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Telemedical and Self-Managed Abortion: A Human Rights Imperative?

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Abstract

Early into the COVID-19 pandemic, abortion rights advocates highlighted the importance of maintaining access to abortion through telemedicine. It was argued that telemedical and self-managed abortion was, in the pandemic context, a human rights imperative. This article argues that providing for telemedical and self-managed abortion remains a human rights imperative beyond the duration of the pandemic. Telemedical and self-managed abortion is safe and effective, supports the pregnant person's preferences and reproductive autonomy, and minimises many of the physical and structural barriers faced by pregnant people in accessing abortion services. International and European human rights standards access to abortion require states to take positive measures to guarantee access to abortion, and this article argues that such measures include telemedical and self-managed abortion.

Keywords

abortion – telemedical abortion – self-managed abortion – human rights – reproductive rights

Introduction

In this paper, I argue that providing telemedical abortion services and enabling self-managed abortion is necessary in order to meet international and European human rights standards on abortion. While the terms 'telemedical abortion' and 'self-managed abortion' are sometimes used interchangeably

in the literature, in this article I use the term telemedical abortion to refer to early medical abortions taking place within formal healthcare structures, and self-managed abortion to refer to those taking place outside those structures. I also use the term 'pregnant people' throughout this article to be inclusive of all people with the capacity to become pregnant. In relation to a discussion on the accessibility of abortion services, gender-inclusive language is particularly important as a failure to recognise the abortion needs of trans men and gender minorities can operate as a significant barrier to those groups accessing abortion services (as is discussed in section 3.2). However, I do use gender-specific language in relation to the gendered stereotypes around motherhood and pregnancy that are imposed on women.

The first section introduces early medical abortion and telemedical and self-managed abortion as two safe abortion pathways. In the second section, I consider telemedical and self-managed abortion in the COVID-19 context, arguing that these two pathways to abortion care are important not just in pandemic times but as a long-term human rights imperative. The third and final section is then dedicated to exploring the international and European human rights standards on abortion that support the provision of telemedical and self-managed abortion. I argue that states must take positive measures to ensure ease of access to abortion by providing telemedical abortion and facilitating self-managed abortion in order to comply with human rights standards around decriminalisation, preventing unsafe abortion, removing barriers to access, ensuring the acceptability of abortion services, and gender equality.

1 Early Medical Abortion

Medical abortion refers to the use of the two medications mifepristone and misoprostol to induce a miscarriage, to be distinguished from more invasive surgical abortion methods.[1] Early medical abortion refers to the use of these medications up to 12 weeks gestation; medical abortion is possible after this point but requires subsequent doses of misoprostol.[2] The World Health Organization (WHO) includes both medications on its Model List of Essential Medicines 'where permitted under national law and where culturally acceptable' and recommends medical abortion using mifepristone and misoprostol

1 J.A Parsons and E.C. Romanis, *Early Medical Abortion, Equality of Access, and the Telemedical Imperative* (Oxford: Oxford University Press, 2021) p. 2–5.

2 *Ibid* p. 4–5.

as a safe and effective method up to 12 weeks' gestation.[3] With early medical abortion, the pregnant person can be afforded more autonomy over the abortion process if they are offered telemedicine as an alternative to taking the pills in an abortion facility under medical supervision. There are multiple configurations for telemedicine (the initial consultation may be remote or in person; the pregnant person may have to collect the pills from a facility, or the pills may be posted out to them) but the pregnant person would be able to take the abortion medication at home.[4] Parsons and Romanis distinguish between full and partial telemedicine, with full telemedicine referring to the entire process available remotely: the consultation, obtaining the pills, taking the pills, and the provision of pre- and post-abortion information and care.[5]

Scholars are increasingly referring to 'self-managed abortion' which denotes the obtaining and use of abortion medication outside of formal healthcare institutions.[6] The term 'self-managed abortion' is used to distinguish between this and unsafe clandestine methods of abortion, and to recognise the facilitation of abortions services by a 'constellation of actors' including informal feminist networks in countries where abortion is illegal or inaccessible.[7] Killinger et al argue that choosing self-managed abortion can come from a place of empowerment or disempowerment.[8] For many pregnant people, this may be

3 WHO, *22nd Model List of Essential Medicines,* 30 September 2021, p. 50; WHO, *Abortion Care Guideline,* 8 March 2022, p. 68–71.

4 In some contexts, the pregnant person may only be allowed to take the second pill, misoprostol, at home after taking the first, mifepristone, in a facility under supervision. This was the policy in Britain prior to the COVID-19 pandemic. See: J.A. Parsons, '2017–2019 governmental decisions to allow home use of misoprostol for early medical abortion in the UK', *Health Policy* 124(7) (2020) 679–683.

5 Parsons and Romanis, *supra* note 1, p. 98–106.

6 See, for example: J.N. Erdman, K. Jelinska, and S. Yanow, 'Understandings of self-managed abortion as health inequity, harm reduction and social change', *Reproductive Health Matters* 26(54) (2018) 13–19; L. Vázquez-Quesada, A. Shukla, I. Vieitez, R. Acharya, and S. RamaRao, 'Abortion Self-Care: A Forward-Looking Solution to Inequitable Access', *International Perspectives on Sexual and Reproductive Health* 46 (Suppl 1) (2020) 91–95; M.P. Assis and S. Larrea, 'Why self-managed abortion is so much more than a provisional solution for times of pandemic', *Sexual and Reproductive Health Matters* 28(1) (2020) 37–39; L. Berro Pizzarossa and P. Skuster, 'Toward Human Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion: A Review of the Last Decade of Legal Reform', *Health and Human Rights Journal* 23(1) (2021) 199–212; L. Berro Pizzarossa and R. Nandagiri, 'Self-managed abortion: A constellation of actors, a cacophony of laws', *Sexual and Reproductive Health Matters* 29(1) (2021) 1–8.

7 Pizzarossa and Nandagiri, *supra* note 6.

8 K. Killinger, S. Günther, R. Gomperts, H. Atay, and M. Endler, 'Why women choose abortion through telemedicine outside the formal health sector in Germany: a mixed-methods study', *BMJ Sexual & Reproductive Health* 48(e1) (2022) 6–12.

due to a lack of alternative options but for others, self-managed abortion is the best option (even where legal abortion services are available) as it allows people to avoid the indignities of formal healthcare settings.[9] Thus, self-managed abortion does not occur solely for humanitarian purposes, to prevent unsafe abortion and associated maternal mortality, but should also be understood as providing an important and often preferable avenue for autonomy-centred abortion care.

The home use of abortion medication is safe and effective when obtained through either pathway. The risks of having an early medical abortion at home, when provided with adequate information on how to take the pills and follow-up care, are equivalent to the already minimal risks of taking abortion medication in a medical facility under supervision.[10] The evidence that telemedical abortion is just as a safe as in-person care has reaffirmed existing knowledge of the safety of self-managed abortion. The use of misoprostol, which was primarily 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.[11] 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

9 Prandini Assis and Larrea, *supra* note 6, p. 38: Erdman, Jelinska, and Yanow, *supra* note 6, p. 14; M. Prandini Assis and J.N. Erdman, 'Abortion rights beyond the medico-legal paradigm', *Global Public Health* (2021) 1–16, p. 8.

10 See, for example: A.R.A Aiken, P.A. Lohr, J. Lord, N. Ghosh, and J. Starling, 'Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study', *BJOG: An International Journal of Obstetrics and Gynaecology* 128(9) (2021) 1464–1474; E.C. Romanis, J.A. Parsons, I. Salter, and T. Hampton, 'Safeguarding and teleconsultation for abortion', *The Lancet* 398(10299) 555–558; M. Endler, A. Lavelanet, A. Cleeve, B. Ganatra, R. Gomperts, and K. Gemzell-Danielsson, 'Telemedicine for medical abortion: a systematic review', *BJOG* 126(9) (2019) 1094–1102; J.J. Reynolds-Wright, A. Johnstone, K. McCabe, E. Evans, S. Cameron, 'Adherence to treatment and prevalence of side effects when medical abortion is delivered via telemedicine: a prospective observational cohort study during COVID-19', *BMJ Sexual & Reproductive Health,* online first, doi: 10.1136/bmjsrh-2021–201263 (2021); A.R.A Aiken, I. Digol, J. Trussell, and R. Gomperts, 'Self reported outcomes and adverse events after medical abortion through online telemedicine: population based study in the Republic of Ireland and Northern Ireland', *BMJ* 357 (2017) 1–8.

11 K. Jelinska and S. Yanow, 'Putting abortion pills into women's hands: Realizing the full potential of medical abortion', *Contraception* 97(2) (2018) 86–89, p. 86; F. Bloomer, C. Pierson, and S. Estrada Claudio, *Reimagining Global Abortion Politics* (Bristol: Policy Press, 2018) p. 37; S.H. Costa and M.P. Vessey, 'Misoprostol and illegal abortion in Rio de Janeiro, Brazil', *The Lancet* 341 (1993) 1258–1261.

networks across Latin America and beyond.[12] Significantly, the increasing use of misoprostol as a method of clandestine abortion correlated with a reduction in maternal mortality and morbidity in this region.[13]

WHO, in its latest guidance document on abortion care, therefore recommends the provision of providing the option of full telemedicine for early medical abortion as part of a plurality of service-delivery approaches.[14] In addition, WHO recommends the option of self-managed abortion within the first 12 weeks, so that the pregnant person can self-assess their need and self-administer the medication without any medical supervision.[15] This supports their previous guidance on self-care interventions for sexual and reproductive health, which recommended the self-management of early medical abortion as a means of eliminating unsafe abortion.[16] As telemedical and self-managed abortion pathways are safe, restrictions on these methods of abortion care are medically unnecessary. This evidence base points towards telemedical and self-managed abortion as important components of providing comprehensive abortion care — yet in many states, abortion medications are not available or are not provided through telemedicine, and additional measures, such as the criminalisation of abortion or restrictions on the dispensing of abortion medications, are taken to restrict self-managed abortion.

2 The COVID-19 Context

At the start of the COVID-19 pandemic, scholars and abortion rights advocates in numerous countries argued that governments should amend their abortion policies to allow abortion medication to be prescribed and taken remotely for early medical abortion, to mitigate the risk of exposure to the virus.[17] Gher

12 Bloomer, Pierson, and Estrada Claudio, *supra* note 11, p. 37; S. De Zordo, 'The biomedicalization of illegal abortion: the double life of misoprostol in Brazil', *História, Ciências, Saúde-Manguinhos* 23(1) (2016) 19–35.

13 Jelinska and Yanow, *supra* note 11, p. 86.

14 WHO, 'Abortion Care Guideline', *supra* note 3, p. 95–96.

15 *Ibid* p. 98.

16 WHO, *WHO Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights*, 2019, p. 67–68.

17 E.C. Romanis, J.A. Parsons, and N. Hodson, 'COVID-19 and reproductive justice in Great Britain and the United States: Ensuring access to abortion care during a global pandemic', *Journal of Law and the Biosciences* 7(1) (2020) 1–23; S. Chandrasekaran, v.S. Chandrashekar, S. Dalvie, and A Sinha, 'The case for the use of telehealth for abortion in India', *Sexual and Reproductive Health Matters* 29(2) (2021) 1–8; A.R.A Aiken, J.E. Starling, R. Gomperts, M. Tec, J.G. Scott, and C.E. Aiken, 'Demand for Self-Managed Telemedicine Abortion in

and Shah argued that the move to telemedicine for early medical abortion was a 'human rights imperative' as delays or denials of abortion care would likely result in more unsafe abortions.[18] The importance of guaranteeing access to abortion during the pandemic was also highlighted in relation to the issues with access to contraception due to supply problems, which may have increased the number of unintended or unwanted pregnancies, and in light of directly or indirectly COVID-related reasons for deciding to have an abortion, such as income insecurity or intimate partner violence, which increased during lockdowns.[19] In response, a number of countries adopted telemedical models for early medical abortion, for example England and Wales, Scotland, and France, and access to telemedicine was increased by some clinics in Hawai'i and in parts of the United States.[20] While France, for example, adopted a partial telemedical model where abortion medication had to be collected from a pharmacy to be taken at home, Britain adopted a fully remote model so that following an online or telephone consultation, the medication was then posted to the pregnant person's home.[21] In Britain, safeguarding measures were inte-

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the United States During the Coronavirus Disease 2019 (COVID-19) Pandemic', *Obstetrics & Gynecology* 136(4) (2020) 835–837, p. 837; International Campaign for Women's Right to Safe Abortion, 'Australia — Call to remove new telehealth restrictions imposed across Australia', 12 August 2020, retrieved 14 March 2022, https://www.safeabortionwomensright.org/news/australia-call-to-remove-new-telehealth-restrictions-imposed-across-australia/; J. Todd-Gher and P.K. Shah, 'Abortion in the context of COVID-19: A human rights imperative', *Sexual and Reproductive Health Matters* 28(2) (2020) 28–30.

18 Gher and Shah, *supra* note 17, p. 28.

19 Gher and Shah, *supra* note 17, p. 28; R. Nandagiri, E. Coast, and J. Strong, 'COVID-19 and abortion: Making structural violence visible', *International Perspectives on Sexual and Reproductive Health* 46 Supp. 1 (2020) 83–89, p. 83.

20 Department of Health and Social Care, 'Temporary approval or home use for both stages of early medical abortion', 30 March 2020, retrieved 14 March 2022, https://www.gov.uk/government/publications/temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion—2; Scottish Government, 'Abortion — COVID-19 – Approval for mifepristone to be taken at home and other contingency measures', 31 March 2020, retrieved 14 March 2022, https://www.sehd.scot.nhs.uk/cmo/CMO(2020)09.pdf; International Campaign for Women's Right to Safe Abortion, 'France — Early abortion via telemedicine permitted as of 10 April 2020', 15 April 2020, retrieved 14 March 2022, https://www.safeabortionwomensright.org/news/france-early-abortion-via-telemedicine-permitted-as-of-10-april-2020/; C. Kerestes, S. Murayama, J. Tyson, M. Natavio, E. Seamon, S. Raidoo, L. Lacar, E. Bowen, R. Soon, I. Platais, B. Kaneshiro, and P. Stowers, 'Provision of medication abortion in Hawai'I during COVID-19: Practical experience with multiple care delivery models', *Contraception* 104 (2021) 49–53; Aiken and others, *supra* note 17.

21 N. Bojovic, J. Stanisljevic, and G. Giunti, 'The impact of COVID-19 on abortion access: Insights from the European Union and the United Kingdom', *Health Policy* 125(7) (2021) 841–858, p. 849; British Pregnancy Advisory Service, 'Pills by Post', retrieved 24 March 2022, https://www.bpas.org/abortion-care/abortion-treatments/the-abortion-pill/remote-treatment/.

grated through remote consultations with healthcare professionals to ensure that consistently high-quality abortion care continued to be delivered.[22]

However, not all governments initiated such progressive responses. In a review of abortion regulation in Europe during COVID-19, Moreau et al highlight the issues with countries primarily relying on surgical methods of abortion: in Germany, mandatory counselling prior to an abortion was made available remotely, but only a minority of abortions in the country are done using medication, and in Hungary, surgical abortions were completely ceased due to a ban on non-lifesaving procedures.[23] Italy moved to expanded access to early medical abortion, by changing the gestational time limit for medical abortion from 7 weeks' gestation to 9 weeks and allowing this to take place as an outpatient treatment in hospitals and health centres instead of the pregnant person remaining in hospital for three days.[24] However, this measure has been critiqued for failing to get around the regional disparities and barriers to accessing abortion services in the country.[25] Further, some anti-abortion governments sought to use COVID-19 as a pretext for bringing in restrictions on abortion. Jones, Lindberg, and Witwer identified that by May 2020, at least 11 US states had attempted to restrict access to abortion services by deeming them non-essential.[26] In April 2020, the Polish government reintroduced a bill to prohibit abortion on the grounds of foetal impairments and those protesting the bill were fined for breaching social distancing rules.[27]

In countries where governments failed to take measures to ensure access to abortion services, such as allowing telemedical abortion, pregnant people

22 J.A. Parsons and E.C. Romanis, 'The Case for Telemedical Early Medical Abortion in England: Dispelling Adult Safeguarding Concerns', *Health Care Analysis* 30(1) 73–96; Royal College of Obstetricians and Gynaecologists and British Society of Abortion Care Providers, 'Telemedical Abortion Care: Safeguarding Young People', April 2021, retrieved 13 June 2022, https://www.rcog.org.uk/media/v3qhzxl5/2021-06-25-telemedical-abortion-care-and-the-safeguarding-of-young-peop.pdf.

23 C. Moreau, M. Shankar, A. Glasier, S. Cameron, and K. Gemzell-Danielsson, 'Abortion regulation in Europe in the era of COVID-19: a spectrum of policy responses', *BMJ Sexual & Reproductive Health* 47(e14) (2021) 1–8, p. 4–5.

24 E. Caruso, "Much Ado About Nothing?' The New Policy on Early Medical Abortion (EMA) in Italy', *The Italian Law Journal* 7(2) 647–658, p. 647–648.

25 *Ibid*.

26 R.J. Jones, L. Lindberg, and E. Witwer, 'COVID-19 Abortion Bans and Their Implications for Public Health', *Perspectives on Sexual and Reproductive Health* 52(2) 2020 65–68, p. 65.

27 J. Bateman, 'In Poland, Abortion Access Worsens Amid Pandemic', *Foreign Policy*, 1 May 2020, retrieved 14 March 2022, https://foreignpolicy.com/2020/05/01/poland-abortion-access-worsens-coronavirus-pandemic/. Abortion on the grounds of foetal impairment is now prohibited in Poland, after being held to be unconstitutional: Polish Constitutional Tribunal Case K 1/20 (22 Oct 2020).

turned to self-managed abortion. Studies have highlighted an increase in the number of pregnant people accessing abortion medication online through alternative providers during the pandemic.[28] Women on Web, one of the main 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.[29] There were an increase in requests to Women on Web by pregnant people in France and Italy, with a significant percentage (around 30% and 50% respectively) citing COVID-19 as the primary reason.[30] In contrast, following the move to fully remote telemedical abortion services, requests to Women on Web by pregnant people in Britain decreased to just one request.[31] However, the option of turning to alternative online providers is not available to everyone, as this requires access to information and the internet. In some countries, the websites of these providers have been blocked. In January 2020, Spain — the only EU state to do so — blocked access to the Women on Web website.[32] Pregnant people in Spain need at least three in-person appointments before they are able to access abortion services due to requirements on information provision and mandatory counselling, requirements which were retained in most regions of the country throughout the national lockdown.[33] Preventing access to alternative sources of abortion medication thus added to the existing barriers faced by Spanish pregnant people in attempting to obtain an abortion during the pandemic. In addition, the pandemic created further issues for pregnant people trying to obtain abortion

28 A.R.A Aiken, J.E. Starling, R. Gomperts, J.G. Scott, and C.E. Aiken, 'Demand for self-managed online telemedicine abortion in eight European countries during the COVID-19 pandemic: a regression discontinuity analysis', *BMJ Sexual & Reproductive Health* 47(4) (2021) 238–245; H. Atay, H. Perivier, K. Gemzell-Danielsson, J. Guilleminot, D. Hassoun, J. Hottois, R. Gomperts, and E. Levrier, 'Why women choose at-home abortion via teleconsultation in France: drivers of telemedicine abortion during and beyond the COVID-19 pandemic', *BMJ Sexual & Reproductive Health* 47(4) (2021) 285–292; K. Brandell, H. Vanbenschoten, M. Parachini, R. Gomperts, and K. Gemzell-Danielsson, 'Telemedicine as an alternative way to access abortion in Italy and characteristics of requests during the COVID-19 pandemic', *BMJ Sexual & Reproductive Health*, online first, doi:10.1136/bmjsrh-2021–201281 (2021).

29 Women on Web, 'Abortion with pills', retrieved 14 March 2022, https://www.womenonweb.org/en/abortion-pill.

30 Atay and others, *supra* note 28; Brandell and others, *supra* note 28.

31 Aiken and others, *supra* note 28, p. 238.

32 Women on Web, 'Spain censors information about abortion amid Covid-19 lockdown', 17 June 2020, retrieved 14 March 2022, https://www.womenonweb.org/en/page/20230/spain-censors-information-about-abortion-amid-covid-19-lockdown.

33 Bojovic, Stanisljevic, and Giunti, *supra* note 21, p. 850.

medication online due to postal delays and the temporary suspension of international postal services.

In countries or regions where abortion is restricted or inaccessible, existing geographical barriers to access were also exacerbated by lockdowns and travel restrictions. For example, in Poland, abortion is illegal except in cases of sexual crime or where the pregnant person's life is at risk. The number of clandestine abortions taking place within Poland has been estimated at between 80,000 to 180,000 per year.[34] Pregnant people who are unable to access clandestine abortion services within Poland travel to countries such as Germany or Britain to have a legal abortion. However, travelling abroad became virtually impossible as many countries imposed border restrictions or quarantine periods, flights were cancelled, and hotels were closed.[35] The increased costs associated with travelling during the pandemic (for example, having to comply with quarantine periods and pay for pre- and post-departure tests) further added to the existing financial burdens of travelling for an abortion, which has a particular impact on the ability of socio-economically disadvantaged people to access abortion services. Thus, not only did the pandemic threaten comprehensive abortion care as provided by the state but, as Senderowicz and Higgins observed, it also threatened the workarounds that have been developed in response to legal restrictions and accessibility limitations.[36]

The COVID-19 pandemic has therefore had significant implications for the realisation of sexual and reproductive rights, which has been highlighted by human rights experts. At the United Nations level, the Office of the High Commissioner and Committee on the Elimination of Discrimination Against Women (CEDAW) issued guidance notes on upholding women's rights, emphasising the importance of providing sexual and reproductive healthcare, including abortion, as essential services.[37] The Special Rapporteur on the right to the highest attainable standard of mental and mental health, Tlaleng Mofokeng, subsequently reported on the challenges of COVID-19 in relation to sexual and

34 Human Rights Council, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover: Mission to Poland', 20 May 2010, UN Doc. A/HRC/14/20/Add.3, para. 47.

35 Bateman, *supra* note 27.

36 L. Senderowicz and J. Higgins, 'Reproductive Autonomy Is Nonnegotiable, Even in the Time of COVID-19', *International Perspectives on Sexual and Reproductive Health* 46 (2020) 147–151, p. 147.

37 UN Office of the High Commissioner, 'COVID-19 and Women's Human Rights: Guidance', 15 April 2020, retrieved 14 March 2022, https://www.ohchr.org/Documents/Issues/Women/COVID-19_and_Womens_Human_Rights.pdf; CEDAW, 'Guidance Note on CEDAW and COVID-19', retrieved 14 March 2022, https://www.ohchr.org/Documents/HRBodies/TB/COVID19/Guidance_Note.docx.

reproductive rights, highlighting that it is critical for pandemic responses to be examined for their impact on access to sexual and reproductive health services including abortion.[38] The Commission for Human Rights for the Council of Europe specifically urged Member States to remove all barriers preventing access to safe abortion care by authorising telehealth consultations.[39] It is important to emphasise, however, that these barriers, which indicated a need to further enable access to abortion through telemedicine and other measures, are not unique to the pandemic. The COVID-19 pandemic exposed and exacerbated the structural inequalities that already existed in relation to the provision of an access to abortion services.[40] International human rights bodies, governments, and healthcare providers must recognise and address these continuing inequalities in access to reproductive healthcare post-pandemic. This must include recognising that enabling telemedical and self-managed abortion is a human rights imperative, not just during the pandemic but as a long-term necessity.

3 Human Rights Standards for Telemedical and Self-Managed Abortion

International human rights standards on abortion have evolved significantly since the recognition of reproductive rights as human rights at the International Conference on Population and Development 1994 in Cairo.[41] Though the ICPD eschewed the task of setting standards on abortion access, abortion has since been recognised as a key element of reproductive rights.[42] While international human rights treaties do not explicitly make reference to reproductive rights, existing human rights have been interpreted to cover sexual and reproductive

38 UN General Assembly, 'Right of everyone to the enjoyment of the highest attainable standard of physical and mental health', 16 July 2021, UN Doc. A/76/172, para. 79.

39 Commissioner for Human Rights for the Council of Europe, 'COVID-19: Ensure women's access to sexual and reproductive health and rights', 7 May 2020, retrieved 14 March 2022, https://www.coe.int/en/web/commissioner/-/covid-19-ensure-women-s-access-to-sexual-and-reproductive-health-and-rights.

40 Nandagiri, Coast, and Strong, *supra* note 19, p. 83.

41 UN Population Fund, International Conference on Population and Development (ICPD), 'Report of the International Conference on Population and Development', 5–13 September 1994, UN Doc. No. A/CONF.171/13.

42 M. Berer, 'The Cairo "Compromise" on Abortion and Its Consequences for Making Abortion Safe and Legal' in L. Reichenbach and M.J. Roseman, *Reproductive Health and Human Rights* (Philadelphia: University of Pennsylvania Press, 2009).

health including access to abortion.[43] The Human Rights Committee (HRC), Committee on Economic, Social, and Cultural Rights (CESCR), and CEDAW have developed (and continue to develop) human rights standards on abortion, requiring that States provide access to abortion, as a minimum, on the grounds of rape, fatal foetal impairment, and where continuing the pregnancy risks the life or health of the pregnant person.[44] While Rebouché highlights that these grounds fail to be inclusive of the majority of abortion decisions, other scholars have argued that international human rights standards require access to abortion more broadly.[45] In recent years, treaty bodies have expanded upon this to require States to decriminalise abortion in order to prevent unsafe abortions leading to maternal mortality and morbidity, and to guarantee access to abortion on the grounds already legalised.[46] Thus, Zampas and Gher argued, even before some of these more progressive comments, that human rights norms around preventing unsafe abortion could be relied upon to advocate for abortion on request or for socio-economic reasons.[47] De Londras et al further argue that grounds-based domestic approaches to legalising abortion still result in violations of international human rights.[48] This, coupled with

43 See: HRC, 'General Comment No. 28: Article 3 (the equality of rights between men and women)', 29 March 2000, UN Doc. HRI/GEN/1/Rev.9, paras. 10–11; HRC, 'General Comment No. 36: Article 6 (right to life)', 3 September 2019, UN Doc. CCPR/C/GC/36, para. 8; 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, paras. 14, 23, 36; CESCR, 'General Comment No. 16: the equal right of men and women to the enjoyment of all economic, social and cultural rights (Article 3 of the ICESCR)', 11 August 2005, UN Doc. E/C.12/2005/4, para. 29; 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; CEDAW, 'General Recommendation No.24: Article 12 of the Convention (women and health)', 1999, UN Doc. A/54/38/Rev.1; 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.

44 See: HRC, 'Gen. Comment 36', *supra* note 43, para. 8; CEDAW, 'Inquiry', *supra* note 43, para. 83; *K.L. v Peru* (2005) UN Doc. CCPR/C/85/D/1153/2003; *L.M.R. v Argentina* (2011) UN Doc. CCPR/C/101/D/1608/2007; *Mellet v Ireland* (2016) UN Doc. CCPR/C/116/D/2324/2013; *Whelan v Ireland* (2017) UN Doc. CCPR/C/119/D/2425/2014; *L.C. v Peru* (2011) UN Doc. CEDAW/C/50/D/22/2009.

45 R. Rebouché, 'Abortion Rights as Human Rights', *Social and Legal Studies* 25(6) (2016) 765–782, p. 777.

46 See, for example: HRC, 'Gen. Comment 36', *supra* note 43, para. 8; CEDAW, 'Inquiry', *supra* note 43, para. 59; CESCR, 'Gen. Comment 22', *supra* note 43, paras. 28; 49.

47 C. Zampas and J. Gher, 'Abortion as a Human Right — International and Regional Standards', *Human Rights Law Review* 8(2) (2008) 249–294, p. 255.

48 F. de Londras, A. Cleeve, M.I. Rodriguez, and A.F. Lavelanet, 'The impact of 'grounds' on abortion-related outcomes: a synthesis of legal and health evidence', *BMC Public Health* 22(936) (2022) 1–14.

the recognition of abortion as an essential healthcare service in relation to the pandemic and the recognition by CEDAW that restrictions on abortion can amount to gender-based violence, demonstrates an emerging requirement that States take sufficient steps to guarantee access to abortion beyond those minimum grounds.[49] CESCR and CEDAW have, in particular, developed standards on the accessibility of abortion services, requiring States to remove barriers such as geographical limitations, mandatory counselling requirements, and the misuse of conscientious objection.[50] Erdman and Cook, in a review of these emerging standards, therefore highlight that compliance with international human rights requires not only the legalisation of abortion, but also the removal of abortion as a legitimate subject of criminal law and guarantees as to a range of procedural and accessibility protections.[51]

At the European level, while the European Court of Human Rights (ECtHR) has been more reserved on the development of human rights standards on abortion due to the application of the margin of appreciation in such cases, its jurisprudence nonetheless suggests that there is a procedural right of access on the grounds already legalised domestically.[52] The European Committee on Social Rights has also affirmed the importance of access to abortion services, finding in two cases that the inaccessibility of abortion in Italy due to conscientious objection is a violation of the right to health.[53] These human

49 UN General Assembly, *supra* note 38; 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.

50 See, for example: CEDAW, 'Gen. Rec. 24', *supra* note 43, paras. 21–25; CEDAW, 'Inquiry', *supra* note 43, para. 86; 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); CESCR, 'Gen. Comment 22', *supra* note 43, paras. 41; CESCR, 'Concluding observations on the sixth periodic report of Poland', 26 October 2016, UN Doc. E/C.12/POL/CO/6, paras. 46–47; CESCR, 'Concluding observations on the initial report of South Africa', 29 November 2018, UN Doc. E/C.12/ZAF/COF/1, para. 65; CEDAW, 'Concluding observations on the combined seventh and eighth periodic reports of Romania', 24 July 2017, UN Doc. CEDAW/C/ROU/CO/7–8, paras. 32–33.

51 J.N. Erdman and R.J. Cook, 'Decriminalization of abortion — A human rights imperative', *Best Practice & Research Clinical Obstetrics and Gynaecology* 62 (2020) 11–24, p. 20–21.

52 *Tysiąc v Poland* App no. 5410/03 (ECHR, 20 March 2007); *A, B, and C v Ireland* App no. 25579/05 (ECHR, 16 December 2010); *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); D. Fenwick, 'The modern abortion jurisprudence under Article 8 of the European Convention on Human Rights', *Medical Law International* 12 (2013) 249–276, p. 274; C. Cosentino, 'Safe and Legal Abortion: An Emerging Human Right? The Long-lasting Dispute with State Sovereignty in ECHR Jurisprudence', *Human Rights Law Review* 15(3) (2015) 569–589.

53 *International Planned Parenthood Federation — European Network* (*IPPF EN*) *v Italy* (10 September 2013) Complaint No. 87/2012; *Confederazione Generale Italiana del Lavoro* (*CGIL*) *v Italy* (12 October 2015) Complaint No. 91/2013.

rights standards support the adoption of positive measures, such as through enabling telemedical and self-managed abortion, as a means of guaranteeing access and removing barriers, preventing unsafe abortion, and as an issue of gender equality.

3.1 *Accessibility and Barriers*

In its General Recommendation 24, CEDAW expanded on the accessibility of healthcare services. States must take steps to 'eliminate barriers that women face in access to health-care services' and 'ensure women timely and affordable access to such services' which includes sexual and reproductive health services.[54] CEDAW also highlighted that women with disabilities may face additional barriers in relation to physical access to healthcare services, which States are under an obligation to address.[55] CESCR commented on the accessibility of sexual and reproductive health services in its General Comment 22, noting that sexual and reproductive healthcare must be 'within safe physical and geographical reach for all' with an emphasis on timely access to services.[56] CESCR has also acknowledged the additional barriers to access for people with disabilities and people living in rural or remote areas, highlighting the need to ensure substantive equality by ensuring accessibility for these groups.[57] This might include dispensing services to remote areas where practicable, ensuring transportation to services, and making accommodations such as ensuring that sexual and reproductive health facilities are physically accessible for people with disabilities.[58] Importantly, CESCR has expanded upon intersectional issues in this Comment, highlighting there are numerous legal, procedural, practical, and social barriers to sexual and reproductive healthcare, which affects marginalised groups in particular.[59]

Telemedical and self-managed abortion can significantly improve access to abortion services for pregnant people who would otherwise face considerable barriers. The ability to take abortion medication at home can minimise the geographical barriers faced by marginalised groups, in particular socio-economically disadvantaged people, people living rurally or significant distances from abortion facilities, and people with disabilities.[60] Attending a facility to take abortion medication may require a pregnant person to rely on

54 CEDAW, 'Gen. Rec. 24', *supra* note 43, paras. 21–23.
55 *Ibid* para. 25.
56 CESCR, 'Gen. Comment 22', *supra* note 43, para. 16.
57 *Ibid*.
58 *Ibid*, paras. 16, 24.
59 *Ibid*, para. 2.
60 S. Calkin, 'Towards a political geography of abortion', *Political Geography* 69 (2019) 22–29, p. 23, 27.

costly or physically inaccessible public transport and incur the additional costs of childcare or taking time off work.[61] In the US and Canada, for example, the costs of travelling to an abortion facility may be significant for pregnant people having to travel to a different state to access an abortion.[62] In a study of pregnant people travelling long distances for an abortion in Utah, some women described denying pain medication after an abortion so that they could drive home immediately afterwards to try and reduce their travel expenses.[63] Further, dedicated abortion clinics tend to be concentrated in urban areas, leaving a dearth of services for rural populations. In India, the reliance on private healthcare providers which 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.[64] For people with disabilities, there are additional barriers if abortion facilities are physically inaccessible or require navigating largely inaccessible transport options. The home use of abortion medication, through full telemedicine or self-managed abortion, can therefore improve accessibility by circumventing these geographical, socio-economic, and physical barriers. This cannot be a substitute for easily accessible abortion facilities as all pregnant people should be able to choose an in-person medical abortion or early surgical abortion if necessary, and access to safe surgical abortion in the later stages of pregnancy will require visiting an abortion facility. However, while telemedical and self-managed abortion cannot eliminate all of the barriers associated with physical inaccessibility, it can circumvent these barriers in relation to early medical abortion.

Telemedical and self-managed abortion can also ensure that pregnant people in situations of vulnerability are able to safely access abortion services. When facing abuse, coercion, or control from an intimate partner, a pregnant

61 *Ibid* p. 23.

62 Lisa R. Pruitt and Marta R. Vanegas, 'Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law', *Berkeley Journal of Gender, Law & Justice* 30 (2015) 76–153; C. Sethna and M. Doull, 'Spatial disparities and travel to freestanding abortion clinics in Canada', *Women's Studies International Forum* 38 (2013) 52–62.

63 K. Ehrenreich and C. Marston, 'Spatial dimensions of telemedicine and abortion access: a qualitative study of women's experiences', *Reproductive Health* 16(94) (2019) 1–10, p. 6.

64 B. Subha Sri and T.K Sundari Ravindran, 'Medical abortion: understanding perspectives of rural and marginalized women from rural South India', *International Journal of Gynaecology and Obstetrics* 118(S1) (2012) 33–39; S. Singh, C. Shekhar, R. Acharya, A.M. Moore, M. Stillman, and M.R. Pradhan, 'The incidence of abortion and unintended pregnancy in India, 2015', *The Lancet* 6(1) (2018) 111–120; R. Yokoe, R. Rowe, S.S. Choudhury, A. Rani, F. Zahir, and M. Nair, 'Unsafe abortion and abortion-related death among 1.8 million women in India', *BMJ Global Health* 4(3) (2019) 1–13.

person may be unable to safely disclose an unwanted pregnancy or abortion, and so accessing abortion medication through telemedicine may be easier to keep secret than a visit to a facility.[65] This also applies to adolescents seeking an abortion without support from an adult, as they may lack the financial means, independence, or transportation to be able to attend an abortion facility without their family members or guardians knowing. Adolescents are among those obtaining abortion medication from online providers as an alternative to in-person care, with a study by Jerman, Onda, and Jones revealing that 41% of those looking for information on self-managed abortion online were minors.[66] The ability to take abortion medication at home is thus an important option for pregnant people in such situations, who would otherwise face risks in accessing abortion care.

Barriers to accessing abortion services compound to disproportionately impact already marginalised groups, reproducing existing structural inequalities. Goodwin has highlighted how poor and Black women in the US are more likely to be disadvantaged in accessing abortion services due to historic socio-economic inequalities.[67] These inequalities have been deepened by the pandemic, with Black and Hispanic abortion seekers in the US disproportionately impacted by COVID-19-related barriers, even in 'abortion friendly' cities.[68] 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.[69] In addition, trans men and gender minorities are likely to face difficulties in accessing abortion services, as trans people are more likely to face multiple marginalisations such as

65 A.R.A Aiken, K.A. Guthrie, M. Schellekens, J. Trussell, and R. Gompers, 'Barriers to accessing abortion services and perspectives on using mifepristone and misoprostol at home in Great Britain', *Contraception* 97(2) (2018) 177–183; E.C. Romanis, J.A. Parsons, I. Salter, and T. Hampton, 'Safeguarding and teleconsultation for abortion', *The Lancet* 398(10299) 555–558, p. 556.

66 J. Jerman, T. Onda, and R.K. Jones, 'What are people looking for when they Google "self-abortion"?', *Contraception* 97(6) (2018) 510–514.

67 M. Goodwin, *Policing the Womb* (Cambridge: Cambridge University Press, 2020) ch. 4.

68 T. Wolfe and Y. van der Meulen Rodgers, 'Abortion During the COVID-19 Pandemic: Racial Disparities and Barriers to Care in the USA', *Sexuality Research and Social Policy* online first, doi: 0.1007/s13178–021–00569–8 (2021).

69 Sethna and Doull, *supra* note 62, p. 56–57; B. Baird, 'Tales of Mobility: Women's Travel and Abortion Services in a Globalized Australia' in C. Sethna and G. Davis (eds.), *Abortion Across Borders* (Baltimore: John Hopkins University Press, 2019) p. 160–161; H. Wurtz, 'Indigenous Women of Latin America: Unintended Pregnancy, Unsafe Abortion, and Reproductive Health Outcomes', *Pimatisiwin* 10(3) (2012) 271–282, p. 273.

being socio-economically disadvantaged.[70] Institutional erasure can also deter trans men and gender minorities from seeking abortion care.[71] Abortion services are often tailored to women; for example, the British Pregnancy Advisory Service, one of the main abortion providers in Britain, states on its website that a woman having an abortion may only be accompanied by a female adult.[72] This exclusion of people perceived as male from entering an abortion clinic therefore excludes trans men and masculine-presenting gender minorities from the outset. In this environment, abortion providers may then misgender pregnant patients who are not women, again deterring trans men and gender minorities from seeking in-person abortion services.[73] Telemedical and self-managed abortion can alleviate some of these intersectional inequities in access to abortion, by circumventing geographical and socio-economic barriers and enabling people to avoid having to attend abortion facilities which are not gender-inclusive.

While CESCR and CEDAW's comments on accessibility refer to sexual and reproductive health services in general, applying them to the abortion context requires states to guarantee the physical accessibility of abortion services. As Calkin notes, there is a tendency to assume that access to abortion requires the pregnant person to be physically present in an abortion facility, which focuses the emphasis on transport and accessible facilities.[74] While states must guarantee physically, geographically, and financially accessible and reachable abortion facilities, providing for telemedical and self-managed abortion is important in order to meet these human rights standards on timely access and

70 N. Ingraham and L. Hann, '"Stigma R us": Stigma management at the intersection of abortion care and transgender care in family planning clinics', *SSM — Qualitative Research in Health* 2 (2022) 1–7, p. 4.

71 On the institutional erasure on trans men around pregnancy, see: A. Hoffkling, J. Obedin-Maliver, and J. Sevelius, 'From erasure to opportunity: a qualitative study of the experiences of transgender men around pregnancy and recommendations for providers', *BMC Pregnancy and Childbirth* 17(332) (2017) 7–20.

72 British Pregnancy Advisory Service, 'Who to bring with you', retrieved 15 March 2022, https://www.bpas.org/abortion-care/supporting-someone-having-an-abortion/who-to-bring-with-you/.

73 H. Moseson, L. Fix, S. Ragosta, H. Forsberg, J. Hastings, A. Stoeffler, M.R. Lunn, A. Flentje, M.R. Capriotti, M.E. Lubensky, and J. Obedin-Maliver, 'Abortion experiences and preferences of transgender, nonbinary, and gender-expansive people in the United States', *American Journal of Obstetrics and Gynecology* 224(4) (2021) 376.e1–11; K. Burns, 'Why I didn't tell my doctor I'm trans before my abortion', *Allure*, 23 November 2020, retrieved 15 March 2022, https://www.allure.com/story/abortion-trans-man-nonbinary-experience; I. Kohn and C. Kasulke, 'The trans men who get abortions', *Mel Magazine,* 2019, retrieved 15 March 2022, https://melmagazine.com/en-us/story/the-trans-men-who-get-abortions.

74 Calkin, *supra* note 60, p. 23.

the removal of barriers. Telemedical and self-managed abortion can alleviate many of these barriers, thereby reducing delays; abortion services become more efficient, and having an abortion is made easier for the pregnant person. In terms of the intersectional barriers highlighted by CESCR, providing telemedical abortion services and facilitating self-managed abortion are important positive measures to reduce the inequalities in access faced by already marginalised groups.

CESCR already requires States to ensure access to the medications on WHO's Model List, which includes mifepristone and misoprostol for abortion and post-abortion care and commented in 2020 on the importance of ensuring access to safe and modern abortion and contraceptive measures, including access to abortion medication.[75] Further, CESCR notes that special attention must paid to scientific research on sexual and reproductive health, which would include advancements in best practice for abortion care.[76] Taking these comments in line with WHO's recommendations on telemedicine and self-care interventions for abortion and the evidence that telemedical and self-managed abortion are both safe and effective, guaranteeing access to abortion services in line with international human rights standards requires states to include telemedical and self-managed abortion as available pathways to safe abortion care. The retention of medically unnecessary restrictions on telemedical and self-managed abortion heightens the barriers to access faced by many pregnant people, in violation of these standards.

The ECtHR has also set out requirements for the accessibility of abortion services, albeit to a much more limited extent. In the three Polish cases, *Tysiąc, R.R., and P and S,* the ECtHR found violations of Convention rights where the applicants had been denied abortion services that they were legally entitled to.[77] The Court indicated that the failure to secure effective access to abortion on the grounds already legalised by the state was a failure to comply with their positive obligation to guarantee the applicants' rights.[78] The ECtHR has been reluctant to expand abortion rights beyond those already guaranteed by the individual state. In *A, B, C v Ireland*, the Court distinguished between applicants A and B, whose arguments related to abortion on grounds not already legalised in Ireland, and C, who should have been legally entitled to an abortion

75 CESCR, 'Gen. Comment 22', *supra* note 43, para. 13; 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.

76 CESCR, 'Gen. Comment 25', *supra* note 75, para. 33.

77 *Tysiac*, *supra* note 52; *R.R.*, *supra* note 52; *P and S*, *supra* note 52.

78 *Tysiac*, *supra* note 52, para. 135; *R.R.*, *supra* note 52, para. 214; *P and S*, *supra* note 52, paras. 99, 112.

but could not access one.[79] These human rights standards on abortion therefore provide more limited support for telemedical and self-managed abortion, as the ECtHR has avoided directing Member States to change their abortion law and policy. However, where the failure to adopt telemedical abortion, for example, is part of broader accessibility issues, this could violate the procedural standards set out by the Court.

3.2 *Unsafe Abortion and Decriminalisation*

The HRC indicated in its 2019 General Comment on the right to life that States have a 'duty to ensure that women and girls do not have to resort to unsafe abortions' which requires measures such as avoiding imposing criminal sanctions on those who undergo or assist with an abortion and the removal of barriers to accessing abortion services.[80] This is supported by statements from CESCR and CEDAW, respectively, on the need to prevent unsafe abortion and lower maternal mortality and morbidity rates, and the criminalisation of abortion as a gender-based issue.[81] As explored in the previous section, medically unnecessary restrictions on abortion reinforce existing barriers to access, and providing for telemedical and self-managed abortion can minimise many of these barriers. However, where these barriers obstruct access to abortion entirely, pregnant people without recourse to safe abortion services will find alternative and potentially unsafe means of terminating their pregnancies. A study of the outcomes of barriers to accessing abortion services in the US found one of the main consequences to be that people attempted to end their own pregnancies through medication, home remedies, or physical trauma.[82] The obligation to prevent unsafe abortion also requires states to remove barriers to access and ensure that safe methods are accessible. As telemedical and self-managed abortion are both safe (with self-managed abortion reducing maternal mortality and morbidity rates in regions with high rates of unsafe abortion) and remove many of the barriers that might lead to unsafe abortion practices, providing for both of these pathways is key to preventing unsafe abortion. In countries where conscientious objection to abortion is widespread, leaving significant regional variation in access to abortion, telemedicine and self-managed abortion can

79 *A, B, and C, supra* note 52, paras. 242, 267.

80 HRC, 'Gen. Comment 36', *supra* note 43, para. 8.

81 CESCR, 'Gen. Comment 22', *supra* note 43, para. 28; CEDAW 'Gen. Rec. 35', *supra* note 49, para. 29; CEDAW, 'Gen. Rec. 24', *supra* note 43, para. 14.

82 J. Jerman, L.F. Frohwirth, M.L. Kavanaugh, N. Blades, 'Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States', *Perspectives on Sexual and Reproductive Health* 49(2) (2017) 95–102, p. 98.

similarly remove this barrier and ensure that pregnant people are not left without access to safe abortion services.[83]

Decriminalising abortion is also particularly important for the safety of self-managed abortion. For self-managed abortion to be safe, pregnant people need access to information on how to properly take abortion medication, legitimate sources of medication, and post-abortion care from formal healthcare institutions without fear of prosecution. CEDAW has expressed concerns over the prosecution and incarceration of pregnant people for having abortions in countries where abortion is illegal, recommending the repeal of criminal provisions and immediate release of pregnant people convicted of abortion-related offences.[84] As the ECtHR observed in *A, B, and C*, the criminalisation of abortion has a 'chilling effect' on healthcare professionals who are reluctant to provide any information on abortion or post-abortion care for fear of prosecution.[85] Healthcare professionals who fear criminalisation may also report patients seeking aftercare following an unsafe abortion; in its 2016 Concluding Observations on El Salvador, CEDAW highlighted that pregnant people were often reported to the authorities when they presented at a hospital in need of treatment.[86] Even where prosecutions for illegal abortion are rare, the criminalisation of abortion nonetheless deters pregnant people from information on safe abortion and from seeking post-abortion care, and healthcare professionals from providing those services — leaving pregnant people at risk of unsafe abortion practices.

In addition to decriminalisation, the obligation to prevent unsafe abortion would also require states to take positive steps towards facilitating self-managed abortion. This includes ensuring that evidence-based information on safe abortion is widely available, removing any medically unnecessary restrictions on the distribution of abortion medications, and facilitating the facilitate the market to ensure the affordability of the drugs.[87] Erdman has highlighted the 'Uruguay Model' of information provision as an effective harm reduction

83 For example, widespread conscientious objection in Italy causes significant inequalities in access to abortion. See: F. Minerva, 'Conscientious objection in Italy', *Journal of Medical Ethics* 41(2) (2015) 170–173.

84 See, for example: CEDAW, 'Concluding observations on the combined eighth and ninth periodic reports of El Salvador', 9 March 2017, UN Doc. CEDAW/C/SLV/CO/8–9, paras. 38–39.

85 *A, B, and C*, *supra* note 52, para. 254.

86 CEDAW, 'El Salvador', *supra* note 84, para. 38.

87 Pizzarossa and Skuster, *supra* note 6, p. 208; Vázquez-Quesada and others, *supra* note 6, p. 93.

strategy.[88] 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.[89] The pregnant person would then be able to access post-abortion care for any complications, with assured confidentiality.[90] Ensuing the availability of information on safe self-managed abortion practices is important, particularly for vulnerable groups such as adolescents who need age-appropriate and reliable guidance and information.[91] The human rights standards set out by the HRC, CESCR, and CEDAW include access to information as necessary to guarantee sexual and reproductive rights.[92] Additionally, Donoghue and Smith highlight that the ECtHR in *R.R.* recognised a right to information in relation to abortion and prenatal genetic testing, and the ECtHR found in *Open Door and Dublin Well Woman v Ireland* that restrictions on counselling agencies from providing information on abortion was a breach of the right to freedom of expression protected under Article 10 of the Convention.[93]

In addition to information provision, abortion medications should be easily accessible. Prandini Assis and Erdman identify a 'new form of abortion criminalization' in Brazil's criminal regulation of the possession and distribution of misoprostol under drug control laws.[94] Numerous countries restrict access to abortion medication by preventing their distribution by pharmacies, restricting imports through customs regulations, and blocking access to online providers such as Women on Web.[95] Such restrictions lead to the unavailability of afford-

88 J.N. Erdman, 'Access to Information on Safe Abortion: A Harm Reduction and Human Rights Approach', *Harvard Journal of Law and Gender* 34 (2011) 413–462.

89 *Ibid* 420–421.

90 *Ibid*.

91 N. Duroseau, M. Loh, L. Sanders, and M. Arden, 'Options for Teens with No Options: A Self-Managed Trimester Abortion', *Journal of Pedriatric & Adolescent Gynecology* 34(2) (2021) 226–227.

92 See, for example: HRC, 'Gen. Comment 36', *supra* note 43, para. 8; CESCR, 'Gen. Comment 14', *supra* note 14, para. 14; CESCR, 'Gen. Comment 22', *supra* note 43; CEDAW, 'Inquiry', *supra* note 43, para. 86.

93 Stephen Donoghue and Claire-Michelle Smyth, 'Abortion for Foetal Abnormalities in Ireland; The Limited Scope of the Irish Government's Response to the *A, B and C* Judgment', *European Journal of Health Law* 20(2) (2013) 117–143, p. 132–133; *Open Door and Dublin Well Woman v Ireland* App no. 14234/88 (ECHR, 23 September 1992).

94 M. Prandini Assis and J.N. Erdman, 'In the name of public health: misoprostol and the new criminalization of abortion in Brazil', *Journal of Law and the Biosciences* 8(1) (2021) 1–20, p. 4, 7.

95 J. Varon, R. Gomperts, M. Xynou, F. Ceratto, and A. Filastò, 'On the blocking of abortion rights websites: Women on Waves & Women on Web', *OONI*, 29 Oct 2019, retrieved

able, reliable, and legitimate sources of abortion medication, increasing the likelihood of unsafe abortion practices.[96] States must therefore decriminalise abortion and ensure access to information and abortion medication for self-managed abortion in order to satisfy human rights standards around preventing unsafe abortion and comprehensive information provision.

3.3 *Acceptability and Discrimination*

CESCR and CEDAW have both set out standards of acceptability in relation to sexual and reproductive healthcare. CEDAW requires that healthcare services are acceptable to women, defining acceptable services as 'those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.'[97] CESCR requires that all sexual and reproductive health facilities, goods, information, and services must be respectful of individuals and communities and sensitive to gender, age, and other characteristics.[98] Cabello and Gaitán have argued that the overmedicalisation of abortion contradicts the requirement in international human rights law that services are acceptable, as such restrictions contradict patient autonomy and are not based on therapeutic considerations.[99] They argue that scientific evidence and human rights standards therefore require States to provide 'increased access to abortifacient drugs in pharmacies and through mail; increased self-managed medical abortions at home; and expanded use of telemedicine counseling for this purpose.'[100] The acceptability standards set out by CEDAW and CESCR support adopting telemedicine and facilitating self-managed abortion as a means of adapting to individual needs and preferences.

Prandini Assis and Larrea argue that, while there is no universal means of improving abortion care, as it must be tailored to individual needs and preferences, there are measures that can make access easier, such as through reducing barriers around abortion medication.[101] The ability to access abortion medication through telemedicine and take the pills at home supports

22 March 2022, https://ooni.org/post/2019-blocking-abortion-rights-websites-women-on-waves-web.

96 Jelinska and Yanow, *supra* note 11, p. 87.

97 CEDAW, 'Gen. Rec. 24', *supra* note 43, para. 22.

98 CESCR, 'Gen. Comment 22', *supra* note 43, para. 20.

99 A.L. Cabello and A.C. Gaitán, 'Safe abortion in Women's Hands: Autonomy and a Human Rights Approach to COVID-19 and Beyond', *Health and Human Rights Journal* 23(1) (2021) 191–197, p. 192–193.

100 *Ibid* p. 192.

101 M.P. Assis and S. Larrea, *supra* note 6, p. 38.

the reproductive autonomy of pregnant people by allowing them to choose where they feel most comfortable having their abortion. Having access to abortion medication through alternative providers, even where abortion is illegal or inaccessible, again enables pregnant people to retain some reproductive autonomy despite the restrictive setting. Studies on the use of telemedicine in England, Wales, and Scotland during the pandemic have demonstrated that this option has high satisfaction rates.[102] In addition to ease of access, pregnant people often prefer to take abortion medication at home as it enables greater flexibility, comfort, and privacy and the ability to be around their chosen support network.[103] The home use of abortion medication will not be the preferred method of all pregnant people, particularly as this requires access to the internet or a phone, access to information, and a safe location to take the pills.[104] It is therefore important the pregnant people are given a choice as to whether they have a medical or surgical abortion, and with medical abortions, whether this happens at home or in a facility.

These arguments are strengthened when taken together with the human rights standards on abortion and gender discrimination, as acceptability also requires the provision of autonomy-focused and gender-sensitive services. The imposition of medically unnecessary restrictions on abortion has been referred to as 'abortion exceptionalism' as abortion is subject to excessive oversight where other medical procedures are not.[105] This exceptionalism is reflective of the continuing stigmatisation of abortion, and feeds into gendered stereotypes around pregnancy. The patriarchal ideals that women should want to become mothers and therefore should prioritise the foetus over their own wellbeing are reinforced through abortion law and policy, where women deciding to have an abortion are deemed selfish or unable to make decisions concerning their

102 Aiken and others, *supra* note 10; M.E. Meurice, K.C. Whitehouse, R. Blaylock, J.J. Chang, and P.A. Lohr, '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', *Contraception* 104(1) (2021) 61–66; Reynolds-Wright and others, *supra* note 10; N. Boydell, J.J. Reynolds-Wright, S.T. Cameron, and J. Harden, 'Women's experiences of a telemedicine abortion service (up to 12 weeks) implemented during the coronavirus (COVID-19) pandemic: a qualitative evaluation', *BJOG: An International Journal of Obstetrics & Gynaecology* 128(11) 1752–1761.

103 Aiken and others, *supra* note 10; Atay and others, *supra* note 28; S.J. Betstadt, K.J. Heyrana, and N.S. Whaley, 'Telemedicine for medication abortion: the time is now', *Current Obstetrics and Gynecology Reports* 9(5) (2020) 66–71.

104 Parsons and Romanis, *supra* note 1, p. 77.

105 Parsons and Romanis, *supra* note 1, p. 13.

pregnancies without medical and legal oversight.[106] The retention of limitations on the home use of abortion medication perpetuate concerns that pregnant people would make reckless or frivolous abortion decisions if they were not supervised by a healthcare professional in a clinic. Likewise, the continued criminalisation of self-managed abortion and the reluctance of governments to ensure that abortion is easily accessible reinforce the idea that abortion is morally wrong. Removing these restrictions and enabling the home use of abortion medication is thus a necessary step to destigmatise abortion and challenge the gendered stereotypes around pregnancy which are embedded in law.

CESCR has linked the decriminalisation of abortion, removal of barriers, and right to make autonomous decisions over one's sexual and reproductive health to the realisation of gender equality, noting that restrictions on abortion such as criminal offences are discriminatory.[107] More recently, CESCR has commented on the need for States to ensure a gender-sensitive approach to sexual and reproductive health, including securing access to abortion on the basis of non-discrimination and equality.[108] CEDAW has stated that it is 'discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women' and recognises the criminalisation of a gendered healthcare service such as abortion as gender-based violence.[109] Additionally, CEDAW has explicitly identified the relevance of gendered stereotypes around pregnancy as relevant to restrictions on abortion. In *L.C. v Peru*, CEDAW found that the refusal of an abortion was influenced by stereotypes around motherhood, placing the protection of the foetus above the health of the pregnant girl.[110] In 2018, CEDAW found that Northern Ireland's abortion portrayed women's primary role as one of motherhood, which sustained negative and stigmatising attitudes towards women who had abortions.[111]

As argued above, abortion exceptionalism reinforces these gender stereotypes and stigmatising attitudes — and States have an obligation to modify socio-cultural prejudices and stereotypes under Article 5 of CEDAW. CESCR notes that substantive equality requires that laws 'do not maintain, but rather

106 M. Boyle, *Re-Thinking Abortion* (Abingdon: Routledge, 1997) p. 28; Sally Sheldon, *Beyond Control* (London: Pluto Press, 1997) p. 36; E. Miller, *Happy Abortions* (London: Zed, 2017) p. 5; J.M.J. Mavuso, 'Understanding the violation of directive anti-abortion counselling [and cisnormativity]: Obstruction to access or reproductive violence?', *Agenda*, 35 (2021), pp. 69–81, p. 70.

107 CESCR, 'Gen. Comment 22', *supra* note 43, paras. 25–29.

108 CESCR, 'Gen. Comment 25', *supra* note 75, para. 33.

109 CEDAW, 'Gen. Rec. 24', *supra* note 43, para. 11; CEDAW, 'Gen. Rec. 35', *supra* note 49, para. 18.

110 *L.C. v Peru, supra* note 44, para. 8.15.

111 CEDAW, 'Inquiry', *supra* note 43, para. 73.

alleviate, the inherent disadvantage that women experience' in exercising their sexual and reproductive rights, as a result of systemic gender-based violence, discrimination, and stereotypes.[112] Human rights standards on the acceptability of sexual and reproductive health services and on gender equality therefore require the removal of medically unnecessary restrictions on abortion which reinforce gender stereotypes, stigmatise pregnant people seeking abortions, and limit reproductive autonomy. Restrictions on telemedicine and self-managed abortion infringe these standards.

Conclusion

International and European human rights standards on abortion emphasise the importance of guaranteeing access to safe abortion services, requiring states to take positive measures to remove barriers to access. In line with the WHO guidance on abortion care, these measures should include providing for telemedical and self-managed abortion as pathways to abortion care that minimise barriers to access and centre the autonomy of the pregnant person. As argued throughout this article, ensuring access to abortion through telemedicine and self-managed abortion is a human rights imperative as these measures will assist states in meeting their human rights obligations in relation to preventing unsafe abortion, improving the accessibility of abortion services, and as an important component of gender equality. However, there are, of course, limitations to current human rights standards on abortion — particularly at the ECtHR level, due to the application of the margin of appreciation — and human rights bodies must continue to evolve these standards to appreciate the importance of ease of access to abortion for all.

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112 CESCR, 'Gen. Comment 22', *supra* note 43, para. 27.