‘Abortion is healthcare’: the promise and pitfalls of framing abortion under the right to health

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<a> INTRODUTION

In recent years, there has been a reiteration of the claim that ‘abortion is healthcare’. Moving away from the mainstream moral debates of ‘life’ and ‘choice’ that are prevalent in Western countries, the healthcare framing seeks to divert attention towards the impacts of unsafe abortion and access to safe, legal abortion services. Public health discourse around unsafe abortion has been a key driver of legislative change at the domestic level, and characterised early international human rights standards on abortion. In seeking to avoid the moral, and therefore political, aspects of abortion, international human rights bodies continue to frame abortion rights standards in this way.

While there is an obvious advantage to doing so, there are also pitfalls to this approach—particularly in the modern era, given the changes in common clandestine abortion methods. In this chapter, I explore the framing of abortion under the right to health (acknowledging its interconnections with other human rights) and how this both supports and limits state obligations to legalise and provide access to abortion services. I begin by looking at the health implications of restricted access to abortion services, before moving on to look at international human rights standards on abortion. I explore how the public health approach underpinning these standards has been useful in pushing for legalised abortion, but fails to recognise the reality of many people who self-manage their own abortions outside of medical institutions. Given the numerous barriers to accessing affordable and comprehensive healthcare in many countries, I support the claims of scholars who advocate for ‘de-medicalising’ abortion

under a health and human rights approach. However, this cannot be taken to undermine state obligations to provide safe, accessible, and affordable abortion services.

<a> ABORTION AND HEALTH

The lack of access to abortion services has well-documented implications for a pregnant person's physical health.[1] Almost half of all abortions performed worldwide are unsafe as a result of dangerous abortion methods (inside and outside of the medical sphere), carrying the potential for complications such as incomplete abortion, internal damage, haemorrhage, or infection.[2] These issues may require hospital treatment, and can even be fatal; an estimate of between 4.7-13.2% of annual maternal deaths worldwide can be attributed to unsafe abortion (though abortions and abortion-related deaths are underreported, so this may be an underestimate).[3] These deaths are avoidable, as abortions using the evidence-based methods recommended by the World Health Organization (WHO), when carried out in line with proper training or guidance, are extremely safe.[4] Unsafe abortions therefore occur largely due to the failure of a state to legalise or provide abortion services, or where healthcare providers have not been trained to use safe, evidence-based methods. Thus, the WHO defines unsafe abortion by reference to 'the lack or inadequacy of skills of the provider, hazardous techniques and unsanitary facilities.'[5]

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[1] Throughout this chapter, I use the terminology of 'pregnant person' to acknowledge the fact that some trans, non-binary, and gender expansive people, as well as cisgendered women, can become pregnant and may require access to abortion services. The lack of inclusive language in abortion care can drive people away from these services, and is therefore of central importance when discussing healthcare and universal access to safe abortion.
[2] Bela Ganatra, Caitlin Gerdts, Clémentine Rossier and others, 'Global, regional, and subregional classification of abortions by safety, 2010-14: estimates from a Bayesian hierarchical model' (2017) 390 *Lancet* 2372, 2377.
[3] Lale Say, Doris Chou, Alison Gemmill and others, 'Global causes of maternal death: a WHO systematic analysis' (2014) 2(6) *Lancet Global Health* 323, 326-327.
[4] World Health Organization, *Abortion Care Guideline* (8 March 2022) <https://www.who.int/publications/i/item/9789240039483> accessed 30 July 2024.
[5] Technical Working Group on the Prevention and Management of Unsafe Abortion and World Health Organization, *The Prevention and management of unsafe abortion: report of a technical working group, Geneva, 12-15 April 1992* (1993) <https://iris.who.int/handle/10665/59705> accessed 30 July 2024, p.3.

There are three key points to note in relation to the definition and causes of unsafe abortion. Firstly, and as I will explore later in this chapter, not all clandestine abortions are unsafe, just as not all legal abortions are safe. The WHO definition on unsafe abortion takes into account that the legality or illegality of abortion services 'may not be the defining factor of their safety.'[6] Further, as Ganatra et al highlight, risk and safety run 'along a continuum' and are affected by a number of determinants, such as gestational age, method used, and access to information on safe termination.[7] Secondly, the criminalisation of abortion has a significant impact on unsafe abortion practices. There is a direct association between restrictive legislation and the number of unsafe abortions, as people facing unwanted pregnancies continue to have abortions regardless of the legal landscape.[8] This association is not only due to a lack of safe, legal abortion services provided by the state, but also because pregnant people who do then use unsafe methods may avoid seeking follow-up care from a formal healthcare provider out of fear of prosecution. Indeed, Fernandez-Anderson notes that public healthcare providers in Latin America often report patients who are suspected of illegal abortions to the police.[9]

Thirdly, while the law does therefore shape the safety of abortion, broader structural and socio-economic issues can affect abortion service delivery, particularly in lower-income states lacking the resources and infrastructure to implement comprehensive reproductive healthcare, or even basic healthcare, services. As such, approximately 97% of unsafe abortions take place in underdeveloped countries, with Asia, Africa, and Latin America accounting for the most unsafe abortions.[10] In 2012 alone, 6.9 million people in underdeveloped countries

[6] Ibid.
[7] Bela Ganatra, Özge Tunçalp, Heidi Bart Johnston and others, 'From concept to measurement: operationalizing WHO's definition of unsafe abortion' (2014) 92(3) *Bulletin of the World Health Organization* 155, 155.
[8] Ganatra, Gerdts, Rossier and others (n2) 2377.
[9] Cora Fernández Anderson, *Fighting for Abortion Rights in Latin America* (Routledge, 2020) p.35.
[10] Ganatra, Gerdts, Rossier and others (n2) 2373.

were hospitalised for complications resulting from unsafe abortion.[11] Importantly, country income level can affect safety more than criminalisation; Ganatra et al found that the proportion of least safe abortions was significantly higher in lower-income countries with restrictive laws than in higher-income countries with similar laws.[12] The legal status of abortion is not the sole indicator of abortion safety, so a health-based focus on abortion must recognise the importance of universal healthcare service delivery and the impact of global inequalities.

While much of the health-based discourse around abortion focuses on physical health and maternal mortality, Sifris recognises that 'the mental health effects often fall under the radar'.[13] The WHO defines health as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[14] At the International Conference on Population and Development 1994 in Cairo (ICPD), where reproductive rights were formally recognised as part of the human rights agenda, this definition was adopted as the definition of reproductive health insofar as it applies to 'all matters relating to the reproductive system and to its functions and processes'.[15] Mental health and social wellbeing is therefore an important aspect of reproductive rights including abortion, and feminist scholars have documented the mental and social effects of restrictions on abortion. Sherwin has highlighted the tendency of non-feminist discussions on abortion to portray pregnancy as a tolerable burden, ignoring the toll that even a wanted pregnancy has on a pregnant person.[16] Mental health problems such as postnatal depression, anxiety, and post-traumatic stress disorder can follow childbirth, which

[11] S. Singh and I. Maddow-Zimet, 'Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world. 2012: a review of evidence from 26 countries' (2015) 123(9) *BJOG* 1489, 1495.
[12] Ganatra, Gerdts, Rossier and others (n2) 2377.
[13] Ronli Sifris, 'Restrictive Regulation of Abortion and the Right to Health' (2010) 18 *Medical Law Review* 185, 199.
[14] World Health Organization, *Basic Documents* (49th Edn, 2020) <https://apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf> accessed 30 July 2024, p.1.
[15] UN, 'Programme of Action of the International Conference on Population and Development' (5-13 September 1994) UN Doc. A/CONF.171/13, para. 7.2.
[16] Susan Sherwin, 'Abortion Through a Feminist Ethics Lens' (1991) 30(3) *Dialogue* 327, 333.

is even more likely where a person was forced to continue an unwanted pregnancy against their will. Sifris thus argues that 'restricting a woman's capacity to exercise a difficult choice is fraught with the potential for untold mental health consequences.'[17] This potential is heightened where the pregnancy results from rape or where the foetus has a serious or fatal impairment.

While it is relatively common to see references to physical and mental health in abortion legislation, abortion for 'social reasons' is often viewed negatively. There is a normative distinction drawn between abortions for 'medical' and 'social' reasons; reasons for which a pregnant person 'chooses' to reject a pregnancy are viewed by some as less morally justifiable than medical grounds, which exist to prevent serious harm. Abortions for non-medical reasons have historically been portrayed as 'deviant' or 'selfish'—women were, and continue to be, expected to fulfil their maternal role.[18] However, Kaposy argues that abortions for social reasons *are* medically necessary, as social wellbeing is encompassed in the World Health Organization's definition of health and denying someone an abortion for social reasons therefore risks their health.[19] Social wellbeing goes beyond mere autonomous choice but encompasses the relational and embodied aspects of pregnancy, including the impact of a pregnancy on one's lived experiences, relationships, and identity. However, recognising the violation of bodily autonomy resulting from being denied an abortion has also been central to feminist thinking on abortion. Thomson, in her famous violinist analogy, highlighted the implications of the non-consensual use of one's body to keep another alive.[20] The violation of bodily autonomy, and the estrangement from one's own body when faced with an unwanted

[17] Sifris (n13) 199.
[18] Katrina Kimport and Lori Freedman, 'Abortion: A Most Common Deviance' in Stephen E. Brown and Ophir Sefiha, *Routledge Handbook on Deviance* (Routlegde, 2017); Sally Sheldon, *Beyond Control: Medical Power and Abortion Law* (Pluto Press, 1997) p.36. For more on the gender stereotypes around motherhood, see Ellie Lee, *Abortion, Motherhood, and Mental Health* (Aldine de Gruyter, 2003); Rosalind Petchesky, *Abortion and Women's Choice: The State, Sexuality, and Reproductive Freedom* (Northeastern University Press, 1990).
[19] Chris Kaposy, 'The public funding of abortion in Canada: going beyond the concept of medical necessity' (2009) 12 *Medicine, Health Care, and Philosophy* 301, 304.
[20] Judith Jarvis Thomson, 'A Defense of Abortion,' (1971) 1 Philosophy and Public Affairs 47.

pregnancy that must be carried to term, is an embodied harm that cuts across physical, mental, and social wellbeing.[21] 'Health' must be interpreted broadly in the context of abortion, to encompass the complex and multidimensional impacts that restrictions can have on a pregnant person's overall wellbeing and bodily autonomy. Reproductive autonomy is therefore fundamental to a person's health.

The recognition that safe, legal abortion is vitally important for the health and wellbeing of people capable of becoming pregnant has translated to the framing of abortion services as 'essential' or 'necessary' healthcare.[22] The implication of this is to place an onus on the state to not only legalise abortion, but to ensure that abortion services are provided alongside other healthcare services, without unnecessary barriers to access. In the United States, following the Supreme Court's overturning of the constitutional right to abortion established in *Roe v. Wade*, many states have enacted restrictive abortion laws.[23] In response, a number of scholars have sought to highlight that this is the deprivation of access to essential reproductive healthcare in violation of human rights, and as a result, has increased health disparities across the country.[24] In framing abortion as healthcare, scholars seek to move the debate away from moral issues around the status of the fetus; in Watson's words, shifting 'us from the ethics of the act of

[21] For more on the embodied harms of abortion restrictions, see Zoe L. Tongue, 'Locating Abortion and Contraception on the Obstetric Violence Continuum' (2024) 17(1) *International Journal of Feminist Approaches to Bioethics* 1, 12-14.
[22] See, for example, Elizabeth Chloe Romanis, 'Abortion Access and the Benefits and Limitations of Abortion-*Permissive* Legal Frameworks: Lessons from the United Kingdom' (2023) 32(3) *Cambridge Quarterly of Healthcare Ethics* 378, 379-380; Evie Kendal, 'All abortions are medically necessary' (2023) 18(3) *Clinical Ethics* 306; Nathan Emmerich, 'We should not take abortion services for granted' (2022) 18(1) *Clinical Ethics* 1.
[23] *Dobbs v. Jackson Women's Health* (2022) 597 U.S. 215. For a commentary on the impacts of this decision, see Elizabeth Chloe Romanis, 'The end of (reproductive) liberty as we know it: A note on *Dobbs V. Jackson Women's Health* 597 USC _ (2022)' (2023) 23(1) *Medical Law International* 71.
[24] Michele B. Goodwin, Rebecca B. Reingold, and Lawrence O. Gostin, 'Abortion Is Health Care' (2024) 331(7) *JAMA* 557, 558; Enze Xing, Rieham Owda, Charisse Loder, and Kathleen Collins, 'Abortion rights are health care rights' (2023) 8(11) *JCI Insight* 1, 3; Katie Watson, 'The Ethics of Access: Reframing the Need for Abortion Care as a Health Disparity' (2022) 22(8) *The American Journal of Bioethics* 22.

abortion to the ethics of access to abortion care'.[25] This is, in many ways, a similar approach to that which has been taken by international human rights bodies.

<a> ABORTION, HUMAN RIGHTS, AND THE RIGHT TO HEALTH

While the ICPD recognised reproductive rights and family planning as important human rights issue, abortion was marginalised within the Programme of Action. Abortion was framed as a public health issue, with concerns raised over maternal mortality and morbidity.[26] However, the criminalisation of abortion was not identified as a contributing factor to unsafe abortion, and the Programme recommended that 'every attempt should be made to eliminate the need for abortion' through the provision of family planning services.[27] While the provision of sexual and reproductive health education and access to contraception is an important aspect of reproductive rights, the language of 'eliminating' abortion frames abortion as an inherently negative event. Watson argues that abortion instead must be recognised as a 'moral good'.[28] Scholars have identified the influence of the Catholic Church, supported by a number of governments, who were against the inclusion of abortion as this would have placed obligations on states to legalise and provide those services.[29] The sparce mentions of abortion in an otherwise progressive Programme has been referred to as the 'Cairo compromise'.[30] This compromise has been critiqued by some scholars for completely ignoring the harms of criminalising abortion, but Sommer and Forman-Rabinovici note the significance of moving

[25] Watson (n24) 23.
[26] UN (n15) para. 8.19.
[27] Ibid para. 8.25.
[28] Katie Watson, 'Abortion as a moral good' (2019) 393 *The Lancet* 1196.
[29] 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); Joanna N. Erdman, 'Abortion in International Human Rights Law' in Sam Rowlands (Ed), *Abortion Care* (Cambridge University Press, 2014) p.245; Udi Sommer and Aliza Forman-Rabinovici, *Producing Reproductive Rights* (Cambridge University Press, 2019) p.173.
[30] Berer (n29).

abortion 'out of the realm of moral policy and into the realm of public health'.[31] In doing so, the ICPD enabled international human rights bodies to (cautiously) approach abortion under the frame of public health.

One of the first explicit mentions of abortion by an international human rights treaty body was by the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee) in 1999, in its General Recommendation 24 on the Right to Health.[32] The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) contains a right to health (Article 12) which requires states to '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, *including those related to family planning*.'[33] In its General Recommendation, the CEDAW Committee highlighted the importance of access to sexual and reproductive healthcare, and while it did not explicitly call for the provision of legal abortion services, it did recommend that 'legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion.'[34] The Committee on Economic, Social, and Cultural Rights (CESCR) took longer to address abortion, making no explicit mention of it in its 2000 General Comment 14 on the right to health, nor its 2005 General Comment 16 on the right to equality between men and women.[35] In the latter, however, provision for abortion could be implied in the call for 'the removal of legal restrictions on reproductive health provisions'.[36]

[31] Ibid p.153-154; Sommer and Forman-Rabinovici (n29) p.180.
[32] CEDAW, 'General Recommendation No. 24: Article 12 of the Convention (Women and Health)' (1999) UN Doc. A/54/38/Rev.1.
[33] UN General Assembly, 'Convention on the Elimination of All Forms of Discrimination Against Women' (18 December 1979) UN Treaty Series Vol. 1249, Article 12 [emphasis added].
[34] CEDAW (n32) para. 31(c).
[35] 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; 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.
[36] CESCR (n3~~5~~4, 2000~~5~~) para. 29.

In subsequent years, the international human rights approach to abortion has evolved significantly. While there is no standalone right to abortion in the UN system, the impacts of restrictions on abortion have been addressed under the rights to life, freedom from cruel, inhuman, and degrading treatment, privacy, non-discrimination, gender equality, health, and the right to decide on the number and spacing of one's children.[37] The Human Rights Committee (HRC) recognised the impacts of restrictive abortion laws in a number of individual communications, and now requires states to, as a minimum, legalise abortion where the health or life of the pregnant person is at risk, where the pregnancy resulted from sexual crime, and where the foetus has a fatal impairment.[38] Moreover, the HRC has taken an expansive approach under the right to life, in recognising the risks associated with clandestine abortion; abortion regulations must not threaten the right to life or cause physical or mental pain or suffering, and states must remove criminal sanctions so that pregnant people do not resort to unsafe abortion.[39] In 2016, CESCR also called for the decriminalisation of abortion in order to prevent unsafe abortion and lower maternal morbidity and mortality rates.[40] Thus, the HRC, CESCR, and CEDAW Committee now all require states to decriminalise abortion; criminal offences for abortion, due to their public health implications, are a human rights violation. The UN therefore draws a distinction between decriminalisation, referring to the removal of criminal offences, and legalisation, referring to the authorisation and provision of abortion services.

Regional human rights systems have also developed their own approaches to abortion, to varying degrees. The European Court of Human Rights (ECtHR), while reluctant to direct

[37] For an overview, see Christina Zampas and Jaime M. Gher, 'Abortion as a Human Right—International and Regional Standards' (2008) 8(2) *Human Rights Law Review* 249; Rebecca J. Cook and Bernard M. Dickens, 'Human Rights Dynamics of Abortion Law Reform' (2003) 25(1) *Human Rights Quarterly* 1.
[38] *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; HRC, 'General Comment No. 36: Article 6 (Right to Life)' (3 September 2019) UN Doc. CCPR/C/GC/36, para. 8.
[39] HRC (n38) para. 8.
[40] 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, para. 49(a).

states to legalise abortion in any particular circumstances, does recognise a procedural right of access under the right to private and family life, meaning that where a state has legalised abortion, it must be accessible in practice.[41] The ECtHR's socio-economic counterpart, the European Committee of Social Rights, has also addressed barriers to accessing abortion as a violation of the right to health.[42] The Maputo Protocol to the African Charter on Human and Peoples' Rights is the only human rights treaty to explicitly include a right to abortion, albeit a somewhat limited one; under a broader right to sexual and reproductive health, states must authorise abortion in cases of sexual crime and where the continued pregnancy endangers the life or health of the pregnant person or foetus.[43] However, compliance with this right has not been substantively monitored or enforced.[44] Finally, the Inter-American system is yet to explicitly address abortion, but scholars have highlighted the likelihood that it would subscribe, at least in terms of minimal standards, to the international human rights position and would therefore provide much-needed support for decriminalisation in the region.[45]

Sifris highlights the importance of framing abortion under a range of rights, as human rights bodies have done, as it is 'inadequate to only consider restrictions on abortion through the lens of one particular fundamental rights as such, a one-dimensional approach invariably results in an oversimplification of the ways in which women experience a denial of legal abortion services'.[46] The specific gender-based rights contained in CEDAW, for example, mean

[41] See *A, B, and C v Ireland* App no. 25579/05 (ECHR, 2010); Chiara Cosentino, "Safe and Legal Abortion: An Emerging Human Right? The Long-lasting Dispute with State Sovereignty in ECHR Jurisprudence" (2013) 15 *Human Rights Law Review* 569.
[42] See *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.
[43] African Union, Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (11 July 2003), Article 14(2)(c).
[44] Charles Ngwena, 'Access to Safe Abortion as a Human Rights in the African Region: Lessons from Emerging Jurisprudence of UN Treaty Monitoring Bodies' (2013) 29 *South African Journal of Human Rights* 399, 401.
[45] Rebecca Smyth, 'Abortion in International Human Rights Law: Missed Opportunities in *Manuela v El Salvador'* (2024) 32 *Feminist Legal Studies* 123; Patricia Palacios Zuloaga, 'Pushing Past the Tipping Point: Can the Inter-American System Accommodate Abortion Rights?' (2021) 21(4) *Human Rights Law Review* 899.
[46] Sifris (n13) 189.

that the CEDAW Committee has been able to go further than the other two UN bodies mentioned here in recognising the ways in which abortion restrictions perpetuate harmful gender stereotypes and infringe upon reproductive autonomy.[47] This is just as important as recognising the implications of criminalisation for the right to life, in capturing the expansive harms associated with restricting abortion. However, advocating for comprehensive access to abortion services warrants a focus on the right to health, under which CESCR and the CEDAW Committee have addressed broader issues with healthcare provision.

Under the right to health, CESCR has expanded on state obligations around sexual and reproductive healthcare, including access to abortion. In its General Comment 22 on sexual and reproductive rights, CESCR highlighted the need for 'unhindered access to a whole range of health facilities, goods, services and information' including safe abortion and post-abortion care, delivered by trained providers.[48] This provision should comply with several key elements: availability, accessibility, acceptability, and quality. Under availability, CESCR requires states to have an adequate number of facilities, services, and personnel for the population and ensure access to essential medicines, including those for medical abortion.[49] Accessibility means physical accessibility, recognising the additional barriers for people with disabilities and those living rurally, affordability, such as through the provision of health insurance for those unable to pay for their healthcare, and information accessibility, taking into account the needs of different people by, for example, providing information in different formats and languages.[50] Acceptability relates to the needs of different people and cultures, and quality requires all services to be evidence-based and medically appropriate.[51] In General Comment 25, addressing scientific advancements, CESCR highlight the importance of ensuring access to safe and

[47] See *L.C. v Peru* (2011) UN Doc. CEDAW/C/50/D/22/2009, para. 8.15.
[48] 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, para. II.
[49] Ibid paras. 12-14.
[50] Ibid paras. 15-19.
[51] Ibid paras. 20-21.

modern methods of abortion, including by providing the abortion medications misoprostol and mifepristone, which are on the WHO Model List of Essential Medicines.[52] These standards thus require states to provide universal access to sexual and reproductive healthcare, including abortion using evidence-based methods and gender-sensitive delivery, and to actively address or remove barriers that would leave people without timely access to care.

The CEDAW Committee has also highlighted the importance of ensuring practical access to abortion services. In its 1999 General Comment, the CEDAW Committee highlighted the need for timely and affordable access to sexual and reproductive health services.[53] The Committee also noted that states should address barriers to access such as far distances from healthcare facilities and a lack of affordable and convenient public transport.[54] The CEDAW Committee has also addressed issues in individual states where abortion is legal but not accessible to all, for example commenting on the lack of access to safe abortion in rural areas in South Africa and the underfunding of reproductive healthcare, including for abortion, in India.[55] CEDAW has also expressed concern over regulatory barriers that impede access, such as requirements in Hungary that a pregnant person undergo mandatory counselling, a three-day waiting period, and must listen to the foetal heartbeat before they can have an abortion.[56] CEDAW and CESCR both accept that healthcare providers may raise conscientious objections to abortion, and thus refuse to provide abortion services, but require a balancing of rights by recommended that states impose mandatory referral requirements so that a healthcare provider

[52] 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.
[53] CEDAW (n32) para. 21.
[54] Ibid.
[55] CEDAW, 'Concluding Observations on the Fifth Periodic Report of South Africa' (23 November 2021) UN Doc. CEDAW/C/ZAF/CO/5, paras. 53-54; CEDAW, 'Concluding Observations on the Combined Fourth and Fifth Periodic Reports of India' (24 July 2014) UN Doc. CEDAW/C/IND/CO/4-5, paras. 30-31.
[56] CEDAW, 'Concluding Observations on the Ninth Periodic Report of Hungary' (2 March 2023) UN Doc. CEDAW/C/HUN/CO/9, paras. 35-36.

must refer the patient to a non-objecting provider.[57] Thus, international human rights bodies are not only concerned with the legal status of abortion, but the way in which it gets provided, funded, and regulated by governments and healthcare institutions.

These standards can be interpreted expansively to support access to abortion on broad grounds. Scholars have argued, for example, that the obligation on states to prevent unsafe abortion supports the legalisation and provision of abortion on request, or at least for socio-economic reasons.[58] Moreover, under the ICESCR, laws that unreasonably restrict safe abortion services would be non-compliant with international human rights and would be viewed as poor public health policy.[59] Critical of the ICPD compromise position on abortion, Berer argues that the 'moral judgment on abortion constantly trumps the public health imperative to save women's health and lives' throughout the Programme of Action.[60] However, the ICPD's promotion of sexual and reproductive rights was a gateway for the recognition of abortion by international human rights bodies, as highlighted above. The public health framing was instrumental for advancing these standards, and Berer concedes that the international position on abortion would have been worse off if not for the Cairo compromise.[61] Such a compromise was necessary in order to work around the opposition to abortion both at the ICPD and the UN; several countries entered reservations to the ICPD Programme of Action insofar as abortion was concerned, despite its already limited inclusion, and to the right to decide on the number and spacing of one's children contained in CEDAW (Article 16(e)).[62]

[57] Ibid; CESCR, 'Concluding Observations on the Sixth Periodic Report of Poland' (26 October 2016) UN Doc. E/C.12/POL/CO/6, paras. 46–47.
[58] Zampas and Gher (n37) 255; 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 *BMC Public Health* 1, 12.
[59] Cook and Dickens (n37) 16.
[60] Berer (n29) 153.
[61] Ibid 162.
[62] UN (n15) Annex I; 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.

In the face of opposition, international human rights bodies at the UN level have taken this compromise position far under the public health framing, albeit short of recognising a guaranteed right to abortion. While the ECtHR takes a much more deferential position, and has not yet directed states to legalise abortion in any circumstances, the HRC, CESCR, and CEDAW Committee have all held states accountable for the violation of human rights by failing to decriminalise and provide abortion services in their Concluding Observations on individual states. In this respect, the public health framing has been significant for advancing an emerging right to abortion at the international and domestic level. There are, however, also notable limitations to this approach, which will be considered in the following section.

<a> PUBLIC HEALTH: PROMISE AND PITFALLS

Public health has been the key impetus for the legalisation of abortion in many countries, including Britain, where concern over the number of hospitalisations associated with illegal abortion led to the passing of the Abortion Act 1967.[63] The use of public health evidence sheds light on the realities of unsafe abortion and can trigger action on an otherwise contentious issue, and human rights rhetoric then provides normative support for this change.[64] The development of international human rights standards on abortion and public health has thus further enabled abortion law reform at the domestic level, particularly when supported by social movements and national courts.[65] In Argentina, for example, the National Campaign for Legal, Safe, and

[63] See Madeleine Simms, 'Abortion Law Reform in Britain in the 1960s—What were the Issues Then?' in Ellie Lee (Ed), *Abortion Law and Politics Today* (Palgrave Macmillan, 1998).
[64] Mahmoud F. Fathalla, 'Safe abortion: The public health rationale' (2020) 63 *Best Practice & Research Clinical Obstetrics and Gynaecology* 2, 2; Joanna N. Erdman, 'Harm reduction, human rights, and access to information on safer abortion' (2012) 118 *International Journal of Gynecology and Obstetrics* 83, 84; Rachel Rebouché, 'Abortion Rights as Human Rights' (2016) 25(6) *Social & Legal Studies* 765, 777.
[65] Zoe L. Tongue, 'Protest as Human Rights Realisation: Lessons from Abortion Rights Movements' *Heidelberg Journal of International Law* [forthcoming]; Johanna B. Fine, Katherine Mayall, and Lilian Sepúlveda, 'The Role

Free Abortion (the 'Campaign') lobbied for the decriminalisation of abortion since its creation in 2005, and repeatedly introduced a law reform bill into Congress until it was eventually passed in December 2020.[66] The legislation removed the criminal offence for terminating one's own pregnancy, permits abortion on request up to 14-weeks' gestation, and after this period in cases of rape or where there is a risk to the life or health of the pregnant person.[67] Significantly, the legislation explicitly states that there is need to prevent maternal mortality as a result of unsafe abortion, and that its provisions have been framed in accordance with several human rights treaties, including CEDAW.[68] Prior to decriminalisation, it had been estimated that unsafe abortion accounted for 20% of the country's maternal mortality rate.[69] Framing access to abortion as a public health and human rights imperative at the local level enabled the Campaign to successfully advocate for reform.

By comparison, in India, the courts have advanced sexual and reproductive rights, with reference to international human rights standards, under the fundamental rights protected by the Indian Constitution. While there is no standalone right to health in the text of the Constitution, the courts have developed the right to health under the right to life and personal liberty (Article 21).[70] This has, in turn, been interpreted to include reproductive rights such as access to maternal healthcare and abortion services.[71] In 2009, the Indian Supreme Court stated that 'a woman's right to make reproductive choices is also a dimension of "personal liberty" as understood under Article 21 of the Constitution of India' which include those choices

of International Human Rights Norms in the Liberalization of Abortion Laws Globally' (2017) 19(1) *Health and Human Rights Journal* 69.

[66] See María Alicia Gutiérrez, 'The National Campaign for Abortion in Argentina: Lessons Learnt' in Birte Siim and Pauline Stoltz (Eds), *The Palgrave Handbook of Gender and Citizenship* (Palgrave Macmillan, 2024).

[67] Voluntary Interruption of Pregnancy Law 2020, Articles 4; 14-18.

[68] Ibid Articles 3, 5.

[69] Fernández Anderson (n9) p.60.

[70] See *Paschim Banga vs State of West Bengal* (1996) AIR Supreme Court 2426, para. 651; *Navtej Singh Johar vs Union of India* (2018) AIR Supreme Court 4321, para. 78.

[71] Zoe L. Tongue, 'Litigating Reproductive Rights: Public Interest Litigation on Maternal Healthcare and Abortion Access in India' (2021) 24 *Trinity College Law Review* 55.

'exercised to procreate as well as to abstain from procreating'.[72] While abortion was legalised in India by the Medical Termination of Pregnancy Act 1971, unsafe abortion is widespread—particularly for socio-economically disadvantage people and in rural areas where there is insufficient access to healthcare.[73] These issues have been addressed by the Indian courts, with reference to international human rights obligations including those set out by CESCR and the CEDAW Committee.[74] For example, in a 2022 case concerning unmarried women's access to abortion, the Supreme Court commented on the prevalence of unsafe abortion due to a number of hurdles to safe, legal services, and reiterated the positive obligations of the state to provide affordable and high quality sexual and reproductive health services, including in rural areas.[75] Krishna highlights the fact that barriers to abortion care nonetheless remain, but the Supreme Court has been able to expand legal access somewhat under a health and human rights frame by extending the gestational time limit (to 20 weeks ordinarily, and 24 weeks under special circumstances) and ensuring that unmarried pregnant people can access abortion services.[76]

In countries where abortion remains heavily restricted, healthcare providers have been able to use the 'health exception' as a means of harm reduction. The 'health exception' refers to the legal ground permitting abortion in order to protect the life or health of the pregnant person, which many countries include as an exception to a prohibition on abortion. Where the health exception is the only legal ground for abortion, access to abortion services can be expanded slightly through a broad interpretation of health. Even a restrictive life-saving exception can encompass mental health grounds including the risk of suicide; this was the case in Ireland prior to 2018.[77] However, González Vélez critiques the assumption that the pregnant

[72] *Suchita Srivastava vs Chandigarh Administration* (2009) 14 SCR 989, para. 11.
[73] Ryo Yokoe, Rachel Rowe, Saswati Sanyal Choudhury and others, 'Unsafe abortion and abortion-related death among 1.8 million women in India' (2019) 4 *BMJ Global Health* 1, 4.
[74] *X vs Health and Family Welfare Department* (2022) AIR Supreme Court 1321, paras. 59; 123-128.
[75] Ibid para. 129.
[76] Geetanjali Krishna, 'Abortion in India: legal, but not a woman's right' (2022) 379 *BMJ* 2733.
[77] Protection of Life During Pregnancy Act 2014 [Ireland].

person's life must be in imminent danger for the health exception to apply, instead looking to the WHO's approach in that a risk of adverse harm is sufficient.[78] In Argentina, prior to the broader legalisation of abortion in 2021, some healthcare providers were willing to interpret the health exception as applying for 'bio-psycho-social' reasons; in other words, where a person's mental and social wellbeing would be adversely affected by a pregnancy.[79] In both Argentina and Uruguay, again before the legalisation of abortion, some healthcare providers would offer abortion counselling as a harm reduction strategy, to ensure that pregnant people had information on how to safely self-manage their own abortions and knew how to obtain misoprostol from a legitimate source.[80] Following from drug-related harm reduction strategies, this approach acknowledged that clandestine abortions would continue to happen, so the focus ought to be on reducing their potential harm. As discussed above, international human rights law provides the 'normative validation' for a health-based harm reduction approach.[81] As such, this approach within international human rights law has supported legislative, medical, and policy-related changes to enable access to abortion at least in some circumstances.

However, the 'social' element of reproductive health is often overlooked, including by international human rights bodies. CESCR and the HRC place significant emphasis on maternal mortality and unsafe abortion as a threat to life or health, and thus advocate for decriminalisation as a means of harm reduction. While this approach has the potential, as discussed above, to advance abortion law reform, it also has significant limitations. In tying the justification for abortion to the risks involved in clandestine abortion, access to abortion is not presented as a social good, but rather as the lesser of two evils. Abortion has been

[78] Ana Cristina González Vélez, '"The health exception": a means of expanding access to legal abortion' (2012) 20(40) *Reproductive Health Matters* 22, 22.
[79] Julia McReynolds-Pérez, 'Abortion as empowerment: reproductive rights activism in a legally restricted context' (2017) 17(Suppl 2) *BMC Pregnancy and Childbirth* 95, 96.
[80] *Ibid* 98; Ana Labandera, Monica Gorgoroso, and Leonel Briozzo, 'Implementation of the risk and harm strategy against unsafe abortion in Uruguay: From a university hospital to the entire country' (2016) 134(1) *International Journal of Gynecology & Obstetrics* 7.
[81] Erdman (n64) 84.

recognised as a good in terms of its importance for gender justice, economic equality (given the economic cost of childrearing), and autonomous reproductive decision-making.[82] Herring further argues that abortion is a 'public good' from an ethics of care approach by promoting flourishing relationships.[83] If access to abortion is necessary for social wellbeing, as argued above, then it is a social good. This does not mean that all abortions will be experienced positively, as each abortion experience is personal and subjective, but rather that access to abortion benefits society (and in particular, people capable of becoming pregnant) at large.

Thus, while some view the public health approach as one which avoids weighing in on the morality of abortion,[84] I argue otherwise. There is, under a public health approach, a threshold of physical or mental harm that must be met (or risk being met) before abortion becomes morally justifiable. As Waltz argues, 'formations of moral categories are not eliminated entirely through the new focus on healthcare' as the morality of abortion simply becomes associated with the 'legitimate enforcement' of abortion provisions.[85] In this context, moral legitimacy is ascribed to abortion by reference to the risk of maternal death or injury. This implication of morality, while not explicit, nonetheless contributes to the stigmatisation of some abortions; many abortions take place in circumstances where there is little risk of harm or suffering. This approach ignores the social harms of abortion restrictions, in terms of the reproductive autonomy of people capable of becoming pregnant and the importance of this for substantive gender equality.

As mentioned above, the gendered harms of abortion restrictions have been recognised by the CEDAW Committee, in acknowledging that such bans perpetuate harmful gender-based

[82] Watson (n28) 1197.
[83] Jonathan Herring, 'Ethics of Care and the Public Good of Abortion' (2019) 1 *Ox. Hum. Rts. Hub J.* 1.
[84] See Fathalla (n64) 2.
[85] Charlotte Waltz, 'Abortion as healthcare: The adaptability of medicalization and legalization in post-repeal anti-abortion politics' (2023) 4 *Feminist Anthropology* 188, 193.

stereotypes around women's reproductive roles.[86] Yet, while the CEDAW Committee recognised that the forced continuation of pregnancy and the criminalisation of abortion could amount to gender-based violence, this was later qualified to refer only to limited circumstances (such as where there is a risk to life or health).[87] By advocating for decriminalisation on the basis that this will reduce the number of unsafe abortions, international human rights bodies fail to account for the more direct harms associated with criminalisation; decriminalisation is not required on the basis that punishing people for having abortions outside of the medical sphere is a human rights violation in itself. Moreover, the criminalisation of abortion frames abortion as an inherent wrong, which translates into ideas of personal moral failure of the part of the individual having an abortion.[88] This construction is informed by the gender stereotyping of women who have abortions as selfish or deviant for rejecting motherhood.[89] By focusing on unsafe abortion and public health as the impetus for decriminalisation, international human rights bodies perpetuate the gendered moral stigma, albeit inadvertently, around abortion.

<b> Self-Managed Abortion

One key assumption underpinning the public health approach is that all abortions taking place outside of medical and legal regulation are unsafe, and thus that all abortions must be brought under medical and legal supervision. For those living in countries with restrictive abortion laws and/or a lack of access to safe abortion facilities, legalisation and evidence-based provision through the healthcare system is, of course, important for increasing access to comprehensive

[86] *L.C. v Peru* (n47).
[87] Committee on the Elimination of Discrimination Against Women, General Recommendation No. 35, Gender-Based Violence Against Women, UN Doc. No. CEDAW/C/GC/35 (2017), para. 18; Committee on the Elimination of Discrimination Against Women, Inquiry Concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to CEDAW, UN Doc. No. CEDAW/C/OP.8/GBR/1 (2018), para. 65.
[88] 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; Erica Millar, *Happy Abortions* (Zed Books, 2017) p. 218-219.
[89] Mary Boyle, *Re-Thinking Abortion* (Routledge, 1997), p. 29, 39.

abortion services and reducing unsafe abortion and the harms of criminalisation. However, abortion rights advocates living in countries with strict abortion laws have developed networks to assist pregnant people in safely self-managing their own abortions.

The term 'self-managed abortion' has been increasingly adopted to refer to the use of the pill misoprostol, either alone or alongside mifepristone, to induce an abortion without medical supervision. These pills, advocated for by WHO as the preferred method of abortion early in a pregnancy, have been found to be extremely safe and effective, particularly when accompanied with information on how to use them.[90] The discovery by informal networks in Latin America that misoprostol, a medication primarily developed to treat gastric ulcers, could be used as a method of pregnancy termination significantly improved the safety of clandestine abortions.[91] Feminist abortion networks such as *Socorristas en Red* (who referred to themselves as 'lifeguards') in Argentina found that the provision of abortion hotlines and pre- and post-abortion counselling alongside medical abortion pills reduces the risk of harm by ensuring that pregnant people know how to take the medication safely.[92] However, a recent study demonstrates that lay people assume self-managed abortion to be always more harmful than abortion taking place within the healthcare system.[93] As Erdman, Jelinska, and Yanow highlight, the self-use of abortifacients has historically been seen as an act of desperation and this perception has been retained through public health discourse.[94] The use of medical abortion pills outside of a legal framework can potentially challenge ideas around the safety of illegal

[90] WHO (n4); Heidi Moseson, Stephanie Herold, Sofia Filippa and others, 'Self-managed abortion: A systematic scoping review' (2020) 63 *Best Practice & Research Clinical Obstetrics& Gynaecology* 87; Lesley Hoggart and Marge Berer, 'Making the case for supported self-managed medical abortion as an option for the future' (2022) 48 *BMJ Sexual & Reproductive Health* 146.
[91] McReynolds-Pérez (n79); Kinga Jelinska and Susan Yanow, 'Putting abortion pills into women's hands: realizing the full potential of medical abortion' (2018) 97(2) *Contraception* 86, 86.
[92] Raquel Irene Drovetta, 'Safe abortion information hotlines: An effective strategy for increasing women's access to safe abortions in Latin America' (2015) 23(45) *Reproductive Health Matters* 47; Soccoristas en Red <http://socorristasenred.org> accessed 30 July 2024.
[93] Andréa Becker, M. Antonia Biggs, Chris Ahlbach and others, 'Medicalization as a social good? Lay perceptions about self-managed abortion, legality, and criminality' (2024) 5 *SSM – Qualitative Research in Health* 1.
[94] Joanna N. Erdman, Kinga Jelinska, and Susan Yanow, 'Understandings of self-managed abortion as health inequity, harm reduction and social change' (2018) 26(54) *Reproductive Health Matters* 13, 14.

abortions and why people opt for self-management. However, this requires moving beyond the dominant assumptions around how and why someone may terminate their own pregnancy, and challenging the misconception that all illegal abortions are unsafe.

Self-managed abortion need not only be viewed solely as a last resort where formal abortion care is unavailable. In fact, numerous scholars have highlighted the social good of self-managed abortion, largely due to the broader issues associated with formal abortion care. Erdman, Jelinska, and Yanow argue that abortion seekers' conceptions of safety goes beyond medical risk, encompassing the 'common mistreatment and abuse of abortion seekers within formal healthcare systems, where providers may believe they have a moral if not legal right to accuse, judge and condemn.'[95] Abortion seekers may be subjected to harassment, bullying, gaslighting, coercion, dehumanisation, and other forms of obstetric violence from their healthcare provider.[96] Healthcare providers are permitted to conscientiously object to providing abortion services, which may delay or entirely obstruct their patient's access to an abortion within the formal system, or cause emotional harm to the abortion seeker.[97] Healthcare providers who do not invoke conscientious objection, but nonetheless hold a moral objection to abortion, may demonstrate judgment or hostility towards their patient even as they provide them with abortion services.[98] In some countries, abortion is permitted but only following mandatory counselling or mandatory ultrasound scans, which some abortion seekers may find stressful or distressing. Mavuso highlights the coercive nature of abortion counselling in South Africa, which they categorise as 'reproductive violence'.[99] More broadly, healthcare provider

[95] Ibid.
[96] Tongue (n21); 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.
[97] Zoe L. Tongue, 'On conscientious objection to abortion: Questioning mandatory referral as compromise in the international human rights framework' (2022) 22(4) *Medical Law International* 349.
[98] Robin Krawutschke, Tania Pastrana, and Dagmar Schmitz, 'Conscientious objection and barriers to abortion within as specific regional context – an expert interview study' (2024) 25 *BMC Medical Ethics* 1, 7.
[99] 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.

biases around gender, race, class, caste, sexuality, and disability, among other intersectional lines, can negatively shape experiences of abortion in the formal healthcare setting.

In contrast, self-managed abortion networks have opened up non-judgmental and supportive avenues for abortion care. Pizzarossa and Nandagiri have recognised the constellation of actors involved in self-managed abortion, which have

> 'fundamentally challenged and altered the meanings of abortion and abortion provision itself: from whose authority and knowledge is valued and centred, to the environments in which abortion is possible, to issuing a broader challenge around how abortion itself is understood and depicted.'[100]

Importantly, these networks normalise and validate the experiences of abortion seekers.[101] This supportive environment which upholds reproductive autonomy and personal decision-making stands in contrast to formal abortion care, where healthcare providers stand in a position of authority to determine whether or not an abortion is granted. In this sense, healthcare providers act as gatekeepers to abortion, whereas self-managed abortion offers a reclamation of 'control over one's bodies and lives'.[102] Abortion seekers may simply have a preference over where and how their abortion happens, and self-managed abortion can offer the privacy and convenience that a facility-based abortion does not.[103] While self-managed abortion continues to be viewed as problematic for transgressing medical knowledge and notions of safety, this avenue for abortion care is, for many people, preferable.[104]

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[100] Lucía Berro Pizzarossa and Rishita Nandagiri, 'Self-managed abortion: a constellation of actors, a cacophony of laws?' (2021) 29(1) *Sexual and Reproductive Health Matters* 23, 28.
[101] Ibid 25.
[102] Rishita Nandagiri and Lucía Berro Pizzarossa, 'Transgressing biomedical and legal boundaries: The "enticing and hazardous" challenges and promises of a Self-Managed Abortion multiverse' (2023) 100 *Women's Studies International Forum* 1, 4.
[103] Zoe L. Tongue, 'Telemedical and Self-Managed Abortion: A Human Rights Imperative?' (2023) 30 *European Journal of Health Law* 158, 178-179.
[104] Nandagiri and Pizzarossa (n102) 6.

Beyond preference, or fear of non-medical harm, practical barriers to accessing formal abortion services may also lead people to opt for self-management. These barriers disproportionately affect marginalised groups. Abortion facilities and information on abortion may not be accessible to disabled people, and the requirement to travel to those facilities imposes an additional burden on people living rurally, socio-economically disadvantaged people, and people with disabilities.[105] Public transport may be unreliable, costly, and physically inaccessible, and the need to take time off work and find childcare adds an additional cost-dimension for many pregnant people.[106] In Australia and Canada, abortion provision varies by state despite decriminalisation, with the result that many states or provinces have few or no abortion clinics and so many people have to travel great distances to access abortion services.[107] Abortion providers are often concentrated in urban areas, resulting in significant geographical inequalities which have a particular impact on Indigenous Peoples who are more likely to live the farthest from urban centres.[108] While some countries such as Britain and France have made abortion pills accessible remotely through formal telemedicine following a telephone consultation, elsewhere there are no such options.[109]

It is in this context that a pregnant person may opt to self-manage their abortion. While CESCR and the CEDAW Committee have placed emphasis on accessibility, many of these issues remain and others, such as conscientious objection, have not been adequately addressed.[110] All of this highlights the need to understand clandestine abortion through a broader lens—not as an unsafe practice to be eliminated, but as either necessity or preference

[105] Sydney Calkin, 'Towards a political geography of abortion' (2019) 69 *Political Geography* 22, 23, 27; Tongue (n103) 171.
[106] Calkin (n105) 23.
[107] 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); Christabelle Sethna and Marion Doull, 'Spatial disparities and travel to freestanding abortion clinics in Canada' (2013) 38 *Women's Studies International Forum* 52.
[108] Ibid.
[109] Tongue (n103) 163.
[110] Tongue (n97).

due to the harms and barriers within formal reproductive healthcare. Decriminalisation is thus important not only to prevent unsafe abortion in highly restrictive contexts, but to prevent the criminalisation of pregnant people who self-manage their abortions. There is the potential for international human rights standards on accessibility and the removal of barriers to support access to self-managed abortion, when interpreted expansively, through the facilitation of access to abortion medication and information on safe use.[111] This would also be in line with WHO's recent guidance supporting the self-use of abortion pills.[112] However, while this is not explicit in international human rights standards, there are no obligations on states to ensure access to self-management beyond decriminalising abortion—and some states use public health narratives to actively restrict access to abortion pills.

For example in Brazil, where abortion remains almost entirely illegal, misoprostol has been removed from pharmacies and access to online providers such as Women Help Women have been blocked.[113] Moreover, Assis and Erdman demonstrate how public health rhetoric has led to new forms of criminalisation, as offences relating to drug counterfeiting, trafficking, and 'crimes against public health' have been applied to the supply of misoprostol.[114] The latter offence has a minimum penalty of 10 to 15 years imprisonment.[115] Assis and Erdman highlight that the case law links the use of misoprostol with death and disability resulting from unsafe abortion, despite the fact that global declines in abortion-related mortality can be attributed to misoprostol.[116] The application of these drug control laws in an already restrictive setting

[111] See Tongue (n103); Lucía Berro Pizzarossa and Patty Skuster, 'Toward Human Rights and Evidence-Based Legal Frameworks for (Self-Managed) Abortion' (2021) 23(1) *Health and Human Rights* 199; Katrina Perehudoff, Lucía Berro Pizzarossa, and Jelle Stekelenburg, 'Realising the right to sexual and reproductive health: access to essential medicines for medical abortion as a core obligation' (2018) 18(8) *BMC International Health* 1.
[112] WHO, 'WHO guideline on self-care interventions for health and wellbeing, 2022 revision' (27 June 2022) <https://www.who.int/publications/i/item/9789240052192> accessed 30 July 2024, p.46-47.
[113] 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) *Journal of Law and the Biosciences*1, 4; 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 30 July 2024.
[114] Assis and Erdman (n113) 7-9.
[115] Brazilian Penal Code Article 273.
[116] Assis and Erdman (n113) 10.

highlight the way in which public health narratives are malleable to the assumption that all abortions taking place outside of law and medicine are unsafe—an assumption which can hinder, rather than improve, abortion safety. Without access to abortion pills, people will use alternative—and less safe—means of terminating their pregnancies, heightening the risk of complications, hospitalisation, and mortality.[117] To adequately address this, international human rights bodies must be clear about the potential for self-management to improve both access to and the safety of abortion, as both a public health and human rights imperative. Decriminalisation and state provision is not enough to guarantee the right to health in relation to abortion; states must also ensure that safe methods of self-management are available, without being subjected to criminal penalty or excessive regulation. This is also important for upholding reproductive autonomy; as Jackson argues, autonomy 'is not just the right to pursue ends that one already has, but also to live in an environment which enables one to form one's own value system and to have it treated with respect.'[118]

<b> Access to Healthcare and Medicalisation

While self-management is and will remain an important option for many people, it cannot be the *only* option; placing too much emphasis on alternatives to publicly availably healthcare risks excusing states from failing to comply with their human rights obligations. Baird highlights the neoliberal underpinnings of Australia's healthcare system, in which abortion care has become increasingly privatised with the result that the public provision of abortion is therefore seriously limited or even non-existent in some states, particularly for those living

[117] Rosia Maria Soares Madeira Dominigues, Sandra Costa Fonseca, Maria do Carmo Leal and others, 'Unsafe abortion in Brazil, a systematic review of the scientific production, 2008-2018' (2020) 10(36 Suppl 1) *Cad. Saude Publica* 1.
[118] Emily Jackson, *Regulating Reproduction: Law, Technology, and Autonomy* (Hart, 2001) p.6.

rurally and in remote locations.[119] Access to abortion in Australia has therefore been described by a Senate Committee report as a 'postcode lottery'.[120] In the absence of comprehensive public abortion services, Baird cautions against the overreliance on self-managed abortion as a means of securing abortion rights: 'when public and even private services are inadequate, responsibility and competency devolve to the individual, who must become 'self-managing' in order to access needed health care'.[121] As explored above, states have obligations under the right to health to ensure the availability, accessibility, and affordability of quality abortion services, and to address barriers to access.

However, resource and budgetary limitations, geographical variations in healthcare regulation, workforce shortages, and infrastructural problems may undermine states' ability or willingness to ensure the adequate provision of abortion services. Recognising the economic cost of fulfilling the right to health and other socio-economic rights, the ICESCR does not require immediate compliance but rather allows for 'progressive realisation'—states must demonstrate that they are taking steps towards full compliance, but will not be deemed to have violated the right if they fall short.[122] Moreover, the CESCR does not require healthcare to be freely available, provided that exceptions are made for disadvantaged or vulnerable groups.[123] As Riedel highlights, healthcare services can be provided publicly or privately or both as long as (some form of) healthcare is affordable for all.[124] As such, the increasing domination of the

[119] Barbara Baird, *Abortion Care is Health Care* (Melbourne University Press, 2023), p.25-32.
[120] Senate Community Affairs References Committee, 'Ending the postcode lottery: Addressing barriers to sexual, maternity, and reproductive healthcare in Australia' (May 2023) <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ReproductiveHealthcare/Report> accessed 30 July 2024.
[121] Baird (n119) p.167.
[122] International Covenant on Civil and Political Rights Article 2(1).
[123] CESCR (n34, 2000) para. 12(b)(iii).
[124] Eibe Ridel, 'The Right to Health under the ICESCR: Existing Scope, New Challenges, and How to Deal with It' in Andreas von Arnauld, Kerstin von der Decken, and Mart Susi (Eds), *The Cambridge Handbook of New Human Rights* (Cambridge University Press, 2020) p.114.

healthcare sector by private healthcare institutions, where some public provision is still available, will not raise concerns for the CESCR.

Issues with access and availability are not solely related to the public versus private provision of healthcare. Where legal changes mean that abortion becomes permitted for the first time, significant adjustments may be required to existing healthcare services. In Northern Ireland, abortion was decriminalised in 2019 and new regulations were passed in 2020, but abortion services have yet to be fully commissioned in the region.[125] Abortion using mifepristone and misoprostol is accessible up to 10 weeks' gestation, but access after this point has been described by Amnesty International as the 'luck of the draw' as it is entirely dependent on finding a willing healthcare provider.[126] Surgical abortion services, which are required at a later gestational stage, are completely unavailable across much of the country.[127] The transition to providing abortion in Northern Ireland, without additional funding and staff training, has proven extremely difficult—many of the NHS trusts report that they lack the premises and staffing capacity to expand their current abortion service provision.[128]

The organisation of abortion services is also heavily reliant on individual healthcare professionals opting into provision. It is a feature of most abortion regimes that, unlike for almost all other medical procedures, healthcare providers may refuse to provide abortion services based on their conscientious objection. This may be accompanied by regulations such as requiring providers to perform emergency abortions, inform their patients of their conscientious objection, and refer their patients to non-objecting providers. However, as noted above, widespread conscientious objection can create significant obstacles to the provision of

[125] Amnesty International, 'Legal but not local: Barriers to accessing abortion services in Northern Ireland' (December 2023) <https://www.amnesty.org.uk/press-releases/northern-ireland-four-years-decriminalisation-abortion-access-right-not-reality-new> accessed 30 July 2024, p.4-6.
[126] Ibid p.40.
[127] Ibid p.43.
[128] Ibid p.71.

abortion services and refusals to provide abortion care can be emotionally harmful to patients.[129] In these environments, providers who do not have a moral objection to abortion may nonetheless refuse to offer abortion services in order to avoid the associated workload burdens and reputational risks.[130] In the Australian context, Baird highlights the 'constant vulnerability' of relying on individual doctors to sustain abortion services.[131] If an abortion provider moves elsewhere or leaves the profession, there may be a gap in services that no other healthcare providers in the region are willing to fill. This is exacerbated by the fact that abortion is an optional field of study for many medical students, and courses teaching abortion may reinforce stigmatising attitudes towards abortion.[132]

Abortion services are therefore vulnerable to the institutional limitations of healthcare provision, and while states are obligated to (progressively) remedy these issues, there is no quick fix. Many scholars thus view law reform and abortion delivery within healthcare institutions as a reality far from the promise of abortion rights, leading to critiques of the 'medicalisation' of abortion.[133] Medicalisation refers to the 'narrow appreciation of the nature of medical power' to the detriment of patients' voices, and in the context of abortion, this has meant that doctors hold a monopoly over the provision of abortion.[134] This is typically viewed as standing in contrast to reproductive autonomy by requiring healthcare providers to approve (and giving them the power to reject) an abortion seekers' request. For example, Nandagiri and Pizzarossa highlight how medicalisation functions across three levels:

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[129] Tongue (n97).
[130] Agustina Ramón Michel, Stephanie Kung, Alyse López-Salm, and Sonia Ariza Navarrette, 'Regulating Conscientious Objection to Legal Abortion in Argentina: Taking into Consideration Uses and Consequences' (2020) 22(2) *Health and Human Rights* 271, 274.
[131] Baird (n119) p.83.
[132] Erica Millar, 'Abortion stigma, abortion exceptionalism, and medical curricula' (2023) 32(3) *Health Sociology Review* 261.
[133] See Baird (n119) p.200; B. Jessie Hill, 'De-Medicalizing Abortion' (2022) 22(8) *The American Journal of Bioethics* 57; Mariana Prandini Assis and Joanna N. Erdman, 'Abortion rights beyond the medico-legal paradigm' (2022) 17(10) *Global Public Health* 2235.
[134] Erica Millar, 'Abortion, decriminalisation and the medico-legal paradigm' (2024) 355 *Social Science & Medicine* 1, 1.

> 'how abortion is framed within laws (e.g., the need for doctors' approval), how it is theorised within the rubric of medical safety (e.g., definition of safe and unsafe abortions) and regulated (e.g., the requirement to meet "minimum medical standards").'[135]

As already discussed, the provision of safe evidence-based abortion services by qualified persons is crucial for reducing unsafe abortion and abortion-related mortality. However, as self-managed abortion practices demonstrate, it is not the only means of doing so, and legislation often *over*-medicalises abortion. Romanis therefore draws a distinction between abortion-permissive and abortion-supportive laws, where the former refers to legal frameworks that permit abortion as mediated through medical power and the latter is supportive of pregnant people's reproductive autonomy (for example, by allowing abortion on request).[136] In abortion-permissive frameworks, it is doctors, rather than pregnant people, who hold the ultimate decision-making power—abortion becomes permissible only where it is medically justified rather than based on the pregnant person's need. Even with early medical abortion, abortion pills are not accessible from pharmacies and in most jurisdictions, pregnant people are required to be physically present in an abortion facility when taking abortion pills so that they are under medical supervision. Moreover, legislation often singles out doctors, and not nurses, midwives, or community health workers, as the only people permitted to legally provide abortion services. As Baird highlights, there is a problem where doctors 'the only ones who can lawfully [provide abortions], yet it is accepted practice that they *do not have to'*.[137] Criminal offences which apply to anyone other than doctors who provide or perform abortions preclude other healthcare personnel from filling staffing gaps; these offences for third parties remain in Australia and

[135] Nandagiri and Pizzarossa (n102) 4.
[136] Elizabeth Chloe Romanis, 'Abortion Access and the Benefits and Limitations of Abortion-*Permissive* Legal Frameworks: Lessons from the United Kingdom' (2023) 32(3) *Cambridge Quarterly of Healthcare Ethics* 378, 384-385.
[137] Baird (n119) p.85.

Northern Ireland, even though self-management has been decriminalised. This medicalised approach can be seen in the international human rights approach, which positions healthcare institutions and healthcare professionals as the single appropriate place for abortion provision.

Baird argues that the claim that abortion is healthcare 'can arguably have the effect of re-centring the medicalisation of abortion to the detriment of other principles such as human rights, bodily autonomy and self-determination, and reproductive justice.'[138] Thus, there is a need for rights-based thinking within healthcare; public health rhetoric and abortion service delivery requires human rights as a normative guide. However, this also requires the right to health to move beyond its medicalised public health approach, to recognise its intersections with a spectrum of other rights, including those to privacy, information, substantive gender equality, and bodily autonomy. Millar argues that the healthcare framing is politically useful but does not capture how abortion relates to 'gendered expressions of autonomy and agency.'[139] As already highlighted above, bodily autonomy is a fundamental aspect of one's social wellbeing. The decoupling of abortion from medical power would, on a practical level, require the removal of excessive regulations, including requirements that doctors review and authorise requests for abortion based on specific approved grounds, and the empowering of a broader group of people to provide early medical abortion to enable the reproductive autonomy of pregnant people to be exercised without excessive constraint.

While international human rights law and campaigning has positioned the desired regulatory regime for abortion as a highly medicalised one, scholars have argued that human rights could and should support a de-medicalised approach to abortion.[140] CESCR's

[138] Ibid p.240.
[139] Millar (n134) 8.
[140] Millar (n134); Perehudoff, Pizzarossa, and Stekelenburg (n106); Assis and Erdman (n127);Amirala S. Pasha and Roma Sonik, 'Their Body, Our Choice: Organized Medicine's Responsibility to De-Medicalize Abortion' (2024) 26(1) *Health and Human Rights Journal* 137; 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 and Human Rights* 191.

acceptability standards are undermined by the over-medicalisation of abortion, which limits pregnant people's ability to have abortions where, when, and how they would prefer.[141] Cabello and Gaitán argue that over-medicalisation 'disregards individuals' dignity' in contravention of the acceptability principle, which 'demands that health systems adapt to people's needs and preferences.'[142] Thus, I follow Perehudoff, Pizzarossa, and Stekelenburg in arguing that a 'coherent public health and human rights approach would confer an unfettered endorsement to essential medical abortion medicines'.[143] As with core essential medicines, abortion pills should be easily accessible without legally mandated obstacles—situating self-managed abortion as healthcare, without the burdens of excessive medicalisation. For the right to health to be fully realised in relation to abortion, international human rights bodies must advocate for access to abortion beyond restrictive medical control given the limitations of institutionalised healthcare delivery and the continuous global backlash against abortion. Above all, access to abortion must be recognised as a right 'not only or even primarily because it is health care, but because, for pregnancy-capable people, abortion enables us to live the lives we want to live.'[144] Comprehensive access to abortion saves lives, but it is also essential for reproductive autonomy—a perspective currently understated in the international human rights approach.

<a> CONCLUSION

The development of international human rights standards on abortion, particularly as expanded upon under the right to health, have been significant in pushing states to legalise and provide access to abortion. The narrative shift from a focus on the morality of abortion to the public health implications of restrictions has enabled this development, drawing attention to the

[141] Tongue (n103) 178-179.
[142] Cabello and Gaitán (n137) 193-194.
[143] Perehudoff, Pizzarossa, and Stekelenburg (n111) 5.
[144] Millar (n134) 8.

consequences of abortion prohibitions in terms of maternal mortality and morbidity. The recognition of the harms of unsafe abortion is important, given the scale of unsafe abortion which primarily affects those living in lower-income countries and countries with restrictive abortion regimes. However, the assumption that abortion must be brought into healthcare institutions and medical control underpins much public health and human rights discourse. In this chapter, I have argued that the delivery of abortion services within healthcare institutions is often deficient or actively harmful towards pregnant people. This requires international human rights bodies to recognise the potential of self-managed abortion to improve abortion safety and access. This is not, however, to be taken to excuse states from meeting their international obligations; instead, human rights standards must require states to ensure access to abortion pills without excessive regulation, and to centre reproductive autonomy rather than medical power within abortion regimes. Only then will the right to health be reflective of what abortion rights movements worldwide demand; the transformation of the healthcare practices which continue to marginalise and stigmatise abortions and the people that have them.