency' (2005) 7(1) *Hum. Rights Rev.* 49, 61.
[26] *Ibid*.
[27] *Ibid* 61-62.

an agent's inconsistency 'bears not on the practical efficacy of his action but only on the logical justifiability of his judgments.'[28] Thus, Gewirth's argument does not attempt to establish that agents are prevented from violating the generic rights because self-contradiction is so problematic. Rather, as all agents must logically accept that all agents have the generic rights, the argument establishes an indisputable reason for all agents not to violate them.

Kohen then objects to the universalising of the generic rights, arguing that an agent could accept Stages I and II in relation to her own generic rights, but reject Stage III without contradiction.[29] Kohen argues that an agent could sidestep inconsistency by believing that 'his victim is somehow less of an agent' where other factors, such as gender, race, or sexuality, preclude him from ascribing his victims the same rights as himself.[30] However, this argument misses the ASA, which prevents the introduction of restrictive qualifying characteristics into the justification for the generic rights. The ASA establishes that if Alice were to deny another agent the generic rights based on their other characteristics, she would be denying the understanding that she has the generic rights as a result of her agency. Alice cannot, therefore, justifiably free herself from the requirements of the PGC, as this would undermine her own rights claim.[31] Thus, contrary to Kohen's argument, an agent cannot consistently accept Stages I and II while denying the requirements of Stage III.

Adina Schwartz makes the argument that there is no reason for the prudential rights recognised in Stage II to become moral rights in Stage III, as it is prudent for each

[28] Gewirth (n1) p.194.
[29] Kohen (n25) 61.
[30] *Ibid* 65.
[31] Gewirth (n1) p.204.

agent to claim rights to their own freedom and wellbeing but they need not grant such rights to any other agent.[32] Schwartz misunderstands the claim to the generic rights by viewing it as relating only to self-interest, and she thus misunderstands how the rights-claim universalises. Similar objections have been addressed by Beyleveld and Gewirth, who establish that all agents must claim the generic rights, on the grounds that they categorically need their freedom and wellbeing and that the PHI is dialectically necessary, are logically committed to granting these rights to all other agents.[33] If Alice must accept that her own generic rights ought not to be interfered with by other agents, Alice is committed to accepting that this universalises to establish that the generic rights held by any agent ought not to be interfered with by other agents. Otherwise, she would be inconsistent with the demands she makes in relation to her own generic rights.

## *3. Application of the PGC*

### *3.1. Direct Application*

The direct application of the PGC concerns the interpersonal transactions between individual agents.[34] The PGC requires the equality of the generic rights, as agents must necessarily act in accordance with their own freedom and wellbeing but must also respect the generic rights of their recipients. This requires refraining from interfering with their

[32] Adina Schwartz, 'Reason and Morality' (1979) 88(4) *Philos. Rev.* 654, 656.
[33] Beyleveld (n2) p.286-287; Alan Gewirth, 'From the Prudential to the Moral: Reply to Singer' (1985) 95(2) *Ethics* 302, 303.
[34] Gewirth (n1) p.200.

recipients' freedom and wellbeing and providing assistance where their recipient is unable to protect their own generic rights. Refraining from interference with the generic rights includes refraining from coercing the recipient and from inflicting harms, but the PGC allows for exceptions where self-defence is necessary to prevent the violation of the generic rights.

In addition, an agent is only required to provide assistance where it is possible for her to do so without depriving herself of the same or more important generic needs. Gewirth categorised the generic conditions of agency into a hierarchy of needs: basic goods, as the necessary preconditions for all purposive actions (life, health, physical integrity, mental equilibrium, freedom);[35] nonsubtractive goods, as the conditions required to retain an agent's capabilities for purpose-fulfilment (e.g. not being lied to, stolen from, subject to dangerous or degrading working conditions);[36] and additive goods, as conditions that enable an agent to increase her capabilities for purpose-fulfilment (e.g. education).[37] Where there would be a comparable cost to the agent, there is no duty for her to offer assistance.[38] If Alice is starving and unable to find food for herself while in Wonderland, the Mad Hatter and the March Hare are required to assist her only if providing Alice with food would not lead them to starvation, as this would be a deprivation of their own basic needs. However, if the Mad Hatter and March Hare would not risk depriving themselves of their basic needs by giving Alice food, the failure to assist her would be a violation of the equality of the generic rights that is required by the PGC.

[35] Gewirth (n1) p.212.
[36] *Ibid* p.233.
[37] *Ibid* p.240.
[38] *Ibid* p.218.

### i. Who is an Agent?

The requirement that Alice accepts that all agents have the generic rights requires Alice to treat apparent agents (beings who demonstrate agential characteristics) as agents.[39] Agency involves self-awareness and executive control of one's mind, allowing action based on reasons and values. Gewirth suggests that agency can thus be inferred by the behaviours of other beings; he assumes that most adult humans are agents, while non-human animals and children lack agency.[40] He argues that there are, however, degrees of approaching agency, such as the gradual development of abilities in children and behavioural patterns that suggest self-awareness in some non-human animals which requires the application of the Principle of Proportionality, holding that the possession of the generic rights varies to the degree to which a being approaches agency (to be inferred through the agential characteristics they demonstrate).[41] Gewirth refers to children as potential agents, as they will become agents as adults, and argues that children should therefore be ascribed the generic rights increasingly as they increasingly mature, accepting a diminution of certain generic rights (such as freedom) only insofar as is required to protect their wellbeing.[42] Partial agents, such an non-human animals who demonstrate some – but not all – agential characteristics, would also be granted partial generic rights under the Principle of Proportionality.

However, this approach has been argued against for making unverifiable inferences about the agency of other beings and for deriving *partial* generic rights from

[39] *Ibid* p.120-121.
[40] *Ibid* p.120.
[41] *Ibid* p.120-121.
[42] *Ibid* p.141.

the PGC which does not require agents to respect the generic rights of non-agents.[43] An alternative approach, precautionary reasoning, was developed by Deryck Beyleveld and Shaun Pattinson. Precaution requires agents to treat other beings as agents but only if and to the extent that it is possible and meaningful to do so.[44] Alice can only know of her own agency; she cannot know whether another being is an agent.[45] Alice might infer agency from the presence or lack of agential characteristics displayed by a being, so she might conclude that the Cheshire Cat, with whom she can communicate with, who appears to have self-awareness, and has reasons for acting, is an agent. She might then conclude that her pet cat, Dinah, is not an agent because, while she is sentient, lacks other agential characteristics. However, Alice cannot verify that the Cheshire Cat is an agent, and nor can she know for certain that Dinah is not an agent.[46]

While Alice cannot verify that the Cheshire Cat is an agent, he behaves like an agent meaning that it is possible and meaningful to treat him as an agent. Alice cannot treat Dinah in the same way, as Dinah does not display the same agential characteristics and appears unable to exercise the generic rights. However, moral precaution requires Alice to act towards Dinah in a way which would respect her generic rights if she were an agent, to avoid violating the PGC.[47] Whereas the Cheshire Cat should be treated as having rights in line with the will theory of rights, Dinah should be treated as having rights in line with the interest theory, in that Alice owes duties of protection to her. Alice must not harm

[43] Pattinson (2002, n3) Ch. 2.
[44] Deryck Beyleveld and Shaun D. Pattinson, 'Defending Moral Precaution as a Solution to the Problem of Other Minds: A Reply to Holm and Coggon' (2010) 23(2) *Ratio Juris* 258, 262.
[45] Pattinson (n7) p.19; Pattinson (2002, n3) p.22.
[46] Pattinson (2002, n3) p.23.
[47] Pattinson (n7) p.20.

Dinah (and other similar beings) and must provide assistance to prevent harm being done to her where this is possible.[48]

As a precaution, Alice should respect the rights of both the Cheshire Cat and Dinah as far as possible. However, in the event of a conflict between the rights of the Cheshire Cat and Dinah, Alice must give effect to the PGC by applying the 'criterion of avoidance of more probable harm'.[49] In simple conflicts between two agents, the hierarchy of the goods necessary for action (as explained above) requires that a duty relating to basic goods takes precedence over a duty relating to nonsubtractive goods and so forth. In relation to a conflict between the same right of the Cheshire Cat, an (apparent) agent, and Dinah, a being who does not behave like an agent, Alice's duties to the former must take precedence.[50] Thus, if the Cheshire Cat and Dinah were in Wonderland with Alice, who only had enough food for one of the cats, both of which would starve without it, she would be required to prioritise the basic needs of the Cheshire Cat, as an apparent agent. More harm would be caused to the Cheshire Cat, who demonstrates agential characteristics and can be treated as an agent, if he was deprived of his basic needs, than if Dinah, who does not behave as an agent, was deprived of hers.

### *3.2. Indirect Application*

The indirect application of the PGC relates to its application to individual agents through social rules and institutions, which are necessary where conflicts are multilateral or more

[48] Pattinson (n7) p.20; Pattinson (2002, n3) p.25.
[49] Pattinson (n7) p.21; Pattinson (2002, n3) p.25.
[50] Pattinson (n7) p.21.

complex and cannot be dealt with through a direct application of the PGC.[51] These rules and institutions must be in conformity with the PGC in order to be morally (and instrumentally) justified, by supporting the equality of the generic rights.[52] Ensuring the protection of the generic rights may involve coercion and encroachment on the freedom of individual agents, such as through prohibitions on harms such as murder.[53] For more complex issues, such as lying, the regulatory response must strike a careful balance between the potential harms caused by that response and the harms alleviated by it.[54] The indirect application of the PGC also supports social rules that may not directly relate to the prevention of harms but are in the common good or seek to prevent the disorder or subsequent harm that might arise from a lack of uniform rules.[55] In addition to prevention of violation of the PGC through these rules, the state and its institutions must also support the redistribution of resources to assist individual agents who are unable to protect their own freedom and wellbeing.[56] For example, in cases of economic deprivation, the state is required to remove or at least reduce this inequality.[57] Through the indirect application of the PGC, state institutions and rules are intended to ensure that all agents can attain conditions where they are able to pursue their purposes free from interference with their generic rights.[58] The PGC can thus support the indirect application of rights through the international human rights framework, as will be explored in the following section.

[51] Gewirth (n1) p.272-273; Alan Gewirth, *Human Rights: Essays on Justification and Applications* (University of Chicago Press, 1982) p.5.
[52] Gewirth (n1) p.276, 292.
[53] *Ibid* p.294-295.
[54] *Ibid* p.344.
[55] *Ibid* p.318, 344.
[56] *Ibid* p.312-313.
[57] *Ibid*.
[58] *Ibid* p.313.

## *4. The PGC as the Foundation of Human Rights*

The moral rights justified by the PGC can be recognised as human rights. As Gewirth argues, the PGC provides 'the elemental basis of human rights' as the generic rights have the universality required to be human rights.[59] The generic rights can be understood to be the rights of every human to the necessary conditions of human action, which governments must secure.[60] Gewirth argues that grounding human rights in the necessary conditions of action provides a rigorous justification for human rights, more so than relying on concepts such as human dignity, and clearly ties rights to morality in order to secure for all humans a fundamental moral status.[61] The PGC conclusively supports universal human rights, relying not on a commonality of values and interests between all people, but rather the common needs of all humans in order to act.[62] The indirect application of the PGC thus supports the recognition of human rights within an international framework, by translating the generic rights into claims that can be made against the state.

In Chapter 1, I identified three key conceptual problems with the current international human rights framework; its inadequate approach towards gender-based human rights issues, issues with the cross-cultural traction of human rights norms, and the relatively weaker protection afforded to ESC rights. I concluded that a feminist transformation of human rights is necessary in order to reform the current framework, resolve these issues, and ensure that the human rights framework is genuinely universal.

[59] Gewirth (n1) p.102-103, 316.
[60] Gewirth (n51) p.3.
[61] *Ibid* p.5.
[62] Alan Gewirth, 'Common Morality and the Community of Rights' in Gene Outka and John P. Reeder (Eds), *Prospects for a Common Morality* (Princeton University Press, 1993) p.37.

As the PGC is the supreme principle of morality and provides the philosophical foundation for human rights, any revision of the human rights framework must proceed in line with the PGC. A feminist transformation premised on the PGC will resolve the three conceptual issues with the current framework, to be explored below, and the specific issues around abortion which will be addressed in the following chapters.

### *4.1. Cross-Cultural Norms*

The transformation of the international human rights framework must ensure the cross-cultural traction of human rights, while retaining a commitment to universalism. In Chapter 1, I considered the distinction between two broad arguments relating to the cultural relativism debate identified by Oloka-Onyango and Tamale.[63] The first argument views human rights as Western constructs imposed on other cultures without regard for differences in experiences and values. This argument supports moral relativism and rejects the idea that there are right or wrong cultural norms, so there can be no universal morality that can be imposed through a universal human rights framework. The second argument does not reject universality in this way but argues: a) that the current human rights framework is rooted in a Western ethical bias; and b) that it, in failing to accommodate cultural difference, represents an imperialist interference on non-Western cultures. The first argument I will refer to as cultural relativism, which cannot be justified by the PGC, and the second as an issue of cross-cultural traction, rather than moral

[63] J. Oloka-Onyango and Sylvia Tamale, '"The Personal is Political," or Why Women's Rights Are Indeed Human Rights: An African Perspective on International Feminism' (1995) 17(4) *Hum. Rts. Q.* 691, 706.

relativism, which can be achieved through accommodations for cultural pluralism within a transformed human rights framework.

### i. Cultural Relativism

Cultural relativism must be rejected, as a human rights framework premised on the PGC requires the recognition of universal rights. Beyleveld has argued that no agent may accept moral relativism, as accepting the PGC (and therefore accepting universal generic rights) is dialectically necessary, meaning that moral relativism is unjustified.[64] As all agents must accept the PGC, cultural traditions or values 'that discriminate against some humans on grounds of race, gender, religion, or other partly interpenetrating variables cannot be permitted'.[65] It is important to reaffirm here that an international human rights framework based on the PGC would not be premised upon specific (Western) cultural values or interests, but in the universally necessary conditions for action. Any cultural values or practices that violate the PGC are thus impermissible.

### ii. Cross-Cultural Traction

The rejection of cultural relativism does not give rise to a dismissal of the concerns raised around cross-cultural traction. As set out above, the first aspect of this issue is the Western ideological underpinnings of the current human rights framework. In Chapter 1,

[64] Beyleveld (n2) p.114.
[65] Alan Gewirth, *The Community of Rights* (The University of Chicago Press. 1996) p.68.

I addressed the argument that rights are an inherently Western concept versus the argument that the ethical basis for rights has existed across different cultures. Gewirth has similarly made the argument that rights-concepts are not unique to the West.[66] However, this is not enough to require all people to accept human rights. Gewirth makes the related point that the fact that human rights have not been accepted in certain periods of history, by some cultures, and for different groups of people within a culture, does not mean that the concept should be abandoned.[67] The concept of human rights is normative; as Beyleveld has noted, Gewirth does not argue that every agent must have the concept of rights, but that every agent ought to have the concept of rights, and so accepting universal human rights does not require the pre-existing universal recognition of human rights.[68] It is not the case that the concept of human rights is inherently ideologically Western; the issue is with the legal recognition of those rights within the current international system. Transforming this system into a human rights framework based upon the PGC would address this, by framing rights in terms of what is required for action by all agents, rather than in terms of culturally specific values.

In order to achieve the cross-cultural traction of human rights, this universal framework must also be capable of encompassing cultural difference and diversity. This requires addressing communitarian conceptions of rights, which view rights as belonging to groups rather than individuals, and the potential for allowing cultural pluralism. Gewirth has argued that communitarian contentions, which view rights as belonging to communities or groups rather than individuals, can be accommodated with the

[66] Gewirth (n1) p.101; Gewirth (n65) p.68.
[67] Alan Gewirth, 'Is Cultural Pluralism Relevant to Moral Knowledge?' (1994) 11(1) *Soc. Philos. Policy* 22, 33.
[68] Beyleveld (n2) p.156-157.

understanding that the PGC requires positive rights.[69] The individualistic element of rights remains important, however, as human rights are intended to protect people from harms caused to them by the cultures or communities to which they belong.[70] Gewirth refers to the mutual and reciprocal rights justified by the PGC as a community of rights.[71] This idea of a community of rights encompasses a communitarian understanding of rights through the positive duties of assistance and the recognition of the equality of rights, while retaining the prioritisation of individualism in the event of a conflict. In addition, the moral universalism of the PGC can accommodate certain aspects of communitarianism or particularism, such as preferential concern for one's family or community. Gewirth has established that the right to freedom justifies the formation of voluntary associations or communities, including the formation of families and friendships, and in turn justifies the preferential concern for members of these groups.[72] This can also support protections for religious groups. This particularism is only justified, however, insofar as it does not violate the rights of other agents.[73] Communitarian priorities which violate the rights to freedom and wellbeing of excluded persons, such as through racism, sexism, and homophobia, for example, can never be justified.[74] Individuals must also be able to opt-out of associations, and their rights prioritised in the event of a conflict in order to ensure protection for their freedom and wellbeing.

[69] Gewirth (n65) p.33.
[70] Gewirth (n67) 35.
[71] Gewirth (n65) p.75.
[72] Alan Gewirth, 'Ethical Universalism and Particularism' (1988) 85(6) *J. Philos.* 283, 294.
[73] *Ibid* 295.
[74] *Ibid* 298.

### iii. Cultural Pluralism

While moral relativism cannot be justified by the PGC, the universal human rights required by the PGC do not operate to reject or suppress cultural diversity insofar as it does not violate those rights. The PGC does not prescribe an absolute universalism which ignores cultural diversity but requires the recognition of universal norms which can then be applied contextually to accommodate pluralism within boundaries set by those norms. Gewirth argues that cultural practices that do not violate the PGC are not only permitted but are encouraged, as cultural diversity must be respected as to do otherwise would violate the rights of members of subcultural groups.[75] Gewirth also refers to the right to cultural pluralism as an affirmative right as well as a negative one, requiring specific protections for diverse cultural groups who are discriminated against by the state and its institutions. [76] Respecting cultural pluralism, in line with the PGC, requires accommodations to be made for the needs of diverse groups, such as recognising the specific issues faced on the basis of race, disability, and gender and the rights protections required by Indigenous Peoples, for example. The recognition of minority rights such as those contained in the UN Declaration on the Rights of Indigenous Peoples can thus be supported by the PGC.

In Chapter 1, I outlined the argument made by Michel Rosenfeld in favour of a comprehensive pluralism. Rosenfeld ranks different norms and argues that accommodations for minority rights and cultural diversity can be made, provided that they do not conflict with fundamental norms.[77] Under the PGC, cultural pluralism can be

[75] Gewirth (n67) 39.
[76] *Ibid* 40.
[77] Michel Rosenfeld, 'Can Human Rights Bridge the Gap between Universalism and Cultural Relativism – A Pluralist Assessment Based on the Rights of Minorities' (1999) 30(2) *Colum. Hum. Rts .L. Rev.* 249.

accommodated for, provided that cultural practices, traditions, and minority rights do not come into conflict with the generic rights. As the generic rights align with the will theory of rights, their benefits can be waived by the rights-holder, so agents could potentially consent to harmful cultural practices or, for example, religious laws. The issue, however, is whether the option for individuals to resist the application of those practices or laws is open to them. Gewirth has argued that even where an individual appears willing to engage in a harmful tradition, there remains the question of whether this conduct is voluntary, not only in the sense of being unforced but also in their being informed of the relevant circumstances.[78] Individuals must also be free to resist such a practice or tradition. In the event of a conflict, however, the PGC and the fundamental universal norms it entails, must not be violated, to ensure that individuals are not harmed by group rights. Returning to the example of FGM highlighted in Chapter 1, then, it would be possible for people to consent to this practice, but there must also be protections in place for individuals who would not.

Accommodating cultural pluralism would also enable universal rights to be applied in culturally appropriate ways, as long as they are PGC-compliant. The indirect application of the PGC requires a careful balance between protecting the generic rights and seeking the most appropriate regulatory response in order to address complex conflicts. Human rights norms, as conceptually universal standards, may be applied contextually in order to respect cultural differences; however, human rights norms must not be diluted to the extent that their application is no longer compliant with the PGC. Compliance may therefore require progressive steps towards addressing cultural norms or values which violate the PGC.

[78] Gewirth (n67) 39.

Thus, the transformation of the human rights framework in line with the PGC would reject cultural relativism but, by supporting a genuinely universal system of rights, would better support cross-cultural traction. This universal human rights framework would be based on common needs rather than culturally specific values. This transformed framework would also accommodate communitarian conceptions of rights to some degree and support cultural pluralism within the boundaries set by the PGC, by allowing the contextual application of human rights to address complex cultural issues while retaining a commitment to universal norms. Through these accommodations, the framework would respect cultural diversity and allow specific issues faced by certain groups (for example, on the basis of race, class, gender and gender identity, or sexuality) to be addressed, while retaining the priority of protecting individuals from harm caused to them by their cultural, community, or other social groups.

### *4.2. Economic, Social, and Cultural Rights*

The transformation of the international human rights framework in line with the PGC would also strengthen the protection afforded to ESC rights. In Chapter 1, I addressed the prioritisation of civil and political (CP) rights over ESC rights stemming from Western liberal conceptions of human rights, which undermines the claimed universality of the current framework. The recognition of ESC rights is supported by the indirect application of the PGC, in a way which would guarantee stronger obligations for their fulfilment.

### i. Positive Rights

As highlighted above, the generic rights consist of both negative and positive rights. Positive rights entail mutual obligations to help others fulfil their needs (where they are unable to do so unaided) and move towards a position of equality, where they can eventually fulfil their own needs and assist others.[79] Gewirth reiterates that such obligations are not merely duties of charity, but are 'perfect, stringent, and in principle enforceable duties of justice'.[80] He uses the example of poverty, arguing that 'assistance must be given to the poor by those who are able to afford it.'[81] This obligation to assist is not merely about alleviating the short-term hardships of poverty, but must also ensure that people are lifted out of poverty to be able to protect their own rights to freedom and wellbeing.[82] People living in poverty therefore have a right to be assisted in terms of access to food, water, and shelter in the short term, and, for example, access to education, safe working conditions, long-term housing, and medical care to enable the person to meet their own needs. Gewirth also addresses the argument that this cannot be a universal right because only some individuals have the right, and only some individuals have the duty. However, the universality of positive rights is not an issue of everyone fulfilling the duty, or being able to fulfil the duty, but is a matter of everyone having, on principle, the right to be assisted when they have the need and the duty to assist where required and where able to do so.[83] Positive duties must accompany rights to ensure the fulfilment of those rights, as fundamentally important for all agents.

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[79] Gewirth (n67) p.32.
[80] Alan Gewirth, 'Duties to Fulfill the Human Rights of the Poor' in Thomas Pogge (Ed), *Freedom from Poverty as a Human Right* (Oxford University Press, 2007) p.219.
[81] Gewirth (n1) p.209.
[82] *Ibid.*
[83] Gewirth (n65) p.63.

In translating this to the human rights framework, Gewirth recognises that the main respondents of rights in relation to assistance are governments. The state is instrumental for the protection of positive rights, as governments will generally have the institutional capacity to redistribute resources in order to assist those in need. Furthermore, effective rights protection requires addressing widespread structural issues. Gewirth argues that the duties arising in relation to positive rights also apply 'to situations where threats to freedom and well-being arise from social or institutional contexts, such as where economic or political conditions make for unemployment, homelessness, or persecution.'[84] The aim of human rights is thus to equip human beings with the ability to protect their generic rights from 'the hardships of political oppression and severe economic deprivation and to attain their opposites.'[85] The positive rights grounded by the PGC generate duties to ensure that all people have equality in rights protection, which requires that people are able to make demands that the state support rights fulfilment through the redistribution of resources.

### ii. State Obligations

The obligations on states to assist those in need must therefore be recognised by the international human rights framework. Gewirth has noted that the generic rights coincide with much of the content of the Universal Declaration of Human Rights (UDHR) – including the socio-economic rights it contains.[86] However, the PGC requires greater protection for ESC rights than is currently granted under the international human rights

[84] *Ibid* p.41.
[85] Gewirth (n80) p.228.
[86] Gewirth (n65) p.29.

framework, as ESC rights are essential for ensuring that the basic needs of agents are met. There remains, however, the issue with holding low- and middle-income states to the same standards as high-income states in relation to protecting ESC rights. As explored in Chapter 1, many countries do not have the resources to fully protect these rights, but the progressive realisation clause in the ICESCR enables high-income states to escape their obligations to, for example, provide comprehensive healthcare and tackle poverty. A PGC-compliant human rights framework must continue to allow for progressive realisation, as low- and middle-income states may be unable to completely satisfy the requirements of all ESC rights. However, it would also require the imposition of stronger obligations on high-income countries which do have the resources to effectively protect these rights. Gewirth argues that resource concerns should not be used to exempt governments from compliance with the requirements of either negative or positive rights, as where complete fulfilment is not possible, progressive steps towards compliance must be taken.[87] States who are unable to fully protect ESC rights are thus still recognised as having duties to protect rights.

Progressive realisation, however, still leaves the issue of lower-income states being unable to ever achieve full compliance. In such circumstances, Gewirth argues that the universality of human rights requires that states unable to fulfil rights are to be assisted by other states. The issue of assistance for states in need in the current human rights framework has been addressed by Lawrence Gostin and Robert Archer, who consider to what extent governments (where they have the capacity to do so, in addition to fulfilling their obligations to their own citizens) have a responsibility to assist

[87] Gewirth (n65) p.67.

underdeveloped states.[88] They consider the requirement of 'international cooperation' under the UDHR, arguing that the states' commitments to cooperate generate obligations to assist states in need where they can intervene effectively.[89] However, in acknowledging that states must prioritise the needs of their own citizens and are thus more likely to assist where it is in their own interest, Gostin and Archer argue that international assistance is uneven and inadequate.[90] They consider that governments are likely to cooperate in relation to global pandemic responses which may require coordinated vaccination programmes.[91] In contrast, states are less likely to offer assistance in tackling issues such as high maternal mortality rates as it is not in their self-interest to do so.[92] The requirement of 'international cooperation' thus currently imposes no clear obligations on states to offer consistent assistance. However, a human rights framework based on the PGC would explicitly require states to assist other states in need where they have the capacity to do so in order to ensure the universal fulfilment of ESC rights. States would have concretised duties in relation to underdeveloped nations; the Declaration on the Right to Development, as just one example, would have greater force under this approach. ESC rights would thus have more weight under this approach, with stronger obligations to fulfil these rights and assist other states in fulfilling them.

Strengthening protection for ESC rights within the international framework also requires addressing that some politico-economic systems do not support the obligations imposed by positive rights. Neoliberal politico-economic systems undermine ESC rights protection, which can be seen in the reports of the Special Rapporteur on extreme poverty

[88] Lawrence O. Gostin and Robert Archer, 'The Duty of States to Assist Other States in Need: Ethics, Human Rights, and International Law' (2007) 35(4) *J. Law. Med. Ethics* 526, 527.
[89] *Ibid* 527.
[90] *Ibid* 531.
[91] *Ibid* 530.
[92] *Ibid* 531.

and human rights on the UK and the US. While the Committee on Economic, Social, and Cultural Rights claims neutrality in relation to the politico-economic systems adopted by member states, this is an issue where neoliberal systems prevent the realisation of the principles contained in the ICESCR.[93] ESC rights violations cannot be seen as unconnected to politico-economic systems and the deliberate distributions of power and resources within those systems. Importantly, Gewirth links economic rights to political rights and institutions, arguing that 'the hunger, malnutrition, disease, poverty, and illiteracy that plague millions of human beings throughout the world reflect distributions of power that are unjust' and that these injustices are generated and solidified by the power of the dominant group.[94] The protection for ESC rights within the human rights framework required by the PGC and the obligations on states to fulfil them would require, at least progressively, states to take steps towards realising politico-economic conditions that support fulfilment. It is generally accepted that certain CP rights, such as the right to vote or the right to own property, require the political background or economic conditions to fulfil those rights.[95] Where certain political and economic circumstances are required to fulfil ESC rights, this must also be acknowledged by the human rights framework.

A human rights framework grounded by the PGC would require the revision of the current progressive realisation clause to strengthen state obligations to comply with ESC rights protection where they have the resources to do so. This must include obligations to take steps towards fulfilment where full compliance is not possible, including moving towards politico-economic systems that can support fulfilment, and a clear duty on states to assist states in need where possible. The transformation of the human rights

[93] CESCR, 'General Comment No.3: The Nature of States Parties' Obligations (Art. 2, Para. 1 of the Covenant)' (14 December 1990) UN Doc. E/1991/23, para. 8.
[94] Gewirth (n80) p.227.
[95] Gewirth (n65) p.68.

framework in line with the PGC, by recognising universal norms that can accommodate cultural pluralism and affirming the importance of ESC rights, would thus address the key issues identified in Chapter 1 around the conceptual biases in the current framework. The final key issue identified in Chapter 1, in relation to gender-based rights, will be considered in the following section after I address feminist objections to the PGC.

# *5. Addressing Feminist Issues with Human Rights*

## *5.1. Feminist Objections to the PGC*

Across the many branches of feminism, feminist approaches to morality and moral theories vary significantly. Different branches of feminism have shared in their critique of Enlightenment philosophy which recognised the possession of rights by rational and autonomous individuals, a category that was not extended to women, people of colour, and other marginalised groups. This critique ranges from the view that rationalist moral theories merely side-lined women, to the view that they 'created woman as the irrational and emotional counterpart to the rational man' which gave women the irreparable status as subordinate.[96] The feminist responses to this exclusion of women from rationalist moral theories then differ, and can be loosely categorised two-fold: a) the inclusion of women in morality, seeking to establish women as rational autonomous beings alongside

[96] Eileen Hunt Botting, *Wollstonecraft, Mill, and Women's Human Rights* (Yale University Press, 2016) p.70; Susan J. Hekman, *Gender and Knowledge* (Polity Press, 1990) p.21, 59.

men; or b) the feminist rejection of rationalist moral theories, viewing such theories as entirely inadequate to respond to feminist values and concerns.

The first response, the inclusion of women, aligns with liberal feminist ideas and the work of early feminist philosophers such as Mary Wollstonecraft. There is variation within the second response, so the approach I will address comes from ethics of care feminists. This section will explore and critique these two approaches. The inclusion of women in rationalist moral theories without the inclusion of feminist values of care and relationality is limited, but the ethics of care approach rejects, wholesale, a universal foundation for morality (which would include a rejection of Gewirth's argument). I will establish a middle ground, requiring a universal foundation for moral rights that is responsive to difference and the values of care and relationality in its application. This is not to suggest that the two strands represent a binary; not all moral theories axiomatically exclude feminist values, but these values have been underacknowledged and require explicit recognition. This is an issue of application, rather than a shortfall of the theory *per se*. The argument to the PGC and its application can therefore accommodate feminist values, addressing the concerns that some feminists have with rationalist moral theories, while retaining a justification for universal norms.

### i. Including Women in Rationalist Moral Theories

In response to the exclusion of women from Enlightenment morality, feminist philosophers such as Mary Wollstonecraft sought to establish that women were rational

and autonomous beings and should have the same rights and duties as men.[97] For Wollstonecraft, the differences between men and women that had marked women as irrational were largely due to the lack of education for girls, as opposed to claimed biological differences.[98] The inclusion of women in rationalist moral theories was politically necessary for early feminists, who could appeal to a position of common humanity that had already been accepted.[99] Receptiveness to the idea of women's rights required a foundation capable of defending universal rights; through a natural law foundation, though this was a religious one, Wollstonecraft was able to argue that the moral rights held by men were also held by women, regardless of the conditions of the positive law.[100] The inclusion of women within existing moral theories thus supported the extension of the rights already recognised.

However, some feminists have remained sceptical of rationalist moral theories on the grounds that they, even where women are included, remain sexist and male-oriented. Deborah K. Heikes has identified the tendency to portray reason or rationality as 'both the source and the result of a thoroughgoing philosophical androcentrism.'[101] For example, Susan Hekman, a postmodern feminist, criticises the 'inherent sexism of Enlightenment epistemology' which relies on the concepts of rationality and autonomy as defined in exclusively male terms.[102] She argues that the male subject of moral theories is 'a separate, autonomous being who is able rationally to abstract from a situation and render a moral judgment according to universal principles.'[103] While Enlightenment philosophers did exclude women from these concepts, this is not inherent in all

[97] Mary Wollstonecraft, *Vindication of the Rights of Woman* (first published 1792).
[98] *Ibid* Ch. 6.
[99] Botting (n96) p.70.
[100] *Ibid* p.87-88.
[101] Deborah K. Heikes, *Rationality and Feminist Philosophy* (Continuum, 2010) p.1.
[102] Hekman (n96) p.8, 33.
[103] *Ibid* p.55.

rationalist moral theories; the PGC ascribes the generic rights to all agents, and agency is not defined in reference to certain qualities or characteristics such as gender, race, or even being human. The issue with moral theories, then, was not the theory itself but how those theories have been applied. Returning to Wollstonecraft's argument that women had moral rights regardless of their lack of recognition in positive law, the exclusion of people from moral theories on the basis of race, gender, disability, sexuality was not because those groups were not rational, autonomous beings but because, in applying the theory, they were not *recognised as* rational, autonomous beings. Rationalist moral theories are not inherently sexist; this is an issue of how they have been applied.

The second issue raised by Hekman is of abstraction, that the subject of moral theories is an atomised, disembodied individual for whom relationships, experiences, and characteristics such as gender are not relevant to moral reasoning. Martha Minow similarly argues that rights theories suggest that individuals 'have wants, desires, and needs independent of social context, relationships with others, or historical setting' and must therefore be distinguished from their socio-political situations and religious identities.[104] For Selma Sevenhuijsen, abstract universal reason requires 'a strict division between body and mind' which requires women to 'abandon their embodiment and conceive of themselves as purely rational beings' if they are to be thought of as moral agents.[105] As explained above, the ASA does not permit the introduction of characteristics beyond agency to provide a justificatory basis for the generic rights. This, however, does not require agents to be conceived of as having no discerning personal qualities.

[104] Martha Minow, *Making All The Difference* (Cornell University Press, 1991) p.151-152.
[105] Selma L. Sevenhuijsen, 'The Morality of Feminism' (1991) 6(2) *Hypatia* 173, 177-178.

Considering the issues with Rawls' 'veil of ignorance' which requires people to disregard their dissimilarities, Gewirth states that 'persons are not in fact equal in power and ability, nor are they so lacking in empirical reason as to be ignorant of all their particular qualities.'[106] As agency is enough to ground moral rights, the argument to the PGC does not require agents to be removed from their personal characteristics and contexts. In addition, the characteristics, socio-political, cultural, or religious contexts, and personal relationships of agents are important in the application of the PGC. As highlighted above, particularism towards one's family, friends, and wider community and cultural differences are supported by the PGC insofar as there is no violation of the generic rights of individual agents. In addition, the application of the PGC requires responsiveness to the specific needs of different groups, thus accounting for gender-based experiences, for example, and disadvantage among agents. Accounting for differences in context and intersectional disadvantage is important for a feminist approach to morality. However, the perceived abstraction of individuals raised by feminists as an issue with moral theories generally is thus not an issue with the argument to the PGC, which does not require agents to be stripped of their personal qualities and contexts, and these characteristics can be accounted for in its application.

### ii. Feminist Rejection of Rationalist Moral Theories

The starting point for ethics of care feminists is this perception that the subject of moral theories is a rational, autonomous, abstract agent, separated from their social group and

[106] Gewirth (n1) p.20.

emotions.[107] This strand of feminism additionally raised issues with the idea that any differences between men and women could be ignored for the purposes of moral reasoning, which in turn ignored the supposedly feminine values of care and sentiment. This idea branched from Carol Gilligan's *In a Different Voice,* which sought to challenge data that suggested that girls reached a lower level of moral development than boys.[108] Gilligan sought to show that studies on women's moral development did not account for different (gendered) ways of reasoning. In her study, a problem was posed to a boy, Jake, and a girl, Amy: should a man steal a drug he cannot afford to buy, in order to save his wife's life?[109] The problem highlighted differing approaches: Jake said that he should steal the drug, suggesting that the law sometimes makes mistakes and that most people would likely agree that he should prioritise his wife's life.[110] Amy, however, did not want the wife to die but also did not think that he should steal the drug. She focused on how the relationship between the man and wife would be affected if he were to go to jail and felt that he could come to an arrangement with the drug provider instead of stealing.[111] Jake's reasoning focused on logic and the law, which Gilligan referred to as an ethic of justice, mapping onto previous understandings of moral maturity. Gilligan referred to Amy's focus on communication and relationships as an ethic of care; while this would have suggested a lack of moral maturity, Gilligan argued that this is simply a different, but not inferior, method of reasoning.

Ethics of care feminists took from this the idea that women reason differently to men; men are more likely to think impartially and abstractly, while women consider the

[107] Virginia Held, *The Ethics of Care* (Oxford University Press, 2005) p.13.
[108] Carol Gilligan, *In a Different Voice* (first published 1982, Harvard University Press, 1993).
[109] *Ibid* p.24-25.
[110] *Ibid* p.26-27.
[111] *Ibid* p.28-29.

needs of particular persons in situational contexts.[112] Applying this to traditional moral theories, ethics of care feminists have argued that concepts of rationality and autonomy are based on the masculine ethic of justice, and so the reasoning of women, along the feminine ethic of care, has been excluded and devalued. The notion of women as irrational and emotional has been taken as an example of how such reasoning has been dismissed as irrelevant to moral theories.[113] From this perspective, traditional moral theories are criticised for gender-bias not only in their exclusion of women and their specific contexts, but also for ignoring the ways in which women think. Ethics of care feminists have therefore argued for an alternative approach to morality based upon care and relationships, rather than universal norms which they see as 'dubious' for excluding the perspectives of women.[114]

Virginia Held argues that a focus on care in moral reasoning would ensure that women's experiences are deemed relevant to morality. In making this argument, she makes repeated references to the experiences of women within the household and as mothers, domestic roles in which caring is central.[115] Her arguments reinforce the idea of a public/private divide; she states that 'moral theories can be seen to be modelled on the experience of men in public life' and not on the experiences of women in the domestic sphere.[116] However, the suggestion that men and women think differently and have different moral concerns reinforces gender stereotypes and fails to afford adequate attention to the fact that these differences are the result of gendered socialisation. Robin West has acknowledged this point, accepting that there is no ironclad correspondence

[112] Marilyn Friedman and Angela Bolte, 'Ethics and Feminism' in Linda M. Alcoff and Eva F. Kittay (Eds), *The Blackwell Guide to Feminist Philosophy* (Blackwells, 2007) p.81-82.
[113] Virginia Held, *Feminist Morality* (University of Chicago Press, 1993) p.46.
[114] Held (n107) p.3.
[115] *Ibid* p.10, 132; Held (n113) Ch.4.
[116] Held (n113) p.132.

between women and care as there are caring men and uncaring women.[117] West then argues, however, that:

> 'It truly would be extremely odd, as [Gilligan] argued, if it turned out that the vastly greater amount of child raising and homekeeping, the world over and throughout history, in which women engage – a fact apparently conceded by all – has *no impact whatsoever* on the moral orientations of the two sexes.'[118]

While accepting that these apparent differences in moral reasoning are a product of socialisation, the approaches of West and Held nevertheless cling to the idea of women as caregivers within the domestic sphere. This is presented as a unifying experience for all women, which then assumes that most women will align with the ethic of care. The limitations of presenting a shared universal experience among all women were raised in Chapter 1; such an approach excludes the intersectional experiences of women in relation to race, class, disability, sexuality, and other co-constructing characteristics, whose fundamental concerns may not lie solely within the domestic sphere. As Paravati Raghuram has argued, the focus on mothering and maternal affection central to care ethics is often based on the experiences of a particular group of white women, ignoring how care and parenting is not a certainty for other groups.[119] In addition, as Eileen Hunt Botting has argued, to dismiss rational approaches of justifying gender-based rights in favour of this kind of approach 'may perniciously reinforce the gender prejudices that feminist philosophy seeks to undercut in the first place.' [120] Sentimentality was considered a feminine weakness of character, so to suggest that concepts of rationality

[117] Robin West, *Caring for Justice* (New York University Press, 1997) p.18.
[118] *Ibid*.
[119] Parvati Raghuram, 'Race and feminist care ethics: intersectionality as method' (2019) 26(5) *Gend. Place Cult.* 613, 624.
[120] *Ibid.*

and autonomy are not relevant to women's experiences because women think in sentimental terms risks reinforcing the very basis for the exclusion of women from rationalist moral theories.

Connected to this focus on care is the importance of emotions as a fundamental aspect of how people relate to one another. Held argues that, because of this exclusion of the relevance of emotions, rationalist moral theories are suited for merely hypothetical agents rather than those of us actually existing.[121] Held thus rejects the need for a supreme moral principle, arguing instead for a relational care-based approach which would recognise emotions as important in shaping moral norms.[122] She argues that emotions are framed as undesirable in order to be rejected as relevant to morality: 'the egoistic feelings that undermine universal moral norms, the favouritism that interferes with impartiality, and the aggressive and vengeful impulses for which morality is to provide restraints.'[123] This objection has been specifically raised in relation to the PGC by Thom Brooks and Diana Sankey, who argue that there is a problem with the exclusion of all emotions which are not 'consistent with rationality' as this ignores an important feature of the human condition.[124] By contrast, Held sees the ethics of care approach as appreciating the 'emotions and relational capabilities that enable morally concerned persons in actual interpersonal contexts' and recognising the need to cultivate emotions such as sympathy, empathy, and sensitivity.[125]

Emotions, under the ethics of care approach, are viewed as central to moral reasoning. In his Oxford Amnesty Lecture in 1993, Richard Rorty made this same

[121] Held (n113) p.42.
[122] *Ibid* p.41.
[123] Held (n107) p.11.
[124] Thom Brooks and Diana Sankey, 'Beyond Reason: The Legal Importance of Emotions' in Patrick Capps and Shaun D. Pattinson (Eds), *Ethical Rationalism and the Law* (Hart, 2017) p.134-135.
[125] Held (n107) p.11.

argument, that appealing to sentiment would be more effective than rationalist approaches.[126] Held supports this approach with the argument that people do not act for individual interests, as their interests are inextricably linked to the interests of the people they care for.[127] She argues that rationalist moral theories would suggest that a parent provides food and shelter for their child because that is what is morally required of them, not because of the feelings of parental affection that leads parents to care for their children. [128] Held contends that the failure of rationalist theories to recognise the importance of emotions thus requires people to be impartial, even in relation to one's own families, friends, and community.[129] Ethics of care feminists thus view rationalist theories as expecting people to act without regard for their emotions or person relationships, and propose an approach to morality which centres these qualities, which are deemed feminine and therefore key to feminism.

The inclusion of care and emotions and relational aspects of morality is important in order to capture different experiences and feminist values, but this need not lead to a rejection of the PGC. As already addressed above, the argument to the PGC does not exclude personal characteristics and contexts (including emotions and relationships) but the ASA does not permit these qualities to be incorporated into the justification of the generic rights. It is not the case, as is suggested by some ethics of care feminists, that the subject of rationalist moral theorists is something closer to the Vulcan species in *Star Trek* than human, who must follow logic alone with no interference from their emotions. Emotions and care can be accounted for in the application of the PGC; it can be recognised

[126] Richard Rorty, 'Human Rights, Rationality, and Sentimentality' in Stephen Shute and Susan Hurley (Eds), *On Human Rights: The Oxford Amnesty Lectures 1993* (Basic Books, 1993).
[127] Held (n107) p.13.
[128] Held (n113) p.31.
[129] *Ibid* p.32.

in this application that the contexts in which people live, including their relationships, are important. Therefore, going back to Gilligan's study of Jake and Amy, it is Amy's reasoning that would align more closely with what is required by the PGC, by taking account of the broader moral context and all parties involved. Further, contrary to Held's belief that rationalist theories require impartiality, the application of the PGC can allow for particularism towards one's family, friends, and wider community, provided that this does not violate the PGC. To use Held's example, the application of the PGC accommodates the issue that affection between a parent and a child will guide their priorities. However, the ethics of care approach suggests that emotions are enough to guide moral reasoning.

Consequently, ethics of care feminists do not adequately account for the ways in which emotions and caring can result in harm. Margaret Farley highlights that emotions are not morally neutral; some forms of care can be destructive, and some forms of relationships can be harmful.[130] Parents may abuse or neglect their children while continuing to love and care for them. Held accepts that many parents exert domination over their children, while others fail to provide adequate care, but she then dismisses this issue to assert that in the absence of abuse, the process of caring for a child is due to love rather than universal moral rules.[131] This latter point can be recognised within the particularism supported by the application of the PGC, but this approach overlooks how universal norms are necessary where action based on care and emotions is detrimental. For many women, it is within interpersonal relationships and communities that gender-based harms are perpetuated. Thus, as Farley asks, according to what norms is care

[130] Margaret A. Farley, 'Feminism and Universal Morality' in Gene Outka and John P. Reeder (Eds), *Prospects for a Common Morality* (Princeton University Press, 1993) p.184.
[131] Held (n113) p.77.

harmful or helpful?[132] While the recognition of relationality and care may be important, these values do not supplant the need for universal moral norms.

Ethics of care feminists reject the claimed universality of the values they see as underpinning rationalist moral theories, viewing care as having greater universal relevance. Virginia Held argues that the ethics of care approach is truly universal as it is based on the universal experience of 'being cared for'.[133] She thus argues that global consensus under this approach is possible, without a reliance on Western liberal values.[134] While some feminists, such as Susan Hekman, argue in favour of rejecting appeals to the universal values of autonomy and freedom entirely,[135] Held does accept that respect for universal human rights is necessary, though she views 'promoting care across continents' as a more effective way of protecting rights than 'mere rational recognition'.[136] Care, however, does not justify rights or require them to be accepted. This is particularly an issue with gender-based rights which may garner opposition, as the rejection of any justificatory foundation for rights does not enable feminist goals to be defensible. Thus, as Heikes argues, we require a conception of reason or rationality capable of defending political and moral concepts in order for the feminist project to succeed; in order for feminist claims to have any traction, there must be 'some manner of determining which are the correct ways of thinking about issues of oppression, justice, equality, and so on.'[137] This need not lead to the exclusion of the values of care and concepts of relationality. The PGC provides a concrete foundation for the recognition of

[132] Farley (n130) p.184.
[133] Held (n113) p.20, 132.
[134] *Ibid* p.132.
[135] Hekman (n96) p.185.
[136] Held (n107) p.17.
[137] Heikes (n101) p.16-17.

moral claims and is compatible with feminist goals in its application through taking account of these values, context, and personal relationships.

### iii. Seeking Middle Ground

Some ethics of care feminists assume that there is a rigid dichotomy between rational and relational approaches, corresponding with masculine and feminine modes of thinking. However, these approaches need not be viewed as oppositional. Farley argues that a more persuasive feminist approach would transcend the differences between women and men and include both autonomy and relationality, reason and emotion, justice and care.[138] Hunt Botting similarly views the reconciliation of rational and sentimental approaches to human rights as an important task for feminist philosophy.[139] Rationalist moral theories do not inevitably exclude relational values; Wollstonecraft, usually thought of as a rationalist, wrote extensively about love and happiness, and the duties she recognised as accompanying rights enabled her to conceptualise relational obligations owed to other people as rational equals.[140] In recognising duties towards other agents within Gewirth's conception of a community of rights, the PGC already has a relational aspect and, as already argued above, is able to take account of personal qualities, relationships, and contexts within the application of the argument. Gewirth's approach therefore strikes a balance between relational or communitarian concerns and the importance of ensuring that individual rights are not compromised, against relationships

[138] *Ibid* p.182-184.
[139] Hunt Botting (n96) p.245.
[140] Wollstonecraft (n97); Hunt Botting (n96) p.82.

or communities which, without respect for individual rights, can be harmful to women and marginalised groups.

Siobhán Mullally has sought to reconcile universalism with relational feminist values. She affirmed that a feminist transformation of human rights must retain a commitment to universalism, which must be understood as accommodating difference.[141] She also argued that a feminist approach to human rights must recognise contexts and relationships in addition to the 'overriding priority' of individual autonomy, and recognises that appealing to universal norms gives feminism an emancipatory edge.[142] Mullally, however, concludes that Gewirth's approach cannot assist with this project as he fails to address the concerns of difference (or ethics of care) feminists.[143] She argues that Gewirth disregards the importance of a feminist re-thinking of rights by relying on 'the very mechanisms of exclusion that have led feminists to distance themselves from liberal political theory'[144] Mullally accepts that the theory supports distributive justice by including some recognition of interpersonal relationships, socio-economic rights, and ethical particularism where it can be justified by the PGC.[145] This, in her view, is nonetheless insufficient to overcome the objections considered above; she perceives this approach as ignoring the significance of context and community within the process of moral reasoning, presenting an abstract, emotionless agent stripped of all but the generic features of action.[146] These objections have already been addressed above. Importantly, however, Mullally presents these objections in light of how Gewirth claims, in *The Community of Rights*, that feminist concerns can be accommodated, but then fails

[141] Siobhán Mullally, *Gender, Culture and Human Rights* (Hart, 2006) p.xxxii.
[142] *Ibid* p.1, 9.
[143] *Ibid* p.xxxvi.
[144] *Ibid* p.28.
[145] *Ibid* p.28, 32.
[146] *Ibid* p.32-33.

to directly address feminist critiques of rights and rationalist moral theories. Thus, while the theory already incorporates relational values, this must be more explicit within the application of the PGC if this approach is to adequately address feminist concerns.

The core issue that leads Mullally to reject Gewirth's approach is in relation to how the argument itself justifies rights claims. She argues that there is a problem with how Gewirth relies on the presumptions of a consensus around freedom and wellbeing and of the possibility of reaching a consensus around cultural practices.[147] This objection is a misreading of the argument to the PGC, which does not rely on any consensus but requires that agents value their freedom and wellbeing as the necessary conditions for any and all action. As established by Stage 1 of the argument, to deny that freedom and wellbeing are necessary would be to deny understanding one's own agency; these conditions must therefore be valued by all agents. The application of the argument also does not presume a consensus around cultural practices, but imposes limits on pluralism in that cultural practices which violate the PGC are unjustifiable.

Mullally argues that Gewirth 'fails to democratise the process of justification' for rights claims, leading her to argue that discourse ethics can provide a stronger means of reconciling feminism with universalism.[148] She argues that discourse ethics starts from a presumption of difference, and can thus take into account context and cultural pluralism. [149] As this approach would encourage democratic participation in the justification of rights claims, Mullally views this process as emancipatory as it would allow for 'free and reasoned deliberation amongst individuals, viewed as moral and

[147] *Ibid* p.35, 38.
[148] *Ibid* p.28.
[149] *Ibid* p.221.

political equals'.[150] She does also note the importance of limiting the consequences of pluralism by appealing to universal principles in order for this approach to work for feminism.[151] Mullally thus follows Seyla Benhabib's 'dual-track' approach to resolving cultural conflicts, which combines legal regulation with moral-political dialogue.[152] Under this approach, legal regulation is seen as a last resort which functions only to place limits on pluralism in line with Benhabib's three normative conditions: egalitarian reciprocity, voluntary self-ascription, and freedom of exit and association.[153] Mullally explains how this would work in relation to the application of religious laws: if a woman consents, human rights law could not deny her this option, but can consider whether she freely consents, whether her membership in a religious community is voluntary, and whether she has the ability to abandon this membership if she contested their practices.[154] Mullally views this approach as addressing the feminist concerns outlined above, by prioritising individual autonomy while also taking account of relationality and the importance of nurturing connections within one's community.[155]

There are, however, limits to this approach. Mullally claims a commitment to universalism through limiting pluralism by the 'institutionalisation of human rights norms, thereby providing us with a framework within which conflicting cultural claims can be negotiated.'[156] Yet, her approach does not establish a foundation for the justification of these norms, or of the three normative conditions referred to above. How, then, can communities be required to accept these limits on pluralism? This is broader issue with the dialogue approach to cultural conflicts, as there is no guarantee that the

[150] *Ibid* p.80.
[151] *Ibid* p.67.
[152] *Ibid* p.69.
[153] Seyla Benhabib, *The Claims of Culture* (Princeton University Press, 2002) p.106.
[154] Mullally (n141) p.113-114.
[155] *Ibid* p.75, 84.
[156] *Ibid* p.74.

outcome will be compatible with feminist values. Women and minorities are often excluded from the process of shaping cultural norms, an imbalance of power which dialogue cannot address if there is no normative obligation for feminist values to be accepted. This approach thus carries with it the same shortcomings as the ethics of care approach, as the promotion of care or dialogue cannot adequately address conflicts involving gender-based harms. Mullally herself accepts, in relation to reproductive rights debates, that discourse ethics cannot guarantee and does not propose substantive outcomes to this dialogue.[157] Consequently, this approach would be of limited assistance in the project to transform human rights in line with feminist values as it fails to justify or defend the universal norms necessary for feminism to succeed.

As established above, the application of the PGC can allow for cultural pluralism to the extent that it does not violate the generic rights. An international human rights framework premised upon the PGC can thus allow for the negotiation of cultural issues within the boundaries provided by the recognition of universal rights. The concrete justification for human rights based on the PGC ultimately lends stronger support to the feminist project, as gendered rights and feminist values can be defended. In addition, the PGC can be understood as a feminist-compatible approach as its application can take into account relationality, care, and specific contexts which may give rise to the recognition of specific rights (such as gender-based rights). As Heikes argues, rationality cannot fully be socially determined, but social influences – including practice and culture – are always relevant.[158] Where the application of rationalist moral theories has excluded these social influences, this has been a problem with the application rather than inherent to the theory itself. This approach to the PGC is therefore able to resolve feminist concerns

[157] *Ibid* p.161.
[158] Heikes (n101) p.134.

regarding rationalist moral theories, while retaining a clear commitment to universalism. Thus, the PGC provides the basis for a feminist transformation of human rights which can address the feminist concerns with the current framework identified in Chapter 1.

### *5.2. Gender-Based Rights*

Feminist critiques of the current human rights framework, as outlined in Chapter 1, question the claim that the framework is universal while inadequately responding to women's rights issues. Additionally, Black and postcolonial feminists have critiqued the homogenising of 'women' and 'men' as categories presumes that all women share experiences of oppression which differ from the experiences of all men. This fails to take into account the complex, intersectional oppressions faced by different groups, and ignores the similar issues faced by people with gender identities outside of the perceived woman/man binary. Thus, the inclusion of women's rights within the framework has only addressed gendered human rights issues to a limited extent, as the concept of also carries with it conceptual limitations. The feminist transformation of human rights must therefore address these issues in order to work towards substantive and inclusive gender equality, which is possible within a human rights framework based upon the PGC.

The issues that feminist scholars have raised in relation to the human rights framework closely mirror feminist concerns with rationalist moral theories. As addressed above, the PGC is inclusive of gender-based concerns and can accommodate feminist values in its application. The conceptual issues that have prioritised some human rights concerns over others would thus not be present in a human rights framework

based on the PGC. In addition, the particularism permitted by the PGC justifies the recognition of specific rights, including gender-based rights such as those contained in CEDAW. This particularism can also support the further recognition of universal rights such as those relating to reproductive health (as will be explored in the following chapter) and gender-based violence, even though these issues are predominantly faced by specific groups, as such rights are necessary for protecting the freedom and wellbeing of those groups. As emphasised in the context of ESC rights, the fact that only some individuals will benefit from certain rights does not undermine their universality if the recognition of those rights is a matter of equalising the abilities of individuals to protect their own freedom and wellbeing.

Following from this, the PGC supports an intersectional approach to human rights. As the generic rights are based only on the conditions of agency as universal needs, a human rights framework based upon the PGC would not presume shared experiences, interests, or values among all people. Rather, the PGC is concerned with what all people need for agency, and the human rights framework would thus seek to ensure that all people have, equally, the ability to pursue their own purposes without threats to their freedom and wellbeing. The equality of the generic rights thus requires the specific threats to freedom and wellbeing faced by certain groups, including threats as a result of historical and systemic oppression, to be addressed.[159] The human rights framework must therefore recognise to the specific issues faced by certain groups in order to equalise their abilities to protect their generic rights, requiring the application of universal norms in a way which adequately captures such experiences and can respond to them contextually. The PGC can therefore support the recognition of gendered rights

[159] Gewirth (n1) p.208.

while avoiding the pitfalls of homogenising women's experiences, and an intersectional approach, supported by the pluralism permitted in the application of the PGC. This can address the complex rights-issues experienced by different groups, without abandoning commitment to universal norms. The concerns of feminist scholars, including the additional issues raised by Black and postcolonial feminists, in relation to human rights can therefore be addressed by the feminist transformation of the human rights framework in line with the PGC.

The final issue to be addressed relates to the inclusion of trans, non-binary, and gender-expansive people in the context of gendered rights. In Chapter 1, I outlined the perceived conflict between the rights of non-trans women and those of trans, non-binary, and gender-expansive people, which has focused particularly on the inclusion of trans women and people read as men in gender-segregated spaces. The issues involved here relate to the needs of trans, non-binary, and gender-expansive people to have their gender identity recognised and to be free from violence and discrimination on the basis of their gender identity, and the needs of non-trans women to be free from gender-based violence, including through the provision of women-only spaces. This is mischaracterised as a conflict, as the needs of both groups can be recognised within the human rights framework. An intersectional approach to human rights can ensure that the specific needs of different groups are accounted for, by recognising that non-trans women face gender-based harms and that trans, non-binary, and gender-expansive people often need access to the same services and protections as non-trans women. In relation to sexual and reproductive health services, for example, the gender stereotypes and stigma that may impact women's ability to access those services must be specifically accounted for, while addressing how some trans, non-binary, and gender-expansive people may also be

excluded from those services, for example trans men and masculine-presenting people in accessing abortion services.[160] As the PGC is concerned with equalising the abilities of all agents to pursue their purposes and protect their freedom and wellbeing, a transformed human rights framework based on the PGC would thus require states to respond to the needs of all non-trans women and all trans, non-binary, and gender-expansive people.

## *Conclusion*

In this chapter, I set out the PGC as the supreme moral principle which establishes moral rights that must be accepted by every agent. The rights set out by the PGC can be recognised as universal human rights, as they relate to the needs of every person in order to act, and the indirect application of the PGC supports the recognition and protection of those rights in an international framework. The feminist transformation of human rights must therefore be grounded by the PGC, which can resolve the key conceptual issues with the current framework outlined in Chapter 1. While the commitment to universal norms requires the rejection of cultural or moral relativism, cultural pluralism is permitted to the extent that the freedom and wellbeing of every individual agent is protected. Communitarian conceptions of rights and cultural practices can thus be accommodated, while prioritising the protection of individuals from harm in the event of a conflict.

The positive rights required by the PGC translates into the recognition of ESC rights, imposing obligations on states to protect those rights from interference and to

[160] Heidi Moseson and others, 'Abortion experiences and preferences of transgender, nonbinary and gender-expansive people in the United States' (2021) 224(4) *Am. J. Obstet. Gynecol.* 376.e1.

assist individuals in meeting their needs, such as through the provision of food and shelter to those living in poverty. While recognising that lower-income states may be unable to fully comply with these requirements, progressive realisation would not excuse states from compliance to the extent possible. In addition, the equality of the generic rights required by the PGC would impose obligations on higher-income states to assist those states unable to fully comply with ESC rights due to resource constraints. Finally, the obligations on states to take steps towards fulfilment must including moving towards politico-economic systems that can support ESC rights.

A human rights framework based on the PGC would also address feminist critiques of human rights. In this chapter, I have addressed feminist objections to universal norms generated by rationalist moral theories. While some feminists have argued for rejecting rationalist morality in favour of alternatives grounded in concepts of care, I argue that it is necessary for feminists to accept rationality in order to concretely ground feminist claims. However, the two approaches need not be seen as oppositional as the PGC can accommodate feminist values around care and relationality in its application. While the argument to the PGC does not take personal characteristics as relevant to the generic rights, the application of the PGC can support an intersectional approach and recognise the specific, contextual needs of different people and groups and ensure the equality of the generic rights. The PGC thus requires the recognition of differences across and within different groups, cultures, and states, in order to respond to inequalities in rights protection and respond to specific (such as gendered) harms. The feminist transformation of human rights must, therefore, have the PGC as its foundation in order to resolve the key conceptual issues with the current framework. In the next chapter, I will demonstrate how the PGC can ground the recognition of a human right to abortion.

# 4

# The Principle of Generic Consistency as the Basis for a Human Right to Abortion

## *Introduction*

In Western contexts, particularly in the US and UK, 'pro-life' and 'pro-choice' have been adopted as the mainstream political labels for anti- and pro-abortion movements. Positions on abortion therefore tend to be categorised as falling on either side, with the 'pro-life' camp advocating for restrictions on abortion based on concern for the foetus as a human life and the 'pro-choice' camp supporting access to abortion as a matter of individual decision-making for all people capable of gestating.[1] However, these labels are politically charged, implying that the other side is anti-choice or anti-life. Kristin Luker aptly noted that 'each side is emphatic that the label used by the other is a mockery of what it is really up to.'[2] Further, the 'pro-life' versus 'pro-choice' framing fails to capture many differing and complex positions on abortion that do not fit neatly into this polarisation. Abortion is a multidimensional issue: approaches to abortion are shaped by political, cultural, religious, and historical institutions, and there are social, economic, and demographic issues, including disparities in access to sexual and reproductive healthcare

[1] While I use the terms 'pregnant people' and 'people capable of gestating' to recognise that people other than cisgender women require access to abortion services, I will refer to 'women' where I am considering gender stereotypes that are specifically imposed upon cisgender women.
[2] Kristin Luker, *Abortion and the Politics of Motherhood* (University of California Press, 1984) p.2.

within and across countries, that are also relevant. Feminists advocating for access to abortion also highlight the ways in which restrictions on abortion perpetuate gender stereotypes around motherhood and women's reproductive roles, arguing that abortion is an issue of gender equality.[3] The harms associated with the criminalisation of abortion and resulting clandestine or unsafe abortion practices are issues also raised by feminists as central to the abortion debate.

The 'pro-choice' label does not always apply to non-Western abortion movements which may adopt social justice or public health narratives, rather than the focus on reproductive choice. The Reproductive Justice framework, as outlined in Chapter 2, has also questioned the appropriateness of the choice framing in relation to the additional barriers and reproductive rights issues faced by already marginalised groups. Additionally, the label 'pro-life' does not distinguish between religious opposition to abortion, such as the Roman Catholic position which employs double-effect (where abortion, though morally wrong, can be performed for morally good purposes such as saving the pregnant person's life), and non-religious opposition which may support abortion on slightly broader grounds (such as in cases of rape).

The key issue with the 'pro-life' versus 'pro-choice' framing of the abortion debate was highlighted by Luker in her 1984 study on how people in the US came to their beliefs on abortion.[4] Luker problematised this framing by arguing that each side will 'dismiss those who disagree with them as being either ignorant of the facts or perversely unwilling to admit the truth when it is presented to them'.[5] As the 'pro-life' camp believes that the foetus has moral status equal to the pregnant person and the 'pro-choice' camp holds that

[3] See, for example: Fran Amery, *Beyond Pro-Life and Pro-Choice* (Bristol University Press, 2020) Ch. 2.
[4] Luker (n2).
[5] *Ibid* p.3.

the foetus has little or no moral status, the two sides 'share almost no common premises and very little common language'.[6] For some feminist scholars, whether or not the foetus has moral status is viewed as irrelevant to whether abortion is justifiable, as the bodily autonomy of the pregnant person is taken to be the overriding consideration.[7] The obvious example here is Judith Jarvis Thompson's unconscious violinist analogy, by which she argued that the unborn foetus, even if it did have a right to life, would not have a right to the use of the pregnant person's body.[8]

However, as Kate Greasley argues, while abortion rights are essential as a matter of justice for women, the moral status of the foetus remains the central determining issue, as abortion could not be justified if the foetus had full moral status equal to that of the pregnant person.[9] The gender inequalities associated with restrictions on abortion are a core part of the debate, and must not be understated, but feminist approaches to abortion must also engage with the status of the foetus. In this chapter, I will set out a moral framework for abortion by considering the status of the foetus, gender inequalities resulting from restrictions on abortion, and a range of other multidimensional issues. This first section will apply the PGC and the precautionary principle to argue that the moral status of the foetus increases throughout pregnancy, but abortion can nevertheless be justified for a wide range of reasons. I will address feminist and intersectional perspectives, including relational approaches, to expand upon these justifications.

[6] *Ibid* p.2.
[7] Emily Jackson, *Regulating Reproduction* (Hart, 2001) p.73-74.
[8] Judith Jarvis Thompson, 'A Defense of Abortion' (1971) 1(1) *Philos. Pub. Aff.* 47.
[9] Kate Greasley, 'Abortion, Feminism, and 'Traditional' Moral Philosophy' in Andelka M. Phillips, Thana C. de Campos, and Jonathan Herring (Eds), *Philosophical Foundations of Medical Law* (Oxford University Press, 2019); Kate Greasley, 'In Defense of Abortion Rights' in Kate Greasley and Christopher Kaczor, *Abortion Rights: For and Against* (Cambridge University Press, 2017).

Arguing that there is a moral right to abortion which must be recognised within the international human rights framework, the second section will address the need to recognise abortion as a socio-economic right. In this section, I will consider further issues around recognising certain legal grounds for abortion, and the importance of decriminalisation. Additionally, a human right to abortion must effectively respond to the context of existing global disparities in economic resources, access to healthcare, and religious, cultural, and political attitudes to abortion. Thus, in the final section, I will establish a framework for the progressive realisation of the right to abortion, in order to set out the minimum core obligations on states leading up to full compliance. This would therefore address the issues with the approach to abortion in the current human rights framework, imposing concrete obligations on states, while also allowing for flexibility where cultural or socio-economic contexts may prevent immediate fulfilment.

# *1. The Moral Justification for Abortion*

## *1.1. Application of the PGC to Abortion*

In the previous chapter, I set out and defended the PGC as the supreme moral principle which must provide the foundation for the feminist transformation of the human rights framework, capable of grounding gender-based rights such as a right to abortion. Gewirth addressed abortion by applying the Principle of Proportionality, in that the foetus approaches having the generic rights as it develops and begins to demonstrate agential

characteristics.[10] On this view, the foetus has partial generic rights in line with its partial characteristics and the rights of the pregnant person would take priority, although Gewirth argues that a stronger justification for abortion is needed later in the pregnancy as the foetus gradually gains the generic rights to a greater degree.[11] However, as covered in the previous chapter, there are issues with the idea of partial generic rights and the precautionary principle provides an alternative means of recognising the moral status of the foetus as an apparent non-agent.

The foetus is not and cannot be treated as an apparent agent, as it does not demonstrate full agential characteristics. On some feminist accounts, while the foetus develops sentience as the pregnancy progresses, the foetus has no moral status until it becomes an independent being after birth, and abortion is thus morally permissible right up until that point.[12] However, whether or not the foetus is an agent (and thus has moral status) cannot be conclusively determined. Consequently, the precautionary principle requires that interest rights are granted to the foetus in order to avoid potentially violating the PGC. Where there is no conflict between the pregnant person and the foetus, the basic needs of the foetus must therefore be protected. If the pregnant person wishes to terminate the pregnancy, and thus there is a conflict between the pregnant person and the foetus, the foetus cannot be treated as having a moral status equal to that of the pregnant person, who is usually an apparent agent.[13] However, as it develops, the foetus will begin to demonstrate some agential characteristics and its moral status will thus increase in line with this development.[14] Precaution therefore requires that the degree of

[10] Alan Gewirth, *Reason and Morality* (The University of Chicago Press, 1978) p.142.
[11] *Ibid* p.142-144.
[12] Mary Anne Warren, 'The Moral Significance of Birth' (1989) 4(3) *Ethics & Reprod.* 46.
[13] Shaun D. Pattinson, *Influencing Traits Before Birth* (Ashgate, 2002) p.74.
[14] *Ibid* p.68.

protection typically afforded to the foetus increase throughout the pregnancy, unless the foetus has a severe or fatal impairment that affects its development.[15]

The above argument proceeds on the assumption that the pregnant person is an apparent agent with full moral status and the competence to voluntarily elect to have an abortion. Two qualifications need to be made here. Firstly, a pregnant person showing signs of permanent unconsciousness would not be an apparent agent, and thus does not have full moral status.[16] There are two cases, one in Ireland and the other in Texas, in which two brain-dead women, who were between 12 and 14 weeks' pregnant at the time, were kept on life support in order to continue gestating the foetus, against the wishes of their family and the other parent.[17] There are ethical issues here in that the pregnancies were still in the early stages, in which the foetus shows relatively minimal agential characteristics, and the other parents did not want to have a child in such distressing circumstances.[18] In both cases, the foetus was unlikely to be born alive.[19] However, where a brain-dead pregnant person is at a late stage of the pregnancy, the foetus is viable and could be successfully gestated for the remainder of the pregnancy, *and* the other parent was in support of this, a balance between the generic rights and interests of the pregnant person and the foetus (and the other parent) may morally justify assisting the continuation of the pregnancy.[20]

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[15] *Ibid* p.74.
[16] I use the term 'permanent unconsciousness' to refer to what is pejoratively known as a 'permanent vegetative state'.
[17] *P.P. v Health Service Executive* [2014] IEHC 622; Michele Goodwin, *Policing the Womb* (Cambridge University Press, 2020) p.1-2.
[18] *Ibid.*
[19] *Ibid.*
[20] In future, the development of artificial womb technology to support partial ectogenesis may provide a preferable alternative to the continued use of the pregnant person's body in such circumstances. See, for example, Elizabeth Chloe Romanis, 'Artificial womb technology and clinical translation: Innovative treatment or medical research?' (2019) 34(4) *Bioethics* 392.

Secondly, in many cases, the pregnant person may not have the competence to decide to have an abortion. Some apparent agents may lack the competence to make some decisions but are competent to make others; competence and incompetence may be time-specific or temporary. Non-apparent agents are not competent to make any decisions. People who lack competence, for example some adolescents and people with learning and neurological disabilities, may be apparent agents lacking the competence to make decisions around their pregnancy but are able to make other decisions. Competence must be decision-specific, and young people or people with certain disabilities must not be presumed to lack competence with regards to pregnancy-related decisions (including the decision to continue a pregnancy, as well as ending one). While they may not be able to decide on and consent to an abortion, the non-competent pregnant person may express that they wish to terminate their pregnancy or that they do not wish to become a parent. The basic needs of the pregnant person must also be considered, in relation to the potential trauma and distress that might result from unwanted pregnancy, childbirth, and the removal of the child if the person is unable to parent them. In these circumstances, the best interests of the pregnant person who lacks competence may justify abortion. This is not a blanket presumption in favour of abortion in relation to pregnant people lacking competence; the European Court of Human Rights recently found that forced abortions done to women with intellectual disabilities in Moldova without informed consent amounted to cruel, inhuman, and degrading treatment in violation of Article 3.[21] However, the arguments below will also apply to non-competent pregnant people, whose exercise of their generic rights must be protected insofar as they are able to competently

[21] *G.M. and others v Moldova* App no. 44394/15 (ECHR, 22 November 2022).

make decisions, and interest rights protected in relation to issues around which they are not able to competently make decisions.

Early into the pregnancy, the foetus demonstrates very few agential characteristics and so has a minimal moral status in comparison to the pregnant person (except in cases of permanent unconsciousness or brain death). Where the pregnant person does not want to continue their pregnancy, being prevented from having an abortion is likely to have a detrimental impact on the pregnant person's mental health. There are also physical health implications, as abortion before 12-weeks' gestation is generally accepted as presenting fewer risks than continuing a pregnancy to term.[22] During this early stage, abortion is justifiable where the pregnant person does not wish to continue the pregnancy, for any reason, because of the risks to their generic rights that would result from preventing abortion. The pregnant person therefore has a moral right to abortion at this early stage.

As the pregnancy progresses, the moral status of the foetus increases and precaution, requiring increasing degrees of protection, will necessitate additional justifications for abortion later into the pregnancy. At no point during the typical pregnancy will the foetus have a moral status equal to the pregnant person, but as abortion will end the life of the foetus, depriving it of a basic need, the hierarchy of needs becomes relevant. The justification for abortion at this later stage is thus dependent on which category of the pregnant person's needs is in conflict with the basic needs of the foetus. Abortion is typically morally justified if the most important basic needs of the pregnant person (their life and health) are in conflict with the life of the foetus, as the

[22] Graeme Laurie, Shawn Harmon, and Edward Dove, *Mason and McCall Smith's Law and Medical Ethics* (11th Edn, Oxford University Press, 2019) p.312.

basic needs of an apparent agent must be prioritised over the basic needs of a non-apparent agent.[23] This justification for later abortion does not provide a justification for infanticide, even though a newborn baby does not demonstrate full agential characteristics. While feminist and non-feminist scholars have debated the moral and developmental significance of birth in the context of abortion, in a conflict between the basic needs of the foetus and pregnant person, birth is relevant in that the needs of a newborn would not be in direct conflict with those of the parent in the same way that a foetus may be in direct conflict with the pregnant person.

In cases where continuing the pregnancy will pose serious risks to the life of the pregnant person, later abortion can thus be quite easily justified. There are a range of other circumstances in which later abortion may be morally justified, beyond a simple conflict of the life of the pregnant person and foetus. Abortion can also be justified where there is a serious risk to the pregnant person's mental or physical health, including where continuing a pregnancy resulting from rape will cause significant psychological distress. As suggested above, in cases where the pregnant person lacks competence, pregnancy and childbirth might also be so distressing that abortion would be in their best interests, particularly where the person has expressed that they do not want to be pregnant. Provisions for later abortion are necessary in these circumstances, as there are likely to be delays in accessing abortion for survivors of rape who experience significant psychological distress from the sexual assault, and it is important to protect people who lack competence who may be unaware or do not understand that they are pregnant. Further, where the pregnant person is carrying a foetus with a fatal impairment, so is likely to die during the pregnancy or shortly after birth, abortion may be a less traumatic

[23] Pattinson (n13) p.75.

experience than waiting to have a stillbirth or giving birth to a baby who will soon die. The detection of many foetal impairments is not possible early into the pregnancy.

In some states, such as England and Wales, abortion is restricted later into the pregnancy with exceptions, including for serious foetal disability without distinguishing between fatal and non-fatal impairments.[24] In some instances, a non-fatal disability may be so severe as to cause the child prolonged pain and suffering if they were to be born, and thus may also justify an abortion. However, in recognising that the foetus has moral status later into the pregnancy, justifying abortion by the presence of a less serious disability is a potential violation of the PGC, as a non-disabled foetus is thus afforded more protection than a disabled foetus.[25] In addition, justifying abortion on the grounds of disability alone, without any need to demonstrate harm to the foetus or pregnant person, or future harm to the child once born, perpetuates discriminatory and stigmatising attitudes towards people with disabilities. Alison Piepmeier has observed how stereotypical attitudes towards people with disabilities arise in discussions around abortion, carrying the assumption that having a child with a disability is undesirable.[26] Feminist narratives of reproductive autonomy have masked this assumption by translating the issue of abortion on disability grounds into a simple matter of choice, ignoring the concerns of disability activists who view this as a weak form of eugenics.[27]

It is difficult in practice to draw a hard line between fatal and serious non-fatal disabilities that would justify abortion, and less serious disabilities that would not, as the extent to which an impairment would limit the life of the foetus or cause pain may be

[24] Abortion Act 1967 s.1(1)(d).
[25] Pattinson (n13) p.87-88.
[26] Alison Piepmeier, 'The Inadequacy of "Choice": Disability and What's Wrong with Feminist Framings of Reproduction' (2013) 39(1) *Fem. Stud.* 159, 159-160.
[27] *ibid* 160-161; Alison Sheldon, 'Personal and Perplexing: Feminist Disability Politics Evaluated' (1999) 14(5) *Disabil. Soc.* 643, 651-652.

unclear. In addition, there may be other factors that point towards a conflict between a foetus (with a disability) and the pregnant person, for example socio-economic status coupled with a lack of comprehensive state support for parents of children with disabilities. Restricting abortion on the grounds of disability to fatal or severe disabilities, without any flexibility, would therefore be an inappropriate response. However, the prevailing feminist response is that a pregnant person should be able to decide for themselves whether to carry a particular pregnancy to term or not.[28] The argument that abortion on the grounds of disability is discriminatory has also been rejected by some scholars.[29] This fails to address how a social context in which disabled people are stigmatised and devalued may shape the decision to abort a disabled foetus. Thus, there is a need to permit abortion on the grounds of foetal disability in some circumstances while avoiding the discriminatory effects of a disability exception to restrictions on abortion, for example by requiring states to support the parents of children with disabilities, people with disabilities in adulthood, and to combat structural inequality and discriminatory attitudes.

Abortion on the grounds of health also requires an expansive interpretation. To use the World Health Organization's definition, health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[30] An agent's basic generic needs go beyond illness and infirmity, so health-based justifications for abortion require us to go beyond issues of life-threatening or severe physical or mental illness to take a holistic view of the pregnant person's health, including the

[28] Jackson (n7) p.98-99; Rosamund Scott, 'Interpreting the Disability Ground of the Abortion Act (2005) 64(2) *Camb. Law J.* 388, 396.
[29] Sally Sheldon and Stephen Wilkinson, 'Termination of Pregnancy for Reason of Foetal Disability: Are There Grounds for a Special Exception in Law?' (2001) 9 *Med. Law Rev.* 85. Sheldon and Wilkinson do, however, argue that 'no woman should be forced to carry to term a disabled, or any other, foetus.' (109).
[30] Preamble to the Constitution of the World Health Organization (World Health Organization, 1946).

impacts of pregnancy on the body, the broader mental health impacts of an unwanted pregnancy, and how an unwanted pregnancy might negatively impact upon the pregnant person's relationships and wider social context. Abortion is a multidimensional issue and there are a number of relevant factors, including structural issues and gender inequality, that must be considered. In the previous chapter, I argued that feminist values and relational approaches can be incorporated into the application of rationalist moral theories. Feminist and intersectional perspectives must be considered in the application of the PGC to abortion, in order to take account of broader contextual and relational factors which are relevant. I will consider these issues in the section below, in order to argue that a precautionary principle must also be applied to any regulatory response to abortion, as there a range of circumstances in which restrictions on abortion would be likely to violate the generic rights of apparent agents. Precaution will require that the potential harm to the generic rights of people capable of gestating caused by restrictions on later abortion is balanced against the potential harms to the generic rights of the foetus. This is particularly important in the international context, as there is significant variation worldwide in the conditions that enable people to avoid unwanted pregnancies, have children safely, and access abortions as early as possible.

## *1.2. Feminist Perspectives on Abortion*

### i. Pregnancy and the Body

Feminist scholars have conceptualised pregnancy as an embodied experience.[31] The impacts of pregnancy on the body have been tied to health and bodily integrity as justifications for abortion. Susan Sherwin has suggested that there is a tendency in non-feminist perspectives on abortion to consider pregnancy a tolerable burden.[32] However, the physical changes involved in pregnancy inevitably have an impact on the health of the pregnant person, ranging from discomfort to causing significant and sometimes permanent harm. During a pregnancy, the pregnant person might experience vitamin deficiencies, nausea, vomiting, and pain of the back, hands, feet, and ankles. Pregnancy can result in more serious issues such as varicose veins, haemorrhoids, gestational diabetes, urinary tract infections (which can lead to kidney infections), preeclampsia or high blood pressure, damage to the pelvic floor and loss of bladder control, both of which can be permanent. There are then the risks of childbirth itself, which vary depending on socio-demographic status and location, but can result in complications requiring surgery, prolonged issues such as obstetric fistula, and can even be fatal. Post-birth, the person may then experience mental health problems such as postnatal depression, and particularly traumatic births might result in PTSD, depression, or anxiety. Christyne Neff thus argued that the physical effects of an unwanted pregnancy, in presenting risks of serious bodily injury, are similar to the effects of bodily intrusion that would be

[31] Iris Marion Young, 'Pregnant Embodiment' in Iris Marion Young, *On Female Body Experience: "Throwing Like a Girl" and Other Essays* (Oxford University Press, 2005).
[32] Susan Sherwin, 'Abortion Through a Feminist Ethics Lens' (1991) 30(3) *Dialogue* 327, 333.

considered battery in other contexts.[33] This is not to be taken as suggesting that discomfort would morally justify a late abortion, but in the context of an unwanted pregnancy, the additional impacts on the physical body represent further intrusions upon the pregnant person's generic rights.

In relation to the risks involved in pregnancy, an intersectional approach requires consideration of circumstances which exacerbate these issues. For a pregnant person living in Britain, with access to free maternal health care via the NHS or with the resources to pay for private care, many of the serious risks involved in pregnancy are potentially avoidable. However, childbirth outcomes vary for minorities and economically disadvantaged people in Western states. In the UK, the maternal mortality rate for Black women is over four times higher than for white women, and the overall maternal mortality rate in the US is significantly higher than other high-income countries, in part caused by a lack of universal affordable healthcare.[34] In states where maternal mortality rates are high and resource constraints mean that maternal healthcare is inaccessible or unavailable to many, the risks to physical health involved in pregnancy are distinctly higher. Issues such as discrimination, obstetric violence, living in close proximity to environmental hazards, unsafe working conditions and the unavailability of maternity leave, intimate partner violence, and poverty also increase pregnancy-related risks. In setting out the health justifications for abortion, it is therefore important to consider this non-exhaustive range of relevant issues which make up the context in which a pregnant person might decide to have an abortion. Restricting later abortions in

[33] Christyne Neff, 'Woman, Womb, and Bodily Integrity' (1990) 3 *Yale J. Law Fem.* 327, 349
[34] MBRRACE-UK, *Saving Lives, Improving Mothers' Care* (November 2021) p.5; Roosa Tikkanen and others, 'Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries' (*Commonwealth Fund*, 18 November 2020) <https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/maternal-mortality-maternity-care-us-compared-10-countries> accessed 14 January 2023.

circumstances where there are real risks involved in a pregnancy, even if they are not immediately present, could amount to a violation of the pregnant person's generic rights.

### ii. Mental Health

Relevant to the justification of abortion on mental health grounds is consideration of the long-term mental health effects of having to continue an unwanted pregnancy to term, give birth, and in many cases raise an unwanted child. Feminists have viewed restrictions on abortion as exceptions to the rights to bodily integrity that are guaranteed in other contexts, thus representing a specifically gendered intrusion. This can be a dehumanising experience with significant impacts upon the mental health of the pregnant person.[35] As a result, in contexts where abortion is restricted or inaccessible, people facing unwanted pregnancies are usually willing to seek out clandestine and potentially unsafe methods of abortion. Thus, the mental health impacts of an unwanted pregnancy appear serious enough to push people to risk a criminal penalty, their health, or even their life in circumstances where safer methods of clandestine abortion are unavailable.[36]

In the British context, feminist scholars have critiqued the Abortion Act 1967 over the requirement of mental or physical harm in order to justify abortion even during the early stages of pregnancy. The valid concerns relating to the distress caused by unwanted pregnancy that were presented as arguments in favour of legalising abortion became a condition for terminating a pregnancy, which many feminists view as requiring a pregnant person to present themselves as desperate or vulnerable in order to be allowed

[35] Amery (n3) p.14.
[36] Pattinson (n13) p.75.

an abortion.[37] At the time, this was a strategic framing as it could counter the narratives of pregnant women as rejecting motherhood (and thus their gender roles) or making selfish and flippant decisions.[38] In practice, the low risk of early abortion compared to carrying the pregnancy to term means that this is not a high threshold, but the wording of the ground is nevertheless seen as outdated and paternalistic when compared to legislation in other states that allows early abortion on demand. Feminists such as Sally Sheldon, Mary Boyle, and Ellie Lee have critiqued this 'medicalisation' of abortion as driven by ideology in seeking to place abortion decisions in the hands of doctors rather than allowing pregnant people to make their own decisions.[39] However, the PGC justifies early abortion without any additional requirements of harm, so mental health or distress at an unwanted pregnancy would only become relevant in the later stages of pregnancy as the moral status of the foetus increases. Additionally, this is not to suggest that proof of severe mental distress over an unwanted pregnancy must be required in order to justify abortion, but rather I argue that unwanted pregnancies are experienced as onerous and violating and that preventing a person from terminating an unwanted pregnancy is thus likely to have significant impacts upon their mental health, particularly when coupled with the potential physical health risks associated with pregnancy.

[37] Jackson (n7) p.81; Sally Sheldon, *Beyond Control* (Pluto Press, 1997) p.35, 38.
[38] Sheldon (n37) p.36.
[39] *Ibid*; Mary Boyle, *Re-Thinking Abortion* (Routledge, 1997) p.45; Ellie Lee, 'Psychologizing Abortion: Women's 'Mental Health' and the Regulation of Abortion in Britain' in Anne Morris and Susan Nott (Eds), *Well Women* (first published 2002, Routledge, 2018).

### iii. The Relational Context of Abortion Decisions

The mental health framing has often been used to distinguish between legitimate reasons for later abortions and abortion for frivolous reasons, for example where the pregnancy or childbirth would interfere with the pregnant person's holiday arrangements. [40] However, as pointed out by Greasley, late abortions are not, in practice, usually undertaken based on trivial considerations.[41] The vast majority of abortions take place within the first trimester, as people facing unwanted pregnancies are likely to seek abortions as soon as possible.[42] There are limitations to these statistics, as they come out of contexts in which later abortions are both restricted and stigmatised, and where women are expected to conform to gender norms around motherhood. However, in England and Wales, where abortion is permitted up to 24 weeks' gestation and on very limited grounds after this point, 89% of all legal abortions took place under 10 weeks in 2021.[43] Even if later abortions were not so restricted, people are likely to seek an abortion as soon as they are able to, given the physical and mental burdens of carrying an unwanted pregnancy. Additionally, as early abortions are safer, particularly where early medical abortion pills are easily available, people are unlikely to wait months into the pregnancy to have an abortion, which would require that they undergo surgery.[44]

There are many significant and legitimate reasons as to why a person might need an abortion later into the pregnancy, such as foetal impairments, risks to the health or life

[40] *Ibid*.
[41] Greasley (2017, n9) p.84.
[42] Erica Miller, *Happy Abortions* (Zed Books, 2017) p.23; Jackson (n7) p.91.
[43] Department of Health & Social Care, Abortion Statistics, England and Wales: 2021 (21 June 2022) <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021> accessed 14 January 2023.
[44] Jackson (n7) p.94.

or the pregnant person, or as a result of delays in accessing abortion services which take place in the context of rape, intimate partner violence, existing mental health problems, and being unaware of the pregnancy until a later stage.[45] In states with a lack of adequate sexual and reproductive health education, adolescents may not understand the early signs of pregnancy and thus will be likely to seek abortion services later on. This is also a potential issue with people who lack competence. In some states, delays can also result from additional requirements such as mandatory counselling, conscientious objection (including undeclared objection), distance from abortion providers, and reporting requirements relating to rape grounds. Where there is a lack of accessible universal healthcare, the cost of abortion services can also cause delays, and people travelling elsewhere for an abortion where it is criminalised or restricted in their own country are likely to have abortions later than they otherwise would have. Adolescents are particularly vulnerable to these delays if they have no independent financial support and have to hide their pregnancy due to familial or socio-cultural stigma. Aside from delays, Foster and Kimport also note that people may seek later abortions due to sudden and unexpected changes to their personal circumstances, such as a relationship breakdown or job loss, during a pregnancy.[46]

Feminists have thus sought to point out that later abortions take place in the context of complicated circumstances and that there is a constellation of justifiable reasons for later abortions. For many feminist scholars, this leads to the conclusion that pregnant people should be able to decide for themselves when an abortion would be appropriate, without restriction or interference by the state. In making this argument,

[45] Diane Greene Foster and Katrina Kimport, 'Who Seeks Abortions at or After 20 Weeks?' (2013) 45(4) *Perspect. Sex. Reprod. Health* 210, 212-216.
[46] *Ibid* 211.

feminists highlight the gendered harms and perpetuation of gender stereotypes resulting from restrictions on abortion. Mary Boyle, for example, argues that seeking an abortion 'is simultaneously to make a statement about motherhood'.[47] Women have traditionally been tied to their reproductive roles, generating the expectation that women have an innate maternal instinct or desire for motherhood, an expectation which the decision to have an abortion subverts.[48] For Michele Goodwin, restrictions on abortion are therefore connected to the historically entrenched patterns of male power and domination over women.[49] In this context, abortion is presented as a 'deviant' choice, which when coupled with concerns over abortions for trivial reasons, portrays people that have abortions as morally deficient, with the extension that pregnant people cannot be trusted to make their own reproductive decisions.[50] In contrast, from the feminist perspective, access to abortion (when combined with access to contraception and sex education) represents a potentially liberatory choice for pregnant people in allowing them to delay or refuse parenthood, and thus reject the imposition of gendered social roles.[51]

As feminists therefore highlight, autonomy over one's reproductive life is an important aspect of the generic rights of people capable of becoming pregnant. For scholars such as Emily Jackson and Rosamund Scott, autonomy in the context of reproduction goes beyond conceptions of bodily integrity to encompass self-determination over significant personal events, in line with the person's values and beliefs.[52] Jackson also notes that autonomy is not merely about individual preferences, but also requires necessary social supports.[53] In order to protect the generic rights of

[47] Boyle (n39) p.28.
[48] Amery (n3) p.21.
[49] Goodwin (n17) p.47.
[50] Boyle (n39) p.29, 39.
[51] Amery (n3) p.13, 15.
[52] Jackson (n7) p.6-9; Rosamund Scott, *Rights, Duties, and the Body* (Hart, 2002) p.61-63.
[53] Jackson (n7) p.6-9.

people capable of becoming pregnant, states must ensure reproductive autonomy through the provision of access to abortion but also by addressing other limitations on a person's ability to make decisions over their reproductive life. The 'pro-choice' narrative has often failed to capture that the decision to have an abortion is often compelled by one's personal and socio-economic situation, rather than being a choice made out of individual preference. Thus, reproductive autonomy must be understood as being limited by social, economic, and cultural contexts, and in addition to the provision of abortion services, also requires states to address these wider limitations so that people capable of becoming pregnant are able to exercise control over their reproductive lives.

Some feminists have also approached the morality of abortion by emphasising the relationship between the pregnant person and foetus.[54] This is the approach taken by the ethics of care branch of feminist thought. Virginia Held thus suggests that the morality of abortion is to be determined, on a personal level, by how the particular pregnant person feels towards the foetus.[55] On this view, abortion is morally justified if the pregnant person seeking an abortion believes it to be morally justified. Greasley has critiqued this approach for identifying the pregnant person's relationship with the foetus as the only relevant criterion for assessing the morality of abortion, as this fails to produce any moral imperatives.[56] This point is supported by PGC, in that it is necessary to consider the moral status of the foetus to determine the morality of abortion. Katrina Kimport and Monica R. McLemore have gone beyond this to critique the very premise that abortion must be justified or legitimised.[57] However, they continue to refer abortion as a right; as I have

[54] Janet Hadley, *Abortion: Between Freedom and Necessity* (Virago, 1996) p.82-83; Catriona Mackenzie, *Abortion and Embodiment* (1992) 70(2) *Australas. J. Philos.* 136, 147.
[55] Virginia Held, *Feminist Morality* (University of Chicago Press, 1993) p.27-28.
[56] Greasley (2019, n9) p.113-114.
[57] Katrina Kimport and Monica R. McLemore, 'The Problem with "Justifying" Abortion: Why Real Reproductive Justice Cannot Be Achieved by Theorizing the Legitimacy of Abortion' (2022) 9(1) *Women's Reprod. Health* 27.

already argued in the previous chapter, feminist rights claims must be premised on a concrete foundation. Further, as abortion is so widely contested, this right must be grounded by appeals to legitimacy.

Further, the uncertainty in outcome of the ethics of care approach leaves it open to be exploited in order to justify restrictions on abortion. As explored in the previous chapter, the ethics of care approach tends to rely on stereotypes of women as mothers and carers without sufficient acknowledgment of how women are socialised. The reliance on women's traditional domestic role in this approach risks reinforcing women's reproductive roles, and the concept of care can be co-opted to undermine support for access to abortion.[58] For example, Celia Wolfe-Devine argued that abortion is a 'masculine' response to an unwanted pregnancy (abortion is characterised as violence exerted to maintain control) and a 'feminine' approach, which would prioritise the value of care, requires the pregnant person to view the pregnancy as an intimate relationship to be nurtured.[59] Any discussion around the pregnant person's rights or bodily integrity reflect, according to Wolfe-Devine, the masculine ethic of justice.[60] This is, however, a marked departure from the relational approach set out by Carol Gilligan. *In A Different Voice* contained a study on abortion decisions, in which Gilligan sought to highlight how pregnant people are likely to consider their relationship to the foetus, including projections as to whether they would be able to care for a child once born, in deciding whether or not to have an abortion.[61] Gilligan's approach thus did not hold that this relationship ought to be the sole determining factor which justifies abortion, but rather

[58] Pamela S. Karlan and Daniel R. Ortiz, 'In a Diffident Voice: Relational Feminism, Abortion Rights, and the Feminist Legal Agenda' (1993) 87(3) *Northwest. Univ. Law Rev.* 858, 896.
[59] Celia Wolfe-Devine, 'Abortion and the "Feminine Voice"' (1989) 3(3) *Public Aff. Q.* 81.
[60] *Ibid* 87.
[61] Carol Gilligan, *In A Different Voice* (first published 1982, Harvard University Press, 1993).

that these relational issues must be taken as relevant. The PGC similarly requires consideration of the relational issues around abortion in its application, in addition to the moral status of the foetus.

Gilligan's work and subsequent feminist thought has raised the important issue that the relational and contextual factors involved in abortion decisions are usually absent from the 'pro-life' versus 'pro-choice' debates. In doing so, feminists have critiqued moral approaches to abortion which ignore the pregnant person, instead focusing entirely on the foetus. Rosalind Petchesky explored the imagery used by anti-abortion groups, noting that they presented the foetus as solitary, excluding the pregnant person from the image.[62] This idea that the foetus is presented as a 'free-floating entity' which renders the pregnant person invisible in abortion debates can be found in much of the feminist literature, thus leading many feminist scholars to emphasise the relationship between the foetus and the pregnant person to whom it is connected.[63] Relevant to this relationship are broader considerations such as the pregnant person's relationships, socio-economic conditions, health needs, and other conditions of freedom, all of which can affect whether a pregnant persons decides to continue a pregnancy or not.[64] Janet Hadley thus argues that it is not convenience or trivial reasons but rather 'the economic pressures of a society marked by poverty, racism, poor housing, and person and institutional injustice and oppression towards women' that lead pregnant people to have abortions. [65] The recognition of the possible harms of restricting abortion and the

[62] Rosalind Pollack Petchesky, 'Fetal Images: The Power of Visual Culture in the Politics of Reproduction' (1987) 13(2) *Fem. Stud.* 263, 268.
[63] Mackenzie (n54) 136; Sherwin (n32) 328.
[64] Petchesky (n62) 288; Sherwin (n32) 329.
[65] Hadley (n54) p.84.

contexts in which pregnant people make decisions regarding ending a pregnancy indicate circumstances in which a later abortion may be morally justified.

These relational issues, as identified by Gilligan and many other feminists, must therefore be incorporated into the application of the PGC to abortion. However, the status of the foetus remains determinative. Under the ethics of care approach, the moral status of the foetus is conditional on how the pregnant person feels about it, which fails to address anti-abortion arguments (as shown above, this approach can possibly support the view that abortion is morally impermissible) and cannot inform a cohesive legal or regulatory response.[66] The concern that the foetus takes central stage in the abortion debate, to the exclusion of the pregnant person, has increasingly translated into the view that any accepting that the foetus has any moral status is contrary to feminist perspectives. Greasley has questioned this view, arguing that the methodological disagreement between feminist and non-feminist approaches is largely illusory.[67] The recognition that the foetus has moral status will inevitably alter the outcome of any approach to abortion, but this does not axiomatically relegate the pregnant person to a secondary position, nor is it incompatible with feminist perspectives on abortion. While the PGC requires an increasing degree of protection to be afforded to the foetus as it develops, abortion in the early stages of pregnancy is morally acceptable and later abortions can be justified where basic harm (construed broadly in light of the factors explored above) would be otherwise caused to the pregnant person. Recognising the potential harm caused by restricting abortion, considered broadly to include the mental health implications of unwanted pregnancy and the relevance of gender stereotypes,

[66] Karlan and Ortiz (n58) 891.
[67] Greasley (2019, n9) p.107-108.

race, socio-economic status, and a broad range of other contextual issues, can point to a range of circumstances in which later abortions can be morally justified.

The final concern to be addressed here relates to the wider potential implications of recognising that the foetus has moral status. Feminists have raised concerns about extending legal protections to foetuses which could support forced medical treatment and place the blame on pregnant people who experience miscarriages or stillbirths.[68] Foetal protection laws have increasingly arisen in the US in recent years, criminalising drug or alcohol use during pregnancy and invoking child protection laws against people who have experienced the loss of a pregnancy, including as a result of suicide attempts or accidents such as falling down a flight of stairs.[69] Black and poor women have been disproportionately targeted by these foetal protection measures.[70] This is in the US context, where issues such as one's health and socio-economic status are seen as a matter of individual responsibility, leading to pregnant people being held entirely accountable for the outcome of their pregnancy. However, foetal protection laws which criminalise pregnant people acting to protect their generic rights would be a violation of the PGC, as would the lack of universal healthcare and the failure of the state to address poverty and racial disparities.

[68] Warren (n12) 59-60.
[69] Goodwin (n17) Ch. 3.
[70] *Ibid.*

### iv. Protecting the Rights of the Pregnant Person Alongside the Foetus

The precautionary approach requires protecting the foetus in conjunction with protecting the generic rights of people capable of gestating. Rosalind Petchesky and Karen Judd argue that individuals 'cannot exercise their reproductive and sexual rights without the necessary enabling conditions for their empowerment' which include cultural and political supports, such as education and political power, as well as material and structural supports, such as childcare and reliable transport.[71] The positive duties placed on individuals by the PGC translate into positive duties on the state, as the state is better equipped than individuals to address the multidimensional issues around abortion in order to ensure the generic rights of people capable of becoming pregnant and give effect to the positive duties on pregnant people to protect the interest rights of the foetus.

The PGC therefore imposes obligations on the state to provide comprehensive sexual and reproductive health education and services, adequate and accessible healthcare services including maternity care and mental health services, including support for drug and alcohol addictions, emotional and psychological support for pregnant people and new parents, and guaranteeing a range of other conditions including food, water, housing, sanitation, social and economic support, safe environmental conditions, and safe working conditions including maternity leave. In addition, the state would have obligations to address inequalities in birth outcomes resulting from race and socio-economic status and ensure the enabling conditions for all people to raise their children, including those with disabilities. Reproductive inequalities are connected to a

[71] Rosalind P. Petchesky and Karen Judd, *Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures* (Zed Books, 1998) p.4-5.

wide range of gendered and racialised issues, including gender-based violence and economic, political, and educational disparities which the state must also address. Population policies which seek to restrict the number of children one may have apply pressure on pregnant people to have abortions, and therefore violate the rights of both the pregnant person and foetus.

Access to abortion must be viewed in the context of a range of sexual and reproductive health services such as 'access to contraception, abortion counselling and clinics, ante and postnatal care, reproductive health screenings, treatment for reproductive cancers and HIV, amongst other conditions' which must be 'non-prejudicial and universally accessible'.[72] Universally accessible contraception is a fundamental for protecting the generic rights of people capable of gestating, in the context of avoiding unwanted pregnancies. Access to contraception must include emergency contraception, and the availability of a range of safe and effective contraceptive methods, which healthcare professionals are properly trained to administer. Training must also be culturally and gender sensitive.

Additionally, the provision of adequate information or counselling on different contraceptive methods is necessary so that individuals may make informed decisions over their use of contraception. This is particularly important given the potential side-effects associated with hormonal contraception, which include negative impacts on physical and mental health; mood disorders and depression is relatively common among users of hormonal contraception, particularly in adolescents.[73] Thus, Leigh Senderowicz

[72] Sumi Madhok, Maya Unnithan, and Carolyn Heitmeyer, 'On Reproductive Justice: 'Domestic Violence', Rights and the Law in India' (2014) 16(10) *Cult. Health Sex.* 1231, 1241.
[73] Charlotte Wessel Skovlund and others, 'Association of Hormonal Contraception with Depression' (2016) 73(11) *JAMA Psych.* 1154.

argues in the context of family planning programmes that maximising contraceptive autonomy requires people to be able to make full, free, and informed choice, so the intentional non-use of contraception must be seen as a positive outcome.[74] Senderowicz highlights issues with contraceptive coercion in family planning programmes operating in lower-income states, with people denied their preferred contraception and coerced into an alternative method and people who do not want to use contraception compelled to do so.[75] There are then broader issues with contraceptive coercion, including the non-consensual sterilisation of marginalised groups, for example the targeting of poor and lower caste women for mass coerced sterilisation and unsafe injectable contraceptives in India.[76] In considering the contraceptive autonomy of people who are not competent, scholars focusing on women with learning disabilities have highlighted the importance of providing assistance so that they are enabled to exercise choice rather than other people making contraceptive decisions on their behalf.[77] To ensure the generic rights of people capable of gestating, the state has an obligation to provide access to, and information about, a range of contraceptives that guarantees free informed choice, including for non-competent people.

As argued above, in the event of an unwanted pregnancy, there is a moral right to abortion without providing a reason in the early stages of pregnancy. While abortion may thus be increasingly morally problematic as the pregnancy progresses, there are, as outlined above, a non-exhaustive range of possible justifications for abortion in the later

[74] Leigh Senderowicz, 'Contraceptive Autonomy: Conceptions and Measurement of a Novel Family Planning Indicator' (2020) 51(2) *Stud. Fam. Plan.* 161.
[75] Leigh Senderowicz, '"I was obligated to accept": A qualitative exploration of contraceptive coercion' (2019) 239 *Soc. Sci. Med.* 112531.
[76] See: Kalpana Wilson, 'For Reproductive Justice in an Era of Gates and Modi: The Violence of India's Population Policies' (2018) 119 *Fem. Rev.* 89.
[77] Susan Ledger and others, 'Contraceptive Decision-Making and Women with Learning Disabilities' (2016) 19(5-6) *Sexualities* 698.

stages, including on the basis of the pregnant person's physical and mental health, the risks involved in pregnancy depending on the person's intersectional characteristics and country of residence, and the issue that preventing access to abortion may push people towards clandestine and potentially unsafe methods of abortion. In addition, feminist scholars have sought to counter the idea that a pregnant person might seek a later abortion for trivial reasons, pointing out that abortion decisions are made in relation to the pregnant person's personal and social context, including gender and racial inequality.

In the event of an unwanted pregnancy, there is a moral right to abortion without providing a reason in the early stages of pregnancy. Accessible early abortion, when supported by measures to empower people to prevent unwanted pregnancy, ensures the generic rights of people capable of gestating. The state would be required to make abortion accessible as early as possible by minimising delays. This requires addressing multiple issues, including many noted above, such as: the provision of comprehensive sexual and reproductive health education and the combatting of stigma around sex, menstruation, and abortion so that people may identify pregnancy early on; the provision of easily accessible pregnancy testing services; and ensuring the universal accessibility of abortion services with minimal unnecessary barriers (which will be considered in depth in the next chapter). Protection for the foetus would also support this approach, by ensuring that the majority of abortions take place early into the pregnancy.

However, the state must also ensure that provisions are made for later abortions. As argued above, when considering the multidimensional issues relevant to later abortions, including issues of structural inequalities, an approach which seriously restricts later abortion is likely to violate the generic rights of some pregnant people. There are various grounds on which a later abortion is likely to be morally justified, and

the state's response thus has to balance the potential harm caused by permitting a small number of later abortions for morally problematic reasons, and that caused to pregnant people by preventing abortion where it would be morally justified. Thus, I argue that the application of the PGC to later abortion requires a precautionary approach in relation to the possible violation of pregnant people's rights, which is a likely result of restrictions on later abortion. This is particularly the case in the current context, where the structural inequalities highlighted above, relating to health, gender, race, and socio-economic status among others, are pervasive.

States would, however, still have obligations to address these inequalities. People have abortions in cases of physical health conditions that would have been avoidable with the provision of adequate healthcare, poverty, and rape, for example, where the decision to terminate a pregnancy is the outcome of external issues. These structural inequalities must be addressed by the state, to minimise unwanted pregnancies including those resulting from sexual assault and ensure that people can continue their wanted pregnancies to term. As mentioned above, the state must also make efforts to combat discriminatory attitudes towards people with disabilities and provide material support to parents of disabled children. However, prohibitions on later abortions will not address these issues nor prevent later abortions, as people will seek clandestine methods.

In light of the above, I argue that there are four key presumptions which must be considered in a regulatory response to abortion (henceforth referred to as policy presumptions):

i. Early abortions are morally justifiable, which supports allowing abortion on request without providing a reason other than that the pregnant person does not want to continue their pregnancy.

ii. Throughout the pregnancy, the foetus increasingly develops agential characteristics. Precaution requires that interest rights of the foetus are protected, so abortion becomes harder to justify as the pregnancy progresses. This presumption is qualified by the following.

iii. Abortion after the early stages of pregnancy may be necessary for a broad range of reasons. Precaution in relation to the rights of pregnant people is necessary, as restrictions on abortion risk violating the rights of pregnant people, as apparent agents, to a greater extent than allowing abortion risks violating those of the foetus.

iv. The generic rights of the pregnant person and the foetus' interest rights require a range of measures relating to the conditions in which people make abortion decisions.

In the following section, I will apply these four policy presumptions based on the PGC to the international human rights context to inform the recognition of a human right to abortion. I will then set out a framework for progressively realising this right.

## *2. Framing a Human Right to Abortion*

In Chapter 2, I outlined the issues with the current approach to abortion in the international human rights framework, which requires a higher threshold of harm for restrictions on abortion to be considered a rights violation. This higher threshold means that states are required to provide access to legal abortion in exceptional circumstances (where there is a risk to the life or health of the pregnant person, in cases of rape, or

where the foetus has a fatal impairment) and decriminalise abortion to avoid pushing people to undergo unsafe abortions. However, there is little pressure on states to legalise abortion beyond these grounds, and while the Committee on Economic, Social, and Cultural Rights (CESCR) and the Committee on the Elimination of Discrimination Against Women (CEDAW) have commented on the importance of universal and consistent access to abortion services, treaty bodies have not adequately engaged with the structural barriers to abortion and other sexual and reproductive health services.

In addition, the approach of the current international human rights framework to abortion is fragmented, with treaty bodies taking varying positions, and its effectiveness is limited by the broader issues with implementation. Highlighting that the current international human rights framework fails to adequately respond to the worldwide disparities in access to abortion, I argued that the feminist transformation of human rights was necessary to address this. I also considered the reproductive justice framing as important for engaging with the gender, class, and race-based dimensions of access to abortion, and the range of other conditions (such as access to contraception, healthcare, housing etc.) required for people to make meaningful decisions around their pregnancies.

In Chapter 3, I set out the PGC as the basis for a feminist transformation of the international human rights framework which would ground genuinely universal rights, thus addressing the conceptual issues with the current framework around gender-based rights issues, cross-cultural traction, and economic, social, and cultural rights. In the first section of this chapter, I applied the PGC to abortion alongside feminist and relational values, to establish that there is a moral right to abortion which must be recognised as a human right. I also set out a number of policy presumptions which must be translated into the international human rights framework. However, in establishing a human rights

response to abortion at the global level, there are an additional range of contextual issues that must also be accounted for. There are worldwide differences in gender inequalities and socio-demographic groups facing discrimination based on caste, race, religion, nationality, disability, sexuality and gender identity, and against Indigenous Peoples. There are also significant economic disparities within and across states, with people living in poverty and states lacking the resources to provide comprehensive access to healthcare and other basic services. For states with significant rural populations, there are additional barriers to accessing healthcare services.[78] All of these issues affect access to sexual and reproductive health services, with significant variations worldwide in access to contraception, abortion, sexual and reproductive health education, and pregnancy-related healthcare, and other limitations on reproductive decision-making resulting from population policies and coercive family planning, as mentioned above.

In recognising a human right to abortion, the human rights framework must also connect this to a range of other rights around reproduction and the broader conditions required by the PGC. Addressing the socio-economic dimensions of access to abortion, as linked to those broader conditions, is fundamentally important. Therefore, I argue that it is necessary to frame a human right to abortion as a socio-economic right which goes beyond the question of legalisation alone. The remainder of this chapter will consider the presumptions and issues raised above to establish the grounds on which states should legalise abortion and set out an argument for decriminalising abortion. In order to address the contextual issues raised above and acknowledge the different starting points of states in their ability to provide access to abortion services, I then set out a framework

[78] See: Lisa R. Pruitt and Marta R. Vanegas, 'Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law' (2015) 30 *Berkeley J. Gender, L. and Just.* 76; B. Subha Sri and T.K. Sundari Ravindran, 'Medical abortion: Understanding perspectives of rural and marginalized women from rural South India' (2012) 118 *Int. J. Gynecol. Obstet.* 33.

for progressive realisation to identify steps that states must take to work towards the universal provision of abortion services and address structural and intersectional inequalities. Additionally, as the starting point of states worldwide varies dramatically in terms of opposition to abortion, this framework for progressive realisation will also recognise a minimum core content in terms of the grounds on which abortion must be legalised, but states must take steps towards full compliance by gradually liberalising their abortion laws. This framework thus intends to balance the requirements of the PGC with what is realistic in the first instance, without resulting in the compromise position that the current human rights framework has adopted.

### *2.1. Early Abortion on Request*

As already established, early abortion is, in the ordinary case, morally unproblematic as the foetus demonstrates only minimal agential characteristics in comparison with the pregnant person. The first policy presumption, that early abortion is permissible for any reason, would thus support a model of abortion on request, with no requirements that a pregnant person must justify their decision to a medical professional. An analysis of global abortion laws and policies in 2018 found that 32% of countries already allow abortion on request, highlighting that there already exists some support for abortion without justification worldwide.[79] Almost all European states allow abortion on request, though a number of them also require mandatory counselling or a several day waiting

[79] Antonella F. Lavelanet and others, 'Global Abortion Policies Database: a descriptive analysis of the legal categories of lawful abortion' (2018) 18(44) *BMC Int. Health Hum. Rts.* 1.

period.[80] Most states also impose gestational time limits for abortion on request, with 12 or 14 weeks as the average, though some states have a later time limit.[81]

The early stage of pregnancy, the first trimester, is the first 12 weeks' gestation, after which the foetus begins to develop agential characteristics such as limb movement and rudimentary brain activity. This point could therefore represent a significant precautionary threshold. However, if the human rights framework is to require all states to introduce early abortion on request, there are potential issues with setting a rigid gestational time limit at this point. Access to abortion within the first 12 weeks requires adequate sexual and reproductive health education, in order to understand the early signs of pregnancy, and access to pregnancy testing and abortion services without delay. As noted above, delays are likely to be caused by the imposition of additional barriers, distances from abortion providers, socio-economic and other structural and intersectional inequalities. Pregnant people unable to access abortion services within this time limit will likely travel to a state with an extended time limit to have an abortion or seek alternative means of terminating their pregnancy. For example, Ireland now permits abortion on request up to 12 weeks' gestation but prohibits abortion after this point unless the pregnant person's life or health is at risk or where the foetus has a fatal impairment.[82] However, pregnant people from Ireland continue to travel elsewhere to access abortion services; in 2021, 206 people travelled from Ireland to England and Wales for abortions.[83]

[80] Center for Reproductive Rights, 'European Abortion Laws: A Comparative Overview' (3 Mar 2021) <https://reproductiverights.org/european-abortion-law-comparative-overview-0/> accessed 14 January 2023.
[81] Center for Reproductive Rights, 'The World's Abortion Laws' <https://maps.reproductiverights.org/worldabortionlaws> accessed 14 January 2023.
[82] Health (Regulation of Termination of Pregnancy) Act 2018 s.9-12.
[83] Department of Health & Social Care (n43).

Additionally, as Joanna Erdman points out, there are inconsistencies in how gestational age is measured.[84] Medical professionals may measure gestational age from the pregnant person's last menstrual period (LMP), assuming the pregnant person has kept an accurate record, by developmental age, or by uterine size, and these estimates are routinely off by a few weeks, resulting in variations in access to abortion.[85] Jackson has also critiqued the fictional start date of a pregnancy relied upon in abortion provision, as the date of fertilisation or implantation is unknowable, unless reproductive technologies were used.[86] Even where the pregnant person has kept an accurate record, calculating gestational age by LMP still may mean that the pregnancy start date is estimated at a few weeks earlier than it actually was.[87] Technology such as ultrasound is required for more accurate gestational age estimation, and this requires states, regions, and particular health facilities to have sufficient resources. Thus, there is likely to be a pronounced variation in the accuracy of gestational age measurements worldwide. For example, study of gestational age estimation in Rajasthan, India found that LMP and fundal height measurement (the size of the pregnant person's stomach) were most commonly used, despite their limited accuracy.[88] Providers were often unable to directly offer ultrasound, a more accurate method of measuring gestational age, and where ultrasound was available, this was usually after the first trimester.[89] Imposing a rigid time limit for abortion on request does not account for the variations in measuring gestational age and problems with assuming that people are able to discover that they are pregnant

[84] Joanna N. Erdman, 'Theorizing Time in Abortion Law and Human Rights' (2017) 19(1) *Health Hum. Rts. J.* 29, 42.
[85] *Ibid*.
[86] Jackson (n7) p.79.
[87] *Ibid*.
[88] Kerry Scott and others, '"I can guess the month… but beyond that, I can't tell" an exploratory qualitative study of health care provider perspectives on gestational age estimation in Rajasthan, India' (2020) 20(529) *BMC Pregnancy Childb.* 1.
[89] *Ibid*.

and access abortion within this time frame. Even where gestational age estimation is accurate and the pregnant person requests an abortion within the time frame, there may be delays of weeks until they can obtain one due to capacity or resource constraints.

12 weeks' is an important threshold, and one which has already been accepted by many states, as noted above. States should therefore be required to allow abortion on request *at least* up to 12 weeks, accompanied with obligations that states also remove barriers that may cause delays, ensure universal, consistent, and equal access to sexual and reproductive health education and services, and address inequalities in access. In addition, to minimise the potential variations and inconsistencies in measuring gestational age which impact pregnant people's ability to access abortion services in this time frame, states must ensure that accurate means of estimation (such as LMR in conjunction with ultrasound) are provided. Where states unable to provide universal means of accurate gestational age estimation, it is necessary for those states to set a later gestational time limit for early access to abortion to account for likely misestimates which would obstruct and delay access to abortion. Where this is necessary, states must have processes in place to determine when to set this later gestational age limit. This need not be a legal time limit but could be regulated at the medical level to account for regional variations within states that impact the resources available to medical facilities. Aside from difficulties with gestational age estimation, there are variations across states and regions in access to pregnancy testing and abortion and other issues such as the likelihood that people will discover their pregnancies too late to obtain an abortion before the 12-week limit. As it is inevitable that some pregnant people will require abortions after this point for a range of reasons, states must also ensure access to later abortions on broad grounds.

## *2.2. Grounds for Later Abortions*

Applying the third and fourth policy presumptions that precaution must be taken in relation to later abortions, due to the range of contextual issues that point towards the provision of later abortions as necessary, the human rights framework must require non-restrictive access to abortion after the 12-week limit. Even where pregnant people have access to early abortion on request, states must also provide abortion services in the later stages of pregnancy. As highlighted above, there are a range of reasons why a person may require a later abortion, including risks to life and health, fatal foetal impairments, rape (as trauma and distress may delay the victim/survivor from seeking an abortion) and intimate partner violence, socio-economic issues, and changing personal circumstances. Additionally, the potential inconsistencies in estimating gestational age, people discovering their pregnancy late, and delays in accessing abortion services due to a range of structural inequalities also point towards the need to ensure access to later abortions.

The international human rights framework already recognises the need for states to legalise abortion where there is a risk to the life or health of the pregnant person, in cases of rape, and where the foetus has a fatal impairment. However, there are problems with the setting out of these limited exceptions to prohibitions on later abortions, which will leave many pregnant people without access to the abortion services they require. As already argued in the first section of this chapter, grounds for abortion relating to the risk to the pregnant person's health or life must be interpreted broadly to encompass a range of considerations. The impact on a person's metal health if they are forced to continue an unwanted pregnancy and give birth to an unwanted child is of particular importance. There are a range of factors that may lead a person to seek an

abortion, beyond health-based considerations and including social and economic issues. Even where abortion on request is available, and thus abortion is already permissible for these reasons in the early stages of pregnancy, states must be responsive to the delays in accessing services that have been highlighted above. As these delays are more likely to impact marginalised groups, states' obligations to address structural and intersectional inequalities will require them to ensure access to abortion in the later stages of pregnancy in order to avoid perpetuating cycles of inequality.

There are also further issues with the setting out of specific grounds which a pregnant person must meet in order to have an abortion. For example, legislation demarcating rape as a legal ground for abortion will require pregnant people to disclose a traumatic event to their doctor. This is in the context of gender and racial stereotyping and pervasive socio-cultural perceptions of rape which result in the blaming of victims/survivors.[90] Even where there is no requirement to report a rape to the police or provide evidence of rape to access an abortion, the issue of whether a pregnant person is making a truthful rape claim persists. In Germany, healthcare professionals must have 'strong reasons to believe' that the pregnancy resulted from an unlawful act.[91] The influence of problematic stereotypes around rape victims/survivors and undue concern over false allegations could thus result in the denial of access to abortion where the pregnant person is not believed. In any event, requiring the disclosure of rape to medical professionals is an onerous burden. This is not to suggest that rape grounds should never be included, as this would be preferable in the context of a restrictive regime where there

[90] Heather D. Flowe and others, 'Rape stereotyping and public delusion' (2009) 20(4) *Br. Journal. Rev.* 21; Stephanie Bonnes, 'Gender and Racial Stereotyping in Rape Coverage' (2013) 13(2) *Fem. Med. Stud.* 208.
[91] German Criminal Code, §218a(3).

would be no other avenue for rape victims to access abortion. However, a preferable approach would be to encompass rape within a broader ground for abortion

### i. Foetal Impairments

Further issues arise in relation to specific grounds allowing later abortions for fatal foetal impairments. As argued above, there are issues with exceptions to prohibitions on later abortions in cases of foetal impairment, as this discriminates between disabled and non-disabled foetuses. Access to abortion in cases of fatal foetal impairment is necessary, but it is also difficult to neatly distinguish fatal from non-fatal impairments. Additionally, some non-fatal impairments can have significant health implications and cause pain to the child once born, and it is important that pregnant people are not forced to have children in contexts that would be distressing and difficult for both the parents and child. As Máiréad Enright and Fiona de Londras have argued, being forced to have a baby with an impairment which is not fatal but nevertheless affects its quality of life can be just as distressing to a pregnant person as being forced to continue a non-viable pregnancy.[92] However, there is also an issue with forcing pregnant people to have children with non-fatal impairments even where this would not be the case, particularly in contexts where people with disabilities face significant stigma and discrimination, and where there is inadequate state support for disabled people and parents of disabled children. The decision to abort a wanted pregnancy on the basis of a foetal impairment is a complex

[92] Fiona De Londras and Máiréad Enright, *Repealing the Eighth* (Policy Press, 2018) p.101,108.

one, and flexibility is required to ensure that pregnant people are able to make a decision based on their specific circumstances.

Andrea Smith highlights that if our response to these issues lacks nuance by simply facilitating abortion for foetuses with impairments, then 'we never actually focus on changing economic policies that make raising children with disabilities difficult.'[93] By extension, prohibiting abortion for foetuses with non-fatal impairments does little to address inequalities for people with disabilities. Thus, States must also be required to address stigma and structural discrimination against people with disabilities and provide material support, including financial assistance and care, for disabled people and the parents of disabled children. Additionally, abortion must be made available for foetal impairments without further entrenching discriminatory attitudes around disabilities and having a disabled child. This would require avoiding setting out a specific ground permitting abortion for foetal impairments and ensuring that pregnant people can access abortion in similar circumstances (such as socio-economic issues) where the foetus does not have any impairment.

The Committee on the Rights of People with Disabilities (CRPD) and CEDAW issued a joint statement in 2018, on the need to legalise abortion in a manner which respects the reproductive autonomy of pregnant people without perpetuating deep-rooted stereotypes against people with disabilities.[94] Enabling access to abortion in the later stages of pregnancy for a range of reasons, going beyond the exceptional circumstances, would help to achieve this, provided that states also ensure that pregnant

[93] Andrea Smith, 'Beyond Pro-Choice versus Pro-Life: Women of Color and Reproductive Justice' (2005) 17(1) *Nat. Women's Stud. Association J.* 119, 129-130.
[94] CRPD and CEDAW, 'Joint Statement by CRPD and CEDAW: Guaranteeing sexual and reproductive health and rights for all women, in particular women with disabilities' (29 Aug 2019) <https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/1_Global/INT_CEDAW_STA_8744_E.docx> accessed 14 January 2023.

people discovering that the foetus they are carrying has an impairment are adequately informed about their future child's disability and do not feel coerced, pressured, or influenced into having an abortion. The removal of disability grounds for abortion without this expansion would likely result in basic harm to pregnant people. For example, Poland's recent removal of the foetal impairment ground for legal abortion in the context of an already restrictive regime clearly undermines the moral right to abortion without offering any increased protection for disability rights.

### ii. Abortion in the Later Stages of Pregnancy

Here, the policy presumption that limiting access to abortion in the later stages of pregnancy will inevitably result in significant violations of pregnant people's generic rights, and thus must be balanced against the precaution afforded to the foetus, must be applied. There are various complex factors pointing towards circumstances in which a later abortion will be morally justified, and so states must ensure that abortion is accessible in the later stages of pregnancy for a wide range of reasons. Demarcating specific grounds as exceptions to a general prohibition on later abortions would likely exclude many pregnant people from accessing abortion care and would, as a result, likely push them towards clandestine abortions. In addition, setting out specific grounds for rape and foetal impairments are problematic. Therefore, after the cut-off point for abortion on request, abortion must continue to be permitted for social, economic, and medical reasons. This should be interpreted broadly by states to cover the range of possible reasons for later abortions noted earlier in this chapter.

In the final stages of the pregnancy, abortion for economic and social reasons becomes much harder to justify, particularly in circumstances where the pregnant person would have been able to access abortion services prior to this point. However, abortion in the final stages must still be available for medical reasons, such as where continuing the pregnancy would threaten the pregnant person's life or cause serious harm to their physical or mental health. Relevant to such a determination is the likelihood that the pregnant person would find alternative means to terminating their pregnancy if denied a legal abortion, as a clandestine abortion at this late stage would likely present significant risks. Adopting the third policy presumption raised above, there is an issue with imposing blanket legal restrictions or gestational time limits, particularly at the international human rights level, as a pregnant person could be in a situation morally justifying a late abortion but are excluded from the remit of legislation. Rather, states may limit abortion in the final stages to serious medical reasons but should also ensure that regulatory measures are in place to assess requests for abortion in the final stages of pregnancy on a case-by-case basis.

In addition to legalising abortion for social, economic, and medical reasons after the first trimester, states must ensure that later abortion services are accessible in practice. Ensuring access to abortion will also require addressing the stigma around abortions in the later stages of pregnancy. In the US, anti-abortion movements and politicians have focused on limiting 'late-term abortions' by restricting access to abortion to the first trimester and banning 'partial-birth abortion'.[95] These are political rather than medical terms, largely in use to create concern over abortions in the later stages of pregnancy and methods of surgical abortion such as dilation and evacuation (D&E) and

[95] Guttmacher Institute, 'Later Abortion' (Nov 2019) <https://www.guttmacher.org/evidence-you-can-use/later-abortion> accessed 14 January 2023; Partial-Birth Abortion Ban Act, 18 U.S.C §1531 (2003).

dilation and extraction (D&X) and thus restrict access to later abortions.[96] These terms are misleading in inference, perpetuating myths that pregnant people in the US could have an abortion moments before birth or even commit infanticide.[97]

Further, even in states where abortion is legal in the later stages of pregnancy, there are issues with medical professionals being reluctant to provide later abortions. Later abortions are thus often inaccessible, particularly in some countries with a majority religious population, as medical professionals will conscientiously object to providing abortion care. For example, in Catholic countries such as Brazil and Poland, where abortion is already largely restricted, many medical professionals will only perform an abortion if it is necessary to save the life of the pregnant person.[98] In such circumstances, abortion may be inaccessible in practice as medical professionals conscientiously object to providing abortion services altogether or may impose arbitrary gestational time limits which are not required by law.[99] States must therefore also ensure that, in addition to the legalisation of later abortion, services are universally and consistently accessible by tackling barriers such as conscientious objection by medical professionals (which will be considered in more detail in the following chapter alongside the imposition of medically unnecessary regulations on abortion service provision).

[96] Guttmacher Institute (n94); Goodwin (n17) p.71.
[97] Goodwin (n17) p.71; Ariana Eunjung Cha, 'Tough questions – and answers – on 'late-term' abortions, the law and the women who get them' (*The Washington Post*, 6 Feb 2019) <https://www.washingtonpost.com/us-policy/2019/02/06/tough-questions-answers-late-term-abortions-law-women-who-get-them/> accessed 14 January 2023.
[98] Debora Diniz, Alberto Madeiro and Cristião Rosas, 'Conscientious objection, barriers, and abortion in the case of rape: a study among physicians in Brazil' (2014) 22(43) *Reprod. Health Matters* 141; Silvia De Zordo and Joanna Mishtal, 'Physicians and Abortion: Provision, Political Participation and Conflicts on the Ground – The Cases of Brazil and Poland' (2011) 21(3 Suppl.) *Women's Health Issues* 32.
[99] In *L.M.R v Argentina* (2011) UN Doc. CCPR/C/101/D/1608/2007, the applicant noted that the hospital denied her daughter an abortion despite a ruling from the Supreme Court of Buenos Aires stating that she was legally entitled to one, as medical professionals claimed that her pregnancy was too far advanced.

### *2.3. Decriminalisation*

Abortion remains a criminal offence in almost all countries. Within the current human rights framework, treaty bodies have recognised the need for the decriminalisation of abortion in addition to legalisation, so that pregnant people seeking abortions outside of the medico-legal system are not criminalised for doing so. However, it is unclear whether these treaty bodies are advocating the partial decriminalisation of abortion (so that abortion is decriminalised on the grounds or gestational time limits in which it is legally available but remains criminalised outside of these parameters) or full decriminalisation, so that no criminal offence for abortion is retained. Feminists advocating for the partial or full decriminalisation of abortion are usually referring to the removal of criminal offences covering the pregnant person and any third party assisting them in an illegal abortion, while offences may be retained for non-consensual or harmful abortions.

The following arguments for the decriminalisation of abortion therefore do not preclude the criminalisation of non-consensual or forced terminations and feticide, and these two issues will be addressed in more detail below. Emma Milne distinguishes between the ending of a pregnancy and the ending of the life of a foetus, arguing that terminations at very late stage of pregnancy should not be understood as abortion as this is a different act from typical abortions, most of which tend to be performed in the early stages of pregnancy.[100] It is difficult in practice to draw this definitional distinction, as it relies on moral justification – which is contextual. However, in terms of how the criminal law should respond, when I refer to the decriminalisation of abortion, I exclude involuntary pregnancy terminations and instances where a pregnancy is terminated at a

[100] Emma Milne, 'Putting The Fetus First – Legal Regulation, Motherhood, and Pregnancy' (2020) 27(1) *Mich. J. Gender & L.* 149, 176-182.

very late stage (where this is not necessary on medical grounds). Further, as criminalisation attaches negative connotations to abortion, I argue that these cases should be labelled as feticide in the criminal law, rather than abortion.

The criminalisation of abortion potentially violates the generic rights of pregnant people who have or want to have abortions. In circumstances where abortion is morally justifiable and should be made legally available and accessible by states, criminalising pregnant people who have illegal abortions is inappropriate as this is due the state's own failure to provide access to abortion. This applies not only to states where abortion is largely prohibited but also to states unable to fully comply with the right to abortion, as will be set out below, and where broader issues, such as structural inequalities in access, are unaddressed. As Rebecca Cook and Joanna Erdman argue, criminal abortion laws inflict mental and physical suffering, amount to torture and cruel, inhuman, and degrading treatment, constitute violence against women, and a range of other severe harms and violations.[101] The current human rights framework has recognised this in relation to the exceptional circumstances, but a transformed framework must recognise the harms caused by the criminalisation of pregnant people for obtaining abortion services that they should legally be able to obtain.

The policy presumption in favour of early abortion on request thus supports the full decriminalisation of abortion in the first 12 weeks of pregnancy, as all pregnant people facing an unwanted pregnancy should be able to access abortion services at this stage. The criminalisation of abortion where it is or should be legal and accessible has additional implications in relation to the stigmatising of people who have abortions and

[101] Joanna N. Erdman and Rebecca J. Cook, 'Decriminalization of abortion – A human rights imperative' (2020) 62 *Best Prac. Res. Clin. Obstet. and Gynaecol.* 11, 20.

the perpetuation of gender-based stereotypes around pregnancy and motherhood. Erica Miller argues that the criminalisation of abortion intensified the shaming and stigmatising of women who have abortions, designating them as criminals.[102] This designation is the result, Miller argues, of the continued linking of women's sexuality to reproduction and the maternal identity of pregnant women, which is rejected through the decision to have an abortion.[103] Through rejecting social expectations around motherhood, this shame is converted into ideas of a personal moral failure on the part of women having abortions.[104] Rebecca Cook similarly argues that criminalisation constructs the social meaning of abortion as inherently wrong, thus ascribing deviance to women seeking abortions.[105] The criminalisation of abortion in the early stages of pregnancy implies that abortion is morally wrong, even where it is legally permitted, contrary to the policy presumptions indicated by the PGC. In relation to the criminalisation of abortion in Britain, Sally Sheldon has argued that the retention of Section 58 of the Offences Against the Person Act 1861, which criminalises the procurement of a miscarriage, alongside the Abortion Act 1967 reinforces the narrative of medical paternalism.[106] As pregnant people are prohibited from obtaining an abortion outside of the legal regulatory framework established by the Abortion Act, criminalisation suggests that women are incapable of making decisions relating to their pregnancy without medical supervision.[107] This again reinforces gender stereotypes.

[102] Miller (n42) p.218.
[103] *Ibid* p.218-219.
[104] *Ibid*.
[105] Rebecca J. Cook, 'Stigmatized Meanings of Criminal Abortion Law' in Rebecca J. Cook, Joanna N. Erdman, and Bernard M. Dickens (Eds), *Abortion Law in Transnational Perspective* (University of Pennsylvania Press, 2014) p.347, 349.
[106] Sally Sheldon, 'The Decriminalisation of Abortion: An Argument for Modernisation' (2016) 36(2) *Oxf. J. Legal Stud.* 334, 356.
[107] Milne (n100) 179.

The criminalisation of abortion in circumstances where abortion is morally permissible is therefore a process of gender stereotyping, with wider implications for all people capable of becoming pregnant by treating their bodies as 'societal procreative assets'.[108] Fiona Bloomer, Claire Pierson, and Sylvia Estrada Claudio have thus argued that criminalisation 'allows women minimal control over their reproductive lives in most settings' and at worst, completely denies reproductive self-determination.[109] These gendered dimensions have been recognised by CEDAW in characterising the criminalisation of abortion and forced continuation of pregnancy as 'gender-based violence' and elsewhere linking restrictions on abortion to gender stereotypes.[110] The decriminalisation of abortion in the early stages of pregnancy is necessary as criminalisation unjustifiably stigmatises pregnant people for obtaining abortions that they are or should be legally able to have by reinforcing gender stereotypes.

After 12 weeks, or later where states must extend the timeframe for early abortion on request to account for the lack of accurate means of estimating gestational age, states must continue to provide access to abortion, though with some additional conditions or restrictions. The increasing precaution that must be afforded to the foetus throughout the pregnancy raises potential issues with the full decriminalisation of abortion in the later stages. However, the human rights framework must acknowledge that while states are unable to fully comply with the right to abortion as set out below, decriminalisation is an important harm reduction strategy. The inability or unwillingness

[108] Charles Ngwena, 'Access to Safe Abortion as a Human Right in the African Region: Lessons from Emerging Jurisprudence of UN Treaty Monitoring Bodies (2013) 29(2) *S. Afr. J. Hum. Rts.* 399, 424.
[109] Fiona Bloomer, Claire Pierson, and Sylvia Estrada Claudio, *Reimagining Global Abortion Politics* (Policy Press, 2019) p.29.
[110] CEDAW, 'General Recommendation No. 35 on Gender-Based Violence Against Women' (26 July 2017) UN Doc. CEDAW/C/GC/35, para. 18; *L.C. v Peru* (2011) UN Doc. CEDAW/C/50/D/22/2009, para. 8.15; CEDAW, 'Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to CEDAW' (6 March 2018) UN Doc. CEDAW/C/OP.8/GBR/1, para. 73.

of a state to provide universal access to safe, legal abortion services will invariably result in pregnant people having clandestine abortions, both in the early and later stages of pregnancy. As with the criminalisation of abortion in the early stages of pregnancy, there are similar issues with criminalising pregnant people for having abortions they are or should be legally entitled to have at this later stage, particularly where having a later clandestine abortion is the result of the state's own failure to provide timely access. There are then further issues with criminalisation in states where abortion is prohibited as this increases the likelihood that clandestine abortions will be unsafe.

Treaty bodies such as the Human Rights Committee and CESCR have connected the importance of decriminalising abortion to state obligations to reduce numbers of unsafe abortions. The criminalisation of abortion increases the risk of unsafe abortion, as pregnant people seeking clandestine abortions may be unable to access information on how to safely terminate a pregnancy, or the threat of criminalisation deters them from seeking necessary aftercare where the abortion goes wrong. As those that assist with an illegal abortion, as well as the pregnant person, may also face punitive charges, criminalisation has a chilling effect on medical professionals who may be reluctant to provide any information on abortion.[111] Medical professionals may also have a legal obligation to report any indication that a person has undergone an illegal abortion, preventing people from seeking post-abortion care which could, in many instances, have significant health implications or even be fatal. In Poland, pregnant people are not criminalised for having clandestine abortions, but medical professionals face up to two years in prison for performing an illegal abortion.[112] Between medical professionals who

[111] De Londras and Enright (n92) p.87.
[112] The Family Planning, Human Embryo Protection and Conditions of Permissibility of Abortion Act 1993, Article 7(2).

conscientiously object to the provision of abortion, and those that fear facing criminal charges if they provide abortion care, this leaves very few doctors willing to terminate pregnancies even on the legal grounds.[113] This makes it more likely that pregnant people, particularly those without the resources to travel to another country, will seek means of terminating their own pregnancies without accessing healthcare from medical professionals.

Additionally, people from already marginalised groups are more likely to face more barriers to abortion access and are also more likely to be disproportionately affected by criminalisation of abortion. In the US, poor people and people of colour, particularly poor Black women, are more likely to be targeted by foetal protection laws; Goodwin has highlighted a number of cases where marginalised women have been charged for harming their foetuses by falling down stairs, attempting suicide, through drug use, or are blamed for having stillbirths.[114] In El Salvador, where abortion is entirely illegal, people suspected of inducing an abortion are often charged and sentenced to between 30 and 50 years in prison, with the result that people experiencing miscarriages, stillbirths, and obstetric emergencies are often also accused of having an illegal abortion.[115] This overwhelmingly affects poor, working class, and rural people, as most of the women prosecuted are reported by staff at public hospitals.[116] The use of the medical abortion pills, misoprostol and mifepristone, have become increasingly used as a safe and effective method of early clandestine abortion in countries where abortion

[113] Joanna Plucinska and Kuba Stezycki, 'Polish doctors torn over mental health as grounds to bypass near-total abortion ban' (*Reuters*, 20 Mar 2021) <https://www.reuters.com/article/us-poland-abortion-idUSKBN2BC06F> accessed 14 January 2023.
[114] Goodwin (n17) Chs. 2-3.
[115] Citizens Coalition for the Decriminalization of Abortion on Grounds of Health, Ethics and Fetal Anomaly, El Salvador, 'From hospital to jail: the impact of women of El Salvador's total criminalization of abortion' (2014) 22(44) *Reprod. Health Matters* 52, 52-53.
[116] *Ibid* 53-54.

remains illegal, and are available from legitimate online providers.[117] However, poorer people and other marginalised pregnant people, including those without access to the internet and other sources of information on abortion, are more likely to experience delays in obtaining a clandestine abortion, are more likely to have an unsafe abortion, and are then more likely to be criminalised upon seeking aftercare.

Within the human rights framework, the decriminalisation of abortion is important where states are unable to fully comply with the right to abortion in order to facilitate access to abortion services. In relation to abortions taking place after 12 weeks' gestation, there is a concern over pregnancy termination for frivolous reasons at a later stage which cannot be supported by the PGC and would therefore justify criminalisation. However, the international human rights framework operates in the following context: no states fully comply with the right to abortion; many states have anti-abortion governments deliberately obstructing access to abortion and imposing disproportionate penalties for illegal abortion; and other states apply criminal offences for abortion inappropriately to cover instances where person should be entitled to an abortion and in ways which disproportionately affect certain groups. There are limitations to the international human rights framework because of the worldwide variation in how states respond to abortion, and the framework cannot adopt a perfect position due to the balances that must be struck. It would be inappropriate to support criminalisation in this context, at least until states can comply with most of the requirements set out in the

[117] Kinga Jelinska and Susan Yanow, 'Putting abortion pills into women's hands: realizing the full potential of medical abortion' (2018) 97(2) *Contraception* 86; Julia McReynolds-Pérez, 'Abortion as empowerment: reproductive rights activism in a legally restricted context' (2017) 17 (Suppl 2) *BMC Pregnancy Childb.* 350, 351; Bloomer, Pierson, and Claudio (n109) Ch. 3.

following section of this chapter. The decriminalisation of abortion in the middle stages of pregnancy is therefore advocated for on pragmatic, rather than moral, grounds.

The decriminalisation of abortion would not amount to deregulation, as Jonathan Herring, Emily Jackson, and Sally Sheldon explain in relation to Britain. Abortion provision is already subject to a range of regulations and processes of informed consent and confidentiality to safeguard pregnant people, and particularly pregnant adolescents and adults lacking competence, from coercion.[118] Other states must also adopt similar regulatory measures to ensure that an abortion is voluntary and consensual. In addition, states should retain criminal offences for the non-consensual termination of pregnancy and feticide. In Britain, the sections of the Offences Against the Person Act which cover abortion are generally used to prosecute people in these two instances, as there is little demand to criminalise people having earlier abortions outside the regulatory framework of the Abortion Act 1967.[119] However, these offences are covered by broad provisions around illegal abortion which do also cover instances of early abortion outside the medico-legal system and therefore stigmatise abortion seekers.

A specific offence for the non-consensual termination of pregnancy would cover instances where a third-party performs or causes and pregnancy termination without the consent or prior knowledge of the pregnant person. This offence should apply for the termination of a pregnancy at any stage, including the early stages of pregnancy, to recognise the harm done to both the pregnant person and foetus. Feticide, as suggested above, refers to the killing of the foetus in the very late stage of pregnancy. However, states must ensure that any feticide offences are not applied inappropriately, such as to

[118] Jonathan Herring, Emily Jackson, and Sally Sheldon, 'Would decriminalisation mean deregulation?' in Sally Sheldon and Kaye Wellings (Eds), *Decriminalising Abortion in the UK* (Policy Press, 2020).
[119] Sheldon (n106) 339-40; Milne (n100) 180.

cover to stillbirths or abortions as in the US and Salvadorean examples raised above, or as a blanket offence that would impact pregnant people requiring late abortions for medical reasons. Thus, states must ensure they have fair and good faith processes in place to determine the appropriate parameters and application of both criminal offences.

The regulation of abortion, through civil or criminal means, must also respond to unsafe and dangerous abortion practices and ensure that medical professionals provide safe, evidence-based methods of abortion and post-abortion care. As I have already argued in this section, the criminalisation of abortion increases the prevalence of unsafe abortion practices and therefore is not an appropriate response where unsafe abortion is the result of the lack of access to legal abortion services. Rather, states must tackle unsafe abortions through the provision of a range of sexual and reproductive health services including information on and access to abortion and post-abortion care. In contexts where the only means of having an abortion is unsafe, it would be inappropriate to criminalise third parties who provide these abortion services, as this would fail to address the lack of safe healthcare provision. However, states could create civil or criminal offences, or other forms of regulation, to target individuals who intentionally, recklessly, or negligently provide dangerous abortion services in contexts with recourse to safe abortion methods. The decriminalisation of abortion must therefore be supported by safeguarding measures and regulatory practices in relation to informed consent, civil or criminal offences to prevent unsafe abortion practices, and criminal offences for non-consensual terminations and feticide. This would enable greater access to abortion as a harm reduction strategy in states which are unable to provide comprehensive abortion services, balanced with protection for the developed foetus.

### i. Sex Selective Abortion

A final issue to consider in the context of criminalisation is in relation to the prevalence of sex selective abortion practices in some states. Sex selective abortion, usually through the termination of female foetuses, is discriminatory and thus not morally justifiable. However, in states where sex selective abortion is common, this issue is often more complex than simple gender bias on the part of the individual pregnant person. In India, for example, sex selective abortion is linked to the State's two-child policy and the practice of dowry (the giving of gifts, property, or money to the husband's family by the daughter's family upon marriage) which is a significant financial burden, particularly for poorer families.[120] Many people attempt to 'balance' their family by trying to have a son, who will attract dowry, to counter the financial loss of having a daughter.[121] There are also significant repercussions for families unable to pay dowry, with so-called 'dowry deaths' where women have been killed or harassed until they died by suicide in instances where it has not been paid.[122] Prohibiting sex selective abortion through criminalisation thus does little to address its root causes, which relate to socio- economic and gender inequalities and the state's own population policies. India has attempted to prohibit sex selective abortion practices, but this has resulted in the opening up of a black market for foetal sex identification.[123] As with the criminalisation of abortion generally, this is an ineffective measure for addressing the social issues that result in sex selection, and criminalisation would have a detrimental impact on women and, again,

[120] Kumkum Sangari, *Solid:Liquid A (Transnational) Reproductive Formation* (Tulika Books, 2015) Ch. 1.
[121] *Ibid*.
[122] Devaki Monani and Felicity Gerry QC, 'Death and the Dowry System: India's Women and Female Children at Global Risk of Gendercide Over Money' (2017) 15(1) *Issues Leg. Scholarsh.* 1.
[123] Suryatapa Bhattacharya, 'India Targets Illicit Sex-Selective abortions' (*The Wall Street Journal,* 31 January 2016) <https://www.wsj.com/articles/india-targets-illicit-sex-selective-abortions-1454280280> accessed 14 January 2023.

disproportionately affect already marginalised groups. States should instead tackle sex selective abortion practice by addressing broader gender inequalities and avoid implementing population policies that exacerbate these issues.

## *3. The Right to Abortion: A Framework for Progressive Realisation*

In this final section, all of the above will be translated into a human right to abortion through a framework for progressive realisation. The scope of this framework will be broad, to reflect a reproductive justice perspective in recognising abortion as interconnected to a range of sexual and reproductive health and social justice issues. It will also be informed by the ways in which restrictions on and barriers to abortion access perpetuate gendered, racialised, class-based, and other structural inequalities. The framework will consist of four tiers, setting out the steps that states are obligated to take to incrementally work towards full compliance. The first tier, outlining the minimum core content for the right to abortion that all states must meet, largely resembles the approach of the current human rights framework by requiring decriminalisation, the legalisation of abortion in exceptional circumstances, and access to abortion on those grounds. The following tiers require states to additionally legalise abortion on request and later abortion for social, economic, and medical reasons.

Each tier requires states to progressively work towards the provision of universal and consistent access to abortion without delay, and thus the removal of barriers to access. The fourth tier requires states to meet a range of conditions relating to the provision of universal sexual and reproductive health services, pregnancy-related

care, comprehensive supports such as those required by other socio-economic rights, and the need to tackle structural inequalities, gender stereotyping, and disability discrimination. States meeting the requirements of the first three tiers must also demonstrate that they are taking steps towards meeting the obligations contained in the fourth tier. Finally, as highlighted in the previous chapter, states which are able to fully comply with the requirements of socio-economic rights are also obligated to offer assistance to states that cannot do so due to resource-constraints. Thus, states able to ensure full or near-full compliance with the right to abortion must also provide assistance to states lacking the resources to implement universally accessible abortion services meeting the conditions required by tier four.

## The Right to Abortion

Recognising that rights to sexual and reproductive health and autonomy are a fundamental aspect of gender equality, States Parties must ensure the right to abortion for all people capable of becoming pregnant.

States Parties must recognise this right as part of a wider range of sexual and reproductive rights and as connected to a range of other economic, social, and cultural rights, which are necessary to ensure that all people capable of becoming pregnant are able to freely decide whether or not to have children.

States Parties have an obligation to meet the minimum core content of this right as set out in the first stage of the framework and must take steps to progress to the following stages until they are able to fully comply with the requirements of the fourth stage. States Parties able to comply with the third and fourth stages have an additional obligation to assist those States Parties unable to meet full compliance.

States Parties must, as part of the requirement to decriminalise abortion, ensure that there are measures in place to obtain informed consent to abortion and to combat unsafe abortion practices. States Parties must also retain criminal offences for involuntary terminations of pregnancy and feticide and have processes in place to ensure that these offences are applied in good faith.

**States Parties must take steps to:**

1. Decriminalise abortion and release all people currently facing criminal punishment for performing or having a consensual abortion. In addition, abortion must be legalised where there is a risk to the life or health of the pregnant person, where the pregnancy resulted from a sexual crime, or where the foetus has a serious or fatal impairment. States Parties have an obligation to ensure that abortion on the legal grounds is universally accessible in practice.

2. In addition to the above, legalise abortion on request up to 12 weeks' gestation, provided that accurate methods of estimating gestational age are universally available. States Parties without accurate methods of estimation must ensure

processes are in place to provide access to abortion on request up to a later point. States Parties have an obligation to ensure that abortion on the legal grounds is universally accessible in practice with minimal delays. Where delays persist, as result of resource or capacity constraints and structural inequalities, States Parties should extend the gestational time limit for abortion on request.

3. In addition to the above, legalise abortion in the later stages of pregnancy for social, economic, and medical reasons, so that later abortion is no longer limited to the exceptional circumstances. States may limit abortion in the final stages of pregnancy to serious medical reasons through regulatory measures. States Parties have an obligation to ensure that abortion on the legal grounds is universally accessible in practice and address all structural barriers to access. States Parties must also ensure that pregnant people are able to access abortion services as early as possible, without delays.

4. In addition to the above, States Parties must:

    a. Ensure the universal and consistent provision of a broad range of sexual and reproductive health services, including access to a wide range of contraceptive methods. States Parties must ensure that people capable of becoming pregnant are empowered to avoid unwanted pregnancies.

b. Minimise the risk of maternal mortality and unsafe abortion through the provision of comprehensive pregnancy-related care and safe, legal, accessible, and evidence-based abortion services.

c. Ensure that medical professionals receive comprehensive training on the safe provision of abortion care, which is sensitive to gender, age, race, caste, disability, sexuality, gender identity, and membership of an indigenous group and is delivered in a culturally appropriate manner.

d. Combat abortion stigma, socio-cultural gender stereotypes around pregnancy and motherhood, and religious, moral, or cultural opposition to abortion to the extent that it obstructs abortion provision.

e. Provide comprehensive economic and social support to pregnant people and parents, ensuring that a wide range of other socio-economic rights including rights to healthcare, housing, food, water, and sanitation, have been universally fulfilled. Broader social issues, such as rape, domestic violence, and sex selective abortion practices, must also be addressed by States Parties.

f. Combat disability discrimination and stigma, ensure that parents are able to meet the needs of children with disabilities through the provision of comprehensive support, and ensure that pregnant people receive non-biased information when discovering that the foetus they are carrying has an

impairment. Pregnant people must not feel compelled or coerced to have an abortion in such circumstances.

g. Address structural and intersectional inequalities in order to ensure that certain groups are not marginalised in accessing sexual and reproductive health services, including abortion. This requires a focus on providing accessible services for poor and rural communities. States Parties must ensure that non-citizens are also able to access abortion services, so not to disadvantage migrants, asylum seekers, and undocumented persons.

The recognition of the right to abortion in a transformed human rights framework would address the issues raised in Chapter 2 in relation to the current human rights approach to abortion. The recognition of an explicit right to abortion resolves much of the problem with the current fragmented approach, by detailing clear obligations and putting pressure on states to make identifiable progress towards full compliance. Moving beyond the current human rights framework's justification for abortion as tied to a relatively high threshold of harm, this approach recognises the forced continuation of an unwanted pregnancy as a violation of pregnant people's generic rights and requires states to permit abortion for a wider range of reasons. Unsafe abortions are to be addressed through the provision of legal and accessible services, and states must ensure the conditions for people to avoid unwanted pregnancies and have the socio-economic supports in place so that people are not compelled to have an abortion due to their personal contexts, in circumstances where they would otherwise choose to continue the pregnancy. UN treaty bodies such as CESCR have already acknowledged that sexual and reproductive rights are

interlinked with other socio-economic rights, and thus this is included as a key aspect of full compliance with the right to abortion.[124]

With the PGC as the foundation for a transformed human rights framework which sets out genuinely universal human rights and through the framework for progressive realisation acknowledging worldwide variation in states' abilities to comply, the issues with cross-cultural traction are minimised in relation to the right to abortion. Further, the recognition of gender-based, intersectional, and socio-economic issues within this also goes some way to address the conceptual issues with the current human rights framework as set out in Chapter 1. It is necessary, however, to further consider socio-economic and cross-cultural issues with the right to abortion, in terms of the barriers to access which have not been considered in detail in this chapter and in the implementation of this right. These issues will be addressed in the remaining two chapters.

## *Conclusion*

The previous chapter recognised that the application of the PGC can account for feminist values and thus support a feminist transformation of human rights. Following on from this, in this chapter I have considered the application of the PGC to abortion in order to establish a moral right to abortion which must be recognised within a transformed human rights framework. In addition to the generic rights of the individual pregnant person and the precaution which must be afforded in relation to the foetus, I also

[124] CESCR, 'General Comment No. 22 on the Right to Sexual and Reproductive Health (Article 12 of the ICESCR)' (2 May 2016) UN Doc. E/C.12/GC/22, paras. 7, 10.

recognise abortion as complex and multidimensional, encompassing a range of issues including gender stereotypes around motherhood, abortion restrictions as perpetuating gender inequality, and structural inequalities and intersectional issues that also relate to the decision to have an abortion. In light of this, and in viewing health-based justifications for abortion broadly in order to understand the harms of being forced to continue an unwanted pregnancy, I set out four key presumptions in relation to the provision of abortion in the different stages of pregnancy.

In the second section of this chapter, I then translated those presumptions to the international human rights context to establish that states must provide early abortion on request and access to later abortions on more limited, but not overly restrictive or inflexible, grounds. I also argue that states must decriminalise abortion, while ensuring that there are other regulations and laws in place to address coerced or unsafe abortion practices, as the criminalisation of abortion is harmful, stigmatising, and ultimately ineffective at protecting the foetus. Rather, states must adopt a range of social and economic measures to ensure that people capable of becoming pregnant are empowered to avoid unwanted pregnancy, that pregnant people are not faced with unwanted pregnancies out of a lack of alternative options, and that pregnant people who are facing unwanted pregnancies can access safe, legal abortion services as early as possible.

The framework I set out in the final section of this chapter recognises the need for the progressive realisation of the right to abortion, as there are significant global disparities in support for abortion rights and the resources to ensure universal access to abortion, among numerous other relevant issues. The framework for progressive realisation sets out clear obligations, requiring states to meet the minimum core content set out in the first tier, leading up to full compliance in the fourth tier. This framework

enables the right to abortion to have cross-cultural traction and address the socio-economic dimensions of abortion, while also moving beyond the limitations of the current human rights approach. Each tier of the framework requires the removal of barriers to access; the most pressing barriers and accessibility issues that states must address will be explored in detail in the next chapter.

# 5

# The Availability and Accessibility of Abortion Services

## *Introduction*

In the previous chapter, I established a framework for the progressive realisation of the right to abortion, which set out the steps that states must take to provide safe, legal abortion services. At all tiers of the framework, states are required to ensure that abortion services are universally accessible in practice with minimal delays. The third tier of the framework additionally requires that states address all structural barriers to access. As the right to abortion therefore requires that barriers are removed to ensure that all abortion-seeking pregnant people can access abortion services as early and easily as possible, there are some additional issues to be addressed in relation to the regulation of abortion, once legalised, at the state level. Medically unnecessary regulations imposed upon the provision of abortion services result in delays or difficulties accessing those services, and these barriers compound to have a particular impact on already marginalised groups.

The Committee on Economic, Social, and Cultural Rights (CESCR) identifies four elements required for the provision of comprehensive sexual and reproductive healthcare: availability, accessibility, acceptability, and quality.[1] While these elements are

[1] CESCR, 'General Comment No. 22 on the Right to Sexual and Reproductive Health (Article 12 of the ICESCR)' (2 May 2016) UN Doc. E/C.12/GC/22, paras. 11-21.

all interrelated, this chapter will address, in particular, how the restrictive regulation of abortion services impacts upon the availability and accessibility of abortion services. This chapter focuses, firstly, on the insufficient regulation of conscientious objection to the provision of abortion by healthcare professionals which limits the availability of abortion services in some contexts. The remainder of this chapter then addresses medically unnecessary regulatory requirements that obstruct access to abortion, such as mandatory waiting periods, pre-abortion counselling, restrictions imposed on abortion providers, and requirements that the pregnant person attends an abortion facility in person for an early medical abortion. Finally, this chapter sets out the arguments supporting telemedicine for early medical abortion, and the facilitating of self-managed abortion where states have failed to provide comprehensive abortion services, as important measures in minimising barriers and inequalities in accessing abortion services. This chapter therefore adds further recommendations to the progressive realisation framework established in the previous chapter. Additional issues relating to the availability and accessibility of abortion services, such as cost, infrastructure, and personnel, are mentioned throughout this chapter but are not expanded upon in depth, in favour of a focus on the regulatory issues around abortion provision that have been insufficiently addressed within the current human rights framework.

# 1. The Availability of Abortion Services

## 1.1. Conscientious Objection

Many states include conscience-based exemptions within their abortion laws, to enable healthcare professionals to conscientiously object to providing abortion services. Conscientious objection (CO) was initially practiced in relation to military service, and this has been afforded protection under the right to freedom of thought, conscience, and religion contained in Article 18 of the International Covenant on Civil and Political Rights (ICCPR).[2] CO is now also used by healthcare professionals, most often around sexual and reproductive healthcare services that are deemed controversial, such as abortion and contraception. While protection for CO under Article 18 has not been explicitly extended to the medical sphere, human rights bodies have not indicated that CO provisions, where appropriately regulated, violate human rights standards on sexual and reproductive health. Rather, human rights bodies have suggested that a balance must be struck to allow CO without impeding the availability of abortion services. Anand Grover, the Special Rapporteur on the right to the highest attainable standard of physical and mental health, recommended in his 2011 report that conscience-based exemptions be 'well-defined in scope and well-regulated in use' and that states ensure the availability of alternative services where a doctor objects.[3] Additionally, the Human Rights Committee (HRC), Committee on the Elimination of Discrimination Against Women (CEDAW), and CESCR have all expressed concerns over the use of CO provisions in particular states where such

[2] HRC, 'General Comment No. 22 on Article 18 of the ICCPR' (27 Sept 1993) UN Doc. CCPR/21/Rev.1/Add.4, para. 11.
[3] Anand Grover, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of mental and physical health' (3 Aug 2011) UN Doc. A/66/254, para. 65(m).

provisions are relied on excessively or are unregulated to the point of obstructing access to abortion services. [4] These bodies have recommended that states implement mechanisms for mandatory referrals and ensure effective means of contesting refusals.[5] In its 2015 Concluding Observations on Slovakia, CEDAW explicitly noted that such a referral mechanism should be implemented while also respecting individual conscientious objectors.[6]

Within the current international human rights framework, a compromise position is therefore taken where a mechanism for mandatory referrals is seen as striking a balance between sexual and reproductive rights and the right to freedom of conscience. However, on the side supporting the exercise of CO, the current human rights approach has been critiqued for affording 'more weight to the woman's right to health than to the health-care provider's right to freedom of conscience'.[7] Mandatory referrals are seen here as undermining the freedom of conscience of an individual.[8] For those concerned with how CO obstructs access to abortion, these existing human rights standards are not expansive enough to cover all situations where CO places other human rights in jeopardy, and more guidance from human rights bodies is therefore needed.[9] As Laura Florence

[4] See, for example: HRC, 'Concluding observations on the seventh periodic report of Colombia' (17 Nov 2016) UN Doc. CCPR/C/COL/CO/7, paras. 20-21; CESCR, 'Concluding observations on the sixth periodic report of Poland' (26 Oct 2016) UN Doc. E/C.12/POL/CO/6, paras. 46-47; CEDAW, 'Concluding observations on the combined seventh and eighth periodic report of Poland' (14 Nov 2014) UN Doc. CEDAW/C/POL/CO/7-8, paras. 36-37; CEDAW, 'Concluding observations on the combined seventh and eighth periodic reports of Romania' (24 Jul 2017) UN Doc. CEDAW/C/ROU/CO/7-8, paras. 32-33.
[5] *Ibid*.
[6] CEDAW, 'Concluding observations on the combined fifth and sixth periodic reports of Slovakia' (25 Nov 2015) UN Doc. CEDAW/C/SVK/CO/5-6, para. 31(d).
[7] Meghan Grizzle Fischer, 'The United Nations and the Right to Conscientious Objection in the Health-Care Field' (2016) 21(1) *Tex. Rev. Law Politics* 201, 232.
[8] *Ibid* 228.
[9] Christina Zampas, 'Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings' (2013) 123 *Int. J. Gynecol. Obstet.* S63, S63; Christina Zampas and Ximena Andión-Ibañez, 'Conscientious Objection to Sexual and Reproductive Health Services: International Human Rights Standards and European Law and Practice' (2012) 19 *Eur. J. Health Law* 231, 255.

Harris et al argue, CO policies seldom take into account the context of reproductive healthcare delivery, and it is this context that leads CO to function as a barrier to abortion access.[10] In considering appropriate obligations placed on states in relation to CO, it is first necessary to consider the extent to which CO obstructs access to abortion worldwide.

### i. The Extent of Conscientious Objection to Abortion Services

The unfettered use of CO provisions creates widespread issues in abortion provision, often acting as a barrier to access even where abortion has been legalised. Poland, a Catholic state with a far-right anti-abortion government, only permits abortion where the life or health of the pregnant person is at risk, or in cases of rape.[11] However, abortion on these legal grounds is, in practice, unavailable due to the widespread use of CO. Doctors in Poland can refuse to perform non-compulsory healthcare services, such as abortion, if those services are incompatible with the individual's conscience.[12] The law also sets out requirements that an objecting doctor must give advance notice to their supervisor, indicate to the patient that their objection is conscientious, and refer the patient to another doctor.[13] However, in 2015, the Polish Constitutional Tribunal held that the referral requirement was a limitation on freedom of conscience and was therefore unconstitutional.[14] Doctors thus no longer have the obligation to refer, but in relation to abortion, this requirement was largely unenforced even prior to the Tribunal's ruling. In

[10] Laura Florence Harris and others, 'Conscientious objection to abortion provision: Why context matters' (2018) 13(5) *Glob. Public Health* 556, 557.
[11] The Family Planning, Human Embryo Protection and Conditions of Permissibility of Abortion Act of 7 January 1993, Article 4a. The ground for foetal impairment was declared unconstitutional in Polish Constitutional Tribunal Case K 1/20 (22 Oct 2020).
[12] Doctor and Dentist Professions Act of 5 December 1996, Article 39.
[13] *Ibid*.
[14] Polish Constitutional Tribunal Case K 12/14 (7 Oct 2015).

*R.R. v Poland* and *P and S v Poland*, the European Court of Human Rights criticised the lack of procedural mechanisms in place to ensure that CO did not interfere with the patient's interest, which enabled doctors to obstruct access to prenatal diagnostic and therapeutic abortion services.[15] Further, *Tysiąc v Poland* highlights how doctors also evade these requirements by refusing to provide abortion services without invoking the CO provision.[16] The applicant, Alicja Tysiąc, had severe myopia (a visual impairment) which doctors concluded would likely worsen following the delivery of the foetus she was carrying.[17] They recommended sterilisation after the birth, due to the risk that pregnancy would have on her eyesight, but refused to certify for an abortion despite her condition meeting the criteria for therapeutic abortion.[18]

Further, the volume of healthcare professionals in Poland who invoke CO, or obstruct access to abortion without invoking this provision, creates a significant barrier to abortion services. Institutional CO is widespread, where senior doctors in public hospitals object on behalf of all staff and prevent any abortions being carried out in that facility.[19] Doctors that do not have a genuine objection may nevertheless refuse to provide abortion services for fear of harassment by the Church or damaging their careers if they are situated in an anti-abortion workplace.[20] The European Court has also identified how the criminalisation of people providing illegal abortions has a chilling effect on doctors, who have to decide whether the requirements for a legal abortion have

[15] *R.R. v Poland* App no. 27617/04 (ECHR, 26 May 2011), paras. 174-176; *P and S v Poland* App no. 57375/08 (ECHR, 30 October 2012), paras. 92-93, 106, 107.
[16] *Tysiąc v Poland* App no. 5410/03 (ECHR, 20 March 2007).
[17] *Ibid* paras. 8-10.
[18] *Ibid*.
[19] Silvia De Zordo and Joanna Mishtal, 'Physicians and Abortion: Provision, Political Participation and Conflicts on the Ground – The Cases of Brazil and Poland' (2011) 21(3S) *Women's Health Issues* S32, S34; *P and S* (n15) para. 59.
[20] De Zordo and Mishtal (n19) S33-S34.

been met in each individual case.[21] The scale of CO in Poland has resulted in the near-complete removal of abortion services from public hospitals.[22] Doctors who do want to provide abortion services tend to do so only in private practices, where institutional CO can be avoided and prosecutions relating to abortion are rare due to the limited governmental and religious control in the commercial sphere.[23] The impact of CO in this context is the removal of already-limited abortion services from public health facilities, creating a divergence in the ability to obtain an abortion on the basis of socio-economic status.

Abortion provision in Italy similarly suffers due to a high rate of CO. Italy's abortion law is more liberal than in Poland, permitting abortion within the first 90 days (around 12 weeks) for health, social, economic, or family reasons, and after this point where the pregnant person's life or health is at risk or if the foetus has a serious impairment. [24] However, obtaining an abortion is difficult in practice as CO is so widespread. In 2019, 67% of gynaecologists conscientiously objected to the provision of abortion services.[25] This, again, has a particular impact on the availability of abortion in public hospitals, of which many are affiliated with the Catholic Church. In Catholic hospitals or hospitals where the senior directors object to abortion, institutional CO means that abortion services are unavailable even where individual doctors may be willing to provide them.[26] Further, many hospitals which do not have institutional CO are

[21] *R.R.* (n15) paras. 192-193.
[22] Agata Chełstowska, 'Stigmatisation and commercialisation of abortion services in Poland: turning sin into gold' (2011) 19(37) *Reprod. Health Matters* 98, 98, 99.
[23] *Ibid* 98, 102-103.
[24] Law 194 of the Italian Republic 1978, Articles 4, 6.
[25] Ministero della Salute, 'Relazione del Ministro della Salute sulla attuazione della legge contenente norme per law tutela sociale della maternitá e per l'interruzione volontoria di gravidanza (legge 194/78) – dati definitivi 2019' (16 Sept 2021) <https://www.salute.gov.it/imgs/C_17_pubblicazioni_3103_allegato.pdf> accessed 14 January 2023, p.56.
[26] Wendy Chavin, Laurel Swerdlow, and Jocelyn Fifield, 'Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study' (2017) 19(1) *Health Hum. Rts. J.* 55, 59-60.

nevertheless staffed only by objectors.[27] While the law requires regional health departments and hospitals to implement procedures to guarantee abortion services, the high percentage of objectors limits the ability of institutions to organise personnel so as to ensure timely access to abortion.[28] In one reported case, a pregnant woman attempting to access an abortion within the first 90 days of pregnancy, in line with the law, was denied an abortion by 23 different public hospitals on the basis of conscientious objection or administrative issues.[29] Elena Caruso highlights that some regions of Italy have just one doctor willing to provide abortions services, while others have none at all, requiring pregnant people in those regions to travel elsewhere to access abortion services.[30] This disparity has a particular impact on socio-economically disadvantaged people.[31] Additionally, there are cases of doctors refusing to perform abortions even where the pregnant person's life was in danger, despite doctors being required to perform abortions in emergency situations if nobody else is available.[32]

The invoking of CO provisions by healthcare professionals for reasons other than a genuine conscience-based refusal to perform abortions is also common. There are two prominent uses of CO provisions for non-conscientious reasons. Firstly, CO provisions are used by healthcare professionals wishing to avoid the potential disadvantages to themselves associated with providing abortion services. As highlighted above in relation to Poland, the stigmatisation and criminalisation of abortion acts as a deterrent for

[27] *Ibid* 59.
[28] Law 194 (n24), Article 9; Chavin, Swerdlow, and Fifield (n26) 59; Francesca Minerva, 'Conscientious objection in Italy' (2015) 41(2) *JME* 170, 171.
[29] La Repubblica, 'Aborto, denuncia Cgil: "Donna respinta da 23 ospedali, soluzione solo dopo nostro intervento"' (1 Mar 2017) <https://www.repubblica.it/cronaca/2017/03/01/news/padova_aborto_respinta_23_ospedali-159526952/> accessed 14 January 2023.
[30] Elena Caruso, 'Abortion in Italy: Forty Years On' (2020) 28 *Fem. Leg. Stud.* 87, 91-92.
[31] *Ibid* 93.
[32] *Ibid* 91.

healthcare professionals who would not otherwise object. In the Italian context, the career disadvantages of being willing to provide abortion services manifest in an increased workload as non-objectors, who represent a minority of gynaecologists, are required to perform most abortions.[33] Agustina Ramón Michel et al refer to the use of CO in these contexts as a 'defensive use' as healthcare professionals invoke CO to avoid personal disadvantage.[34] This defensive use of CO provisions has also been identified by scholars in numerous countries. [35] This problem is worsened where healthcare professionals lack comprehensive understanding of their state's abortion laws and regulations, or where resource limitations incentivise the use of CO.[36]

Secondly, healthcare professionals often misuse CO provisions in order to deliberately obstruct access to abortion. Fink et al identify a spectrum of conscientious objection from extreme objectors, who oppose abortion and actively prevent patients from accessing those services by refusing to refer and by giving inaccurate legal and medical information, to partial objectors, who refuse to provide abortions on an ad-hoc basis.[37] They situate moderate objectors, those that conscientiously object and are willing

[33] Chavin, Swerdlow, and Fifield (n26) 60; Tommaso Autorino, Francesco Mattioli, and Letizia Mencarini, 'The impact of gynecologists' conscientious objection on abortion access' (2020) 87 *Soc. Sci. Res.* 1, 6.
[34] Agustina Ramón Michel and others, 'Regulating Conscientious Objection to Legal Abortion in Argentina: Taking into Consideration Its Uses and Consequences' (2020) 22(2) *Health Hum. Rts. J.* 271, 274.
[35] See, for example, Michel and others (n34) 274; Stephanie Andrea Küng and others, '"We don't want problems": reasons for denial of legal abortion based on conscientious objection in Mexico and Bolivia' (2021) 18(44) *Reprod. Health* 1, 2; Emily Freeman and Ernestina Coast, 'Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices' (2019) 221 *Soc Sci Med* 106, 112; Dubravka Ida Gladoić Håkansson, Pernilla Ouis, and Maria Ekstrand Ragnar, 'Navigating the Minefield: Women's Experiences of Abortion in a Country with a Conscience Clause – The Case of Croatia' (2021) 22(1) *J Int Women's Stud.* 166, 174-175; Louise Anne Keogh and others, 'Conscientious objection to abortion, the law and its implementation in Victoria, Australia: perspectives of abortion service providers' (2019) 20(11) *BMC Med. Ethics* 1, 6.
[36] De Zordo and Mishtal (n19) S35; Jane Harries and others, 'Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study' (2014) 11(16) *Reprod. Health* 1, 4; Harris and others (n10) 560.
[37] Lauren R. Fink and others, '"The Fetus Is My Patient, Too": Attitudes Toward Abortion and Referral Among Physician Conscientious Objectors in Bogotá, Colombia' (2016) 42(2) *Int Perspect. Sex. Reprod. Health* 71, 74-75.

to refer patients or provide accurate information, somewhere between them.[38] This categorisation, however, suggests that 'moderate' objectors take a middle-ground position, when their refusal to provide abortion services aligns them more closely with 'extreme' objectors. It is the objection to referral that distinguishes 'extreme' and 'moderate' objectors. CO to the provision of abortion services can be, instead, categorised as complete or selective; Fink et al's categories of extreme and moderate objection are both examples of complete objection to the performance of an abortion. CO to referral can also be categorised as complete or selective, and healthcare professionals who completely object to providing abortion services may completely or selectively object to referral. I will adopt the label 'extreme objection' to refer to the subset of healthcare professionals who completely object to both performance and referral, and additionally take further action (such as hiding that a refusal to provide abortion services in due to their CO) to obstruct the patient from obtaining an abortion. Poland presents an example of widespread extreme objection; CEDAW has noted the abuse of CO by healthcare professionals in the country, and the three European Court cases mentioned above highlight the use of CO as a means of intentionally preventing access to abortion.[39] Selective objection also hinders abortion provision, as healthcare professionals may refuse to provide abortions beyond a certain gestational time limit or on certain grounds, despite their legality. For example, healthcare professionals in Brazil will often invoke CO for abortion on the grounds of rape where they do not feel that enough proof has been given, and a study of CO in Mexico and Bolivia revealed gestational age and foetal viability to be a key factor.[40] This selective objection is also used by healthcare professionals to

[38] *Ibid*.
[39] CEDAW (n4, 2014) para. 37(b); *P and S* (n15); *R.R.* (n15); *Tysiąc* (n16).
[40] Debora Diniz, Alberto Madeiro, and Cristião Rosas, 'Conscientious objection, barriers, and abortion in the case of rape: a study among physicians in Brazil' (2014) 22(43) *Reprod. Health Matters* 141, 146-147; Küng and others (n35) 6.

reinforce traditional sexual and gender roles and reinforce stigmatising attitudes around unwanted pregnancies, such as through invoking CO where the pregnant person did not use contraception.[41]

The misuse of CO provisions in this way amounts to the imposition of personal beliefs on patients, and an attempt to circumvent the legalisation of abortion.[42] As Charles Ngwena identifies, CO can become a 'Trojan horse for popular patriarchal and religious prejudices that deny women's reproductive agency'.[43] Thus, the lack of sufficient regulation of CO can create anti-abortion medical cultures in lieu of anti-abortion laws and policies, and to the same effect. Fiala and Arthur argue that there is a continuum of harm associated with CO.[44] Where CO provisions are misused, CO can obstruct access to abortion and leave even those needing emergency terminations without abortion services.[45] However, Fiala and Arthur also argue that even where the impacts of CO are relatively minimal, refusals to provide abortion care are still harmful as they stigmatise pregnant people seeking abortions and cause delays.[46] Faced with a healthcare professional who is objecting, pregnant people may be treated disrespectfully or judged for attempting to obtain an abortion.[47] Additionally, delays have a disproportionate impact on already marginalised groups, such as socio-economically disadvantaged pregnant people, and can result in additional barriers such as where the delay prevents

[41] Michel and others (n34) 274; Freeman and Coast (n35) 107.
[42] Ana Cristina González Vélez and Laura Gil Urbano, 'Improper Use of Conscientious Objection to Abortion/Authors' Response' (2016) 42(2) *Int Perspect. Sex. Reprod. Health* 221; Verónica Undurraga and Michelle Sadler, 'The misrepresentation of conscientious objection as a new strategy of resistance to abortion decriminalisation' (2019) 27(2) *Reprod. Health Matters* 17.
[43] Charles G. Ngwena, 'Conscientious Objection to Abortion and Accommodation Women's Reproductive Health Rights: Reflection on a Decision of the Constitutional Court of Colombia from an African Regional Human Rights Perspective' (2014) 58 *J Afr. Law* 183, 209.
[44] Christian Fiala and Joyce H. Arthur, 'There is no defence for 'Conscientious objection' in reproductive health care' (2017) 216 *Eur J Obstet. Gynecol. Reprod. Biol.* 254, 255.
[45] *Ibid*.
[46] *Ibid*.
[47] Christian Fiala and Joyce H. Arthur, '"Dishonourable disobedience" – Why refusal to treat in reproductive healthcare is not conscientious objection' (2014) 1 *Woman – Psych Gynaecol. Obstet.* 12, 13.

a pregnant person obtaining a termination from a non-objecting doctor within the gestational time limit. CO must, therefore, be regulated to ensure that CO provisions are not misused and so that pregnant people are able to access abortion services with minimal disruption or delay, which will require, in many contexts, much more than mandatory referrals.

### ii. Balancing Conscientious Objection with the Right to Abortion

The PGC requires the balancing of the generic rights of healthcare professionals who are conscientiously opposed to abortion with those of pregnant people requiring abortion services. It is necessary to balance the right to abortion with the right to freedom of conscience in a way which minimises the respective costs to each party. As the above section has highlighted, there are a range of harms resulting from the misuse or excessive reliance on CO provisions; preventing a pregnant person from accessing the abortion services they are morally entitled to amounts to a basic harm. However, forcing an objecting doctor to perform an abortion they believe is, for example, murder is also a basic harm.[48] For healthcare professionals with a weaker opposition to abortion, restricting CO would likely result in a less serious harm.[49] Further, in relation to the invoking of CO to avoid stigma or an increased workload, restricting would also result in a less serious harm and this could be mitigated through alternative measures. Allowing CO will inevitably have costs in relation to the provision of abortion services (to varying

[48] Clayton Ó Néill, *Religion, Medicine and the Law* (Routledge, 2019), p.185-186.
[49] *Ibid* p.186.

extents, depending on the context) and its sufficient regulation will have costs for healthcare professionals who are extreme objectors to abortion.

Clayton Ó Néill argues that the current position on CO in England, Wales, and Scotland under section 4 of the Abortion Act 1967 represents a sufficient compromise between the respective generic rights of pregnant people and objecting doctors.[50] The Abortion Act allows doctors to conscientiously object to participation in an abortion procedure, except where the abortion is necessary to save the life of or prevent grave permanent injury to the pregnant person.[51] Feminist scholars have critiqued s.4 for inadequately minimising the impacts on pregnant people attempting to access abortion services. Emily Jackson and Sally Sheldon have pointed out the potential for regional and socio-economic variations in the availability of abortion across Britain.[52] In rural areas with fewer abortion providers, CO is likely to present a greater barrier to access. Additionally, Jackson notes that pregnant people have no way of knowing in advance if their doctor is an objector, and some people may therefore mistake their doctor's refusal as an indicator that they are not eligible for an abortion.[53] Further, doctors may intentionally take advantage of this uncertainty; in *Saxby v Morgan*, it was claimed that a doctor had told a pregnant woman that at 18-19 weeks' gestation, she was 'too far gone' for an abortion, despite falling within the time limit of s.1(a) of the Abortion Act.[54]

In 1990, the UK Parliament rejected a proposal that would have required doctors to register their objections on a publicly available list; Sheldon accepts that such a

[50] *Ibid* p.187.
[51] Abortion Act 1967 s.4.
[52] Emily Jackson, *Regulating Reproduction* (Hart, 2001), p.86; Sally Sheldon, *Beyond Control* (Pluto Press, 1997), p.56.
[53] Jackson (n52) p.85-86.
[54] *Saxby v Morgan* [1997] P.I.Q.R. P53, cited in Shaun D. Pattinson, *Medical Law and Ethics* (Sweet & Maxwell, 6th Edn, 2020), p.260.

measure would have been inappropriate due to the possibility of discrimination against those doctors, and would have, in any event, failed to minimise the impacts of CO.[55] Instead, Sheldon advocates for a referral requirement as a means of balancing the interests of doctors and pregnant people.[56] While s.4 does not confer a mandatory referral requirement upon objecting doctors, the General Medical Council (GMC) guidance indicates that doctors must make efforts to make patients aware of the objection in advance, inform patients that a refusal to provide treatment is based upon CO, and ensure that the patient has enough information to seek treatment from a non-objecting doctor.[57] Importantly, the guidance also includes requirements that doctors do not express their personal beliefs in a way which implies judgement of the patient.[58] These requirements address the concerns raised by Jackson in relation to pregnant people being unaware that the refusal is based upon CO, and the potential issues of doctors using CO provisions to impose their own beliefs on pregnant people seeking abortions.

The Abortion Act's CO provision has also, however, been criticised for giving insufficient protection to objecting healthcare professionals. In *Janaway*, the word 'participate' contained in s.4 was interpreted narrowly to mean participation in the abortion treatment itself, so a secretary could not rely on the CO provision to refuse to type a referral letter for an abortion.[59] This was reaffirmed more recently in *Doogan*, a case concerning two Catholic midwives who wanted to rely on s.4 to refuse to perform

[55] Pattinson (n54) p.259; Sheldon (n52) p.59, 61.
[56] Sheldon (n52) p.61.
[57] GMC, 'Personal Beliefs and Medical Practice' <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/personal-beliefs-and-medical-practice/personal-beliefs-and-medical-practice> accessed 14 January 2023, paras. 10-12.
[58] *Ibid* para. 12(a).
[59] *Janaway v Salford Area Health Authority* (1989) AC 537.

administrative and supervisory tasks relating to patients who had abortions.[60] In this case, the Supreme Court adopted an interpretation of 'participate' as referring to direct involvement, in a 'hands-on' capacity, in abortion treatment; as administrative and supervisory tasks did not amount to direct involvement, the midwives could not rely on s.4.[61] Mary Neal has critiqued this narrow reading, as the abortion treatment context involves a range of people beyond those directly involved in the procedure itself and people who have an indirect role are still participating in an act which goes against their own conscience.[62] Ó Néill agrees that this case law interprets s.4 too narrowly, as facilitating an abortion – even indirectly – represents a basic harm to a healthcare professional who views abortion as unconscionable, and so the differentiation between direct and indirect involvement is impermissible.[63] However, Neal does qualify her argument: in the British context, if s.4 was extended to all healthcare professionals involved (directly and indirectly) in an abortion procedure, there is no realistic prospect of CO being so widespread as to threaten the provision of abortion.[64] This approach cannot, therefore, be applied in other contexts such as Poland and Italy, where CO is so widespread that greater limitations may be necessary in order to strike an appropriate balance between access to abortion and freedom of conscience.

As already highlighted above, the current human rights approach takes referral to be a sufficient compromise between the interests of pregnant people seeking abortions and objecting healthcare professionals.[65] Yet, mandatory referral requirements do not

[60] *Glasgow Health Board v Doogan and others* [2014] UKSC 68.
[61] *Ibid* paras. 37-38.
[62] Mary Neal, 'Commentary: The Scope of the Conscience-Based Exemption in Section 4(1) of the Abortion Act 1967: *Doogan and Wood v NHS Greater Glasgow Health Board* [2013] CSIH 36' (2014) 22(3) *Med. Law Rev.* 409, 417.
[63] Ó Néill (n48) p.188-189.
[64] Neal (n62) 420.
[65] Bernard M. Dickens, 'Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical' (2009) 28 *Med. and Law* 337, 344.

always strike an appropriate balance, particularly in contexts such as Poland and Italy where CO is so widespread that doctors either ignore these requirements or there is a lack of non-objecting doctors to refer patients to. Additionally, mandatory referral requirements are not taken to be a satisfactory compromise position by proponents of the rights of either party. Carolyn McLeod argues that, while referral may be a compromise for those concerned with ensuring access to abortion, it does not represent a true compromise for anti-abortion doctors who genuinely believe abortion to be murder.[66] Sara Fovargue and Mary Neal have argued along these lines, that requirements placed on healthcare professionals to inform the patient of their conscientious objection and refer them to another doctor entails complicitly in the objected practice.[67] For an anti-abortion doctor, any involvement or association with an abortion is unacceptable.

At the other end of the spectrum, the harms caused by CO cannot be escaped by mandatory referrals. Feminist scholars who have accepted the need for CO provisions acknowledge that even where CO is regulated, it is still likely to cause delays in accessing abortion services.[68] However, Fiala and Arthur go further to argue that CO is never acceptable as these provisions are routinely abused, undermine standards of non-judgmental healthcare, violate pregnant people's right to health, and result in the stigmatising of abortion providers.[69] To this end, they argue that CO is an unethical abandonment of professional obligations (which they refer to as 'dishonourable disobedience') and CO should therefore be eliminated from the reproductive healthcare sphere.[70] Udo Schuklenk and Ricardo Smalling argue that a 'society that grants medical

[66] Carolyn McLeod, 'Referral in the Wake of Conscientious Objection to Abortion' (2008) 23(4) *Hypatia* 30, 34-35.
[67] Sara Fovargue and Mary Neal, ''In Good Conscience': Conscience-Based Exemptions and Proper Medical Treatment' (2015) 23(2) *Med. Law Rev.* 221, 241.
[68] See, for example: Jackson (n52) p.86; Sheldon (n52) p.60.
[69] Fiala and Arthur (n47).
[70] *Ibid* 18-20.

professionals a conscientious objection-based opt-out will have to accept suboptimal health outcomes' and that refusing to grant CO is the most efficient means of ensuring that access to healthcare services such as abortion is not undermined.[71] This would not mean forcing anti-abortion doctors to be involved with abortion treatment; they argue that people who object to abortion should not be allowed to enter medical fields such as gynaecology and obstetrics.[72] Schuklenk and Smalling make this argument in relation to the Canadian context, where abortion is decriminalised and not legally regulated at the federal level, but this is applicable in countries where abortion is largely prohibited, as healthcare professionals can enter those medical fields on the assumption that they will not be required to provide abortion services.

Further, this is already the policy in Sweden, where healthcare professionals are unlikely to be employed in fields such as gynaecology, obstetrics, and midwifery if they are unwilling to certify that they would provide abortions and contraception.[73] In 2020, the European Court issued decisions in two cases concerning midwives who had been refused employment in women's clinics after informing their prospective employers of their objection to provide abortions.[74] The Court rejected the two applications as manifestly ill-founded, noting that there is no right to occupy a post in the civil service.[75] While the Swedish position may be a key factor in the accessibility of abortion in the country, Irene Domenici has expressed concerns over the *de facto* exclusion of Catholics

[71] Udo Schuklenk and Ricardo Smalling, 'Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies' (2017) 43(4) *JME* 234, 273, 240.
[72] *Ibid* 239.
[73] Christian Fiala and others, 'Yes we can! Successful examples of disallowing 'conscientious objection' in reproductive health care' (2016) 21(3) *Eur J Contracept. Reprod. Health Care* 201, 202.
[74] *Grimmark v Sweden* App no. 43726/17 (ECHR, 11 Feb 2020); *Steen v Sweden* App no. 62309/17 (ECHR, 11 Feb 2020).
[75] *Grimmark* (n74) para. 22; *Steen* (n74) para. 17.

from the midwifery profession which the European Court seems to accept.[76] The effective total exclusion of anti-abortion healthcare professionals from certain medical fields would not be PGC-compliant as this would not give enough protection to the generic rights of objectors who wish to enter those fields (although less harm would be caused by this approach than one which forced objecting doctors to perform abortions). Additionally, such an approach may have undesirable consequences on a practical level. The policy ban on CO in Sweden has resulted in a midwife shortage, with a negative impact on pregnant people who are continuing their pregnancies to term.[77] Further, healthcare professionals may enter those fields with an undeclared objection to abortion and refuse to provide abortions without any safeguards in place.

Concerned with ensuring comprehensive service delivery alongside permitting CO, Daniel Rodger and Bruce Blackshaw suggest the use of quotas to limit, but not entirely prohibit, the number of medical trainees entering fields such as gynaecology and obstetrics.[78] This would be a long-term solution, by imposing quotas at the point that medical trainees enter their specialist pathways rather than excluding already-trained doctors from their field.[79] They propose two instances where the quota system would be appropriate: firstly, in states such as Italy where existing CO practices significantly obstruct access to abortion; and secondly, through the use of employment quotas in states without current provision for CO in order to avoid disrupting existing abortion services.[80] In states where CO does not cause this level of disruption, such measures would be

[76] Irene Domenici, 'Antigone Betrayed? The European Court of Human Rights' Decisions on Conscientious Objection to Abortion in the Cases of *Grimmark v. Sweden* and *Steen v. Sweden*' (2021) 28 *Eur. J. Health Law* 26, 47.
[77] Daniel Rodger and Bruce P. Blackshaw, 'Quotas: Enabling Conscientious Objection to Coexist with Abortion Access' (2021) 29 *Health Care Anal.* 154, 160.
[78] *Ibid* 155.
[79] *Ibid* 160-161.
[80] *Ibid* 155.

unnecessary and CO need not be so restricted in order to balance the competing rights; an approach such as that taken by the Abortion Act 1967 (and the GMC guidance), for example, may be sufficient. In other contexts, such as where CO is used defensively to avoid workload pressures, measures such as offering financial benefits, promotions, or other incentives for providing abortion services may be more effective and easier to implement. This could also address the problem of a lack of non-objecting healthcare professionals where there are insufficient numbers for the quotas approach to work.

### iii. Regulating Conscientious Objection in Line with the PGC

The international human rights framework must adopt an approach to CO that balances the generic rights of objecting healthcare professionals and abortion-seeking pregnant people, with minimal costs. CO must not result in widespread delays and obstacles to abortion access, and pregnant people must be able to easily access safe, legal, and non-judgmental abortion services in line with the right to abortion set out in the previous chapter. This requires an approach capable of responding to a range of contexts, including those where the harms associated with CO are significant. The current international human rights approach, which relies on mandatory referrals to strike this balance, is inadequate at protecting access to abortion. However, the lack of provision for CO or a total prohibition on objecting healthcare professionals entering reproductive healthcare practice would also fail to appropriately protect the rights of those professionals. As there is worldwide variation in the prevalence of CO and how CO impacts access to abortion services, it would be inappropriate (and ineffective) for the international human rights framework to prescribe specific means of regulating CO. This is demonstrated by the

current international human rights approach, taking mandatory referral as the means of balancing CO with abortion provision, which fails to address contextual issues such as those raised throughout the above sections. The international human rights framework must, instead, impose a duty on states to ensure that CO is permitted and regulated in a way which guarantees unobstructed access to abortion services in line with the obligations set out in the previous chapter. The means by which this is achieved is to be reviewed at the national level, in order to assess specific contextual issues and any potential consequences of adopting particular regulations.

In addition to this procedural duty, there are a number of specific requirements that should also be set out. The international human rights framework should echo the recent statement by the International Federation of Gynecology and Obstetrics (FIGO) that CO should not be used by entire institutions or in the provision of post-abortion care.[81] FIGO also states that auxiliary staff members should not be allowed to object.[82] However, as the indirect involvement of anti-abortion healthcare professionals may still constitute a basic harm, CO should be allowed for direct and indirect involvement unless there are overriding reasons to avoid doing so, such as where this would have a detrimental impact upon the availability of abortion services.

Further, as Harris et al argue, CO policies must take account of the economic, social, and political pressures on healthcare providers which may lead to the defensive use of CO provisions, as mentioned above.[83] These pressures shape both the ability of healthcare professionals, in the context of available resources and their workload, to

[81] FIGO, 'Conscientious objection: a barrier to care' (19 Oct 2021) <https://www.figo.org/resources/figo-statements/conscientious-objection-barrier-care> accessed 14 January 2023.
[82] *Ibid.*
[83] Harris and others (n10) 557.

provide abortion services and have an impact upon dominant attitudes towards abortion.[84] Thus, in addition to the regulation of CO, states must adopt policies aimed at improving the allocation of resources to reproductive healthcare services and ensure that healthcare professionals who do not object to providing abortions are informed of the relevant regulations, have the support of their colleagues, and any other relevant workplace conditions are met.[85] This will, in turn, require the comprehensive training of medical students on abortion as well as attempts to tackle abortion stigma in healthcare settings.[86] McLeod argues that the acceptance of referral requirements will necessitate demonstrating to doctors why this is a moral requirement; training on abortion must also, therefore, emphasis that abortion provision is morally necessary.[87] As wider socio-cultural attitudes around women's reproductive roles will have an impact on CO and the availability of abortion, states must also take steps to change these attitudes, aimed at combatting opposition to abortion. This is particularly important in relation to later abortions, as CO to abortion beyond certain gestational ages has the effect of imposing gestational time limits which are not indicated by law.

Putting this into framework that can be adopted alongside the progressive realisation framework for the right to abortion as set out in the previous chapter, the obligation to sufficiently regulate CO must also be progressively realised alongside it. Ó Néill suggests two relevant considerations that will be taken into account here: firstly, that an objecting doctor has a range of options to avoid compromising her conscience and has chosen her profession or specialism in light of this; and secondly, that the breadth of defensible CO is connected to the breadth of abortion provision, so greater restrictions

[84] *Ibid* 560-561.
[85] *Ibid* 562.
[86] *Ibid*.
[87] McLeod (n66) 42.

on CO can be justified where there are greater restrictions on abortion provision.[88] Where the higher tiers of the right to abortion have not been met, or where CO obstructs access to abortion, CO must be restricted to a greater extent than in states where the impact is less harmful. The measures that must be taken towards regulating CO therefore correlate to the extent to which states comply with the right to abortion.

### *1.2. Recommendations on Regulating Conscientious Objection to Abortion*

1. States Parties must allow conscientious objection to abortion, provided that it is regulated to ensure that access to abortion services in line with the right to abortion is not obstructed. States Parties have a duty to implement procedural mechanisms to assess if and how conscientious objection should be regulated to this effect, and take steps to progressively realise this obligation. Where States Parties have only met the earlier tiers of the right to abortion, and abortion has therefore only been legalised on a limited basis, or where conscientious objection obstructs access to legal abortion services, more restrictive measures will be necessary to ensure that conscientious objection does not operate to prevent any abortion services from being carried out.

2. States Parties must not permit conscientious objection where an abortion is necessary to save the life of or prevent serious harm to the pregnant person, or in

[88] Ó Néill (n48) p.186.

relation to post-abortion healthcare. Institutional objections, where senior management objects on behalf of all staff members, also must not be permitted.

3. Alongside providing for conscientious objection, all States Parties must ensure that abortion services are sufficiently staffed and resourced, and that healthcare professionals are properly trained and have sufficient understanding of the relevant regulations. Medical trainees should be given gender-sensitive education on abortion (and contraception), and States Parties must take steps towards a socio-cultural understanding of abortion (and contraception) as a moral right and necessary healthcare service. This is particularly important in relation to later abortions, in order to address selective objection to abortions past a certain gestational time limit.

## *2. Access to Abortion Services*

### *2.1. Medically Unnecessary Regulations*

Some states impose additional regulatory requirements on abortion services, such as mandatory waiting periods, pre-abortion counselling, and requirements for in-person visits to an abortion facility. These requirements are unnecessary on medical, social, psychological, or other heath-based grounds (referred to as 'medically unnecessary' throughout this section for ease) but do create barriers to accessing abortion services.

Germany, for example, has mandatory pre-abortion counselling requirements for all abortions other than for medical reasons or in cases of rape, with a minimum three-day waiting period between the counselling and the abortion procedure.[89] The World Health Organization (WHO) has noted that such measures are medically unnecessary, and therefore contribute to the prevalence of unsafe abortions by imposing barriers to access.[90] The Committee on the Elimination of Discrimination Against Women has also recommended, in line with WHO guidance, that states should ensure access to safe abortion without subjecting pregnant people to mandatory counselling and waiting periods.[91] This forms part of the broader existing standards on ensuring timely access to sexual and reproductive health services alongside the removal of barriers such as cost, distance from abortion providers, and unnecessary administrative burdens.[92] However, while the Committee on Economic, Social and Cultural Rights (CESCR) has recommended that states refrain from implementing mandatory waiting periods, it only takes issue with '*biased* counselling' and the dissemination of medically unsound information.[93] The Human Rights Committee has not commented on these issues.

While voluntary and non-directive pre-abortion counselling should be available as an option, mandatory counselling requirements may cause delays in accessing abortion services and therefore act as a medically unnecessary barrier to abortion. The imposition of additional bureaucratic requirements such as mandatory counselling and waiting periods create additional hurdles that a pregnant person must overcome in order

[89] German Criminal Code, §218a(1).
[90] WHO, *Safe Abortion: Technical & Policy Guidance For Health Systems* (WHO, 2015) p.4.
[91] CEDAW (n6) para. 30(c); CEDAW, 'Concluding observations on the combined seventh and eighth periodic reports of Germany' (9 March 2017) UN Doc. CEDAW/C/DEU/CO/7-8, para. 38(b).
[92] See, for example: CESCR (n1) paras. 12-19; CEDAW, 'General Recommendation No. 24 on Article 12 (Women and Health)' (1999) UN Doc. CEDA/A/54/38/Rev.1, paras. 21, 23.
[93] CESCR (n1) para. 41; CESCR, 'Concluding observations on the third periodic report of Slovakia' (14 November 2019) UN Doc. E/C.12/SVK/CO/3, para. 42(b).

to access abortion services. These hurdles amount to a significant barrier for socio-economically disadvantaged people and pregnant people living rurally, by requiring multiple trips to an abortion facility, which is a particular issue in countries such as the US where, in many regions, abortion providers are sparsely located.[94] Barriers such as living rurally, being low-income, and facing hurdles such as mandatory counselling compound to create a significant obstacle to accessing safe, legal abortion services. These regulations could also delay an abortion beyond the gestational time limit, for example preventing a pregnant person from accessing an early abortion on request by delaying the procedure until after 12 weeks. In a study of the impacts of barriers to accessing abortion in two US states, Jenna Jerman et al found three main consequences: abortions obtained at a later gestational age, negative mental health outcomes, and attempts by pregnant people to end their own pregnancies through medication, home remedies, or physical trauma.[95] As highlighted in the previous chapter, states must ensure that pregnant people are able to easily access abortion services without delay and as early as possible. States are also obligated, as part of the right to abortion, to address structural inequalities such as those reinforced by these barriers.

The imposition of medically unnecessary requirements forms part of what has been termed 'abortion exceptionalism' in the US context, as abortion is uniquely subject to onerous regulations where other procedures are not.[96] While the exceptional or differential treatment of a medical procedure is not necessarily unjustified, abortion is

[94] Jordan A. Parsons and Elizabeth Chloe Romanis, *Early Medical Abortion, Equality of Access, and the Telemedical Imperative* (Oxford University Press, 2021) p. 42-43, 51; Rachel K. Jones and Jenna Jerman, 'Abortion Incidence and Service Availability In the United States, 2014' (2017) 49(1) *Perspect. Sex Reprod. Health* 17.
[95] Jenna Jerman and others, 'Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States' (2017) 49(2) *Perspect. Sex Reprod. Health* 95, 98.
[96] Ian Vandewalker, 'Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics' (2012) 19(1) *Mich. J Gend. Law* 1, 6.

often treated unfairly through the imposition of additional requirements. As abortion is safe, particularly in the early stages, these additional regulations are not medically required to protect the health of the pregnant person, but rather serve an anti-abortion function. In the US, the constitutional right to abortion established in *Roe v. Wade* (prior to *Dobbs v. Jackson*) was qualified by *Planned Parenthood v. Casey*, in which the Supreme Court established the 'undue burden' standard for abortion restrictions. Restrictions or regulations which amount to a substantial obstacle to accessing abortion services pre-viability are unconstitutional; however, this is a relatively high threshold and the effect of this has been to allow medically unnecessary regulations which aim to dissuade pregnant people from having abortions.[97] This resulted in Targeted Regulation of Abortion Providers (TRAP) laws which both aim to dissuade pregnant people from having abortions and impose onerous health and safety requirements on abortion providers. 30 states have 'informed consent' requirements which involve giving pregnant people medically inaccurate materials and information on alternatives to abortion, with some states requiring that pregnant people are urged to choose an alternative such as adoption.[98] Some of those states also include requirements that pregnant people be informed of the risks to themselves, despite the lack of causation between abortion and long-term health outcomes.[99] Additionally, 29 states impose counselling requirements followed by mandatory waiting periods.[100] As Jordan Parsons and Elizabeth Chloe Romanis argue, while these requirements are not deemed an undue burden as they 'do not literally prevent a person from choosing abortion', they nevertheless interfere with that decision by making accessing abortion services a stressful and difficult experience.[101]

[97] Reva B. Siegel, 'Why Restrict Abortion? Expanding the Frame on *June Medical*' (2021) 8 *Sup. Ct. Rev.* 17.
[98] Parsons and Romanis (n94) p.34-35, 171-172.
[99] *Ibid*.
[100] *Ibid*.
[101] *Ibid* p.36-37.

This is particularly the case where TRAP laws have led to the closure of abortion clinics, increasing the distances that pregnant people must travel for abortion services in some states.[102] Now that both *Roe v. Wade* and *Planned Parenthood v. Casey* have been overturned by the recent *Dobbs v. Jackson* decision, states are able to pass more onerous restrictions.[103]

Anti-abortion actors have increasingly claimed that these regulations serve the purpose of protecting women's health, despite the fact that they are medically unnecessary and can be harmful to pregnant people left without access to safe, legal abortion services. These requirements are enacted as an intentional barrier to abortion, by attempting to prevent pregnant people from accessing services through indirect means.[104] They add to socio-cultural stereotypes of abortion as wrong and harmful through the claimed aims of foetal protection and women's health. This is particularly an issue in anti-abortion contexts, such as where significant numbers of healthcare professionals conscientiously object to abortion, as pre-abortion counselling can become directive. For example, Jabulile Mavuso highlights how non-directive counselling requirements in South Africa have become coercive in an anti-abortion environment, as healthcare providers portray abortion as irresponsible and dangerous.[105] Mavuso highlights how mandatory counselling in an anti-abortion context can therefore produce or exacerbate psychological harm by stigmatising unintended pregnancy, the abortion decision, and the framing of parenthood as the safe and ethical option.[106]

[102] See: Linda Greenhouse and Reva B. Siegel, '*Casey* and the Clinic Closings: When "Protecting Health" Obstructs Choice' (2016) 125 *Yale Law J.* 1428.
[103] *Dobbs v. Jackson Women's Health* 597 U.S. ___ (2022).
[104] Parsons and Romanis (n94) p.36.
[105] Jabulile Mary-Jane Jace Mavuso, 'Understanding the violation of directive anti-abortion counselling [and cisnormativity]: Obstruction to access or reproductive violence?' (2021) 35(3) *Agenda* 69, 70.
[106] *Ibid* 73.

Linda Greenhouse and Reva Siegel had critiqued the application of the 'undue burden' standard as a context-insensitive rule, a critique which also applies to the way in which the current international human rights framework treats barriers to abortion access.[107] As indicated in Chapter 2, international human rights bodies do not require the removal of abortion regulations unless they would cause a certain degree of harm, such as preventing therapeutic abortion or resulting in unsafe abortion. Yet, as highlighted throughout this section, medically unnecessary regulations that do not universally prevent access to safe, legal abortion services are nevertheless harmful to pregnant people through obstructing or delaying access to abortion or resulting in psychological harm. These regulations are thus in conflict with the right to abortion, as States should not make it difficult or stigmatising for pregnant people to access the abortion services to which they have a right to. Enacting such regulations for the purpose of foetal protection is inappropriate as they can delay the gestational age at the time of the abortion, and concern for foetal interests must be realised through social and economic policies. In line with the requirements to remove barriers to access and address structural inequalities, States must therefore remove or refrain from adopting medically unnecessary regulations which represent barriers to abortion access such as mandatory counselling, waiting periods, and biased informed consent requirements.

[107] Greenhouse and Siegel (n102) 1478.

## *2.2. Access to Early Medical Abortion*

Ensuring that pregnant people can easily access abortion services without medically unnecessary delays or barriers will also require that States provide access to medical abortion pills, particularly in the early stages of pregnancy. Medical abortion refers to the use of two medications, mifepristone and misoprostol, to induce a miscarriage, which is less invasive than surgical abortion methods.[108] WHO includes both medications on its model list of essential medicines ('where permitted under national law and where culturally acceptable') and recommends medical abortion as a safe and effective method up to 24 weeks gestation.[109] Early medical abortion refers to the use of mifepristone followed by misoprostol up to 12 weeks gestation, to be distinguished from medical abortion after this point which requires subsequent doses of misoprostol.[110] Early medical abortion is therefore the most straightforward method of abortion. Abortion service delivery must be responsive to the different needs of individual pregnant people, so surgical abortion (through vacuum aspiration in the early stages of pregnancy) should also be provided as an option.[111] However, early medical abortion should be provided routinely to ensure that abortion services can be delivered in a simple and timely manner. In addition, States should not impose medically unnecessary restrictions on the provision of early medical abortion, such as by restricting who can dispense the medications and requiring the medications to be taken in-person. As the framework for the right to abortion set out in the previous chapter indicates that States should allow abortion on

[108] Parsons and Romanis (n94) p.2-5.
[109] WHO, *22nd Model List of Essential Medicines* (WHO, 2021), p. 50; WHO, *Safe abortion: technical and policy guidance for health systems* (WHO, 2nd Edn, 2012) p.3.
[110] *Ibid*; Parsons and Romanis (n94) p.4-5.
[111] WHO (2012, n109) p.3; Parsons and Romanis (n94) p.3-4.

request up to 12 weeks' gestation, an abortion within this time frame should be easily accessible and therefore healthcare professionals such as pharmacists, midwives, and nurses should be authorised to dispense abortion medications, in addition to doctors.

### i. Telemedicine for Early Medical Abortion

States should also provide telemedicine for early medical abortion (TEMA) to ensure that safe, legal abortion services are universally accessible. TEMA entails a remote consultation with a healthcare professional, and the abortion medication is then posted to the pregnant person to be taken at home.[112] The pregnant person would receive information on how to safely take the medication, any potential risks or side-effects, and the availability of post-abortion care if necessary.[113] The risks of having an early medical abortion at home, when provided with this information and access to post-abortion care, are equivalent to the already minimal risks of taking abortion medication in a medical facility under supervision.[114] However, of the States that do provide abortion medication for early abortions, few of those provide access via telemedicine.

In March 2020, temporary regulations were put in place to permit TEMA up to 10 weeks gestation in England and Wales and up to 12 weeks gestation in Scotland for the

[112] Abigail R.A. Aiken and others, 'Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study' (2021) 128(9) *BJOG* 1465; British Pregnancy Advisory Service, 'Pills by Post – Abortion Pill treatment at home' <https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/> accessed 14 January 2023.
[113] *Ibid*.
[114] See, for example: Aiken and others (n112); Margit Endler and others, 'Telemedicine for medical abortion: a systematic review' (2019) 126(9) *BJOG* 1094; John Joseph Reynolds-Wright and others, 'Adherence to treatment and prevalence of side effects when medical abortion is delivered via telemedicine: a prospective observational cohort study during COVID-19' (2021) 48(3) *BMJ Sex Reprod. Health* 185; Elizabeth Chloe Romanis and others, 'Safeguarding and teleconsultation for abortion' (2021) 398(1) *Lancet* 555.

duration of the COVID-19 pandemic.[115] Studies on the use of TEMA in Britain during this period have demonstrated high satisfaction rates among pregnant people using the service.[116] Additionally, a study comparing access to abortion before and after the change in regulations found that access had improved as waiting times decreased, and that there was no evidence of increased risks.[117] TEMA is safe and effective, so requirements that a pregnant person attends a facility in person to obtain abortion medication are medically unnecessary. Further, as telemedicine enables abortion services to become more efficient, thereby reducing delays, the adoption of TEMA would enable States to meet the requirement of ensuring access to abortion services as early as possible.

Requiring people to attend a healthcare facility in person to take abortion medication creates accessibility barriers for people from marginalised groups, imposing a particular burden on socio-economically disadvantaged people, people living rurally or significant distances from abortion facilities, and people with disabilities.[118] Attending a facility to take abortion medication may require a pregnant person to rely on costly or physically inaccessible public transport and incur the additional costs of childcare or taking time off work.[119] In the US and Canada, for example, the costs of travelling to an

[115] Department of Health and Social Care, 'The Abortion Act 1967 – Approval of a Class of Places' (30 March 2020) <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf> accessed 14 January 2023; Scottish Government Chief Medical Officer, 'Abortion – COVID-19 – approval for mifepristone to be taken at home and other contingency measures' (31 March 2020) <https://www.sehd.scot.nhs.uk/cmo/CMO(2020)09.pdf> accessed 14 January 2023.

[116] Nicola Boydell and others, 'Women's experiences of a telemedicine abortion service (up to 12 weeks) implemented during the coronavirus (COVID-19) pandemic: a qualitative evaluation' (2021) 128(11) *BJOG* 1752; John Joseph Reynolds-Wright and others, 'Telemedicine medical abortion at home under 12 weeks' gestation: a prospective observational cohort study during the COVID-19 pandemic' (2021) 47(4) *BMJ Sex Reprod Health* 246; Marielle E. Meurice and others, 'Client satisfaction and experience of telemedicine and home use of mifepristone and misoprostol for abortion up to 10 weeks' gestation at British Pregnancy Advisory Service: A cross-sectional evaluation' (2021) 104(1) *Contraception* 61.

[117] Aiken and others (n112) 1469.

[118] Sydney Calkin, 'Towards a political geography of abortion' (2019) 69 *Polit Geog.* 22, 23, 27.

[119] *Ibid* 23.

abortion facility may be significant for pregnant people having to travel to a different state to access an abortion.[120] Further, as abortion facilities tend to be concentrated in urban areas, this has an impact on indigenous populations who are more likely to be socio-economically disadvantaged and live the furthest from those areas.[121] In India, the reliance on private healthcare providers which, again, operate mostly in urban areas means a lack of access to safe, legal abortion services for pregnant people who live rurally or are socio-economically disadvantaged, which increases the likelihood of unsafe abortion practices.[122] The use of TEMA can improve accessibility by circumventing these geographical and socio-economic barriers and thus can address some of the structural inequalities in access faced by marginalised groups. Parsons and Romanis further argue that the use of telemedicine in low- and middle-income countries can potentially lessen inequalities in global health outcomes by making services available in regions with limited facilities.[123] TEMA cannot be a substitute for easily accessible abortion facilities as pregnant people should be able to choose an in-person medical abortion or early surgical abortion if necessary, and access to safe abortion in the later stages of pregnancy will require visiting an abortion facility. However, while these issues therefore remain for surgical or later medical abortions, and must be separately addressed by States, they are largely avoidable in relation to early medical abortion.

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[120] Lisa R. Pruitt and Marta R. Vanegas, 'Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law' (2015) 30 *Berkeley J. Gender, L. and Just.* 76; Christabelle Sethna and Marion Doull, 'Spatial disparities and travel to freestanding abortion clinics in Canada' (2013) *Women's Stud. Int. Forum* 38.

[121] Sethna and Doull (n120) 56-57; Barbara Baird, 'Tales of Mobility: Women's Travel and Abortion Services in a Globalized Australia' in Christabelle Sethna and Gayle Davis (Eds), *Abortion Across Borders* (John Hopkins University Press, 2019) p.160-161; Heather Wurtz, 'Indigenous Women of Latin America: Unintended Pregnancy, Unsafe Abortion, and Reproductive Health Outcomes' (2012) 10(3) *Pimatisiwin* 271, 273.

[122] B. Subha Sri and T.K Sundari Ravindran, 'Medical abortion: understanding perspectives of rural and marginalized women from rural South India' (2012) 118(S1) *Int. J. Gynaecol. Obstet.* 33; Susheela Singh and others, 'The incidence of abortion and unintended pregnancy in India, 2015' (2018) 6(1) *Lancet Glob. Health* e111; Ryo Yokoe and others, 'Unsafe abortion and abortion-related death among 1.8 million women in India' (2019) 9(4) *BMJ Glob. Health* 1.

[123] Parsons and Romanis (n94) p.76.

The provision of telemedicine is also important in relation to the acceptability of abortion services. Studies have demonstrated that the home use of abortion medication is acceptable and has high satisfaction rates among pregnant people using this service.[124] In addition to ease of access, pregnant people often prefer to have an early medical abortion through telemedicine due to the flexibility, comfort, and privacy that it enables.[125] In situations of abuse, coercion, or control from an intimate partner or family members where the pregnant person may be unable to safely disclose an unwanted pregnancy or abortion, accessing abortion medication through telemedicine may be easier to keep secret than a visit to a facility.[126] Further, for trans men and pregnant gender minorities, obtaining an abortion poses additional difficulties such as being misgendered by abortion providers, which may again lend preference to telemedicine.[127] TEMA is therefore important for the acceptability of abortion provision as it enables ease of access to abortion services, greater privacy and comfort, and the minimising of risks that may come with visiting an abortion facility for some people. Telemedicine may not always be the preferred method of obtaining an early medical abortion, as some people may not have a safe, private home environment or access to the internet.[128] However, with the option of both in-person (provided that facilities are physically accessible) and remote early medical abortion, access to safe and acceptable abortion services would be improved.

[124] Aiken and others (n112); Reynolds-Wright and others (n116).
[125] Aiken and others (n112); Sarah J. Betstadt, Katrina J. Heyrana, and Natalie S. Whaley, 'Telemedicine for medication abortion: the time is now' (2020) 9(5) *Curr. Obstet. Gynecol. Rep.* 66; Hazal Atay and others, 'Why women choose at-home abortion via teleconsultation in France: drivers of telemedicine abortion during and beyond the COVID-19 pandemic' (2021) 47(4) *BMJ Sex Reprod. Health* 285.
[126] Abigail R.A. Aiken and others, 'Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain' (2018) 97(2) *Contraception* 177; Romanis and others (n111) 556.
[127] Heidi Moseson and others, 'Abortion experiences and preferences of transgender, nonbinary, and gender-expansive people in the United States' (2021) 224(4) *AJOG* 376.e1.
[128] Parsons and Romanis (n94) p.77.

The comments of human rights bodies such as the CESCR and CEDAW on the accessibility and acceptability of sexual and reproductive health services can lend (limited) support for the adoption of telemedicine. CESCR requires that States provide access to the medicines on the WHO model list, including mifepristone and misoprostol for abortion services, and has commented that the accessibility of sexual and reproductive health services requires that facilities are within 'within safe physical and geographical reach for all'.[129] Recognising that some groups, such as people with disabilities and people who live rurally, face additional barriers in accessing facilities, CESCR also requires that positive measures are implemented to ensure substantive equality in access.[130] CEDAW has made similar recommendations in relation to ensuring timely access to healthcare services and the removal of barriers.[131] Although these comments are referring to access to healthcare facilities, Sydney Calkin has critiqued the assumption that accessibility requires a pregnant person's physical presence in an abortion facility.[132] The positive measures taken to remove barriers, such as those outlined above, and ensure access to abortion could therefore include the implementation of TEMA. Additionally, both CEDAW and CESCR have commented on the acceptability of sexual and reproductive health services as requiring sensitivity to the needs and characteristics of individuals.[133] Cabello and Gaitan interpret such comments to mean that non-therapeutic restrictions on abortion which contradict patient autonomy are unacceptable under international human rights standards.[134] Telemedicine is

[129] CESCR (n1) para. 16.
[130] *Ibid* para. 16; 24.
[131] CEDAW (n92) paras. 21; 23-24.
[132] Calkin (n118) 23.
[133] CESCR (n1) para. 20; CEDAW (n92) para. 22.
[134] Andrés López Cabello and Ana Cecilia Gaitán, 'Safe Abortion in Women's Hands: Autonomy and a Human Rights Approach to COVID-19 and Beyond' (2021) 23(1) *Health Hum. Rts. J.* 191, 192-193.

therefore a means of meeting these existing human rights standards that abortion must be timely, accessible, and acceptable.

However, as human rights bodies do permit some non-therapeutic restrictions on abortion, there is currently insufficient pressure on states to implement abortion service delivery in a way which ensures ease of access for pregnant people in varying contexts. Restrictions on the home use of abortion medication are medically unnecessary, contradict standards of acceptability, and operate as a barrier to access. Regulations that require abortion medication to be taken in a healthcare facility rather than at home are often not in place out of legitimate safety concerns, but in a similar vein to the US TRAP laws claim the purpose of protecting pregnant people's health in order to make it harder to access abortion services. Further, these overly protective regulations reinforce gendered stereotypes and concerns that pregnant people would make reckless or frivolous abortion decisions if they were to take this medication without direct supervision. Parsons and Romanis argue that there is a 'telemedical imperative' where implementing telemedical abortion services is safe, effective, and acceptable.[135] This should be adopted within the international human rights framework. Where it is possible to safely implement abortion service delivery via telemedicine, restrictions on the home use of abortion medication undermine the right to abortion. States must therefore take steps to provide for TEMA in order to meet the obligations of ensuring access to abortion as early as possible, removing barriers to access, and addressing structural inequalities.

Furthermore, implementing TEMA is an immediate step that can be taken towards meeting States' other obligations under the right to the abortion where full compliance is not possible. For example, telemedicine would be an effective initial response to tackling

[135] Parsons and Romanis (n94) p.76-87.

the widespread regional disparities in access to abortion resulting from CO in a country such as Italy. This would also reduce the workload burdens on non-objecting doctors, as telemedicine is a more efficient means of abortion service delivery. Additionally, telemedicine is an easier route to providing abortion services in states lacking the resources to set up abortion facilities and can therefore assist States in progressively realising the right to abortion where they are unable to fully comply due to socio-economic limitations. Full compliance with the right to abortion will require additional measures, beyond TEMA, to ensure that abortion services are universally accessible without socio-economic and regional disparities. This will require the availability of abortion facilities, comprehensively trained personnel, and the funding of abortion services to ensure that they are affordable to all. However, the provision of telemedicine will improve accessibility in the short-term where progression towards universal access to in-person services is slower.

### ii. Self-Managed Medical Abortion

Where states are unable or unwilling to provide access to early medical abortion, the decriminalisation of abortion is important in ensuring that pregnant people can access safe abortion medication even where abortion in the early stages of pregnancy has not been legalised or is inaccessible. The use of misoprostol, a drug developed for the treatment of gastrointestinal ulcers, was discovered to be an effective abortifacient by pregnant people in Brazil in the 1980s against the backdrop of abortion prohibitions,

limited access to contraception, and high rates of unintended pregnancies.[136] As the drug was relatively cheap and could be obtained from pharmacies without a prescription, knowledge of misoprostol's use as an abortifacient spread through informal networks across Latin America and beyond.[137] Significantly, the increasing use of misoprostol as a method of clandestine abortion correlated with a reduction in maternal mortality and morbidity in this region.[138] Recognising that access to information on taking abortion medication safely, in the absence of formal medical structures providing this information, has led to the creation of safe abortion hotlines such as *Socorristas en Red* in Argentina and *Samsara* in Indonesia.[139] The provision of pre- and post-abortion counselling by these networks reduces the risks of harm or incomplete abortion.[140] Women on Web, one of the most prominent online providers of abortion medication and information on taking the pills safely, provides safe access to abortion for pregnant people living in countries where abortion is legally restricted or inaccessible.[141] Women on Waves, its sister organisation, sails a ship to countries where abortion is illegal in order to provide abortion and contraceptive services and information, and has also used drones to deliver abortion medication to pregnant people in Northern Ireland and Poland.[142] Operating in

[136] Fiona Bloomer, Claire Pierson, and Sylvia Estrada Claudio, *Reimagining Global Abortion Politics* (Policy Press, 2018) p.37; Kinga Jelinska and Susan Yanow, 'Putting abortion pills into women's hands: realizing the full potential of medical abortion' (2018) 97 *Contraception* 86, 86; Sarah H. Costa and Martin P. Vessey, 'Misoprostol and illegal abortion in Rio de Janeiro, Brazil' (1993) 341(8855) *Lancet* 1258.
[137] Bloomer, Pierson, and Claudio (n136) p.37; Silvia De Zordo, 'The biomedicalization of illegal abortion: the double life of misoprostol in Brazil' (2016) 23(1) *Hist Cienc Saude Manguinhos* 19.
[138] Jelinska and Yanow (n136) 86.
[139] Socorristas en Red, '¿Cómo hacerse un aborto seguro con medicamentos?' <http://socorristasenred.org/> accessed 14 January 2023; Samsara, 'Samsara Hotline' <https://samsara.or.id/samsara-hotline/> accessed 14 January 2023.
[140] Raquel I. Drovetta, 'Safe abortion information hotlines: An effective strategy for increasing women's access to safe abortions in Latin America' (2015) 23(45) *Reprod. Health Matters* 47; Caitlin Gerdts and Inna Hudaya, 'Quality of Care in a Safe-Abortion Hotline in Indonesia: Beyond Harm Reduction' (2016) 106(11) *Am. J. Pub. Health* 2071.
[141] Women on Web, 'Abortion with pills' <https://www.womenonweb.org/en/abortion-pill> accessed 14 January 2023.
[142] Women on Waves, 'Who Are We? <https://www.womenonwaves.org/en/page/650/who-are-we> accessed 14 January 2023.

effectively the same way as a formal telemedicine system, obtaining a clandestine early medical abortion through these routes can be just as safe as having an early medical abortion within the medico-legal system.[143]

Given that clandestine abortion is an inevitability where access to safe, legal abortion services is restricted, enabling abortion medication through these alternative routes is imperative to ensure that pregnant people use the safest possible method. As early medical abortion outside of medico-legal regulation is relatively safe, scholars have increasingly begun to refer to this as 'self-managed abortion' (SMA) to distinguish between this and methods of unsafe abortion.[144] While SMA may be conceived of as an interim solution to minimise the harms associated with clandestine abortion until abortion is safe, legal, and accessible, SMA provides, for many pregnant people, an alternative to the possible indignities of formal settings.[145] This is particularly relevant in spaces where barriers such as widespread conscientious objection, mandatory counselling, in-person requirements, and the stigmatising attitudes of healthcare professionals make accessing abortion services a difficult and psychologically harmful experience. Thus, Mariana Prandini Assis and Sara Larrea argue that SMA is the best option for many pregnant people across the world.[146] This may also be the case in

[143] Drovetta (n140); Gerdts and Hudaya (n140); Rebecca Gomperts and others, 'Provision of medical abortion using telemedicine in Brazil' (2014) 89(2) *Contraception* 129; Abigail R.A. Aiken and others, 'Self reported outcomes and adverse events after medical telemedicine: population-based study in the Republic of Ireland and Northern Ireland' (2017) 357 *BMJ* 1.

[144] See, for example: Joanna N. Erdman, Kinga Jelinska, and Susan Yanow, 'Understandings of self-managed abortion as health inequity, harm reduction and social change' (2018) 26(54) *Reprod. Health Matters* 13; Mariana Prandini Assis and Sara Larrea, 'Why self-managed abortion is so much more than a provisional solution for times of pandemic' (2020) 28(1) *Sex. Reprod. Health Matters* 37; Lucía Berro Pizzarossa and Rishita Nandagiri, 'Self-managed abortion: a constellation of actors, a cacophony of laws?' (2021) 29(1) *Sex. Reprod. Health Matters* 1.

[145] Erdman, Jelinska, and Yanow (n144) 14; Mariana Prandini Assis and Joanna N. Erdman, 'Abortion rights beyond the medico-legal paradigm' (2021) *Glob. Public Health* 1, 8.

[146] Prandini Assis and Larrea (n144) 38.

contexts where state-provided legal abortion services are unsafe, overburdened, or can only offer surgical methods.

However, in addition to the criminalisation of abortion outside of the medico-legal system, many states restrict SMA by other means. This can include restrictions on the distribution of abortion medication by pharmacies and customs regulations restricting imports, leading to the unavailability of affordable, reliable, and legitimate sources of abortion medication.[147] In a number of states, such as Brazil, South Korea, Iran, and Spain, access the Women on Web and Women on Waves websites has been blocked.[148] In Brazil, where abortion is permitted only in the exceptional circumstances and 200,000 pregnant people are hospitalised for abortion-related complications each year on average, the use of misoprostol for SMA has also been limited through its removal from pharmacies.[149] Further, Brazil's criminal regulation of the possession and distribution of misoprostol under drug control laws represents a 'new form of abortion criminalization'. [150] Restricting access to safe sources of abortion medication in states that do not fully comply with the right to abortion increases the likelihood of unsafe abortion practices. Where states are unable to or have failed to implement measures to ensure comprehensive access to abortion services, it is therefore inappropriate for those states to take measures to prevent access to abortion through alternative means.

[147] Jelinska and Yanow (n136) 87.
[148] Joana Varon and others, 'On the blocking of abortion rights websites: Women on Waves & Women on Web' (OONI, 29 Oct 2019) <https://ooni.org/post/2019-blocking-abortion-rights-websites-women-on-waves-web/> accessed 14 January 2023; Women on Web, 'Spain censors information about abortion amid Covid-19 lockdown' (17 Jun 2020) <https://www.womenonweb.org/en/page/20230/spain-censors-information-about-abortion-amid-covid-19-lockdown> accessed 14 January 2023.
[149] Bruno Baptista Cardosa, Fernanda Morena dos Santos Barbeiro Vieira, and Valeria Saraceni, 'Abortion in Brazil: what do the official data say?' (2020) 36 (Suppl 1) *Cad. Saúde Pública* 1; Jelinska and Yanow (n132) 87.
[150] Mariana Prandini Assis and Joanna N. Erdman, 'In the name of public health: misoprostol and the new criminalization of abortion in Brazil' (2021) 8(1) *J. Law Biosci.* 1, 4, 7.

States should, instead, remove regulatory restrictions on access to abortion medication, facilitate the market to ensure the affordability of the drugs, and ensure that pregnant people have access to evidence-based information on self-managed abortion.[151] Joanna Erdman has highlighted the 'Uruguay Model' of information provision as an effective harm reduction strategy.[152] Prior to the legalisation of abortion on request within the first 12 weeks, healthcare professionals in Uruguay could provide pregnant people with evidence-based information of the risks of different clandestine abortion methods and indicate safer abortion methods such as the use of misoprostol.[153] The pregnant person would then be able to access post-abortion care for any complications, with assured confidentiality.[154] The provision of information through the formal healthcare system ensures its accessibility to pregnant people without access to the internet or without knowledge of alternative information providers.

It is necessary for a human rights approach to foster an enabling environment for SMA, not only as a harm reduction strategy but as a means of increasing universal access to abortion services where states are unable or unwilling to provide them. Lucía Vázquez-Quesada et al argue that supporting SMA is a fundamental means of addressing the current inequities in access to abortion services globally.[155] As an example, they consider the impact of an active policy supporting SMA in countries such as India, where the majority of abortions already take place outside the medico-legal system despite abortion

[151] Lucía Berro Pizzarossa and Patty Skuster, 'Toward Human Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion: A Review of the Last Decade of Legal Reform' (2021) 23(1) *Health Hum. Rights* 199, 208; Lucía Vázquez-Quesada and others, 'Abortion Self-Care: A Forward-Looking Solution to Inequitable Access' (2020) 46 (Suppl 1) *Int. Perspect. Sex. Reprod. Health* 91, 93.
[152] Joanna N. Erdman, 'Access to Information on Safe Abortion: A Harm Reduction and Human Rights Approach' (2011) 34 *Harv. J. L. Gender* 413.
[153] *Ibid* 420-421.
[154] *Ibid*.
[155] Vázquez-Quesada and others (n151) 93.

being legal.[156] They view this as a means of increasing universal healthcare coverage.[157] The facilitating of SMA cannot, however, be a substitute for states' own obligations to take steps towards the comprehensive provision of abortion services (for example, through implementing formal telemedicine services). Erdman additionally emphasises that SMA as a harm reduction strategy cannot discharge states of their responsibility to address the prevalence of unsafe abortion.[158]

Finally, the facilitating of SMA could also open up avenues for those states able to comply with the right to abortion to assist those that are unable to due to resource-limitations. As indicated in Chapter 3, the PGC as a foundation for the international human rights framework places a moral imperative on states to assist other states to comply with human rights. Tamara Hervey and Sally Sheldon have already argued that the European Union's rules could permit an accredited doctor to prescribe abortion medication by telemedicine to a pregnant person in a different member state.[159] At the global level, Women on Web demonstrates the effectiveness of a telemedical abortion service operating worldwide. If states avoid restricting or criminalising the importing or exporting of abortion medication, and decriminalise abortion in order to permit SMA, it could be possible for state assistance to be provided through the cross-border provision of abortion medication by qualified healthcare professionals. This would be an easy and cost-effective means of state assistance which could make significant improvements in abortion provision, by guaranteeing access to reliable information and safe drugs until states are able to provide this without assistance.

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[156] *Ibid* 90.
[157] *Ibid* 93.
[158] Erdman (n152) 451.
[159] Tamara Hervey and Sally Sheldon, 'Abortion by telemedicine in the European Union' (2019) 145(1) *Int. J. Gynaecol. Obstet.* 125.

### *2.3. Recommendations to Ensure Access to Abortion Services*

1) States Parties must remove or refrain from implementing medically unnecessary regulatory requirements. States must not impose restrictions such as mandatory counselling, waiting periods, medically unnecessary limitations on which healthcare professionals are able to dispense abortion medication, and requirements that a pregnant person must attend an abortion facility in person for an early medical abortion.

2) States Parties must ensure that that accurate, evidence-based information on abortion is universally available, including the provision of information on self-managed abortion in the absence of full compliance with the right to abortion.

3) States Parties must provide access to a range of abortion methods, including early medical abortion. States Parties must therefore ensure that the medications recommended for safe early medical abortion by the World Health Organization, as indicated in their Model List of Essential Medicines, are made available. Further, States Parties should ensure that early medical abortion services can be routinely provided through telemedicine where feasible, or alternative measures to improve the universal delivery of abortion services. States Parties in compliance with the right to abortion should facilitate the cross-border provision of abortion medication in order to assist those States Parties unable to fully comply due to resource-limitations.

4) Where abortion is not broadly legalised or accessible, States Parties must implement appropriate measures to facilitate self-managed abortion. States Parties must not restrict or criminalise the distribution of abortion medication in such a way that would increase the likelihood of unsafe abortion practices or prevent universal access to abortion services.

5) The provision of telemedicine and the facilitating of self-managed abortion are not substitutes for the fulfilment of States Parties obligations under the right to abortion. States Parties must continue to take steps towards ensuring comprehensive access to abortion services through setting up physically accessible abortion facilities, ensuring that healthcare professionals are trained to provide abortion, and that abortion services are affordable to all.

## *Conclusion*

Expanding on the requirements set out in the framework for progressively realising the right to abortion that states must, at all stages, remove barriers to accessing abortion services, this chapter has addressed some of the key regulatory issues which limit the availability and accessibility of abortion. Firstly, in relation to CO, the current international human rights framework recommends implementing a mandatory referral mechanism to balance CO with access to abortion. However, the effectiveness of this is limited where CO is widespread and consequently has a significant impact on the

availability of abortion services, and objecting healthcare professionals may avoid referring patients for abortion. The regulation of CO is therefore context-dependent, with fewer restrictions being necessary where CO has a minimal impact on the provision of abortion services. I set out recommendations imposing a duty on States to regulate CO to ensure that access to abortion services is not obstructed.

Secondly, this chapter considered the impact of medically unnecessary regulatory requirements such as mandatory pre-abortion counselling, waiting periods, restrictions on abortion providers, and requirements that a pregnant person attends an abortion facility in person for an early medical abortion. These requirements, though they may not completely obstruct access to abortion, create barriers for some pregnant people, particularly for socio-economically disadvantaged people, those living rurally or in regions without abortion facilities, and other marginalised groups. I set out recommendations that states must remove or refrain from implementing medically unnecessary regulatory requirements, and work towards universal access to abortion services by providing TEMA in addition to in-person services. For states unwilling or unable to provide comprehensive access to abortion services including TEMA, SMA should not be restricted as this may represent the safest or most accessible option for many pregnant people. While states must take steps towards full compliance with their obligations under the right to abortion, enabling TEMA and SMA can facilitate access to safe abortion services in the interim.

# 6

# Realising the Right to Abortion

## *Introduction*

In this chapter, I seek to address the practical significance of recognising a right to abortion in the international human rights framework despite its relatively weak mechanisms for enforcement. International human rights standards on abortion can be influential in domestic contexts and can be relied upon by local abortion rights movements, national courts, and regional human rights bodies to put pressure on governments to reform the law. In addition, as the realisation of the right to abortion requires addressing specific contextual issues that vary between states, the monitoring of rights implementation by local movements and courts is important. These local actors can respond to specific socio-economic, cultural, or gender-based issues and broader issues around sexual and reproductive rights where international human rights bodies may be inadequately placed to do so.

In the first section of this chapter, I consider critiques around the ineffectiveness of the international human rights framework. I address the claims made by critical legal theorists around alternative or 'counter-hegemonic' human rights practices, and instead view these practices as forming part of the implementation of codified human rights. In the second section, I introduce the concept of the vernacularization of human rights – the

translation of universal human rights concepts to local contexts – and highlight the importance of feminist movements in translating the right to abortion, particularly where there is political or cultural resistance to reproductive rights. I consider the recent changes to abortion law in Argentina, Ireland, and Northern Ireland and how human rights were adopted by feminist movements in order to propel these changes. In the third section, I then explore the importance of the national courts for realising the right to abortion, as a strategy to complement abortion rights activism and as a means to effect legal change where political avenues are closed off, with a focus on the courts in Colombia and Argentina as examples of varying degrees of judicial action on the right to health and abortion. In this section, I also explore the limitations of the national courts and look to the three regional human rights systems (the African, European, and Inter-American systems) as also playing an important role in the realisation of international human rights. Despite the limitations around enforcement of the international human rights system, the right to abortion could, therefore, be progressively realised through these alternative avenues – and the recognition of the right to abortion is necessary for those avenues to be successful.

## *1. Human Rights Effectiveness*

There has been a growing body of literature critiquing and even dismissing human rights as ineffective: for presenting overly romanticised narratives of the emancipatory effects of human rights; for operating merely as a 'palliative' which only helps a limited number of people; for their inability to account for everyday experiences of injustice; for failing to

support material or distributive equality.[1] Some of these critics recognise that human rights are nonetheless important, as a globally available vocabulary which has brought incalculable benefits and as a radical tool for people living in conditions of oppression.[2] Others, however, conclude that the human rights framework is irredeemable, or that human rights should not be the main tools for working towards global equality.[3] While these critiques point to conceptual issues within the international human rights system, these problems are not inherent to the concept of human rights itself and can therefore be remedied through a feminist transformation of the human rights framework in line with the PGC, as demonstrated in previous chapters in relation to the right to abortion.

The recognition of the right to abortion would be symbolically significant and would empower human rights bodies to put more pressure on states to take steps towards the full realisation of the right of abortion. However, there remains one key critique of the international human rights system to be addressed – its ineffectiveness. As highlighted in Chapter 2, international human rights bodies have relatively weak enforcement and follow-up mechanisms. These limitations on human rights bodies' ability to hold states accountable for human rights violations present a particular problem in relation to contested rights issues such as abortion and gender-based rights.

Further, critical legal scholars have been sceptical of the ability of the international human rights system to challenge existing systems of power, imagine radical alternatives,

[1] Günter Frankenberg, 'Human rights and the belief in a just world' (2014) 12(1) *ICON* 35, 51; Costas Douzinas, *Human Rights and Empire* (Routledge-Cavendish, 2009) p.293; Ratna Kapur. 'Precarious desires and ungrievable lives: human rights and postcolonial critiques of legal justice' (2015) 3(2) *Lond. Rev. Int. Law* 267, 285; David Kennedy, 'International Human Rights Movement: Part of the Problem?' (2002) 15 *Harv. Hum. Rts. J.* 101, 111; Samuel Moyn, *Not Enough: Human Rights in an Unequal World* (Harvard University Press, 2018) p.2-3.

[2] Frankenberg (n1) 36; Douglass Cassel, 'Does International Human Rights Law Make a Difference?' (2001) 2 *Chi. J. Int'l L.* 121, 122; Ratna Kapur, 'Human Rights in the 21st Century: Take a Walk on the Dark Side' (2006) 28 *Sydney L. Rev.* 665, 683.

[3] Ben Golder, 'Beyond redemption? Problematising the critique of human rights in contemporary international legal thought' (2014) 2(1) *Lond. Rev. Int. Law.* 77, 104; Moyn (n1) p.220.

and guarantee freedom.[4] Where states resist the realisation of human rights and human rights bodies do not have the means to combat this, states can retain systems, laws, and policies that infringe human rights without significant consequences coming from treaty bodies. However, critical and postcolonial legal scholars have also highlighted 'alternative' human rights practices coming from the subaltern (formerly colonised populations who were socio-economically and political excluded from power) and within activism.[5] For example, Shaimaa Abdelkarim refers to 'counter-hegemonic' practices of human rights, through which these excluded subjects contribute to reproduction of human rights beyond the institutional and codified structures.[6]

Within critical legal scholarship, these critiques and alternative practices are taken to be an anti-foundational approach to human rights.[7] However, within a feminist transformation of the human rights system which has the PGC as its foundation, these localised practices of human rights realisation need not be viewed as an alternative to the international system. Rather, these practices of localised activism can work in co-operation with human rights instruments in order to effectively realise human rights. While some may view these 'counter-hegemonic' practices and domestic pressure as possible even without the international system, the recognition of a legal and moral foundation for human rights provides concrete support for the claims made by activists.[8]

[4] Konstantine Eristavi, 'Performing Defiance with Rights' (2021) 32 *Law and Critique* 153, 154; Ratna Kapur, *Gender, Alterity and Human Rights* (Edward Elgar, 2020).
[5] See, for example, Shaimaa Abdelkarim, 'Subaltern subjectivity and embodiment in human rights practices' (2022) 10(2) *Lond. Rev. Int. Law* 243; Eristavi (n5); Kathryn McNeilly, 'After the Critique of Rights: For a Radical Democratic Theory and Practice of Human Rights' (2016) 27 *Law and Critique* 269; Upendra Baxi, *The Future of Human Rights* (Oxford University Press, 2006, 3rd Edn).
[6] Abdelkarim (n5) 244.
[7] *Ibid* 243; Eristavi (n4) 161.
[8] See, for example, Eric Posner, *The Twilight of Human Rights* (Oxford University Press, 2014) p.83.

In the following section, I will highlight the potential of an explicit right to abortion in the context of successful movements for abortion law reform.

## *2. Abortion Rights Movements*

The recognition and expansion of women's and gender-based rights in the current international human rights framework has been informed by feminist movements. The Vienna World Conference on Human Rights in 1993, the Cairo International Conference on Population and Development in 1994, and the Beijing World Conference on Women in 1995 were key platforms for the recognition of women's and reproductive rights. Significant numbers of civil society organisations attended each of these conferences, and the successful organisation of transnational feminist networks around these events initiating the recognition of gender-based rights within the international framework.[9] Civil society organisations, including women's rights and feminist organisations, have been increasingly recognised as having an important role to play in the periodic reporting process for each treaty body. Civil society organisations can identify gaps between ratification and implementation, and often submit shadow reports to comment upon the failures of the state to meet certain human rights standards. In highlighting the underrepresentation of gender-based interests, these organisations have become essential to the realisation of gender-based rights.[10]

[9] Alicia Ely Yamin, *When Misfortune Becomes Injustice* (Stanford University Press, 2020) p.79-84.
[10] Srila Roy, 'Transnational Feminism and the Politics of Scale' in Ashwini Tambe and Millie Thayer (Eds), *Transnational Feminist Itineraries* (Duke University Press, 2021) p.75.

Feminist organisations interact with international human rights bodies and state governments in order to advance compliance with treaties such as CEDAW, and in the absence of mechanisms to allow treaty bodies to hold state parties directly accountable for human rights violations. Joanne Sandler and Anne Marie Goetz argue that it is independent feminist monitoring and reporting that 'expose abuses in ways that activate states to improve performance'.[11] This conclusion is supported by Laurel Weldon and Mala Htun's findings that a strong feminist movement was a significant predictor of positive policy responses to gender-based violence, particularly where this was supported by international norms.[12] International treaties also give normative leverage to activists, and thus international human rights standards and feminist movements can magnify the effect of one another.[13] That international human rights standards are influential as a lobbying tool in relation to abortion has already been noted by scholars, but the role that feminist movements could play in implementing a human right to abortion is worth elaborating on.[14] The relationship between feminist movements and international human rights is not simply a "boomerang effect" where activists reach out to treaty bodies to put pressure on the state but is a more complex process of human rights translation and influencing international standards.[15]

[11] Joanne Sandler and Anne Marie Goetz, 'Can the United Nations deliver a feminist future?' (2020) 28(2) *Gend. Dev.* 239, 258.
[12] S. Laurel Weldon and Mala Htun, 'Feminist mobilisation and progressive policy change: why governments take action to combat violence against women' (2013) 21(2) *Gend. Dev.* 231, 236, 243-244.
[13] *Ibid* 245.
[14] See, for example, Johanna B. Fine, Katherine Mayall, and Lilian Sepúlveda, 'The Role of International Human Rights Norms in the Liberalization of Abortion Laws Globally' (2017) 19(1) *Health Hum. Rts J.* 69.
[15] On the "boomerang effect" theory of transnational activism, see: Margaret E. Keck and Kathryn Sikkink, *Activists Beyond Borders* (Cornell University Press, 2014) p.36.

## *2.1. The Vernacularization of Abortion Rights*

Sally Engle Merry introduced the concept of 'vernacularizing' human rights, where universal ideas are extracted and translated into a language which resonates in specific local contexts.[16] In relation to the vernacularizing of gender-based rights, Engle Merry argued that while these rights ideas 'are repackaged in culturally resonant wrappings, the interior remains a radical challenge to patriarchy.'[17] The fundamental meaning of the right in question is not changed, but local interpretations enable norms to adopted from the ground-up rather than imposed by an international body.[18] This process of vernacularization 'converts universalistic human rights into local understandings of social justice' and provides the means for local movements to raise human rights issues in a way that resonates.[19] These local movements are supported by the legitimacy of international human rights standards and treaty bodies, but are positioned to adopt or translate these standards based on what makes sense in that contexts.

This can be done by adapting or expanding on the content of a specific human right to respond to local issues, or by avoiding reference to human rights at all by translating human rights norms to fit with other values. Feminist movements modify or reframe rights in order to facilitate their acceptance.[20] If adopting the language of human rights would hinder progress on gender-based issues, movements can adopt alternative

[16] Sally Engle Merry, *Human Rights and Gender Violence* (The University of Chicago Press, 2006).
[17] *Ibid* p.221.
[18] *Ibid* p.225.
[19] Sally Engle Merry and Peggy Levitt, 'The Vernacularization of Women's Human Rights' in Stephen Hopgood, Jack Snyder, and Leslie Vinjamuri (Eds.) *Human Rights Futures* (Cambridge University Press, 2017) p.213.
[20] Peggy Levitt and Sally Engle Merry, 'Making Women's Human Rights in the Vernacular: Navigating the Culture/Rights Divide' in Dorothy L. Hodgson (Ed.) *Gender and Culture at the Limit of Rights* (University of Pennsylvania Press, 2011) p.91.

framings while retaining a commitment to the conceptual foundations of gender-based rights. In Argentina, activists have directly referenced international human rights standards on abortion (which will be discussed in more detail in the following subsection), gender-based violence, and the rights of people with disabilities, to indicate just a few examples, to push for reforms.[21] In other contexts, reference to these norms may be less impactful. In one of Engle Merry's studies of human rights vernacularization, she considers a group of women in Gujarat who drew inspiration for framing their opposition to domestic violence from international human rights documents such as CEDAW but did not cite or refer to these documents in their advocacy.[22] This group is still doing the work of vernacularizing human rights, but in a way which is further removed from the letter of international human rights documents.

In addition, social movements are not merely translators of human rights, but are key actors in the development, expansion, and realisation of human rights. Zakiya Luna presents the concept of the 'revolutionary domestication' of human rights as an alternative to vernacularization, in recognising how reproductive justice organisations in the US have adopted a more radical framing of human rights than international human rights standards.[23] The translation or adaptation of human rights can be expansive where the discourse of human rights in seen as radical or significant in that context, but this may not be possible if human rights have little traction in the local vernacular. Revolutionary domestication is not, as Luna suggests, different to Merry's concept, as the extent to which an ambitious interpretation of human rights is possible depends on the local context. I

[21] See: Barbara Sutton and Elizabeth Borland, 'Abortion and Human Rights for Women in Argentina' (2019) 40(2) *Frontiers* 27; Gráinne de Búrca, *Reframing Human Rights in a Turbulent Era* (Oxford University Press, 2021) Ch. 4.
[22] Sally Engle Merry, 'What is Legal Culture? An Anthropological Perspective' (2010) 5(2) *J. Comp. Law* 40, 56.
[23] Zakiya Luna, *Reproductive Rights as Human Rights* (New York University Press, 2020) p.17-18.

will adopt the idea of revolutionary domestication below in considering how human rights standards on abortion translate to domestic spheres, however, as a way of capturing the potential of rights vernacularization on access to abortion.

Further, while vernacularization is a process through which human rights can gain cross-cultural traction while avoiding the potential issues of imperialism considered in Chapter 1, it is important that this process is not interpreted as simply about the translation of Western rights-based values into non-Western contexts. Madhok has critiqued the phrase 'vernacularization' as a verb which reinforces the idea of rights as unidirectional, travelling from the West to the non-West where they are then appropriated or repackaged.[24] Instead, Madhok uses the phrase 'vernacular rights cultures' in order to recognise the non-linear relationship between human rights and social movements.[25] This non-linear relationship was acknowledged by Engle Merry and Levitt; they point out that social justice movements have been central to the naming of human rights violations, leading to their subsequent recognition by international bodies.[26] They also recognise that the organisations they studied were part of a mutually constitutive transnational process in which human rights ideas circulate between local, regional, and international levels.[27]

Following from this, I adopt an understanding of vernacularization as a circular process in which activists play a key role in the implementation and expansion of human rights protection at the national level, and in turn can influence both human rights activism in other states and the development of international and regional human rights

[24] Sumi Madhok, *Vernacular Rights Cultures* (Cambridge University Press, 2021) p.20.
[25] *Ibid*.
[26] Engle Merry and Levitt (n19) p.216.
[27] Levitt and Engle Merry (n20) p.90.

standards. This incorporates Madhok's conception of vernacular rights cultures as spaces where human rights are politically productive, and Luna's recognition of the potential for revolutionary domestication of human rights.

In the remainder of this section, I will consider the vernacularization of international human rights standards on abortion, focusing on Argentina, Ireland, and Northern Ireland in particular, as states with recent abortion law reforms that were influenced (to varying degrees) by international human rights. In doing so, I will consider the potential for abortion rights activists to play a significant role in pushing states towards the full realisation of the right to abortion I set out in the previous two chapters. Feminist movements for abortion law reform have increasingly adopted rights-based discourse, for example through the idea of the 'right to choose' in pro-choice activism and the framing of reproductive justice as a human right. In some contexts, this use of human rights language is disconnected or distanced from international human rights standards around reproductive rights.

However, in other contexts, international human rights standards on abortion provide a key avenue for putting pressure on state actors to liberalise abortion. In the face of domestic resistance, international human rights bodies and transnational feminist networks can be an attractive source of legitimacy.[28] Further, where there is socio-cultural or religious resistance to abortion, abortion rights movements can do what international human rights bodies cannot; they can be better positioned to undergo the work of changing attitudes to abortion and prominent socio-cultural stereotypes around motherhood and pregnancy. Yamin highlights the importance of vernacularization in

[28] Kate Hunt, 'Social movements and human rights language in abortion debates' (2021) 20(1) *J. Hum. Rights* 72, 75.

relation to sexual and reproductive health indicators, as a way of responding to specific socio-cultural contestations and understandings of sexuality, pregnancy, and the relationship between the pregnant person and foetus.[29] In the framework for the right to abortion set out in the previous two chapters, it is left open to individual states to determine the steps to be taken towards progressively realising the full content of the right and how to respond to the issues around guaranteeing access to abortion. This can be guided by local abortion rights movements who are able to identify contextual issues and put pressure on the State to adequately respond to them.

### *2.2. Argentina*

In December 2020, Argentina's National Congress passed legislation, the *Ley de Interrupción Voluntaria del Embarazo* (abbreviated henceforth using the Spanish acronym IVE), to decriminalise abortion and allow abortion on request up to 14 weeks' gestation.[30] Prior to this, abortion was criminalised under the Argentine Penal Code of 1984. The Code set out a criminal penalty of up to four years imprisonment for medical professionals who performed abortions (or ten years if the abortion was performed without consent).[31] This penalty could be higher if the abortion resulted in the death of the pregnant person.[32] There was also a penalty of up to four years imprisonment for a pregnant person who caused or consented to someone else causing her abortion.[33] Two

[29] Yamin (n3) p.185.
[30] IVE Articles 4; 14-18.
[31] Argentine Penal Code (1984) Article 85.
[32] *Ibid*.
[33] *Ibid* Article 88.

exceptions were provided, allowing a medical practitioner to perform an abortion with the consent of the pregnant person if: there was a danger to the life or health of the pregnant person, and this danger could not be avoided by other means; or where the pregnancy resulted from the rape or indecent assault of a person with a mental disability.[34] There was a lack of certainty in relation to both exceptions, as the first ground was unclear as to what constituted a sufficient danger and the wording of the second group suggested that a pregnant person could only have an abortion on the grounds of rape if they also had a mental disability.[35] These issues further obstructed access to abortion, with healthcare professionals hesitant to provide abortion services where there was any doubt as to whether one of the exceptions applied. As a result, the number of clandestine abortions taking place in Argentina each year (prior to legalisation) was calculated between 486,000 and 522,000 – accounting for approximately 40% of all pregnancies in the country.[36] It was also estimated that unsafe abortion accounted for just over 20% of the country's maternal deaths, while around 49,000 pregnant people were discharged from hospital following abortion-related complications each year.[37]

The National Campaign for the Right to Legal, Safe and Free Abortion formed in 2005 as a collective of movements and organisations working to legalise abortion in Argentina.[38] The IVE bill was first presented to Congress by the Campaign in 2007 and in subsequent years after this until it was debated for the first time in 2018, and eventually

[34] *Ibid* Article 86.
[35] Paola Bergallo, 'The Struggle Against Informal Rules on Abortion in Argentina' in Rebecca J. Cook, Bernard M. Dickens, and Joanna N. Erdman (Eds) *Abortion Law in Transnational Perspective* (University of Pennsylvania Press, 2014) p.146.
[36] Cora Fernández Anderson, *Fighting for Abortion Rights in Latin America* (Routledge, 2020) p.60.
[37] Fernández Anderson (n36) p.60; Mariana Romero and Agustina Ramón Michel, 'The Shift From Criminalization to Legalization of Abortion in Argentina' (2022) 328(17) *JAMA* 1699.
[38] Campaña Nacional por el Derecho al Aborto Legal, Seguro y Gratuito <http://www.abortolegal.com.ar> accessed 14 January 2023.

passed in 2020.[39] Employing a human rights framing was a key aspect in gaining support for the bill from politicians and other state actors, as the Campaign could highlight the state's obligations under international human rights law. Existing international human rights standards require states to decriminalise abortion and address unsafe abortions; the prosecution of doctors and pregnant people for assisting or obtaining illegal abortions and the widespread issue of unsafe abortions as connected to the country's maternal mortality rate could therefore be raised as examples of the Argentine government infringing or failing to comply with human rights requirements.[40] The Human Rights Council had previously found Argentina in violation of several rights contained in the ICCPR in *LMR v Argentina*, and the country's abortion law fell short of meeting human rights standards on the minimum grounds on which abortion must be legalised (where there is a risk to life or health of the pregnant person, where the pregnancy results from rape, and in cases of fatal foetal impairment) and access to abortion on those legal grounds.[41] The Campaign could therefore push for ambitious reform by emphasising the public health issues around unsafe abortion and making specific claims as to what was required of the state by reference to international human rights documents.[42]

This was particularly effective in Argentina because of the resonance of human rights discourse in the local vernacular in light of the country's dictatorship past. Argentina's military dictatorship of 1976-1983 was responsible for countless human rights violations, including forced disappearances, killings, torture, and imprisonment.[43]

[39] Barbara Sutton, 'Intergenerational encounters in the struggle for abortion rights in Argentina' (2020) 82 *Women's Stud. Int. Forum* 1, 1; Agostina Allori, 'Assessing the "Green Tide": An International Human Rights Advocacy Analysis of the "National Campaign for Legal, Safe and Free Abortion" of 2018 in Argentina' (2018) 4 *Disrupted* 32, 35.
[40] Sutton and Borland (n21) 44.
[41] *L.M.R. v Argentina* (2011) UN Doc. CCPR/C/101/D/1608/2007.
[42] Alba Ruibal and Cora Fernández Anderson, 'Legal obstacles and social change: strategies of the abortion rights movement in Argentina' (2020) 8(4) *Politics, Groups, and Identities* 698, 703.
[43] Sutton and Borland (n21) 32.

The dictatorship was also responsible for restrictions on reproductive rights, including further restricting the limited exceptions to the criminal offence of abortion that were contained in the 1922 Penal Code (which the 1984 Code reverted back to). Post-dictatorship, Argentina was influenced by international human rights standards in its transition to democracy, and the desire of the new democratic government to distance themselves from this history of state terrorism created an in-road for human rights ideas to become significant.[44] Many of Argentina's political parties actively promote human rights campaigns and have sought the prosecution of those responsible for and involved in forced disappearances and other rights violations between 1976-1983, and human rights campaigns had been successful on other fronts (including on contraception, LGBT+ rights, and disability rights).[45]

The Campaign tied abortion rights to this history by framing access to abortion as a 'debt of democracy', as well as through its use of imagery; the key symbol of the movement was a green triangular kerchief, mirroring the white kerchief worn by the Mothers of Plaza de Mayo, a group of mothers of people forcibly disappeared by the dictatorship.[46] The Mothers of Plaza de Mayo had also used human rights campaigning in pressuring the UN and international governments to condemn the dictatorship regime between 1976-83.[47] The translation of human rights to resonate with local and historical issues in Argentina is an example of how international human rights standards can have an indirect effect on abortion law reform. International human rights standards on

[44] Debora Lopreite, 'Travelling ideas and domestic policy change: The transnational politics of reproductive rights/health in Argentina' (2012) 12(2) *Glob. Soc. Policy* 109, 109, 122; Sutton and Borland (n13) 32.
[45] Lopreite (n44) 112-113; Lynn M. Morgan, 'Reproductive Rights or Reproductive Justice? Lessons from Argentina' (2015) 17(1) *Health Hum. Rts J.* 136, 142-143; Sutton and Borland (n21) 45; Omar G. Encarción, 'International Influence, Domestic Activism, and Gay Rights in Argentina' (2013) 128(4) *Political Sci. Q.* 687; De Búrca (n21) Ch. 4.
[46] Sutton and Borland (n21) 37; Sutton (n39) 3.
[47] Keck and Sikkink (n15) p.17.

abortion bolstered the claims made by the Campaign and informed the content of the IVE bill; the version now in force explicitly states that its provisions have been framed in accordance with several human rights treaties, including the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social, and Cultural Rights (ICESCR), and the Convention on the Elimination of Discrimination Against Women (CEDAW).[48]

In addition, the Campaign interpreted international human rights standards broadly, an example of the revolutionary domestication of human rights in relation to abortion. The Campaign focused on intersectional social justice issues around the criminalisation of abortion, emphasising that it was poorer people at risk of dying from unsafe abortions, and poorer people that were more likely to face arrest and prosecution when showing up at public health facilities for post-abortion aftercare.[49] Further, one of the Campaign's constituent groups, *Ni Una Menos* (Not One Less), was formed in 2015 as a feminist movement campaigning against gender-based violence, and linked access to abortion to wider feminist struggles in Argentina such as femicides, sexual harassment, gender roles, and trans rights.[50] These movements connected feminist struggles to those experienced by Indigenous communities, workers, people living in poverty, and LGBT+ communities and related all of these struggles to class inequality and poverty.[51] Abortion was therefore conceptualised as part of a broader struggle for gender-based rights and bodily autonomy; as a result, the IVE is inclusive of trans, non-binary, and gender

[48] IVE Art. 3.
[49] Mariela Daby and Mason W. Moseley, 'Feminist Mobilization and the Abortion Debate in Latin America: Lessons from Argentina' (2021) *Politics & Gender* 1, 12-13; Sutton and Borland (n13) 48-49.
[50] Daby and Moseley (n49) 2.
[50] *Ibid* 3.
[51] Verónica Gago, *Feminist International* (Verso, 2020) Ch.1; Mabel Bellucci, 'Women's struggle to decide about their own bodies: Abortion and sexual rights in Argentina' (1997) 5(10) *Reprod. Health Matters* 99, 104.

expansive people (the IVE explicitly refers to 'women and people with other gender identities capable of gestation') and also highlights the need for comprehensive sexual and reproductive health education.[52] Beyond a simple transplanting of international human rights standards into the domestic sphere, the Campaign built upon these standards to address contextual issues and priorities around access to abortion.

It is important to highlight here that there is a constellation of factors that point towards the legalisation of abortion. In the context of Latin America, scholars have suggested that three factors lend themselves towards abortion law reform: a left-wing government, a President who supports abortion decriminalisation, and the relatively weak presence of the Catholic Church.[53] In addition, attempting to rely on international human rights standards on abortion in a context which is hostile towards the idea of human rights would not have the same impact as it did in the Argentine case. Still, in Argentina, it took years before the IVE bill was first debated in Congress as previous governments were reluctant to support access to abortion. Also relevant to the eventual success of the Argentine campaign was the impact of transnational support. Barbara Sutton and Elizabeth Borland note that the presence of support and increasing attention from non-governmental organisations outside of Argentina conveyed an international pressure for the state to decriminalise abortion.[54]

At the time, only three countries in Latin America (Cuba, Guyana, and Uruguay) had legalised abortion on request, but in other parts of the region, incremental progress was being made on abortion. Chile, for example, criminalised abortion without exception until 2017, when limited exceptions (where the pregnant person's life was at risk, where

[52] IVE Articles 2, 13.
[53] Daby and Moseley (n49) 4.
[54] Sutton and Borland (n21) 43.

the foetus would not survive, or in cases of rape where the pregnancy is within the first 12 weeks gestation) were introduced.[55] Weldon and Htun highlight how international norms are often spread through 'regional diffusion' as the policies of countries within the same region, particular those that are similarly socio-culturally situated, are influential to one another.[56] Thus, these developments, even though they were narrow in Chile's case, nonetheless represented a turning tide in relation to abortion in Latin America, and support from other abortion rights movements in the region was therefore key to the success of the reproductive rights claims made elsewhere.[57] The translating of international human rights standards into the local vernacular in Argentina, with the eventual effect of leading to abortion law reform, was possible because of these context-based issues. Elsewhere, the vernacularizing of human rights might look very different. Further, there appear to be ongoing issues with the accessibility of legal abortion services – official statistics show that 73,487 legal abortions were performed in 2021, which is a substantially lower figure than the estimated numbers of unsafe abortion taking place prior to legalisation.[58] Nonetheless, the decriminalisation of abortion in Argentina is indicative of the indirect impact that international human rights standards can have.

Finally, in order to address Madhok's concerns about the suggestion that vernacularization suggests a unidirectional movement from international treaty body to local setting, I will briefly address here the circular development of reproductive rights standards between Argentina (and Latin America more broadly) and international

[55] Ley Núm. 21.030, *Regula la Despenalización de la Interrupción Voluntaria del Embarazo en Tres Causales*, September 23 2017, Diario Oficial [D.O.].
[56] Weldon and Htun (n12) 244.
[57] The decriminalisation of abortion in Argentina could therefore represent a significant turning point for access to abortion in Latin America, in bolstering the claims of movements in other countries.
[58] Dirección Nacional de Salud Sexual y Reproductiva, 'Implementar IVE-ILE: Ley 27.610: informe annual 2021' (Ministerio de Salud de Argentina, July 2022) <https://bancos.salud.gob.ar/recurso/implementar-ive-ile-ley-27610-informe-anual-2021> accessed 14 January 2023, p.34.

human rights bodies. Lynn Morgan refers to Argentina as a 'powerhouse of knowledge production in sexual and reproductive rights' and thus similarly critiques the idea of a one-directional flow from reproductive rights movements in the West to Argentina.[59] Reproductive rights ideas were advanced in workshops on abortion in Argentina in the late 1980s, prior to their popularisation within the international human rights framework.[60] Argentine feminist movements were part of the shaping of women's and reproductive rights norms at the World Conferences mentioned earlier in this chapter, and more recently have contributed to the recognition of obstetric violence as an international human rights issue.[61] In addition, as already discussed in the previous chapter, the use of misoprostol as an abortifacient was discovered and shared by feminist networks in Latin America; progress on reproductive rights and self-managed abortion worldwide is therefore, at least in part, because of feminist activism around these issues within this region. The implementation of international human rights standards on abortion through vernacularization is part of the same cycle of feminist movements articulating reproductive rights issues that were subsequently recognised and expanded on within the international system.

### *2.3. Ireland and Northern Ireland*

In other contexts, international human rights standards can have a less overt role or in abortion law reform but remain nonetheless influential. Prior to 2018, abortion was illegal in Ireland except where the pregnant person's life was at risk. Sections 58 and 59

[59] Morgan (n45) 143.
[60] Barbara Sutton and Elizabeth Borland, 'Framing Abortion Rights in Argentina's Encuentros Nacionales de Mujeres' (2013) 39(1) *Fem. Stud.* 194, 216-217, 219.
[61] Patrizia Quattrocchi, 'Obstetric Violence Observatory: Contributions of Argentina to the International Debate' (2019) 38(8) *Med. Anthropol.* 762.

of the Offences Against The Person Act 1861 (OAPA) criminalised abortion until 2013, when the Protection of Life During Pregnancy Act 2013 was passed, setting out a criminal offence for abortion carrying a 14 years sentence with exceptions for preventing a risk to the life of the pregnant person, including the risk of suicide.[62] The 8th Amendment to the Constitution, passed in 1983, equated the life of the foetus with that of the pregnant person in order to preclude exceptions to the criminal offence beyond risk to life.[63] The 8th Amendment was repealed by referendum in May 2018 with 66.9% voting in favour of repeal, and the Health (Regulation of Termination of Pregnancy) Act 2018 was subsequently passed to allow abortion on request up to 14 weeks' gestation, and after this point where there is a risk to the life or health of the pregnant person or in cases of fatal foetal impairment.[64]

Prior to this, the European Court of Human Rights (ECtHR) found in *A, B, and C v Ireland* that Ireland had failed to comply with its positive obligations to ensure access to a legal abortion where a pregnant person's life was at risk, and that the criminalisation of abortion created a chilling effect on doctors who were reluctant to perform abortions for fear of prosecution.[65] In 2016 and 2017, respectively, the Human Rights Committee (HRC) heard the cases of *Mellet v Ireland* and *Whelan v Ireland*, and found a violation of the right to freedom from cruel, inhuman, and degrading treatment where two women had been left with no choice but to travel to England for an abortion when the foetuses they were carried were diagnosed with fatal impairments.[66] Gráinne de Búrca argues that while

[62] Protection of Life During Pregnancy Act 2013 s.22, 7-9. Prior to this legislation, the Irish Supreme Court had affirmed that an abortion was permissible where there was a risk to the pregnant person's life, including a risk of suicide, in *Attorney General v X* [1992] IESC 1.
[63] Constitution of Ireland, Article 40.3.3º.
[64] Health (Regulation of Termination of Pregnancy) Act 2018 s.9-12.
[65] *A, B, and C v Ireland* App no. 25579/05 (ECHR, 16 December 2010) paras. 254-266.
[66] *Mellet v Ireland* (2016) UN Doc. CCPR/C/116/D/2324/2013; *Whelan v Ireland* (2017) UN Doc. CCPR/C/119/D/2425/2014.

abortion law reform in Ireland took place in the context of broader cultural, political, and economic transformations over decades, interactions between domestic abortion rights advocates and international human rights bodies played an important part in the eventual success of the Repeal the 8th Campaign.[67] The *A, B, C* decision had a direct, albeit limited, impact on abortion law reform in Ireland, as the government implemented the ECtHR's judgment by repealing sections 58 and 59 of the OAPA and replacing them the Protection of Life During Pregnancy Act 2013. The decisions in *Mellet* and *Whelan* did not have this level of direct impact but were nonetheless significant in lending support to the claims already being made by domestic advocates, changing the way that the denial of abortion was viewed in Ireland.

De Búrca further argues that the act of bringing cases alleging that prohibitions on abortion violate human rights is also an important part of the relationship between domestic activists and international treaty bodies.[68] *A, B, C* was one of several ECtHR cases establishing a procedural right to abortion, and the *Mellet* and *Whelan* decisions were central to the expansion of the HRC's approach to abortion in recognising that the denial of abortion services could amount to cruel, inhuman, and degrading treatment.[69] These cases not only gave weight to the demands of abortion rights advocates in Ireland, but were also an important part of the regional diffusion of abortion law reform in relation to Northern Ireland. Northern Ireland was the only region of the UK where the Abortion Act 1967 did not apply; abortion was a criminal offence under sections 58 and 59 of the OAPA and section 1 the Infant Life (Preservation) Act 1929, with exceptions only where the pregnant person's life was at risk or where there was a serious risk of permanent injury

[67] De Búrca (n21) p.182.
[68] *Ibid* p.181.
[69] *Ibid.*

to their long-term health.[70] Many of the issues raised in the Irish context also applied to Northern Ireland; the chilling effect of the OAPA as identified in *A, B, and C* also applied here, with uncertainty as to the narrow exceptions to the criminal offence, and pregnant people had no choice but to travel to Britain for abortions in similar circumstances as in *Mellet* and *Whelan*. Further, following the repeal of the 8th Amendment in Ireland, activist efforts to decriminalise abortion in Northern Ireland galvanised, and human rights discourse was also deployed here.

In 2018, the Supreme Court handed down its judgment in relation to the Northern Ireland Human Rights Commission (NIHRC)'s judicial review action challenging the region's abortion regime as a violation of the rights to freedom from torture (Article 3) and the right to private life (Article 8) of the European Convention on Human Rights.[71] While the Supreme Court highlighted that Northern Ireland's prohibition on abortion in cases of rape and fatal foetal impairment was a violation of the Article 8, the case was unsuccessful as the NIHRC did not have standing.[72] Further, only a minority of the Supreme Court bench were of the opinion that Northern Ireland's abortion law also amounted to a violation of Article 3.[73] In light of this decision, Lynsey Mitchell argues that human rights had a limited impact because the issues involved in the prohibition of abortion services do not fit the 'paradigmatic rights violation narrative'.[74] However, while

[70] These exceptions were established in a series of cases: *R v Bourne* [1939] 1 KB 687; *Northern Health and Social Services Board v F and G* [1993] NI 268; *Northern Health and Social Services Board v A and others* [1994] NIJB 1; *Western Health and Social Services Board v CMB and the Official Solicitor* (NI High Court, 1995); *Re CH (a minor)* (NI High Court, 1995).
[71] *The Northern Ireland Human Rights Commission's Application, Re Judicial Review* [2018] UKSC 27.
[72] *Ibid* paras. 102-103.
[73] *Ibid* paras. 223-225.
[74] Lynsey Mitchell, 'Reading narratives of privilege and paternalism: the limited utility of human rights law on the journey to reform Northern Irish abortion law' (2021) 72(1) *N.I.L.Q.* 89, 92.

this case did not directly lead to abortion law reform, it was influential in supporting the claims made by activists from a human rights perspective.

Further, CEDAW's 2018 inquiry into abortion in Northern Ireland, which found that the near-total prohibition on abortion was a 'grave and systematic' violation of the Convention, pushed the UK government to step in and introduce new abortion regulations.[75] Section 9 of the Northern Ireland (Executive Formation etc) Act 2019 repealed sections 58 and 59 of the OAPA, specifically noting that this measure was in line with CEDAW's recommendations.[76] The Abortion (Northern Ireland) Regulations 2020 were then passed to set out grounds for a legal abortion: on request within the first 12 weeks, where there is a risk to the physical or mental health of the pregnant person up to 24 weeks, and after this point where there is a risk to the life or of grave permanent injury to the health of the pregnant person, and in cases of severe or fatal foetal impairment.[77] While there remain significant issues with access to abortion in Northern Ireland, the regulations indicate a more progressive approach to abortion than that of the Abortion Act 1967. Thus, Máiréad Enright, Kathryn McNeilly, and Fiona de Londras argue that the strategic deployment of international human rights standards laid the groundwork for the decriminalisation of abortion in Northern Ireland.[78] International human rights standards need not directly translate up to the macro-political level or be instrumental in judicial decision for them to be significant, as the indirect support of human rights bodies was nonetheless important in both the Irish and Northern Irish contexts.

[75] CEDAW, 'Inquiry concerning the United Kingdom of Great Britain and Northern Ireland under article 8 of the Optional Protocol to CEDAW' (6 March 2018) UN Doc. CEDAW/C/OP.8/GBR/1, para. 1.
[76] Northern Ireland (Executive Formation etc) Act 2019 s.9(1)-(2).
[77] Abortion (Northern Ireland) Regulations 2020 s.3-7.
[78] Máiréad Enright, Kathryn McNeilly, and Fiona de Londras, 'Abortion activism, legal change, and taking feminist law work seriously' (2020) 71(3) *N.I.L.Q.* 7, 23.

As de Búrca notes, any causal relationship between international human rights standards and law reform is difficult, if at all possible, to substantiate.[79] The extent to which human rights had an impact on abortion law in the contexts discussed above is impossible to determine, particularly as those changes came after decades of work from activists and in the context of broader social change. However, international human rights standards can be useful in changing socio-cultural attitudes towards abortion (and gender-based rights more broadly); human rights discourse can play an important role in addressing entrenched attitudes, even if this does not directly translate to the legislative level. Rebecca Smyth highlights how human rights provide a useful means of articulating claims against the state, in the absence of other discourses with the same symbolic and practical force.[80] In the abortion rights campaigns of Argentina, Ireland, and Northern Ireland, international human rights standards, as part of broader strategies, were influential as activists had the leverage of international support and could make claims that the state must comply with the recommendations that had been set out by treaty bodies. The contextual adoption of international human rights in the vernacular of abortion rights movements could therefore be successful in implementing a human right to abortion as set out in the previous chapters, particularly in filling the gaps left open in terms of progressive realisation and what is required to ensure the accessibility of abortion services in local settings.

[79] De Búrca (n21) p.187.
[80] Rebecca Smyth, ''Repeal the 8th' in a transnational context: the potential of SRHSs for advancing abortion access in El Salvador' (2020) 124 *Fem. Rev.* 192, 198.

### *2.4. Limitations*

The examples given above highlight how international human rights standards on abortion can be used strategically to push for liberal reform, but in other contexts, the extent to which human rights discourse has an impact may be more limited. In the face of stringently anti-abortion governments, efforts to push for abortion law reform in compliance with international human rights standards may be unsuccessful or take significant periods of time. In these contexts, and where resources limitations prevent states from being able to fully comply, abortion rights movements may need to compromise on their claims. Engle Merry and Levitt have noted the potential issues with the vernacularization of human rights where they become further removed from international documents; where a right is extensively transformed to fit within existing social structures, it is less likely to challenge those structures.[81] Human rights discourse in the vernacular can be appropriated, and the dominant interpretation of a right may be problematic. They use the example of abortion, where anti-abortion movements adopt the language of the right to life in relation to the foetus.[82] Kate Hunt's more recent study highlights that the human rights frames which are frequently adopted by pro- and anti-abortion actors are repeated by mainstream media sources.[83] Hunt argues that human rights discourse has traction where the national context is resistant to a movement's idea, so this could be a tool to 'challenge stable policy environments concerning women's reproductive rights from abortion to birth control'.[84] The appropriation of human rights framings by anti-abortion movements could work to undermine access to abortion in

[81] Engle Merry and Levitt (n19) p.216.
[82] *Ibid* p.235.
[83] Hunt (n28) 73.
[84] *Ibid* 75.

states that already comply with reproductive rights standards. This is a particular issue in contexts where rights-based discourse is removed from international human rights standards and has acquired the force of absolutism, to be used as a 'trump card' in the face of opposition.[85] It would be key to the realisation of a human right to abortion, therefore, that human rights vernacularization is not too far disconnected from international standards – and here, the clarity as to what is required from states in order to fully comply, as intended through the progressive realisation framework I set out, would be of importance so that human rights standards on abortion cannot be misinterpreted or misappropriated.

## *3. Abortion Rights in the Courts*

Alongside feminist movements putting pressure on state actors, the courts can also play a significant role in the realisation of reproductive rights. Cases challenging reproductive rights violations are often brought as part of the broader strategy of social movements, to be heard at the UN level, by regional human rights bodies, or in front of the national courts. While the UN treaty bodies have limited enforcement mechanisms, regional human rights bodies such as the Inter-American Commission on Human Rights and the European Court of Human Rights have follow-up mechanisms in place which can be advantageous.[86] National courts can often, depending on the country, interpret

[85] Maree Pardy, 'Under Western eyes again? Rights vernacular and the gender culture 'clash'' (2013) 19(1) *Aus. J. Hum. Rts.* 31, 35.
[86] Luisa Cabal and Suzannah Phillips, 'Reproductive Rights Litigation: From Recognition to Transformation' in Malcolm Langford, César Rodrígues-Garavito, and Julieta Rossi (Eds), *Social Rights Judgments and the Politics of Compliance* (Cambridge University Press, 2017) p.422.

constitutional rights in line with human rights standards and direct governments to comply with those standards, and are better placed than international bodies to respond to specific contextual problems. In the face of political opposition – or a lack of political will – to the legalisation of abortion, feminist movements may be ineffective in putting pressure on their elected representatives.

As recent rulings from the Mexican Supreme Court and Colombian Constitutional Court demonstrate, the realisation of the right to abortion may be more effective through the courts in historically anti-abortion contexts. In 2021, the Mexican Supreme Court unanimously ruled that the criminalisation of abortion is unconstitutional, thereby decriminalising abortion across the country (although legalisation is determined by each state, and only nine out of 32 states currently provide for legal abortion).[87] Abortion was legalised on request up to 12 weeks' gestation in Mexico City in 2007, but had remained restricted elsewhere (except for Oaxaca, which also legalised abortion on request up to 12 weeks' in 2019) until 2021, with exceptions only for risk to the pregnant person's life and where the pregnancy resulted from rape.[88] In Colombia, the Penal Code of 1981 criminalised abortion with no exceptions.[89] In 2006, the Colombian Constitutional Court ruled that this total ban was unconstitutional and set out that abortion was to be permitted if the pregnancy threatened the life or health of the pregnant person, in cases

[87] Mexican Supreme Court AI 148/2017; AI 106/208 and 107/2018; AI 54/2018 (7 September 2021). English summary available at Mexico's Supreme Court of Justice of the Nation, 'Landmark Decisions at the Vanguard for Reproductive Rights Worldwide' (1st October 2021) <https://www.internet2.scjn.gob.mx/red2/comunicados/comunicado.asp?id=6606> accessed 14 January 2023; Reuters, 'Mexico's Guerrero state becomes ninth to allow abortions' (18 May 2022) <https://www.reuters.com/world/americas/mexicos-guerrero-state-becomes-ninth-allow-abortions-2022-05-18/> accessed 14 January 2023.

[88] Human Rights Watch, 'Mexico City Legalizes Abortion' (1 May 2007) <https://www.hrw.org/news/2007/05/01/mexico-city-legalizes-abortion> accessed 14 January 2023; Ipas, 'Mexico's Oaxaca State decriminalizes abortion and makes history' (1 November 2019) <https://www.ipas.org/news/mexicos-oaxaca-state-decriminalizes-abortion-and-makes-history/> accessed 14 January 2023.

[89] Colombian Penal Code 1981, Articles 343-345.

of sexual crime, or where the foetus had an impairment meaning it was not viable.[90] In 2022, the Constitutional Court decriminalised abortion up to 24 weeks' gestation, permitting abortion on request up until this point.[91]

In this section, I will expand on how national courts have developed protections for the health rights and reproductive rights in ways which support the realisation of international human rights standards. I will also briefly address how regional human rights bodies can also support the realisation of international human rights standards, by developing their own standards in line with those aforementioned and in their jurisprudence. While debates over the justiciability of socio-economic rights, the appropriate role of the courts, and subsidiarity in relation to regional human rights courts are relevant here, these issues will not be discussed in this section. Rather, I aim to highlight how national courts and regional human rights bodies can practically aid in the realisation of the right to abortion. In doing so, I will discuss the development of the right to health in the Colombian courts and the implementation of the case of *L.M.R. v Argentina* by the Argentine Supreme Court. I will then address the effectiveness of national court judgments on abortion, as well as limitations, which is where regional human rights bodies can be of importance.

[90] Colombian Constitutional Court, Decision C-355 of 2006. English translation summary available at: Rebecca J. Cook, 'Excerpts of the Constitutional Court's Ruling that Liberalized Abortion in Colombia' (2007) 15(29) *Reprod. Health Matters* 160.
[91] Colombian Constitutional Court, Decision C-055 of 2022.

### *3.1. Colombia*

The Colombian Constitution of 1991, which was introduced following a period of significant political violence, introduced fundamental rights including socio-economic rights such as the right to freely decide on the number and spacing of one's children (under the right to found a family, Article 42), gender equality (Article 43), and the right to access services that 'promote, protect, and restore health' (Article 49).[92] The Constitution also established the Constitutional Court (Article 116), and provided that any affected individual could bring a *tutela* (writ of protection) before the Court where the immediate protection of their fundamental constitutional rights was threatened by the act or omission of any public authority (Article 86).[93] The health rights under Article 49 placed obligations on the state around the organisation of healthcare services, but in practice, the healthcare system was subject to limited regulation or public scrutiny and reforms were passed in a piecemeal manner.[94] *Tutelas* for health rights became the most common form of claims brought before the Court, in light of these significant inequities and inefficiencies in the healthcare system.[95] These claims were individualised, with people requiring access to specific treatments or services and in the majority of cases, the Court was simply enforcing existing policies.[96]

[92] Colombian Constitution of 1991, Title II. English translation available at: Constitute Project, 'Colombia's Constitution of 1991 with Amendments through 2015' <https://www.constituteproject.org/constitution/Colombia_2015.pdf?lang=en> accessed 14 January 2023.
[93] *Ibid* Title V, Title II.
[94] Yamin (n3) p168.
[95] Aquiles Ignacio Arrieta-Gómez, 'Realizing the Fundamental Right to Health through Litigation: The Colombian Case' (2018) 20(1) *Health Hum. Rts. J.* 133, 137.
[96] Alicia Ely Yamin and Oscar Parra-Vera, 'Judicial Protection of the Right to Health in Colombia: From Social Demands to Individual Claims to Public Debates' (2010) 33(2) *HICLR* 431, 443.

However, in 2008, in case T-760/08, in addition to addressing 22 individual *tutela* claims, the Constitutional Court reaffirmed the right to health as a justiciable right and issued a set of structural orders to address the key problems with the healthcare system as a whole.[97] In this decision, the Court highlighted that right to health was a fundamental constitutional right with both negative and positive aspects, the positive aspects of which were not always to be subject to gradual protection but required realisation.[98] In doing so, the Court highlighted the state's international human rights obligations under Article 12 of the ICESCR and the Committee on Economic, Social, and Cultural Rights (CESCR) General Comment 14 on the right to the highest attainable standard of health.[99] The Court noted that CESCR recognised obligations to respect, protect, and fulfil rights, and that the obligation to fulfil requires states 'to adopt appropriate legislative, administrative, budgetary, judicial or other measures towards the full realization of the right to health'.[100] This obligation was taken to mean that the Court had a duty to step in and remove barriers to the realisation of the right to health.[101] Thus, the Court sought to address the inequities in healthcare provision by making orders to the relevant public authorities, including requirements to update health coverage plans, allocate resources to the healthcare system, and regulate private companies, putting follow-up mechanisms in place to ensure compliance.[102]

[97] Colombian Constitutional Court, Decision T-760 of 2008. English translation summary available at: ESCR-Net, 'Judgment T-760/08 July 31, 2008' <https://www.escr-net.org/sites/default/files/English_summary_T-760.pdf> accessed 14 January 2023.
[98] *Ibid* paras. 3.3.1-3.3.6.
[99] *Ibid* para. 3.3.15.
[100] *Ibid* para. 3.4.2.9.3, quoting CESCR, 'General Comment No. 14: the Right to the Highest Attainable Standard of Health (Article 12 of the ICESCR)' (11 August 2000) UN Doc. E/C.12/2000/4, para. 33.
[101] *Ibid* para. 3.4.2.9.4.
[102] *Ibid* section III.

Following the restructuring of the healthcare system in line with these orders, the number of *tutelas* brought for health rights violations significantly reduced.[103] Yamin notes that a particular impact of the reforms to health coverage plans was improved access for poorer people, although inequalities in healthcare provision – reflective of broader societal inequalities – still remain.[104] In addition, the Court's intervention in T-760/08 was key to establishing the recognition of a national right to health in line with international human rights standards; in treating international human rights documents as part of the Colombian Constitution, the Court was able to advance the progressive realisation of the (internationally recognised) right to health at the national level.[105] This case therefore highlights the comparatively better position of national courts to promote human rights protection in the absence of more powerful enforcement mechanisms by international treaty bodies.

However, there are potential issues with the justiciability of more controversial rights, such as abortion. Yamin was critical of the failure of the Constitutional Court to engage with reproductive rights in the T-760/08 case, making no reference to the reproductive health dimensions of General Comment 14, nor the fact that individuals had been bringing *tutela* claims in order to access therapeutic abortions in the line with the Court's 2006 judgment.[106] Yamin thus concludes that Court's important role in shaping the political agenda around the right to health was limited by overlooking women's realities in the healthcare sphere.[107] Whilst I agree with Yamin's conclusion, it is also relevant to emphasise that international human rights standards on abortion and

[103] Arrieta-Gómez (n95) 139.
[104] Yamin (n3) p.170.
[105] Katharine G. Young and Julieta Lemaitre, 'The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa' (2013) 26 *Harv. Hum. Rights J.* 179, 183; Arrieta-Gómez (n86) 138.
[106] Yamin (n3) 169.
[107] *Ibid* 173.

reproductive health have developed incrementally, and as highlighted in Chapter 2, there has been no clear impetus for states (or national courts) to expansively legalise abortion.

The Constitutional Court's 2006 ruling in the C-355/06 case, which legalised abortion in the three exceptional circumstances, was largely in line with international human rights standards on abortion at this particular point in time.[108] The Constitutional Court in this case interpreted the Constitution in line with human rights treaties such as the ICESCR, ICCPR, and CEDAW. The Court recognised that the total criminalisation of abortion violated pregnant people's fundamental rights (including the rights to life, health, dignity, bodily autonomy, and gender equality), which were protected by the Constitution in conjunction with those international treaties.[109] Access to abortion was, albeit in very restricted circumstances, held to be a Constitutional requirement; at this point in time, this was a landmark case for the judicial implementation of international human rights standards on abortion.

Further, in the case C-055/22 which decriminalised abortion in the first 24 weeks' of pregnancy, the Colombian Constitutional Court engaged with the evolving international human rights standards on abortion.[110] The Court accepted that developments had taken place since the 2006 case which were relevant, including the evolution of the right to health in Colombia following T-760/08 and the increasing recognition by international human rights bodies of the need for decriminalisation and access to abortion services.[111] Daigle, Duffy, and López Castañeda highlight that the combined effect of the 2022 and 2006 cases is to make Colombia the most progressive

[108] C-355/06 (n90).
[109] Cook (n90) p.160-161.
[110] C-055/22 (n91).
[111] *Ibid*; Mónica Arango Olaya, 'The Fundamental Right to Abortion in Colombia' (Oxford Human Rights Hub, 10 Mar 2022) <https://ohrh.law.ox.ac.uk/the-fundamental-right-to-abortion-in-colombia/> accessed 14 January 2023.

abortion regime in Latin America.[112] Yet they also highlight that ongoing (post-)conflict inequalities will continue to leave abortion inaccessible to many pregnant people, particularly those who are Afro-Colombian, Indigenous, and/or socio-economically deprived.[113] However, the ongoing use of *tutelas* to address barriers in healthcare delivery will likely mean the ongoing role of the Court in improving access to abortion services in Colombia.[114] These cases, around the development of the right to health and establishing abortion as a fundamental right, highlight the importance of the national courts in enforcing and expanding international human rights standards, particularly in the context of persistent resistance to abortion legalisation and structural or resource issues which human rights bodies may be unable to fully address.

### *3.2. Argentina*

Short of being able to expand access to abortion or protection for human rights, national courts can nonetheless play an important role in upholding procedural guarantees where abortion is already legalised. As the *L.M.R. v Argentina* case highlighted, abortion on the legal grounds at that time were difficult to access, with burdensome administrative processes in place.[115] There was also uncertainty over the specific wording of the rape ground for legal abortion, which suggested a requirement that the pregnant person also had a mental disability, which left many pregnant people unable to access abortion

[112] Megan Daigle, Deirdre N. Duffy, and Diana López Castañeda, 'Abortion access and Colombia's legacy of civil war: between reproductive violence and reproductive governance' (2022) 98(4) *Int. Affairs* 1423, 1423.
[113] *Ibid* 1446.
[114] Arrieta-Gómez (n95) 139.
[115] *L.M.R.* (n41).

services under this ground.[116] In what Paola Bergallo referred to as the 'procedural turn' in the abortion rights movement, activists brought court cases in order to push for the adoption of clearer guidelines on the legality of abortion and press the state to comply with the recommendations of international human rights bodies.[117] In 2012, the Argentine Supreme Court heard the case *F, A. L.* which concerned a 15-year-old girl who had become pregnant as a result of rape, and began to experience depression and suicidal ideation as a result of the pregnancy.[118] The Superior Court of Chubut affirmed that girl could have a legal abortion under the rape ground.[119] However, this decision was appealed to the Supreme Court on behalf of the unborn child, challenging the application of the rape ground as the girl did not have a mental disability.[120] The Supreme Court agreed with the decision of the Chubut Court, and established two key changes to Argentina's abortion regime.

Firstly, the Court affirmed that abortion in cases of rape must not be subject to judicial proceedings, noting that the informal rule that court approval was required had been generated from misinformation and had never been a legal requirement.[121] Secondly, the Court reinterpreted the rape ground so that it would not be limited to pregnant people with mental disabilities.[122] The Court relied on international human rights standards (including the HRC in *L.M.R.*) on access to abortion in cases of rape, and noted that international human rights treaties formed part of the constitutional legal

[116] Bergallo (n35) p.146.
[117] *Ibid* p.144.
[118] F, A.L. s/ Medida Autosatisfactiva, Expediente Letra "F", No 259, Libro XLVI (2012) Supreme Court of Justice. English translation available at: Hugo Leal-Neri, '*F, A. L.* Unofficial Translation' <https://www.law.utoronto.ca/sites/default/files/documents/reprohealth/Case-Argentina_abortion_rape_English.pdf > accessed 14 January 2023, paras. 1-2.
[119] *Ibid.*
[120] *Ibid* para. 3.
[121] *Ibid* paras. 8, 18.
[122] *Ibid* paras. 9, 17.

order and so the state had a responsibility to comply with them.[123] In addition, the Court noted that limiting abortion on the grounds of rape to women with mental disabilities was unreasonable differential treatment amounting to discrimination – which was also contrary to human rights standards.[124] While the government had not acted in response to the HRC's recommendations in *L.M.R.*, the case still had an impact in the national courts as the Supreme Court was able to hold the state accountable for failing to comply with international human rights standards on accessibility. The Argentine courts may therefore continue to play a role in guaranteeing the ongoing accessibility of legal abortion services in line with human rights standards.

### *3.3. Limitations*

As the Colombian and Argentine examples highlight, national courts can play a key role in the realisation of human rights, which is particularly important for both the legalisation of and continuing access to abortion. However, there are limitations – most obviously, the costs, in both money and time, to bringing a case. Bergallo has highlighted that the Argentine system has enabled litigation on the right to health because of the *beneficio de litigar sin gastos*, a cost waiver if the plaintiffs claim fails, which incentivised private lawyers to work for free where the result of a case was uncertain.[125] In countries where the financial risk of litigation is not minimised in this way, it will be harder for

[123] *Ibid* para. 12-14, 7.
[124] *Ibid* paras. 15-16.
[125] Paola Bergallo, 'Argentina – Courts and the Right to Health: Achieving Fairness Despite "Routinization" in Individual Coverage Cases?' in Alicia Ely Yamin and Siri Gloppen (Eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011) p.48.

individuals to bring claims – particularly as those experiencing barriers to healthcare or abortion services are more likely to be socio-economically disadvantaged.

Global or local non-governmental organisations can sometimes support important cases challenging human rights violations. The Center for Reproductive Rights (CRR) is a global organisation which has been key to bringing abortion cases to human rights bodies and national courts by partnering with local advocacy groups and movements. Many of the landmark human rights cases around abortion have been supported by CRR, including *K.L. v Peru*, *L.C. v Peru*, *Mellet* and *Whelan* at the UN level, *R.R. v. Poland* and *P and S v Poland* at the European Court of Human Rights.[126] The CRR has supported cases in national courts in the US, Latin America (including the recent Colombian Constitutional Court case which decriminalised abortion), and elsewhere, both on abortion and sexual and reproductive healthcare more broadly.[127] However, these cases are often strategic – brought where there is a gap in case law and/or the outcome would likely have a significant and far-reaching impact, rather than just achieving a win for the individual the case concerned. For example, Yamin highlights that *Alyne da Silva Pimentel v. Brazil,* the first maternal mortality case to be decided by an international human rights body, was brought because Alyne's death happened at precisely the same time as when CRR were looking to bring a case on maternal health.[128] While these strategic cases are influential on international human rights standards and the protection of human rights in countries beyond those the decisions apply to, this selective approach to supporting cases does mean that many individual rights violations will not be heard.

[126] Center for Reproductive Rights, 'Landmark Cases' <https://reproductiverights.org/our-work/landmark-cases/> accessed 14 January 2023.
[127] *Ibid*.
[128] Yamin (n3) p.170.

The effectiveness of litigation, even with a winning case, is also dependent on the remedies issued by the court. Ciara O'Connell argues that the failure to implement and enforce non-repetition remedies designed to address the 'underlying sociocultural practices that place women in a position of less power' seriously limit the impact of reproductive rights cases.[129] For the courts to effectively protect human rights, this requires directing broader systemic changes – such as the orders around restructuring the healthcare system made by the Colombian Constitutional Court in the T-760/08 case. While inequalities in the healthcare system do remain, the effectiveness of these restructuring orders is evidenced by the reduction in the number of health rights *tutela* claims being brought in subsequent years. However, non-repetition remedies may have limited impact where there is a lack of political will to comply with orders or where there are genuine resource limitations.

Through public interest litigation system in India, the courts have addressed reproductive rights violations and have implemented non-repetition remedies over maternal health issues. For example, in 2010 the Delhi High Court addressed two petitions concerning rights violations around maternal health.[130] The first concerned Shanti Devi, a woman who miscarried and was denied urgently required treatment to remove the foetus by multiple hospitals as she could not prove she was living below the poverty line and eligible for free healthcare.[131] She became pregnant again after this and died from preventable complications after giving birth at home without the presence of a healthcare professional.[132] The second concerned Fatema, a woman who had given birth

[129] Ciara O'Connell, 'Litigating Reproductive Health Rights in the Inter-American System: What Does a Winning Case Look Like?' (2014) 16(2) *Health Hum. Rts. J.* 116.
[130] *Laxmi Mandal v. Deen Dayal Haringar Hospital & Ors.* (2010) W.P.(C) 8853/2008; *Jaitun v. Maternity Home MCD, Jangpura & Ors.* (2010) W.P.(C) 10700/2009 (High Court of Delhi).
[131] *Ibid* paras. 28.2-28.5.
[132] *Ibid* para. 28.8.

under a tree in full public view as she was unable to access maternal health services and was denied financial aid to support her child.[133]

Recognising the systemic issues in access to the public healthcare system, the Court ordered the central and state governments to make improvements to and monitor the implementation of schemes intended to support access to healthcare services for socio-economically disadvantaged people, including ensuring guaranteed access to maternal healthcare services.[134] In public interest litigation judgments, the courts will often implement interim measures and continuously monitor the extent to which the government has taken steps towards fulfilment of the orders, allowing for progressive compliance with order concerning resource allocation or policy change.[135] However, this has been insufficient in addressing barriers to healthcare services, including reproductive healthcare, as access varies significantly between states, most healthcare institutions are private, and hospitals are concentrated in urban areas, leaving socio-economically disadvantaged people and those living rurally without access.[136] Thus, while the courts have recognised the importance of reproductive rights and have attempted to implement non-repetition remedies, this has not translated into the effective protection of reproductive rights.

Even where a case does have a limited direct impact, judgments supporting the realisation of abortion rights can nonetheless be symbolically important. Yamin highlights that while traditional assessments of the effectiveness of human rights cases

[133] *Ibid* paras. 29.1-29.6.
[134] *Ibid* paras. 62-70.
[135] Cabal and Phillips (n86) p.422.
[136] Partners for Law in Development and SAMA Resource Group, *Sexual Health and Reproductive Health Rights in India* (2018) p.78; Linda Sanneving and others, 'Inequity in India: the case of maternal and reproductive health' (2013) 6(1) *Glob. Health Action* 1.

focuses on the direct impact, the symbolic effect of litigation is also important.[137] This might include raising awareness over an issue where a case comes with media coverage, as well as changing public attitudes and the agendas of both civil society organisations and political parties.[138] Cesar Rodríguez Garavito argues that a broad range of political and civil society actors are likely to adopt rulings and become involved in the informal monitoring of compliance with a judgment, in turn helping the courts overcome political resistance. [139] In relation to a right to abortion, where political resistance to implementation is likely, this symbolic influence of litigation would be of importance – and could lend additional support to feminist movements putting pressure on governments to legalise abortion. However, this is not a one-way process; bringing court cases can be an important part of an abortion rights movement's strategy, and civil society involvement in cases can act as a catalyst for political action.[140] The case C-055/22 which decriminalised abortion in Colombia, for example, was brought by Causa Justa, a collective of feminist and human rights organisations working towards abortion rights protection.[141] While this does require public confidence in the courts (and a functional, accessible judiciary), litigation is an important avenue for the realisation of abortion rights where alternative political routes are closed off.

[137] Yamin (n3) p.116.
[138] César Rodríguez-Garavito, 'Beyond the Courtroom: The Impact of Judicial Activism on Socioeconomic Rights in Latin America' (2011) 89 *Texas Law Rev.* 1669, 1696; Yamin (n**Error! Bookmark not defined.**) p.116-117.
[139] Rodríguez-Garavito (n138) 1696.
[140] Yamin (n3) p.167-168.
[141] Causa Justa, 'Quiénes Somos' <https://causajustaporelaborto.org/quienes-somos-2/> accessed 14 January 2023.

### *3.4. Regional Human Rights Bodies*

Finally, regional human rights bodies could support the realisation of a right to abortion through adopting similar human rights standards, providing a safety net where feminist activism and litigation in the national courts is unsuccessful. Weldon and Htun have recognised that regional human rights agreements strengthen international human rights standards on violence against women by emphasising the way these norms apply in more localised contexts.[142] Regional human rights bodies are more likely to have strengthened enforcement or follow-up mechanisms – which is important in political contexts where the status of abortion as a human right might be questioned.[143] While interventions from regional human rights bodies will have a limited impact in the face of genuine resource limitations, these bodies can nonetheless put additional pressure on governments to incrementally guarantee access to abortion. However, at present, regional human rights bodies have addressed abortion to a lesser extent than in the international human rights framework.

#### i. African Charter

The Women's Protocol to the African Charter on Human and Peoples' Rights is the only human rights instrument to explicitly indicate a human right to abortion. Under Article 14(2)(c), states are required to 'protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest' and where continuing the

[142] Weldon and Htun (n12) 243-244.
[143] Cabal and Phillips (n86) p.400.

pregnancy would endanger the life, physical health, or mental health of the pregnant person or the life of the foetus (i.e. where the foetus has a fatal impairment).[144] While Article 14(2)(c) has been recognised as groundbreaking for setting out a clearly enforceable obligation on states to guarantee access to abortion on those grounds, its significance is limited by restricting the right to abortion to exceptional circumstances.[145] Charles Ngwena argues that this 'risks reinforcing the historical treatment of abortion as a criminal act, as well as an unjust stereotype of women as mothers'.[146]

The requirements of Article 14(2)(c) have not been followed by all African states; of the 55 African countries, six prohibit abortion altogether and numerous others only permit abortion to save the pregnant person's life.[147] There are also limitations around enforcement. Six countries are yet to ratify the Women's Protocol (including Mauritania and Egypt, where abortion is completely prohibited), and 22 have not ratified the African Court Protocol to allow cases on violations to be brought.[148] For those individuals living in countries that have ratified both the Women's Protocol and the African Court Protocol, bringing a case is made difficult (beyond the lack of access to resources, legal aid, and legal representation for many women) by the fact that complaints must be referred to the

[144] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Article 14(2)(c).
[145] Charles G. Ngwena, 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *HRQ* 783, 785.
[146] *Ibid* 786.
[147] Center for Reproductive Rights, 'The World's Abortion Laws' <https://reproductiverights.org/maps/worlds-abortion-laws/?> accessed 14 January 2023. The United Nations only recognised 54 African countries, but the African Union additionally recognises the Sahrawi Arab Democratic Republic (also known as Western Sahara) as an independent state.
[148] African Union, 'List of countries which have signed, ratified/acceded to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa' (16 October 2019) <https://au.int/sites/default/files/treaties/37077-sl-PROTOCOL%20TO%20THE%20AFRICAN%20CHARTER%20ON%20HUMAN%20AND%20PEOPLE%27S%20RIGHTS%20ON%20THE%20RIGHTS%20OF%20WOMEN%20IN%20AFRICA.pdf> accessed 14 January 2023; African Union, 'List of countries which have signed, ratified/acceded to the Protocol on the Statute of the African Court of Justice and Human Rights' (18 June 2020) <https://au.int/sites/default/files/treaties/36396-sl-PROTOCOL%20ON%20THE%20STATUTE%20OF%20THE%20AFRICAN%20COURT%20OF%20JUSTICE%20AND%20HUMAN%20RIGHTS.pdf> accessed 14 January 2023.

Court by the African Commission, an African intergovernmental organisation, or brought as an inter-state complaint.[149] If a case was to be brought in relation to abortion, Ngwena argues that is would be likely for the Court to defer to the state 'the cloak of the doctrine of the margin of appreciation, so as not to offend domestic political and religious sensibilities'.[150] This is all the more likely if a case concerned access to abortion services beyond the limited grounds recognised by Article 14(2)(c).

### ii. European Convention on Human Rights

The ECtHR has addressed violations of rights contained in the European Convention in the context of abortion but has not gone so far as to require Member States to legalise abortion. Instead, the Court has only been willing to find violations where access to abortion services on the grounds already legalised by the states is obstructed.[151] In *A, B, C v. Ireland,* the Court distinguished between three applicants who had all travelled to England to access abortion services after becoming pregnant unintentionally.[152] A had a history of depression and alcoholism and felt that continuing her pregnancy would jeopardise her mental health and sobriety.[153] B had taken emergency contraception which had failed.[154] C had a rare form of cancer which was in remission at the time of her pregnancy, but she was unable to access information of the risks the pregnancy would

[149] Annika Rudman, 'Women's access to regional justice as a fundamental element of the rule of law: The effect of the absence of a women's rights committee on the enforcement of the African Women's Protocol' (2018) 18 *Afr. Hum. Rights Law J.* 319, 328.
[150] Ngwena (n145) 813.
[151] See: *Tysiąc v Poland* App no. 5410/03 (ECHR 20 March 2007); *R.R. v Poland* App no. 27617/04 (ECHR, 26 May 2011); *P and S v Poland* App no. 57375/08 (ECHR, 30 October 2012).
[152] *A, B, C* (n65).
[153] *Ibid* paras. 13-17.
[154] *Ibid* paras. 18-21.

pose to her cancer.[155] All three applicants faced significant delays in accessing abortion as a result of being required to travel abroad, and A and B reported financial difficulties in doing so. The Court determined that A and B had accessed abortion services for health and wellbeing reasons, whereas C feared there was a risk to her life.[156] As Article 40.3.3º only permitted abortion to save the pregnant person's life, a violation was found only in relation to C as there were no processes in place to determine whether she qualified for a legal abortion.[157]

The Court has been critiqued for failing to approach abortion as a human right and failing 'to acknowledge that the option to travel abroad for abortion is not open to everybody and that being forced to travel to another country fora critical health service can entail suffering that rises to the level of cruel and inhuman treatment.'[158] However, the ECtHR's jurisprudence on abortion has established a procedural right of access under the Article 8 right to private life, imposing positive obligations (albeit limited ones) on Member States.[159] Further, in the cases of *R.R. v. Poland* and *P and S v. Poland,* the Court was also willing to recognise violations of the Article 3 right to freedom for torture and cruel, inhuman, and degrading treatment.[160] Chiara Cosentino has argued that these cases could open up a substantial right to abortion under Article 3, as a non-derogable right to which the margin of appreciation does not apply.[161] It would therefore be possible for the

[155] *Ibid* paras. 22-26.
[156] *Ibid* para. 125.
[157] *Ibid* para. 243.
[158] Johanna Westeson, 'Reproductive health information and abortion services: Standards developed by the European Court of Human Rights' (2013) 122 *Int. J. of Gynecol. Obstet.* 173, 175.
[159] Joanna N. Erdman, 'The Procedural Turn: Abortion at the European Court of Human Rights' in Rebecca J. Cook, Joanna N. Erdman, and Bernard M. Dickens (Eds), *Abortion Law in Transnational Perspective* (University of Pennsylvania Press, 2014); Daniel Fenwick, 'The modern abortion jurisprudence under Article 8 of the European Convention on Human Rights' (2012) 12 *Med. Law Int.* 249.
[160] *R.R.* (n151); *P and S* (n151).
[161] Chiara Cosentino, 'Safe and Legal Abortion: An Emerging Human Right? The Long-lasting Dispute with State Sovereignty in ECHR Jurisprudence' (2015) 15(3) *Hum. Rights Law Rev.* 569, 587-588.

ECtHR to find a violation even where there is no procedural right to abortion at stake. In July 2021, the ECtHR gave notice to the Polish government of 12 applications concerning abortion rights, highlighting that over 1,000 similar applications had also been received.[162] It has been some time since the ECtHR last addressed the issue of abortion, in the judgment of *P and S v. Poland* issued in 2012. Since this time, international standards on abortion have evolved, notably in the cases of *Mellet* and *Whelan* on fatal foetal impairments and in relation to decriminalisation, so the European Court could take this opportunity to further develop its own standards.

The European Court has also addressed issues around conscientious objection to abortion. In *Pichon and Sajous v. France*, two pharmacists argued that their convictions over refusing to sell contraceptives violated their Article 9 right to freely manifest their religious.[163] The Court rejected the complaint as manifestly ill-founded, noting that Article 9 does not permit the applicants to impose their religious beliefs on others 'as a justification for their refusal to sell such products.'[164] In *Grimmark v. Sweden* and *Steen v. Sweden*, two midwives challenged the Swedish policy not to employ midwives who refused to provide abortion services; the complaints were again rejected as manifestly ill-founded.[165] While these cases might appear to uphold access to abortion, the Court was deferring to the state in both complaints – and in *Z v. Poland*, the Court also rejected as manifestly ill-founded a complaint that the applicant's daughter had died as a result of conscientious objection to abortion by healthcare professionals.[166] It is likely that a

[162] ECHR, 'Notification of 12 applications concerning abortion rights in Poland' ECHR 217 (8 July 2021) <https://hudoc.echr.coe.int/app/conversion/pdf/?library=ECHR&id=003-7074470-9562874&filename=Notification%20of%20applications%20concerning%20abortion%20rights%20involving%20Poland.pdf> accessed 14 January 2023.
[163] *Pichon and Sajous v. France* App no. 49853/99 [2001] ECHR 898.
[164] *Ibid*.
[165] *Grimmark v. Sweden* App no. 43726/17 (ECHR, 11 Feb 2020); *Steen v. Sweden* App no. 62309/17 (ECHR 11 Feb 2020).
[166] *Z v. Poland* App no. 46132/08 (ECHR, 13 Nov 2012).

challenge to the permitting of conscientious objection, unless this clearly violated a procedural right of access as in the Polish cases, would be unsuccessful as the margin of appreciation would be applied.

### iii. Inter-American System

Article 4 of the American Convention on Human Rights recognises the right to life as applying 'in general, from the moment of conception'.[167] The Inter-American System is the only major human rights system to do so, and the European Court has, in previous cases, refused to hold that the right to life applies before birth.[168] However, in the *Baby Boy* case, which challenged the legality of abortion in the US, the Inter-American Commission explicitly highlighted that the words 'in general' were inserted as Article 4 was not intended to limit abortion.[169]

This was affirmed by the Inter-American Court in the case of *Artavia Murillo et al v Costa Rica* in the context of a prohibition on IVF treatment.[170] In exploring the status of the embryo/foetus, the Court considered comments from the HRC and CEDAW on abortion and pregnancy, the ECtHR cases rejecting the right to life of the foetus, and Article (14)(2)(c) of the African Women's Protocol.[171] The Court concluded that the embryo could not be understood as a person for the purposes of Article 4, but in any event

[167] Organization of American States, *American Convention on Human Rights* (22 November 1969), Article 4(1).
[168] *Paton v. United Kingdom* App no. 8416/78 (1981) 3 EHRR 408; *Vo v. France* App no. 53924/00 [2004] ECHR 326.
[169] *White and Potter ('Baby Boy') v the USA,* Inter-Am. Comm. H.R., Case 2141, Report No. 23/81 (16 October 1981).
[170] *Case of Artavia Murillo et al. v Costa Rica,* Inter-Am. Ct. H.R., Series C 257 (28 November 2012).
[171] *Ibid* paras. 224-243.

the words 'in general' permitted exceptions to the general rule.[172] Thus, the Court found it disproportionate for Costa Rica to 'aspire to an absolute protection of the embryo' and found the prohibition to violate a number of rights protected by the American Convention.[173] This judgment could open up avenues for the Inter-American Court to find that prohibitions on abortion also violate the Convention – though this potential is limited by the fact that the Court weighed up the effectiveness of the prohibition on IVF in protecting embryos, emphasising that the risks were minimal and further that IVF was about the 'creation of life'.[174] That Article 4 permits the legalisation of abortion does not equate to an obligation to legalise abortion, and a challenge to a prohibition on abortion could easily be distinguished from *Artavia Murillo* on the Court's own reasoning.

The Court declined to recognise the impact of the complete criminalisation of abortion in the recent case of *Manuela v El Salvador*.[175] Manuela was an unknown number of weeks pregnant, when she fell heavily and injured her pelvic area, and was later found in her bedroom unconscious and bleeding.[176] She had given birth at home and the baby was found in the septic tank; Manuela could not remember what happened, but thinks she gave birth over the toilet.[177] The Court noted that she had previously attempted to seek medical care for several lumps on her neck which were later diagnosed at Hodgkin's lymphoma, and she had severe preeclampsia which could have contributed to premature delivery and foetal death.[178] Manuela had also suffered from a postpartum haemorrhage after the birth.[179] She was arrested for a suspected abortion, but it was later determined

[172] *Ibid* para. 264.
[173] *Ibid* paras. 311, 317.
[174] *Ibid* paras. 314-316, 311.
[175] *Manuela v El Salvador*, Inter-Am. Ct. H.R., Series C 441 (21 November 2021).
[176] *Ibid* paras. 49-51.
[177] *Ibid* paras. 53, 80.
[178] *Ibid* para. 137.
[179] *Ibid*.

that the baby had been born alive and she was sentenced to 30 years imprisonment for aggravated homicide.[180] She died as a result of her lymphoma in 2010.[181]

The Court addressed the fact that the Trial Court had relied heavily on gender stereotypes. As the baby had been born alive, the Trial Court had assumed that Manuela must have committed a crime and they did not take into account the effect of her existing illnesses and the postpartum haemorrhage.[182] Further, the Trial Court assumed that she would have hidden the pregnancy from her family and attempted to end the pregnancy as she had become pregnant outside of marriage and would have been ashamed of this.[183] The Court noted the context of the complete criminalisation of abortion in El Salvador, referring to comments by CEDAW and CESCR on the situation, but does not expand upon the broader systemic issues around this. The Court instead focused on the issues of pretrial detention, the presumptions that she was guilty because of gender stereotypes, and the shortcomings with the medical care she received. The Court's non-repetition orders were thus limited to the regulation of medical professionals, adapting the pretrial detention regulation, and awareness-raising on gender stereotyping for public officials.[184] Recognising that the sentence Manuela received for infanticide amounted to cruel, inhuman, and degrading treatment in contravention of the American Convention, the Court also required the state to amend the sentence given for infanticide to ensure proportionality.[185]

The Court did not recognise these issues as linked to the total criminalisation of abortion, nor that the same gender stereotypes are applied for people who are

[180] *Ibid* para. 83.
[181] *Ibid* para. 88.
[182] *Ibid* paras. 144, 137.
[183] *Ibid* para. 154.
[184] *Ibid* paras. 284-295.
[185] *Ibid* paras. 172, 296.

prosecuted for illegal abortion. Further, the Court only fleetingly cited international human rights documents, and did not refer to the emerging requirements around decriminalisation. Patricia Palacios Zuloga argues that the strides made on sexual and reproductive rights by the Inter-American Court suggest that 'the System could be well positioned to support a claim that holds that the criminalisation of abortion is a violation' of the Convention.[186] While the case remains significant and establishing standards incrementally may be advantageous, the fact that the Court missed the opportunity in *Manuela* to address the impact of prohibiting abortion suggests their reluctance to impose clear obligations on this issue.

### *3.5. Limitations*

There are limitations to the approach of all three regional human rights systems to abortion. While the African Women's Protocol is the only treaty to explicitly recognise a right to abortion, it is restricted in scope and the inaccessibility of the African Court poses further problems for enforcement. Although the European and Inter-American Courts have established that abortion is permissible and have addressed procedural issues in different contexts, they have both stopped short of placing obligations on States to legalise abortion. For regional human rights systems to be effective avenues for bringing abortion rights cases, they must adopt similar standards as the international framework around the human right to abortion. As all three regional bodies do rely on international human rights standards, the recognition of the right to abortion as set out in Chapter 4

[186] Patricia Palacios Zuloaga, 'Pushing Past the Tipping Point: Can the Inter-American System Accommodate Abortion Rights?' (2021) 21(4) *Hum. Rts. Law Rev.* 899, 913, 933.

would provide more of an impetus for the regional human rights courts to interpret their respective treaties as placing obligations on states to provide access to abortion.

Though the limitations around bringing abortion cases to the African Court may limit its ability to develop its own standards, Ngwena argues that the African Charter organs can 'can derive persuasive value from rulings of the European Court and United Nations treaty monitoring bodies' which fill the gap in African jurisprudence.[187] The use of the margin of appreciation by the European Court and the inconsistent application of international human rights standards on abortion by the Inter-American Courts temper their role in the realisation of abortion rights. However, both courts have gradually developed their own standards on abortion which may lead to an emerging right to abortion in those systems, as suggested by Cosentino and Palacios Zuloga.[188] If these regional bodies can develop standards on abortion which mirror international standards, they would be well-placed to address regional patterns in violations and issues which are more localised, thus complementing the right to abortion as would be set out in the international framework. Regional human rights bodies could play an important role in abortion law reform, particularly in the face of significant government opposition to abortion and the failure or reluctance of the national courts to respond. As indicated above, this will in turn require ongoing mobilisation from abortion rights movements (including, in some contexts, bringing cases to the national courts) to put regional human rights judgments into effect.[189]

[187] Charles G. Ngwena, 'State obligations to implement African abortion laws: Employing human rights in a changing legal landscape' (2012) 119 *Int. J. Gynecol. Obstet.* 198, 202.
[188] Cosentino (n161); Palacios Zuloga (n186)
[189] Charles G. Ngwena, 'Protocol to the African Charter on the Rights of Women: Implications for access to abortion at the regional level' (2010) 110 *Int. J. Gynecol. Obstet.* 163, 166.

## *4. The Impact of a Right to Abortion*

In some parts of the world, significant progress is being made on abortion and the examples given throughout this chapter highlight how a combined strategy of feminist activism, litigation, and relying on international and regional human rights bodies can effectively achieve abortion law reform. Yet in others, as highlighted in Chapter 2, there has been recent backsliding and ongoing resistance on abortion rights. In political contexts where abortion is a polarised issue, abortion rights have a 'pendular character' and can swing back and forth between progressive and restrictive regimes.[190] Progress on abortion is non-linear, which means that rollbacks such as in the US are to be expected and abortion is unlikely to become a 'resolved' issue in these contexts. Whether progressive abortion law reform is possible depends on a range of socio-political factors, including the political leanings of the current government and their support (or opposition to) abortion, the makeup and scope of the courts, and the influence of religious institutions, pro- or anti-abortion movements, non-governmental and human rights organisations, and other actors. While this pendular nature of abortion means that access remains insecure even where abortion is currently legalised, this also means that prohibitions on abortion are not static. In countries experiencing rollbacks or continuing hostility towards abortion, the possibility for this to change remains open, as demonstrated by the gradually increasing number of countries in Latin America starting to overcome heavily restrictive regimes.

[190] Clara Franco Yáñez, 'Abortion Rights in Latin America: An Unsettled Battle' (2021) 3 *GIGA Focus* 1, 1.

This will take time to achieve, however, and in the interim, self-managed abortion is an important aspect of feminist mobilisation for abortion rights. As already covered in the previous chapter, self-managed abortion networks help pregnant people safely access and take abortion medication where they cannot access legal abortion services. These networks have already existed in the US, particularly in states lacking abortion clinics, and are expanding following the *Dobbs* decision to help pregnant people who have been left without access. Materials on how pregnant people can safely self-manage their own abortions have also been published and shared online.[191] Self-managed abortion is not without risk, however, and is no substitute for comprehensive abortion services. Pregnant people who self-manage their abortions and the people helping them can be subject to criminalisation; in 2022, Polish abortion rights activist Justyna Wydrzynska was arrested and put on trial for illegally providing abortion medication to a pregnant woman in 2020.[192] In Texas, the SB-8 Bill means that anyone suspected of helping a person obtain an abortion can be sued, which deters people from seeking healthcare as their doctor could report them to the police or risk being accused of assisting with an illegal abortion.[193] While self-managed abortion can fill some of the gaps left in the absence of safe, legal, state-provided services, more people will be left without access to abortion or will face prosecution.

Against this backdrop, it is all the more important for international human rights bodies to explicitly recognise abortion as a human right. As argued in Chapter 2, the gaps

[191] See, for example, Natalie Adler and others, *We Organize to Change Everything* (Verso, 2022) Chs. 19 and 20; SASS, 'Spread the Word!' <https://abortionpillinfo.org/en/sass> accessed 14 January 2023; Plan C, 'The Plan C Guide to Abortion Pill Access' <https://www.plancpills.org/find-pills> accessed 14 January 2023.
[192] Amnesty International, 'Poland: Charges against activist accused of aiding an abortion must be dropped' (13 July 2022) <https://www.amnesty.org/en/latest/news/2022/07/poland-charges-against-activist-accused-of-aiding-an-abortion-must-be-dropped-2/> accessed 14 January 2023.
[193] Clea Skopeliti, 'Criminalisation harms people self-managing abortions' (*Huck*, 16 August 2022) <https://www.huckmag.com/perspectives/criminalisation-harms-people-self-managing-abortions/> accessed 14 January 2023.

left in the current international human rights approach to abortion can provide legitimacy to the restrictions imposed by some states. Some theorists may argue that human rights occupy the space of perhaps more effective frames, but the importance of recognising abortion as a human right is in achieving compliance with the PGC, rather than the language of human rights itself. Thus, in states where human rights discourse may have limited effect, alternative ways of approaching abortion law reform can nonetheless guarantee the moral right to abortion required by the PGC. Further, while states may continue to impose restrictions on abortion following the recognition of a human right to abortion, this would bolster localised abortion rights movements, national courts, and regional human rights systems in pushing for reform. Entrenching abortion as a human right in the international human rights framework and in national contexts is therefore imperative for challenging the worldwide ongoing resistance to abortion.

## *Conclusion*

This chapter has addressed concerns around the limited effectiveness of the international human rights framework. Though international treaty bodies have relatively weak enforcement mechanisms, which is a particular issue in relation to contested rights such as abortion, there are number of avenues for realising the right to abortion on a more localised scale. Feminist movements, national courts, and regional human rights bodies have adopted international human rights standards on abortion to challenge restrictive abortion regimes and could therefore play an important role in the implementation and progressive realisation of the right to abortion. Gender-based human rights concepts are

translated to the local vernacular by feminist movements, in order to respond to contextual factors and ensure that rights arguments resonate. Through this process, human rights gain cross-cultural traction and local movements can fill in the gaps that international human rights bodies are not well positioned to address. Recognising abortion as a human right would place greater pressure on states to progressively reform their abortion laws and would equip feminist movements and national courts to hold their governments to account on compliance. The recognition of an explicit right to abortion in the international system would therefore be a significant step towards realising comprehensive access to abortion worldwide.

# Conclusion

The principal argument advanced in this thesis is that there is a moral right to abortion that must be recognised in the international human rights framework. In advancing this argument, I refer to the PGC to establish that there are generic rights which must be accepted by all agents. Applying this to the issue of abortion, I balance the generic rights of pregnant people with those of the foetus, incorporating feminist theory and values to argue that the morality of abortion is context dependent. While I consider a broad range of circumstances in which abortion might be justifiable, rather than presenting a rigid answer to the question of when abortion is morally acceptable, I offer four policy presumptions that are translatable to the regulatory level. Thus, my thesis advances an original contribution to the abortion debate which goes beyond the mainstream pro-choice/pro-life framing and is defensible against anti-abortion arguments.

Before setting out my key conclusions and contributions, I will briefly recap the structure of this thesis. In Chapter 1, I set out the three key conceptual issues with the international human rights framework: its limitations concerning gender-based rights, cross-cultural traction, and economic, social, and cultural (ESC) rights. I argue that a feminist transformation of human rights is necessary to address these limitations. Chapter 2 then focuses on the limitations of the international human rights framework in relation to abortion. I argue that the current approach is inadequate, which I then consider in light of worldwide variations in access to abortion. I identify gaps in the

existing literature on human rights and abortion, which I seek to fill by arguing in favour of an explicit right to abortion.

In Chapter 3, I set out and defend the PGC as the supreme moral principle, the indirect application of which provides the foundation for the international human rights framework. I consider feminist debates around rationalist and relational morality and argue that feminist values can be incorporated in the application of the PGC. I highlight how this approach addresses the three limitations outlined in Chapter 1, thus providing the basis for the feminist transformation of human rights. In Chapter 4, I apply the PGC to abortion in conjunction with feminist perspectives. I establish the presumptions that early abortion is morally justifiable on request; that abortion becomes harder to justify as the pregnancy progresses and foetus develops agential characteristics; that abortion may be morally justifiable in the later stages of pregnancy for a range of reasons; that upholding the generic rights of both pregnant person and foetus requires measures relating to the context of abortion decisions. I set out a framework for the progressive realisation of the right to abortion consisting of a number of tiers, covering issues such as the decriminalisation of abortion, legalisation in various circumstances, measures relating to accessibility and the removal of barriers, and a range of other conditions.

Chapter 5 follows from this to consider some pressing issues with accessibility and barriers: conscientious objection, medically unnecessary regulations, and early medical abortion through telemedicine and self-management. I offer broad recommendations on how states should respond to these issues in different contexts. After setting out this framework and recommendations, Chapter 6 addresses the question of whether a right to abortion would be effective. While international human rights bodies have relatively weak enforcement mechanisms, and some scholars have questioned the usefulness of

human rights, I argue that the right to abortion could be realised indirectly through social movements, domestic courts, and regional human rights bodies.

In addition to the overall contribution to the abortion debate, this thesis also contributes to specific debates around human rights. While the identification of the issues around gender-based rights and debates around cultural relativism and ESC rights are prominent in the literature, my contribution lies in bringing these three issues together and adopting the PGC as a way of addressing them. I engage in each of these debates, to argue that gender-based rights must be intersectional and inclusive of trans, non-binary, and gender expansive people; to highlight the importance of cross-cultural traction while rejecting cultural relativism; and to argue that states must have stronger obligations in relation to ESC rights. I build on the concept of a feminist transformation of human rights already present in the literature, adding my own original contribution by incorporating cross-cultural traction and ESC rights protection as well as gender-based issues, and by establishing a specific foundation for this – the PGC. My framework for the right to abortion is therefore just one example of such a transformation. This concept, and the three issues I identified in Chapter 1, thread through the foundation for my framework, which incorporates feminist perspectives, includes both ESC and civil and political elements, and takes account of inter- and intra-state differences.

My thesis also substantively contributes to the existing literature on abortion and human rights. I provide an up-to-date analysis of the evolving approaches of key treaty bodies and identify the key limitations with the international human rights approach to abortion. By tying these limitations together with the three overarching conceptual issues identified in Chapter 1, I add to this by presenting the issues with human rights standards on abortion as part of a larger critique. Further, the original framework for recognising a

right to abortion which I develop across Chapters 4 and 5 goes beyond the current literature to offer a workable way around those limitations to comprehensively protect access to abortion at the international level. In arguing for the recognition of a new right to abortion, my thesis contributes an original proposal to the existing scholarship on abortion and human rights. Recognising that compliance with this right may be a lengthy and gradual process, my approach presents tiers of progress without resulting in the compromise position of the current framework.

My final chapter aims to challenge and rebut the arguments that human rights are inherently ineffective or lacking in usefulness. The critiques I highlight in the earlier chapters are not innate to the concept of human rights; rather, they are limitations of the current legal framework capable of being addressed by a transformation premised on the PGC. The practical limitations of the international system may persist, particularly in relation to contested rights such as the right to abortion, where some states may resist compliance in the face of weak enforcement mechanisms. However, as I argue in Chapter 6, there are alternative avenues to the realisation of human rights which can and should be viewed as part of the domestic implementation of human rights standards. Thus, the right to abortion could be effectively realised in this way. Together, my thesis presents an original approach to abortion from an international human rights perspective whilst also contributing to the broader debates in these fields.

There are a number of areas which could have been further developed given the space for further research. The framework for the right to abortion that I have developed in this thesis is at the international level and is broad enough to be applied in specific contexts – but there may be particular issues or limitations within some states that have not been considered here. For example, the issues with the availability and accessibility

of abortion services considered in Chapter 5 were confined to pressing and topical issues that international human rights bodies have not yet been comprehensively addressed. In some states, there are broader issues with the availability and affordability of abortion services where providers are sparse, or there is a lack of public or free healthcare provision. In addition, there are issues relating to the acceptability of abortion services such as the provision of information, non-discrimination, and culturally and age-sensitive abortion care. The literature on obstetric violence has considered the structural nature of harm caused by healthcare professionals in birth contexts, and recently, some scholars have expanded this to look at abortion-related obstetric violence.[1] The terminology of obstetric violence has not yet been fully adopted by international human rights bodies, so there is perhaps scope for future research on how this could be incorporated in the recognition of explicit reproductive rights such as abortion.

Further, Chapter 6 only gives a brief snapshot of the potential of social movements and domestic courts in relation to realising the right to abortion. Further consideration of these avenues in other states or regions may be necessary. My focus in this chapter was limited to the indirect role of social movements in the implementation of human rights. However, there has been consideration of the role of non-governmental organisations in formal international human rights mechanisms such as the Universal Periodic Review and whether these organisations could or should be recognised as direct human rights actors. [2] More could therefore be said about how the formal inclusion of non-governmental organisations in these mechanisms could strengthen protection for the

[1] Sara Larrea, Mariana Prandini Assis, and Camila Ochoa Mendoza, '"Hospitals have some procedures that seem dehumanising to me": Experiences of abortion-related obstetric violence in Brazil, Chile and Ecuador' (2021) 35(3) *Agenda* 54.
[2] Michael Lane, 'The Universal Periodic Review: A Catalyst for Domestic Mobilisation' (2023) *Nordic Journal of Human Rights* [online ahead of print].

right to abortion. Finally, my interpretation of a feminist transformation of human rights premised upon the PGC could be expanded beyond the issue of abortion to consider the recognition of other reproductive rights, and gender-based rights beyond this.

In this thesis, I have constructed an argument for the recognition of abortion as a moral right, the framework for this right to be adopted at the international level, and the potential means for it to be realised. However, the issues surrounding access to abortion worldwide span political, economic, religious, social, and cultural spheres, and abortion is likely to remain contested – as recent developments in the US highlights. It is imperative in this context that abortion is recognised as a human right, to push states to ensure access to comprehensive and safe abortion services.

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