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Neglecting abortion: Negative psychological consequences of the denial of women's reproductive autonomy

The absence of the right to abortion in international law

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Introduction

The discipline of psychology has always focused on how humans relate to and treat each other, how they interact, how society form their minds, the emergence of groups structures, the creation of power dynamics and how interpersonal relations work.
It is quite surprising how psychology and human rights have developed in different directions, growing almost in isolation one from the other before finally establishing a connection only in recent times.

The deep entanglement and interrelatedness become apparent in the precise moment we realise that the central objectives of psychology are mirrored in human rights principles. Both have a fundamental and aspirational role in improving and ensuring human well-being, empowering individuals to be in charge of their lives, to be conscious of their dignity and their rights, to secure the best possible physical and mental health conditions and protect people from violence and abuse.

The high value of the interconnection between human rights and psychology stems partially from psychologists' specific competence and knowledge about human life and well-being; in fact, psychology research and studies have transmitted knowledge on psychological effects of human experiences. Psychologists are confronted in their everyday practice with victims of serious traumatic events, such as victims of rape, domestic violence and sexual abuse, but they also play an important role in helping people cope with everyday stressful life events originating from patterns of discrimination, stigmatization or marginalization.

Individuals suffering from these traumatic and distressing life experiences are often victims of human rights violations. In fact, human rights reflect fundamental rights belonging to every individual and they represent standards that recognise the dignity of all human beings.

This thesis focuses on women's sexual and reproductive health and rights, and more specifically on the voluntary interruption of pregnancy, which are often objects of restrictive policies impeding the equal enjoyment of these rights.

Psychological research has been used as an instrument to justify the restriction of access to abortion, through the claim that the practice is highly damaging to women's mental and physical health. Where does the truth lie? Is abortion or its denial the cause of negative psychological consequences?

The first chapter presents an analysis of the major international legal instruments in order to assess if a direct right to abortion exists. Specifically, the first section of the chapter provides a brief definition of reproductive health and the emergence of the concept of reproductive rights in international law. Throughout the second section, which deals with the different international legal instruments and preparatory works, emerge the absence of a direct right to abortion and a complex of more "justiciable" human rights that are usually invoked in cases of abortion brought to international courts. The first chapter continues delineating the jurisprudence and international bodies' positions about abortion through the analysis of two main abortion case laws (A.B.C v Ireland and L. C. v Peru) and through General Comments, Recommendations and opinions providing guidelines on how to interpret the different human rights' violations that a case of abortion may entail. In conclusion, the inclusion of a direct right to abortion in international human rights systems would be too controversial, therefore the abortion issue is considered to pertain to the domestic level.

The second chapter of this thesis addresses the systemic inequality that stems from the denial of women's right to reproductive health and the importance of the recognition of subliminal mechanisms that operate in this context. The analysis begins with the description of a male-oriented international legislation that does not consider women's accounts, necessities and different perspectives and reflects this inequality in the scope of various human rights. The analysis further shows how neglecting women's reproductive autonomy is a form of discrimination that often goes unnoticed and unreported. The second section depicts the situation of abortion in criminalizing legislations, showing that rendering the practice illegal does not to the decrease of abortion rates, but rather to an increased maternal mortality and morbidity. A total prohibition of abortion may indeed be considered a form of torture, inhuman and degrading treatment from which women escape by recurring to alternative abortion practices.

The third section of the second chapter describes common barriers to lawful abortion such as conscientious objection, non-exhaustive coverage of abortion clinics in the territory and mandatory pre-abortion counselling and waiting periods, which contribute to the unequal enjoyment of the right to abortion.
The last section of this chapter highlights the detrimental role of gender stereotypes in the field of women's reproductive health and how States are obliged to eradicate them.

The last chapter presents a careful analysis of psychological literature on the consequences of having an abortion, demonstrating that not only there is no scientific evidence proving the development of mental health problems after an abortion, but rather its denial is far more harmful to a woman's health. The analysis addresses stigmatizing attitudes towards abortion and women who choose to have an abortion by identifying features of abortion stigmas and proving false myths wrong. It has been demonstrated that negative psychological consequences after an abortion are rare but, when present, are triggered by predictive risk factors rather than by the abortion experience itself. In conclusion, some social changes for a better understanding of women's perspectives, such as abortion curricula in psychology schools and in medical environments, are analyzed and suggested.

Chapter 1 - The absence of the right to abortion in International law: an analysis of international legal instruments

Abortion is often depicted as one of the most painful and traumatic experience one can face in life. A trauma that can hardly be forgotten, from which one can barely heal, an experience that irremediably affect one's life, in a negative way. Nevertheless, abortion is one of the commonest gynaecological procedures. 121 million unintended pregnancies occurred each year globally between 2015 and 2019, according to the Guttmacher Institute.[1] Out of these unintended pregnancies, 61% ended in abortion, meaning that the abortion procedures provided amount to 73 million per year. These data depict a real situation, irrespective of the region in which occur, the income level or the legal status of abortion. Women do abort.

As a matter of a fact, unintended pregnancy rates are highest in countries in which access to abortion is restricted or limited. On the contrary, the lowest numbers are registered in countries where abortion is legal. Indeed, abortion rates appear to be higher in those countries where the practice is prohibited or highly limited than in countries where abortion is available on request.[2]

If conditions like poverty or disadvantaged economic conditions, nationality, religion, being single or being already a mother of two or more children or a legal system that criminalize abortion do not discourage women from recurring to voluntary interruption of pregnancy, why does the idea of abortion as a distressing and traumatic experience persist?

To trace down some historical stages in the abortion discourse, the practice was illegal in almost every country in the world at the end of the 19th century, while China seems to be the only country that has never placed criminal restrictions on abortion.[3]

The Centre of Reproductive Rights (CRR) gives us a series of interesting information on the matter. It has grouped countries into four different categories based on the degree of legal access to abortion, which range from "most restricted", where access is prohibited altogether or limited to the case in which life of the woman is in danger, to "least restricted", which is to say when there are no

[1] Guttmacher Institute. Unintended Pregnancy and Abortion Worldwide.
[2] J. Marecek, C. Macleod, L. Hoggart. (2017). Abortion in legal, social, and healthcare contexts. *Feminism & Psychology,* p.10.
[3] M. Berer. (2017). Abortion Law and Policy Around the World: In search of decriminalization, *Health and Human Rights Journal*, p. 14.

restrictions and abortion is permitted on a request. Specifically, 5% of women of reproductive age live in countries that prohibit abortion altogether, 22% live in countries that permit abortion to save the life of the woman, 14% of women live in countries that allow abortion on health grounds, 23% of women live where abortion is allowed on broad social or economic grounds and, lastly, 36% of women live in countries that allow abortion on request but set gestational age limit. To sum up, while 59% of women of reproductive age live in countries where abortion is widely allowed, we cannot ignore the 41% of women, that is to say 700 million women of reproductive age, who live in countries where abortion is highly restricted or fully prohibited.[4]

The issue of reproductive rights, especially abortion, has been central in international human rights discourse. Reproductive rights have been recognized to have implications not only on the more strictly medical sense, as might be mistakenly assumed, but permeate different spheres of the life of every human being.[5] Aside from being central on the private reproductive and sexual life of the individual, their impacts can be observed in the social, economic and civil areas; of fundamental importance is the problem of maternal mortality and morbidity that has modelled governments policies worldwide.

The aim of this chapter is therefore to provide the reader with a better understanding of the international legal instruments with regard to reproductive rights, analysing more in detail the issue of abortion.

[4] Center for Reproductive Rights. (2021). The World's Abortion Laws.

[5] Rebecca J. Cook and Mahmoud F. Fathalla. (1996). Advancing Reproductive Rights Beyond Cairo and Beijing. *International Family Planning Perspectives*. Guttmacher Institute.

1. Human rights and reproductive health in the International agenda

1.1 Definition of reproductive rights and a brief history of the emergence of reproductive rights in international law

For the purpose of this work is useful to make a brief introduction of the internationally recognized notion of "health" as formulated in the Constitution of World Health Organization, signed on 1946 and entered into force on 7 April 1948:[6]

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

With this definition of health, the WHO has emphasised the necessity to broaden the meaning and the concept of health to include what has often been underestimated, such as mental well-being and social welfare. A decisive focus on a new concept of reproductive rights is to be ascribed to a more recent series of conferences, the most relevant of them is the United Nations International Conference on Population and Development, held in Cairo in 1994, and the subsequent Fourth World Conference on Women, held in Beijing in the following year. These two conferences have set the starting point of the reproductive rights discourse, which is still at the centre of the political discussion and the cause of an ongoing controversy. The Programme of Action adopted in Cairo puts the focus on the fundamental role of human rights in the protection and the promotion of reproductive health.

Taking into consideration the World Health Organization definition of health, the Programme of Action declines the notion to embrace a more specific understanding of reproductive health:

> "Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so."[7]

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[6] Constitution of the World Health Organization. In: *Basic Documents,* 39th ed. Geneva, World Health Organization, 1992.

[7] Ibid., supra note at 5, p. 115.

The Programme of Action furthermore specifies in Principle 8 that:

> "everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."

Reproductive health affects our life in multiple ways. Recognizing its fundamental role in shaping the mental and social well-being of every individual, the Programme of Action takes an important step in formulating a notion of what is to be considered reproductive health in the context of primary health care. In this way, States are urged to take appropriate measures, on a basis of equality of men and women, to ensure access to a more comprehensive health care that includes a list of specific services that should enable countries to deal with every individual's necessity with particular attention to women's needs and leaving, hopefully, little space to actions that hamper the enjoyment of the highest attainable standard of health care.[8]

Abortion is addressed in the Programme of Action as pertaining to the decisional-making power of each country and, as a result, the subject is relegated to the national legislative process, hence no moral, ethical or legal opinion is given upon the matter on the Programme itself.[9] On the one hand, the guideline urges all Governments, intergovernmental and non-governmental organizations to cope with the impact of unsafe abortions, considering its consequences a major public health concern; on the other hand, the abortion procedure should in no way be considered or promoted as a method of family planning or contraception. In cases where abortion is not against the law, the practice must be conducted in the safest way. In any case, as we find specified in the Programme of Action, States cannot be exempted from assuring health care in the management of post-abortion consequences nor from taking action in preventing abortion with improved family-planning services.

As we have seen so far, reproductive health care is conceived as "the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems".[10] Sexual health is also included in the definition of reproductive health care, underling the importance of its role not only when talking about

[8] Cairo Programme of Action, 7.6.
[9] A/CONF.171/13. Programme of Action adopted at the conference on ICPD in Cairo 1994, chapter VII para. 25.
[10] Programme of Action of the International Conference on Population and Development, New York, United Nations, 1994, para. 7.2.

reproduction-related counselling and sexually transmitted diseases, but acknowledging the importance it covers in the enjoyment of personal relations and in the building of a healthy social life.[11] Even tough sexual health is mentioned in the reproductive health discourse, a precise definition of what is included within the concept of sexual rights is difficult to be found, which creates an enormous gap in the acknowledgment of the rights as such, furthermore, complicating the problem when LGBTQI+ sexual rights are involved.[12] Conversely, special attention is given to women's necessities in the field of reproductive rights but, most importantly, it underlines the urgency and the commitment to achieve women's empowerment in the decision-making process, the planning and the implementation of health policies in a field that affect them the most, given that "…improving the status of women also enhances their decision-making capacity at all levels in all spheres of life, especially in the area of sexuality and reproduction. This, in turn, is essential for the long- term success of population programmes."[13]

In the Programme of Action there emerges a clear awarness of the unequal position of women, that sees their decision power jeopardized precisely in the reproductive health dimension. In the document a special section is reserved to tackle the particularly problematic issue of gender equality and empowerment of women and stresses the urgency in taking action into "eliminating all practices that discriminate against women; assisting women to establish and realize their rights, including those that relate to reproductive and sexual health".[14]

Despite a clear and globally accepted definition of reproductive rights as encompassing a complexity of needs in various fields, the same complexity leads to an equally intricated legal framework that arises when a violation of reproductive rights occurs. While there is little doubt regarding the violation, and therefore the recognition of the right to reproductive health, a confusing scenario might arise in appointing a specific right to invoke.

The process of formal recognition of reproductive rights initiated in the Cairo Programme, was set forward with the work of the Beijing Declaration and Platform for Action that takes an important step in the reconceptualization of the concept of health, women's health: "Women's health involves their emotional, social and physical well-being and is determined by the social, political and economic context of their lives, as well as by biology."[15] Recognizing that well-being is not merely a matter of

[11] A/CONF.171/13. Programme of Action adopted at the conference on ICPD in Cairo 1994, chapter VII para. 7.2.
[12] Alice M. Miller. (2000). Sexual but Not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights. *Health and human rights.*
[13] Programme of Action, para 4.1.
[14] Programme of Action, para 4.4 (c).
[15] Beijing Platform for Action, C, Women and Health.

having a healthy body and mind, and therefore simply a matter of biological wellness, brings under the spotlight areas whose relevance is often underestimated that see as protagonists, unfairly more than unfortunately, the female population. Hence, always bearing in mind the principle of equality and equity that must guide every government in their agenda, the focus on women's rights must consider that "…the limited power many women have over their sexual and reproductive lives and lack of influence in decision-making are social realities which have an adverse impact on their health."[16] Good health is essential in leading a productive and fulfilling life and the right of all women to control all aspects of their health, in particular their own fertility, is at the basis of their empowerment.

One aspect of these aforementioned documents needs to be underlined. Specific instructions are given to States on how to deal with the rights represented in the documents. The nature of these two instruments is not legally binding but indeed assume the form of soft law, accordingly States are not accountable for violations of the rights enshrined in the documents in front of a mechanism of implementation. The Cairo Programme and the Beijing Platform propose a series of recommendations and guidelines designed to help States incorporate the provisions presented and to adopt them as goals in their national programmes. Despite not being binding, their role is still crucial in posing the international community's attention on critical issues like the one regarding reproductive health and more in general, health.

It should not be forgotten that reproductive rights are to be considered enshrined in human rights and are entitled of the same recognition of the fundamental rights. Reproductive rights and health, as we already said, have repercussions in all the different areas of every human being's life. The Millennium Developments Goals underline how important are the recognition, the protection and the promotion of reproductive rights to the benefit of the global community in its entirety, not only to the benefit of a single individual.[17]

Development can be achieved only if all the goals set in the MDGs are pursued. Maternal mortality is a problematic issue that need to be, if not eradicated, at least reduced. In the MDGs' plan, the aim proposed was to diminish maternal mortality ratio of three quarters by 2015, aim that was achieved only in part.[18] The progress has been little and slow and dropped the mortality ratio to less than half of what was set in the plan, which perpetrate the necessity to include in the subsequent Sustainable

[16] Beijing Platform for Action, C, Women and Health, 92, p. 56.
[17] L. B. Pizzarossa. (2018). Here to Stay: The Evolution of Sexual and Reproductive Health and Rights in International Human Rights Law. *Laws*, p. 10.
[18] The Millennium Development Goals Report 2015, United Nations.

Development Goals both the achieving of gender equality and the empowerment of all women and girls and the decrease of maternal mortality ratio to less than 70 per 100,000 live births.

1.2 Does a direct right to abortion exist in international law? An analysis of international legal instruments and preparatory works

At this point of the study, it is particularly useful to analyse the international legal instruments and preparatory works on the matter of abortion with the aim of better understanding the international positions about reproductive rights. The analysis focuses on two of the United Nations' legal instruments that deal with the topic of this research, the International Covenant on Political and Civil Rights (ICCPR) and the Convention on the Elimination of All forms of Discrimination against Women (CEDAW). To give the most comprehensive picture of the major legal treaties the analysis will proceed with the main regional legal instruments at our disposal, the European and the American Convention on Human Rights and the African Charter on Human and People's Rights and the Maputo Protocol. The question that needs to be assessed is: does a direct right to abortion exist, and how do the respective bodies interpret and tackle the issue of the interruption of pregnancy, are there cases of rightful abortion and which are these exceptional cases.

Abortion is one of the most contentious issues that dominates the political discourse on a global level, having its roots in religious and ethical debate. Governments, the religious community and more in general every institution are divided between the recognition of a right to abortion or the criminalization or restriction of the procedure. At the centre of the debate stands the controversial issue of the life of the foetus, historically seen in contraposition to the life or health of the mother. The ethical aspect will not be examined in depth in this thesis, if not necessary for the purpose of the analysis. For a conscious reading of the following legal interpretation of the human rights treaties we are going to examine, a definition of abortion is necessary. The term abortion identifies the deliberate termination of pregnancy, either self-induced or practiced by a provider. The abortion procedure can be either safe or unsafe depending on the conditions before, under and after the process. The WHO provides a definition of unsafe abortion as "a procedure for terminating an unintended pregnancy

carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both."[19]

1.2.1 United Nations Framework

1.2.1.1 International Covenant on Political and Civil Rights and International Covenant on Economic, Social and Cultural Rights (ICCPR and ICESCR)

The United Nations enjoys the title of one of the most avant-garde bodies in the field of human rights, being the first to draft the Universal Declaration of Human Rights, the milestone in the field of human rights law. When talking about human rights the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights will inevitably be mentioned. These two Covenants are integral parts of the International Bill of Human Rights, together with the Universal Declaration.

The first aspect to notice is that the words "reproductive rights" do not appear in the aforementioned documents. What is given to know is that the issue of reproductive rights, more precisely abortion, was indeed tackled during the preliminary discussion for the drafting of the ICCP. The issue was brought into the discussion when dealing with the right to life.[20] As mentioned above, the ethical and religious accounts, when talking about the right to life, cannot be ignored. In proposing the text of the Declaration, the participant representatives of States were divided on the matter of defining the moment from which a person is entitled of human rights or whether to add a specification or not. In the first session, Lebanon proposed to add to the definition of Article 1: "It shall be unlawful to deprive any person, *from the moment of conception*, of his life or bodily integrity, save in the execution of the sentence of a court following on his conviction of a crime for which this penalty is provided by law."[21]

Recognizing the right to life from the moment of conception posits an enormous challenge in recognizing women's reproductive autonomy and opens the debate on which life needs to be protected, the unborn child's life or the woman's. Different governments' interests were brought into

[19] Unsafe abortion incidence and mortality. Global and regional levels in 2008 and trends during 1990 –2008. WHO.
[20] E/CN.4/21 annex G, Drafting Committee report submitted to the Commission on Human Rights, 1st session, 1947.

[21] Ibid.

the discussion table, but the delicacy of the argument would have risked jeopardizing the ratification of the document by many governments, therefore the choice adopted was to not include any specification that would indirectly suggest the existence of the right to abortion or the prohibition of it.[22]

The choice was to be neutral on the matter. Reproductive rights have different forms and can assume various shapes in the human rights framework. As assessed by the ICPD, the term embraces certain human rights that are already recognized in international human rights documents. The absence of a precise article regulating reproductive rights takes the analysis towards a search for rights that can be ascribed to reproductive health cases and can be invoked to protect people from being deprived of their reproductive and sexual rights.

When taking into consideration the International Covenant on Civil and Political Rights, the right to life is the first that comes to mind when reproductive rights, and more specifically the issue of abortion, are engaged. As we have seen, maternal mortality and morbidity constitute an emergency of public health concern. Risks, even if preventable, may arise in safe medical environment due to complications of the pregnancy, but the serious emergency arises when precarious conditions in the health care system put women through unsafe abortion procedures. In front of unsafe interruption of pregnancy, the life of women is in danger. Abortion cannot be and must not be eliminated. In origins, the right to life as included in the ICCPR has been proposed with the original purpose to defend people from being subjected to arbitrary deprivation of life. Article 6.1 recites: "Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life."

The right to life was originally meant to address cases of death penalty. In this context it resurfaces the controversial issue of the inherent right to life of the foetus in contraposition to the life of the mother. Article 6(5) continues as follows: "Sentence of death shall not be imposed for crimes committed by persons below eighteen years of age and *shall not be carried out on pregnant women*."[23] With the advancing of human rights, the scope of the right to life needs to be reconceptualized. A broader interpretation of the concept is needed in order to promote a renewed meaning which should include matters relating to different forms of deprivation of life, such as the one pertaining to all women risking their life to exercise their will in terminating a pregnancy. A more integrative

[22] E/CN.4/L.1542, Commission of Human Rights, 36th session, 1980, para. 7 and 10.

[23] ICCPR, Art. 6.5.

paradigm of the right to life is to be invoked to cope with avoidable deaths occurring in cases of pregnancy complications and, in particular, in case of unsafe abortion procedures.[24]

Notwithstanding the ongoing debate on the moment from which a human being is entitled of the right to life, the highest courts in many countries have declared that legal protection originates at live birth.[25] In the draft proposal of the Political Covenant, as we have seen, the issue of abortion was expressively discussed and the final decision was that of not including any provision either permitting or prohibiting abortion, since the legislation of most States already provided differing disposition at national level that would have made reaching a common view nearly impossible. During the discussion concerning Article 6, a working group (composed by Chile, China, Egypt, Lebanon, UK, Northern Ireland and Yugoslavia) proposed to add a subparagraph specifying that abortion, declared unlawful, should only be allowed only under three circumstances regulated domestically, namely: when is necessary to save a woman's life, when pregnancy is the result of rape and when parents suffer from mental diseases.[26]

Opposition was encountered on both the radical and the liberal views. The choice to add the subparagraph was highly criticized by States which condemned abortion *in toto* mostly because by ratifying the Covenant they would have been in the position to acknowledge exceptions from the total prohibition of abortion and therefore proposed to delete the provision. On the other hand, States which adopted in their national legislation provisions permitting abortion in almost if not all cases, would find it difficult to ratify the convention if these exceptions would have not been deleted from the provision, because it would have meant to retrocede in the recognition of women's rights.

What we can observe until now is that, in the abortion discourse, women's perspectives as well as their legitimate interests in reproductive autonomy is not considered even once in the drafting process of the Political Convention. Reproductive and sexual rights and, more in general, everything pertaining to women's reproductive health can be ascribed also to the right to private and family life enshrined in article 17 of the Political Covenant: "No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attack on his honour and reputation."[27]

[24] R. J., Cook. (1994). Women's Health and Human Rights: The promotion and protection of women's health through international human rights. *World Health Organization*, p. 24.
[25] R. J. Cook, J. N. Erdman and B. M. Dickens. (2003). Abortion Law in Transnational Perspective: Cases and Controversies, *University of Pennsylvania Press*, p. 23.
[26] E/CN.4/56, Commission on Human Rights, 2nd session, 1947, p. 6.
[27] ICCPR, Article 17.

The situation regarding health and reproductive health is not so linear under the ICCPR because of the phenomenon described by Sara De Vido:

> "the 'indirect protection' of the right to health is that the HRC, which has been – at least for the time being – one of the most active bodies at UN level in addressing issues of women's health, is not competent to consider alleged violations of the right to health; this right is not enshrined in the International Covenant on Civil and Political Rights (ICCPR), of which the HRC is the guardian."[28]

Health is protected under the International Covenant on Economic and Social Rights, although reproductive rights are not expressively mentioned. According to Article 12 of the Economic Convention, States parties "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

Proceeding with Article 12, guidelines are suggested to ensure the full realization of the right by including: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child… (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases… (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.[29] Even in this case reproductive rights are treated indirectly when mentioning the reduction of cases of stillbirth and complications which would put at stake the survival of the unborn, such as the case of short intervals between multiple pregnancies. Priority is given, again, to the life of the unborn with no mention to the risks women may face during and after a pregnancy, what impacts may have to cope with in case of a pregnancy too close to another. These problems may affect both the unborn and the woman, but the focus is always directed on the unborn life and never on the well-being of the woman.

What is of principal interest in this Article is the reference to mental health, which is becoming more and more present in the reasoning behind the right to health discourse. Recognizing that mental health is equally important to physical well-being in the human right discourse, theoretically must lead to significant conclusions on the women's rights side. Rebecca Cook remarkably shows a perspective that needs to be considered to fully understand the women's health discourse and asserts: "because mental and social well-being are components of health, unwanted pregnancy that endangers mental or social well-being is as much a threat to women's health as is pregnancy that endangers survival, longevity, or physical health."[30] Even in this case, States parties have obligations to protect women's lives, especially after recognizing that maternal mortality is preventable through government actions

[28] S., De Vido. (2020). Violence against women's health in international law. *Manchester University Press*, 3.
[29] R. J., Cook. (1993). International Human Rights and Women's Reproductive Health. *Studies in Family Planning*, p. 36
[30] Ibid., p. 82.

and might be held accountable for not achieving the desired results in safeguarding women's safety. Member States might be asked to report their advancement in achieving the goal to reduce maternal mortality according to the competent monitoring body, in this case the Economic Committee can observe States' results according to WHO's indicators on maternal mortality ratio goals.

The Economic Covenant provides another important right that may be invoked when reproductive rights and abortion are involved, which is the right to the benefits of scientific progress enshrined in Article 15(1)(b). According to Article 15 everyone is entitled to take advantage from scientific progress and its applications. By applying the right to benefit from the scientific progress in the reproductive health discourse, States have the duty to furnish whoever needs reproductive health care with the best and informed alternatives at disposal.[31] These methods can include male fertility regulating methods, contraceptives implants, nonsurgical abortion and contraceptives vaccines.[32] States have the priority to extend the availability of contraceptive methods, to encourage the use of safe birth-control methods while, where abortion is a legal procedure, States are required to offer non-surgical abortion methods, as result of scientific advances in reproductive care. States must safeguard the interests and well-being of everyone in the first place, hence are obliged to ensure that medical practitioners provide accurate information and practice the most recent scientific discoveries. Under these obligations, States are accountable of violation of the Convention in cases where abortion techniques proposed are not the safest available; a recurring example might be when evacuation is proposed to the patient instead of a safer practice such as suction abortion. Rebecca Cook suggests a clarifying example of how Italy has modified laws to meet the requirement of the right to the highest attainable scientific research progress by assuring "the use of modern techniques of pregnancy termination, which are physically and mentally less damaging to the woman and are less hazardous."[33]

1.2.1.2 Convention on the Elimination of All forms of Discrimination against Women (CEDAW)

The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) is the world's primary legal document on women's equality. It reflects the consensus of the international community on the specific protections and actions states are obliged to take to ensure equality between men and women. The CEDAW is the outcome of thirty years of hard work by the UN

[31] Ibid., 40.
[32] Ibid, 82.
[33] Ibid, 83.

Commission on the Status of Women. The aim of the Commission was to put under the spotlight all the failures in achieving women's equality with men on different grounds and to propose a document comprehensive of the existing declarations and conventions on the matter of gender equality and non-discrimination.

The Convention is a powerful instrument that not only furnish an international bill of rights for women but outlines an agenda for States to guarantee the enforcement of women's rights. Furthermore, it is the first international treaty that establish for its States Parties the legal obligation and duty to take action in eliminating all forms of discrimination against women. The Convention is built on the Universal Declaration of Human Rights but recognizes the urgency to dedicate specific attention to women's human rights condition. It is certainly not new that women find themselves in a disadvantaged position when talking about the enjoyment of human rights, it is even clearer if we are willing to take into consideration the disparities women face when reproductive and sexual rights are engaged.

The Convention is considered an instrument to eliminate discrimination in the economic, social, civil, political and cultural life by acknowledging that "extensive discrimination against women continues to exist", and stresses that such discrimination "violates the principles of equality of rights and respect for human dignity".[34] To eliminate the pervasive forms of discrimination, government action is necessary to empower women in all the different spheres of life. Discrimination is subtle and can permeate actions in all the field of social and cultural life affecting women's role in the society in multiple ways. Women's reproductive ability has historically been at the centre of population control policies through pro natalists campaign to boost the birth rate or, on the contrary, campaign to reduce birth rate in order to fight shortage of natural resources and reduce world hunger and poverty, at the point that the control over women's bodies has become the priority. For this reason, the Convention underlines that women must be able to enjoy their right to reproductive healthcare without being victims of sex-based discrimination. As we can read in article 12, "States Parties shall 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." Member States of CEDAW are also obliged to ensure access to pregnancy and post-natal services, proper nutrition and every health-related service and, when necessary, these services must be provided for free, as stated in the second point of Art. 12.

[34] UN General Assembly, *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, United Nations, Treaty Series, vol. 1249, preamble.

Discrimination based on sex in the field of healthcare arises when health services that only women need are neglected. In shaping the discrimination character of norms and policies, the role of sex and gender stereotypes cannot be ignored.[35] State's legislation should be examined to ensure that do not discriminate women in their enjoyment of the right to health, for example on the basis of their biological predisposition to pregnancy that distinguish them from men. Women's pregnancy capability may lead to various disadvantages or exclusion in fields such as education, employment or other work-related position precisely due to women's biological predisposition to childbirth, which in turn may lead to specific sex and gender-based forms of disadvantage that only women suffer. Laws that restrict or neglect women's access to healthcare, and specifically to those health services that only women need, put at stake the right to health and other human rights such as the right to privacy and the right to family planning, therefore condemning women to a more disadvantaged position in comparison to men, amounting to a form of discrimination against women.

In the CEDAW abortion is not explicitly covered due to the divergent positions of States Parties of the Convention, which would have impaired the achievement of a satisfactory ratification rate and the inclusion of the laws in the national legal systems of each States. This is another case in which the issue of abortion was too controversial to be included in an international human rights instrument, hence is considered a matter of internal affairs and is delegated to the sphere of each State's sovereignty.

1.2.2 Regional human rights systems

I have so far described what the legal framework of the right to health is, and what is provided for by the legislation on the abortion issue at the UN level. Regarding the regional human rights systems, the major instruments I am going to examine are the European Convention on Human Rights for what concern the European area.

The European Convention on Human Rights was adopted by the Council of Europe in 1950 and entered into force on 3 September 1953. At the moment, it counts 47 States parties who have both signed and ratified the document. The Convention originally created both a European Commission and a European Court of Human Rights entrusted with the observance of the engagements undertaken by the High Contracting Parties to the Convention, but with the entry into force of Protocol No. 11 to the Convention on 1 November 1998, the control machinery was restructured so that all allegations

[35] Cook. Women's Health and Human Rights, p. 21.

are now directly referred to the European Court of Human Rights in Strasbourg, France. This Court is the first, and so far the only, permanent human rights court sitting on a full-time basis.

The next to be analysed is the American Convention on Human Rights, 1969, also commonly called the Pact of San José, Costa Rica, since it was adopted in that capital city. The American Convention entered into force on 18 July 1978 and has 25 ratifying States parties, following the denunciation of the treaty by Trinidad and Tobago on 26 May 1998. The Convention reinforced the Inter-American Commission on Human Rights, which since 1960 had existed as "an autonomous entity of the Organization of American States". It became a treaty-based organ which, together with the Inter-American Court of Human Rights, "shall have competence with respect to matters relating to the fulfilment of the commitments made by the States Parties" to the Convention (art. 33).

Lastly, the chapter will conclude the analysis with the African Charter on Human and People's Rights on the Rights of Women in Africa, known as the Maputo Protocol, to cover the African area. The adoption of the African Charter on Human and Peoples' Rights in 1981 can be considered as the beginning of a new era in the field of human rights in Africa. With the entry into force on 21 October 1986, it now counts 54 ratifying States parties.

Although strongly inspired by the Universal Declaration of Human Rights, the two International Covenants on human rights and the regional human rights conventions, the African Charter reflects a high degree of specificity due to the African conception of the term "right" and the place it accords to the responsibilities of human beings. The Charter contains a long list of rights, covering a wide spectrum not only of civil and political rights, but also of economic, social and cultural rights. The African Charter further created the African Commission on Human and Peoples' Rights, "to promote human and peoples' rights and ensure their protection in Africa" (art. 30). In 1998, the Protocol to the Charter on the Establishment of an African Court of Human Rights was also adopted but entered into force only in November 2005, having been ratified by the required 15 member nations of the African Union, the protocol entered into force.

Out of the 55 member countries in the African Union, 49 have signed the protocol and 42 have ratified and deposited the protocol. Lastly, the additional Protocol concerning the rights of women in Africa, the Maputo Protocol, has been created within the framework of the African Commission on Human and Peoples' Rights, the Commission having been assisted in this task by the Office of the United Nations High Commissioner for Human Rights. The protocol provides broad protection for women's human rights, including their sexual and reproductive rights. These treaties have contributed to important changes in the laws of many countries, and, in view of the large number of States having

ratified, acceded or adhered to them, they are also becoming particularly important for the work of judges, prosecutors and lawyers, who may have to apply them in the exercise of their professional duties. Many of the provisions of the general treaties have been extensively interpreted, inter alia with regard to the administration of justice and treatment of persons.

1.2.2.1 European Convention on Human Rights

The European Convention on Human Rights and Fundamental Freedoms reaffirms the already recognized human rights principles present in the United Nations' Universal Declaration of Human Rights. In the preamble of the text, it is highlighted the historically inherent interest and respect for the recognition of fundamental human rights by the entirety of European governments, as a marker of ideals, freedom, principles and political, as well as legislative, traditions that unite the European community. The aim of the Convention, as established by the European Court of Human Rights, is obviously to achieve a situation where the respect of the fundamental human rights enshrined in the text is globally shared and "to ensure the observance of the engagements undertaken by the High Contracting Parties"[36].

Reproductive rights are not mentioned in the Convention, hence what we can observe is that reproductive and sexual rights have been ascribed in the Court's jurisprudence, even if in a broad manner, to Article 8 (right to respect for private and family life), which declares:

> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The European Court has ruled on issues regarding abortion under Article 8, trying to assess whether a right to abortion exists under this article.[37] The Court recognizes a wide margin of interpretation of the scope of the articles included in the Convention, the reason is driven by the necessity to adapt the

[36] ECHR, Art. 19.
[37] Cook. International Human Rights and Women's Reproductive Health, p. 81.

meaning of the principles to the diversity of each case in order to meet the new challenges of the ever-changing world.

The conclusion of the Court is that a right to abortion does not exist under the Convention, however in the famous case of *P. and S. v Poland* the decision was explanatory in saying that every State has the decisional autonomy in establishing the circumstances under which abortion may be authorized, if a right to abortion is in contraposition to the right to life of the fetus and eventually decide which interpretation enforce.[38] In fact, the Court does not take a position over moral issues but rather analyzes the cases to assess if the law was rightfully applied in accordance with the principles of the Convention or if there was a discrepancy in the enforcement. The content provided on the Guide on Article 8 of the Convention, published by the European Court of Human Rights, was created with the purpose of informing legal practitioners on the Court's fundamental judgements and decisions delivered on this specific article.

Through past cases on the matter, the Court has contributed to give helpful clarifications to Member States for a correct observance of the article and about the engagement that derives from the ratification of the document, hence posing certain standards of protection of human rights. Regarding the right to respect for private and family life, the Court has reserved specific attention to the issue of reproductive rights in a dedicated paragraph. The topic of abortion is the first to be analyzed, in which the Court specifies that "the prohibition of abortion when sought for reasons of health and/or wellbeing falls within the scope of the right to respect for one's private life and accordingly within Article 8"[39].

The Court provides for States Parties both obligations, the provision of a regulatory framework and an enforcement machinery, and the implementation of specific measures, where necessary. When a State's legal framework contemplates the right to abortion, this should be shaped in a manner coherent with the obligations deriving from the Convention. Ascribing reproductive rights under Article 8, leads to the result of limiting women's reproductive activity and sexual freedom to the private sphere.

This approach can have different consequences. On the one hand, it might be positive to assign a private character to abortion, pertaining only to women, if this leads to the capacity of every woman to decide freely over her reproductive life without interference; on the other hand, it absolves States

[38] J. N. Erdman. (2014). The Procedural Turn: Abortion at the European Court of Human Rights in Rebecca J. Cooks et al.'s Abortion Law in Transnational Perspective Cases and Controversies. Philadelphia *University of Pennsylvania Press*, p. 122.

[39] Council of Europe: European Court of Human Rights. (2020). *Guide on Article 8 of the European Convention on Human Rights - Right to respect for private and family life*, p. 28.

from taking concrete action into the advancement of reproductive rights, hence implying that the State has no say over reproductive and private matters. On the absence of a right to health or a right to reproductive health, Sara De Vido has written in her work that:

> "Regional human rights courts and UN treaty bodies, by means of interpretation, have easily overcome the absence of an express treaty provision on the right to health by applying 'other' human rights. In other words, international and regional jurisprudence has not directly ensured respect for the right to health; rather, it has indirectly promoted the right's content by applying other, more 'justiciable' rights. This affirmation does not reduce the importance of the right to health. The right to health *is* a human right and so is the right to reproductive health; despite being 'latecomers' among the human rights, that is economic, social, and cultural rights, these rights *are* human rights, which create legal obligations on states that ratified the international treaty in which the same rights are enshrined. Furthermore, at the domestic level, the right to health has found wide recognition; more than two-thirds of the world's constitutions make some reference to the right to health, and 'health-related litigation is now commonly pursued in domestic courts.' The right to reproductive health has recently gained momentum, thanks to an increasing number of cases, in particular on abortion- related issues."[40]

The European Court's jurisprudence takes a clear direction over the matter, which can be easily grasped from two landmark cases, the one of R.R. v. Poland and P. & S. v. Poland.

R.R. v Poland has confirmed what can be regarded as an international common direction, determining a direction of interpretation of cases of abortion but also created a legal ground of action in the international community. This case has acknowledged that when a serious mechanism of blockage occurs, de facto impeding access to legal abortion and to related services, this problem cannot be reduced only to one act of interference by the State (Article 8) but can amount, here lies the novelty of this case, to a violation of the State's positive obligations under Article 3 (prohibition of torture and inhuman or degrading treatment).[41] The case of P. & S. v. Poland further clarifies the Court's stance that reproductive health services that are legal must also be accessible.

As highlighted by Johanna Westeson, Regional Director for Europe, Center for Reproductive Rights, the same Center that represented the applicants before the ECtHR, it also develops important reasoning on the vulnerability of young rape victims as well as their right to personal autonomy in matters of reproductive choice. Westeson notes also that this groundbreaking case is particularly relevant with regard to the sexual and reproductive rights of adolescents because it legally challenges regimes that put restrictions to young people's reproductive self-determination, even in a context of

[40] De Vido. Violence against women's health in international law, p. 4.
[41] A. Timmer. (2011). R.R. v. Poland: of reproductive health, abortion and degrading treatment. *Strasbourg Observers*.

absence of an effective right to health or reproductive health, by posing limits such as parental consent or strict requirements to prove rape as the basic ground to access to legal abortion.[42]

Both the landmark cases mentioned are explanatory of the Court's modus operandi in absence of a direct right to health. In fact, the Court can easily recognize and protect the victims from a violation of their right to health, or more specifically their reproductive health, by applying other rights, such as Article 3 and Article 8 as we have just seen. Unfortunately, the Court has never decisively taken sides in the abortion discourse.

In the X. v. United Kingdom, the Court held that the fetus does not enjoy an absolute right to life.[43] At the opposite, the Court's approach has taken a turn in Vo. v. France that sees pregnancy as not pertaining entirely to the private life of the mother, therefore assessing that the fetus does have rights under certain circumstances.[44] This is a clear demonstration that the Court was unwilling to take a decisive step in leading the advancing of abortion laws. Another consideration that is missing in the Court' stance, that emerges clearly in the P. and S. v. Poland case, is the will to recognize the discriminatory nature of these violations, which in turn cannot be ignored by the women whose reproductive and sexual rights are denied. In both the cases just mentioned the applicants claimed a violation of the prohibition of discrimination (Article 14) in relation to other relevant articles, precisely because the delay or the denial of reproductive health services is a form of discrimination against women.

These are not the only cases in which the Court declined to give an opinion on the matter. Although the Court is increasingly open to acknowledging reproductive rights as human rights under the Convention, at least when problems arise with practical access to legal services and protection against humiliation and harassment in the reproductive health field, reproductive rights advocates still have ways to go to convince the Court that these violations also are an expression of gender discrimination.[45]

[42] J. Westeson. (2012). P and S v. Poland: adolescence, vulnerability, and reproductive autonomy. *Strasbourg Observers*.
[43] X v United Kingdom, no.8416/79, ECmHR 1980.
[44] Vo v France [GC], no. 53924/00, §80, ECtHR 2004.

[45] Westeson. P and S v. Poland: adolescence, vulnerability, and reproductive autonomy.

1.2.2.2 American Convention on Human Rights

The first indication of legal provisions related to abortion that we find in the American Convention on Human Rights is Article 4. In Article 4, the American Convention protects the right to life from the moment of conception:

Article 4. RIGHT TO LIFE. 1. Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.

What is conveyed in the article leads to the initial assumption that a general prohibition of abortion is legally supported in the Convention and that States Parties are entitled to limit or criminalize abortion in their national laws. We find a clarification on the matter by the respective human rights tribunal, the Inter-American Commission on Human Rights (IACHR). Examining the IACHR jurisprudence, and in particular the interpretation of article 4 proved to be ambiguous in the Baby Boy case, we assume that, in general, the right to life starts from the moment of conception.[46] The words "in general" indicate that the Convention does not necessarily give priority to unborn life over the life or health of born persons, since protection of prenatal life does not clearly withdraw protections from born persons.[47]

The provision in the Convention may require protection of unborn life against injuries, for instance, that would impair the life of a human being, but not necessarily limit abortion to preserve the life or health of a woman, or indeed of other children in her family. In this sense, national legislation which permits abortion, whether in any case or under certain circumstances, according to the Court does not constitute a violation of Article 4 precisely because the right to life of the mother must prevail and should be weighed against the right to life of the unborn. Is therefore reasonable to assume that the intention behind the provision regulating the right to life is not in contraposition to the decision-making power of every ratifying State? The intention of the Convention is not to create an obligation to prohibit or criminalize abortion, but rather to give State members the freedom to decide upon the matter in their domestic legislation.

In contrast, in the American Declaration on the Rights and Duties of Man the issue of the life of the unborn is not mentioned, but it is rather recognized the right to life of every “human being”. In the

[46] IACHR, *White and Potter (Baby Boy) v. the United States*, resolution 23/81, Case 2141, 1981
[47] A. Paul. (2012). Controversial Conception: The Unborn and the American Convention on Human Rights. *Loyal University Chicago International Law Review*, p. 215.

preamble of the Declaration the observation that "all men are born free and equal" suggests that these principles are conditional on live birth.[48] The Inter-American Commission determined that the 1973 famous US Supreme Court decision, in Roe v. Wade case, recognizes women's constitutional right to abortion, therefore clarifying that the American Declaration is inapplicable to the unborn and that abortion is compatible with the Declaration itself. Shifting the focus to the broader sphere of reproductive rights, under the American Convention on Human Rights we find different rights pertaining to this ambit. Article 11 provides the right to decide the number and spacing of one's children, which is protected also under the Protocol of San Salvador in Article 10; Article 17 establish the right to start a family (as well as Article 15 of the Additional Protocol of San Salvador); moreover, the Convention recognizes the right to access to family planning information and education (Art. 13) and the right to family planning methods (Art. 10 of the Protocol of San Salvador).

1.2.2.3 African Charter on Human and People's Rights on the Rights of Women in Africa and the Maputo Protocol

The African region is afflicted by a major, and unfortunately, widespread problem which is the high mortality ratio due to unsafe abortion procedures that challenge the African states' public health.[49] It is true that there is a common trend toward the liberalization of abortion at a global scale, of which Africa has been part, but criminalization still constitutes an obstacle to the full achievement of women's health rights. Efforts to achieve a reform of abortion legislation need to be directed towards the promotion of women's full access to specific health care, which implies target actions pursued by States to ensure that the already existing laws permitting abortion are effectively implemented. After having recognized that from highly restrictive laws or the total criminalization of abortion originates an important link to maternal mortality and morbidity, the African region has taken steps in the liberalisation process of abortion from three decades already.

In this scenario, a turning point in the human rights framework is the recognition of abortion, for the first time, as a right established by the African Charter on Human and People's Rights. Despite being the primary treaty providing a framework for human rights in the region, its provisions on women's rights are largely seen as ineffective and inadequate. Women's rights are recognized in three

[48]R. Copelon et al. (2005). Human Rights Begin at Birth: International Law and the Claim of Fetal Rights. *Reproductive Health Matters: An international journal on sexual and reproductive health and rights,* p. 125.
[49] World Health Organization. Preventing unsafe abortion. https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion

provisions of the Charter. Article 18(3) requires States Parties to "ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman.", while article 2 provides that the rights and freedoms enshrined in the charter shall be enjoyed by all, irrespective of race, ethnic group, color, sex, language, national and social origin, economic status, birth or other status.[50]

To conclude, article 3 of the African Charter affirms that every individual shall be equal before the law and shall be entitled to equal protection of the law. And yet the protocol notes that "despite the ratification of the African Charter ... women in Africa still continue to be victims of discrimination and harmful practices." The protocol, which resulted from years of activism by women's rights supporters in the region, has attempted to reinvigorate the African Charter's commitment to women's equality by adding rights that were missing from the charter and clarifying governments' obligations with respect to women's rights. The article which regulates abortion is contained in Article 14 of the Protocol of the African Charter on Human and People's Rights on the Rights of Women in Africa, which provides a detailed list of provisions in the field of health and reproductive rights:

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

a) The right to control their fertility;

b) The right to decide whether to have children, the number of children and the spacing of children;

c) The right to choose any method of contraception;

d) The right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;

e) The right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognized standards and best practices;

f) The right to have family planning education.

[50] R. J. Cook. (1994). Human Rights of Women: National and International Perspectives. *University of Pennsylvania Press*, p. 290.

2. States Parties shall take all appropriate measures to:

a) Provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas.

b) Establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;

c) Protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

In the Maputo Protocol, unlike what we have seen so far, reproductive rights are directly mentioned and are not merely included in the scope of the right to health or ascribed to other relative rights. This aspect is particularly important since the issue of reproductive rights, and more importantly the right to abortion, acquires the just relevance that belongs to the matter. In fact, by including the right to abortion in the African Charter, the nature of the law is strengthened and the aspects deriving from being ascribed to a lawful and protected practice gives it, as a matter of a fact, equal dignity to the other fundamental and unquestioned rights.

Article 14(2)(c) specifies that abortion is permitted in cases of sexual assault, rape, incest, when the physical health of the woman or the fetus are in danger and, interestingly, extends the right to all the cases in which the mental health of the pregnant woman is at stake. As we can read in the General Comment No.2 on the same article,

> "it should be noted that the Maputo Protocol is the very first treaty to recognize abortion, under certain conditions, as women's human right which they should enjoy without restriction or fear of being prosecuted" and also, "… it is for the first time that the right to safe abortion in the limited cases listed is expressly established by a legally binding international instrument."[51]

The merit of the Maputo Protocol is that, in recognizing the gender inequality afflicting women, establishes its commitment in eliminating the gap between men and women, which is undoubtedly

[51] General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

considered the cause undermining the social, economic and political empowerment and in turn have, more generally speaking, effects on human security.[52]

The Women's Protocol was adopted in 2003 but entered into force only in 2005 and at the moment counts 49 signatories, 42 of which have ratified the document. To have full effect, the Protocol needs not to be only ratified but also incorporated in the domestic law of every State Party in order to achieve the full enforceability at national level. Unfortunately, not all African States have included the regulations provided by the Protocol in their legal system. Ratification of the Protocol means that women are protected against inequality, abuses and violence on paper, but this makes no difference in women's life if there is no adherence into national standards. In fact, States should be held accountable for violations of women's human rights under the Charter and its additional Protocol for lack of effective implementation of existing abortion laws, which can be an important juridical tool for creating a legal framework to secure access to safe abortion.

The African Charter provides the establishment of the respective Commission, which have the duty to "promote human and people's rights and ensure their protection in Africa" through various means, such as requiring States Parties to the Charter to submit periodic reports on the legislative and other measures taken to promote and protect the rights enshrined in the Charter and to ensure the enjoyment of sexual and reproductive health of women and girls.[53] The African Commission has also formulated an interpretive guidance through a general comment to assist governments, especially their ministries of health, to design and apply abortion laws in a balanced, transparent, fair, and nonarbitrary manner.[54]

1.3 Jurisprudence and international bodies' positions about abortion

1.3.1 International abortion case law in the absence of a direct right to abortion

According to the Guttmacher Institute, approximatively 121 million unintended pregnancies occurred each year between 2015 and 2019.[55] The possibility to incur in an undesired pregnancy is a constant

[52] R., Sigsworth and L., Kumalo. (2016). Women, peace and security – implementing the Maputo Protocol in Africa. *Institute for Security Studies*, p. 4.
[53] Organization of African Unity (OAU), *African Charter on Human and Peoples' Rights ("Banjul Charter")*, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), art. 62.
[54] J. N., Erdman and R. J., Cook. Decriminalization of abortion – a human rights imperative. *Best practice & research. Clinical obstetrics & gynaecology*, p. 17.
[55]Guttmacher Institute. "Unintended Pregnancy and Abortion Worldwide". https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide

in women's and girl's lives. Every woman in her fertile period of life has come to a point in which the possibility of incurring in a pregnancy has crossed her mind, every woman has taken consciousness of the possibility. In fact, these numbers might be surprising only for the fact that many, if not the majority, of women who undergo abortion do not report it easily to their acquaintances, sometimes keeping it secret even to the family or their intimate partners, often driven by the fear to be the subject of stereotypes and stigma regarding abortion.

After a first look at the matter, it is not so difficult to believe that those numbers are real and that they depict a scenario not so hard to imagine. Abortion is a normal medical procedure as much as incurring in an unintended pregnancy. Many cases were brought in front of the various international treaty bodies in which unintended pregnancy and abortion were the focus, that lead to the development of a shared position of the Courts on the matter of abortion and giving us a more comprehensive and complete picture of the issue in the international human rights scene.

Jurisprudence has been implemented and has contributed to an ever-growing attention to the issue of reproductive and sexual health rights, also thanks to the work of the various global movements, NGOs and reproductive health centers around the globe that fight for the recognition of women's needs.

In the last section of the chapter, the analysis will focus on how different treaty bodies have ruled on selected abortion cases in the absence of a direct right to abortion in international law, how the jurisprudence has evolved over the years and how these cases have improved women's sexual and reproductive health and rights. I have so far shown that international human rights treaties do not comprehend provisions establishing a right to abortion, with the only regional exception of the African Charter and the Maputo Protocol, indeed they give instructions on how to interpret the legal instruments to protect and guarantee reproductive and sexual rights.

Anti-abortionists argue that in no cases there is an internationally recognized "right" to abortion, that abortion is not part of customary norms of international law, that a "right to die" does not exists, hence abortion, assisted suicide and euthanasia are not mentioned nor are implicit anywhere in human rights treaties. The question that arises is how human rights monitoring bodies have acted in cases of abortion considering that this difficult issue is of domestic jurisdiction.

The CEDAW Committee has issued one ground-breaking decision in the case L.C. v. Peru, involving the critical issue of the access to safe and legal abortion, built on recent developments in the

interpretation of international standards on the above-mentioned rights. L.C. was 13 years old when she was repeatedly raped by a 34-year-old man who lived in the same poor neighbourhood near Lima. As a result of the abuse, she became pregnant and developed a serious form of depression, which led the girl to attempt suicide by jumping from a building. She was then diagnosed with a vertebromedullar cervical trauma and a complete medullar section with a risk of a permanent disability caused by the fall. The damage caused paraplegia to both the upper and lower limbs requiring emergency surgery. The head of the neurosurgical department recommended immediate realignment of her spine, but the surgeon refused to perform the surgery due to her pregnancy. The medical board refused to perform an abortion, even though Peruvian law permits abortion in cases where the health or the life of the woman are at risk. L.C. was operated only after she miscarried and after a period of three months. Needless to say, the surgery was to be performed immediately. Unfortunately, the delay diminished the success of the intervention and L.C. is now quadriplegic.

The case was brought in front of the Committee by the mother of L.C., which was represented by the Centre for Reproductive Rights and the Centre for the Promotion and Protection of Sexual and Reproductive Rights. The author claims a violation of articles 1, 2(c) and (f), 3, 5, 12 and 16(e) of the CEDAW.

The Committee considered the claim admissible and proceeded to examine if a violation had occurred. It was noted that the Peruvian Health Act repealed the procedure for therapeutic abortion and created a legal vacuum, since it did not provide any instruction to request the therapeutic abortion that is indeed allowed under article 119 of the Penal Code.

The author asserted that there was a clear connection between the postponement of the necessary surgery and her pregnancy status, claiming a violation of article 5 (freedom from sex role stereotyping and prejudice) “because timely access to medical treatment was made conditional on carrying to term an unwanted pregnancy, which fulfils the stereotype of placing L.C.’s reproductive function above her right to health, life and a life of dignity”.[56]

The Committee agreed on that the respondent state had violated Article 5 of the convention insofar as the decision to postpone the surgery was clearly influenced by the stereotype that the health of the fetus should prevail over the health of the mother.

[56] CEDAW. L.C. v. Peru, Communication No. 22/2009, 8.10.

This is an extremely common scenario where the medical personnel place their personal beliefs, in the majority of the cases driven by their religious background, before the interests of the patient, causing numerous problems and difficulties to the person requiring abortion. She also alleged a violation of article 12 (right to health) of the Convention because the continuation of the pregnancy represented a threat to the physical and mental health of L.C. In this sense, it is of uttermost importance the statement of the Committee, which noted that the failure of the State Party to protect women's reproductive rights by establishing a clear legislation permitting abortion on the grounds of sexual abuse and rape are facts that contributed to the situation of the victim of the violations. The Committee also considered that the repeal of domestic legislation that had provided for therapeutic abortion consistent with the provisions of Article 119 of the Penal Code had left L.C. without legal recourse when the respondent state denied her request for a legal abortion.

The Committee concluded that such circumstances constituted a failure to "take all appropriate measures to eliminate discrimination against women in the field of healthcare," as required under Article 12 of the Convention. The significance of this statement resides in the recognition, as highlighted by Sara De Vido, that "the legislation caused or created the conditions in which violence against the applicant occurred",[57] an approach that will be discussed in detail in the next chapter. The applicant invoked also Article 16, paragraph 1(e), claiming a violation of her right to decide the spacing and the number of children, but it was considered unnecessary to rule on the possible violation of Article 16, paragraph 1(e) of the Convention. In the decision of the Committee clearly emerges the urgency to make States accountable for their obligations to take appropriate measures and eliminate discrimination against women in the field of health care, to ensure equality of men and women in this specific field, especially in matters of family planning. In this sense, the Committee recalls its General Comment No. 24 according to which it is a discriminatory practice if a State Party refuse to provide for the legal performance of certain reproductive health services for women, not to mention the obligation to respect, protect and fulfil women's rights to health care.

According to the Committee, the medical board denied the termination of the pregnancy because it did not consider L.C.'s life to be in danger, but most importantly, failed to recognize the damage to her health, ignoring the mental suffering, which is a right protected under the Constitution of the State Party. The key element of the decision, together with another landmarking CEDAW's decision (Alyne da Silva Pimentel v. Brazil), marks the first time a UN treaty monitoring body has established that a State have violated the right to lawful access to health care as an aspect of a discriminatory

[57] S., De Vido. (2020). Violence against women's health in international law. *Manchester University Press*, p. 75.

practice on the basis of sex by failing to guarantee adequate reproductive health services in conditions of equality.[58]

The Committee reinforced its stance by calling on Peru to review its law with the aim of establishing a mechanism for effective access to therapeutic abortion at least under conditions that protect women's physical and mental health and to decriminalize abortion when the pregnancy is the result of sexual abuse or rape. The Committee's stance is part of a wider set of standards enshrined in human rights treaties and developed by regional and national courts. UN treaty bodies have been producing an ever-growing body of jurisprudence that establish, along with the decriminalization and the circumstances when abortion must be legally accessible, the mandatory obligation for States to provide rapid access to post-abortion care regardless the legal status of the medical procedure.

The Committee concluded that Peru had violated Articles 2(c) (equal protection), Article 3 (guarantee of basic human rights and fundamental freedoms), Article 5 (freedom from sex role stereotyping and prejudice) and Article 12 (right to health) to be read together with Article 1 (freedom from discrimination) of the Convention.
The significance of LC v Peru lies in the recognition that State has a specific obligation, the duty to make national abortion law transparent and enjoyable not only on the paper. The right to abortion, where existent, must be enforced in practice; women must be in the position to enjoy of any abortion-related right and reproductive health services that the state displays in its legislative system. L.C. v Peru makes a significant contribution in the developments of international jurisprudence under the power of a globally ratified treaty, one that specifically requires states to protect women's reproductive rights, equally and free from discrimination. This case has the merit of putting under the spotlight an important point of view, now increasingly shared, that abortion is a human right that goes beyond what could be simplistically addressed as a matter of domestic political, ethical and religious interests.

Turning our attention to the European scene, on December 16, 2010, the European Court of Human Rights delivered its decision in *A, B and C v. Ireland*. The case of *A, B and C v. Ireland* was brought by three undisclosed applicants, A, B and C, each of whom was forced to travel to England in order to procure a safe abortion. The applicants contested Ireland's failure to implement its existing abortion law, which only authorizes abortion if a woman's life is at risk, also challenging its restrictive

[58] E. Kismödi et al. (2012). Human rights accountability for maternal death and failure to provide safe, legal abortion: the significance of two ground-breaking CEDAW decisions. *Reproductive health matters,* p. 34.

law as such. The Irish Constitution, unlike the European Convention on Human Rights, explicitly extends the right to life to the unborn foetus. Abortion is moreover prohibited under the criminal law by section 58 of the Offences Against the Person Act 1861 ("the 1861 Act") providing as penalty "penal servitude for life". However, this does not mean that abortion constitutes a criminal act in all circumstances in Ireland.

The 1861 legislation needs to be read in light of the amended Irish Constitution, which states in Article 40.3.3: "The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, and, as far as practicable, by its laws to defend and vindicate that right; this subsection shall not limit freedom to travel between the State and another state; This subsection shall not limit freedom to obtain or make available, in the State, subject to such conditions as may be laid down by law, information relating to services lawfully available in another state."[59]

Bearing in mind the legal context, applicant A sought an abortion for what the Court called "health and well-being" reasons. She was living in poverty when she became pregnant unintentionally, believing that her partner was infertile.[60] She had four young children in foster care and had experienced depression during each of her previous pregnancies. Applicant A declared that having another child at that time would have placed her health at risk and jeopardized the potential reunification of her family. She believed that she was not legally entitled to an abortion in Ireland, and therefore decided to travel to England. She borrowed the money needed for travel expenses and for the treatment at a private clinic in England from a money lender at a high interest rate.

Applicant B sought an abortion for, according to the Court, "well-being reasons." Like applicant A, she also became pregnant unintentionally and despite using emergency contraception. She decided to travel to England for an abortion, because she could not care for a child by herself at that point in her life and believed that she was not legally entitled to an abortion in Ireland. Applicant B also encountered difficulties in finding the money necessary to cover her travel expenses due to her poor financial situation. Upon her return to Ireland, she began to pass blood clots, but delayed seeking medical care because she was unsure about the legality of traveling abroad for an abortion.

[59] Elizabeth Wicks. (2011). A.B.C v Ireland: Abortion Law under the European Convention on Human Rights. *Human Rights Law Review*, p. 2.
[60] Strasbourg Observers. (2011). A.B. and C. v. Ireland: Abortion and the Margin of Appreciation.

Applicant C unintentionally became pregnant while in remission from cancer. Unaware that she was pregnant, she underwent tests for cancer that were contraindicated during pregnancy. Upon discovering that she was pregnant, she was unable to find a doctor willing to provide sufficient information about the pregnancy's impact on her life and health or what consequences would have been on the fetus with the various medical examinations. Consequently, she researched the risks to the fetus and decided to travel to England for an abortion.

The Court delivered two different outcomes distinguishing between the circumstances of the first and second applicant on the one hand, having travelled to obtain an abortion for health and/or wellbeing reasons, and the third applicant, who feared for her life, on the other. Each applicant alleged that the law, which forced them to travel abroad to obtain an abortion, caused physical and psychological anxiety amounting to a violation of article 3 (right to be free from inhuman and degrading treatment) which was dismissed by the Court in all the three cases.

All the three applicants alleged that there was also a violation of their right to be free from discrimination based on sex while applicant A claimed she allegedly suffered also from discrimination as an impoverished woman (Article 14). Applicants A and B declared also to have suffered a violation of their right to respect for private life and their physical integrity due to the prohibition of requiring an abortion in Ireland for health and well-being reasons.

Applicant C alleged that the State's failure to adopt a clear legislation implementing the right to abortion, enshrined in the constitution, even when women's lives are at risk violates the same right to private life (Article 8). According to the applicants the Irish system impeded them to avail themselves of an effective remedy for challenging the restrictive law and, in the case of applicant C, also the inadequate legal framework regulating legal abortion violated her right to an effective domestic remedy (article 13). In addition, Applicant C stressed that the State's failure to implement the constitutional right to life (Art. 40.3.3 of Irish Constitution) permitting abortion when the woman's life is at risk, made impossible to require abortion in Ireland even when there is a threat to life, hence applicant C claimed a violation of her right to life (Article 2).

The European Court of Human Rights determined that no violation of Article 3 arose (prohibition of torture or inhuman or degrading treatment) for any of the three applicants because the minimum level of severity of mistreatment had not been reached, the same goes for Article 13 (the right to an effective remedy), for Article 14 (prohibition of discrimination) and for Article 2 (right to life) with regard to Applicant C. The Court proceeded to evaluate the case on the basis of Article 8, to be read in conjunction with Article 13 and 14 on some supplementary issues. Ireland was found in violation of

its positive obligations with respect to Applicant C under Article 8 (the right to respect for private life). The same violation was not found with regard to Applicant A and B.

Several critical points emerge from this case. To start with, the uncertainties that pervade the possibility to undergo an abortion in Ireland and, more specifically, what cases are permitted under Irish law. Each of the three applicants reported uncertainty about the eligibility criterion in requiring the procedure. The possibility to require post-abortion medical care was also unclear to the applicants, as shown in Applicant B's claim, which was suffering from blood clots and hesitated to ask for help because she was not sure about the legality of travelling abroad to require an abortion. As far as the applicants might have known they were conducting criminal acts.

An entire aura of mystery surrounds the whole process of requiring an abortion. Proof of this is the opinion delivered in the joint observations of Doctors for Choice and British Pregnancy Advisory Service (BPAS), who thankfully brought to the attention of the Court the perspective of the medical profession. They highlighted that also Irish doctors' position was unclear, they didn't have instructions on what they could do, even when they needed to provide advice to women requesting abortion, they "faced criminal charges, on the one hand, and an absence of clear legal, ethical or medical guidelines, on the other".[61] Most shocking is the statement according to which doctors do not receive any medical training on abortion techniques, which translates in a poor medical service offered to women that surely do not meet the highest standards of health care.[62]

So far, it seems that even in case of risk to the woman's life, which is the only case theoretically permitted under Irish law, Ireland fails to provide an adequate service and fails to show commitment in protecting women's life in favor of the right to life of the unborn. The joint observation of BPAS and Doctors for Choice points out that they had "never heard of any case where life-saving abortions had been performed in Ireland".[63] In a situation where lawful abortions are non-existent in Ireland, if not on the paper, it is quite surprising that the Court decided to ignore the important consequences this negligence can have. States are exhorted to respect their obligations to remove legal, medical, clinical and regulatory barriers to reproductive health information under the Cairo and Beijing Platform and to provide a regulatory framework on reproductive rights under Article 8 of the Convention. As for the domestic legislation, art. 40.3.3 of the Irish Constitution provides that the

[61] Joint observations of Doctors for Choice (Ireland) and BPAS, A.B. and C. v. Ireland, p. 57.
[62] Ibid.

[63] A, B and C v. Ireland, No. 25579/05 Eur. Ct. H.R. (2010). at para 207.

prohibition of abortion "… shall not limit freedom to obtain or make available, in the State, … information relating to services lawfully available in another state."

Ireland fails to provide clear information not only to women who request abortion but also to medical personnel, while women lawfully entitled to abortion find no legal or medical support due to the absence of a guideline to assess when their lives are to be considered at risk and therefore eligible to the procedure. The claim was declared inadmissible because the first two applicants failed to demonstrate which information they could not obtain. However, it was not so long ago that the same European Court of Human Rights "held Ireland in violation of individual's right to receive and impart information because the government tried to prevent the circulation of information about abortion services legally available in Britain"[64].

At the present day, the new law removes criminal penalties for the person who get an abortion, but it maintains them for doctors who helps women get an abortion outside the terms of the law. Activists point out that this creates a chilling effect for doctors in formulating their interpretation of the new abortion law. Doctors end up working in a climate of fear for a potential criminalization, they take a cautious approach that inevitably penalize clients and results in delays and misinformation. [65]

Even when women might be entitled to a lawful abortion inside the State, the unclear environment surrounding abortion leaves no option other than traveling abroad to exercise what in other states is recognized as a human right. This debated solution carries with itself a series of problems that, even though highlighted by the Court, did not get proper attention and that will be analyzed in detail in the next chapter. Traveling abroad to require a highly stigmatized and prohibited medical procedure "constituted a significant psychological burden on each applicant."[66]

However, psychological distress is not the only burden women may face. Financial difficulty is a component that a woman requiring an abortion in Ireland must consider, which not only could be considered a ground of discrimination as such but was also presented to the Court by applicant B as an aggravating factor.[67] This solution was proposed to balance the competing right to life of the unborn, or better to say the profound morals of the Irish people, and the right to request an abortion for health and well-being reasons. However, this decision excuses Ireland for forcing women to travel

[64] Cook and Fathalla. Advancing Advancing Reproductive Rights Beyond Cairo and Beijing, p. 119.
[65] S. Calkin. (2020). The conversation, "One year on, it's clear that the new Irish abortion services have serious limitations".

[66] Ibid, supra note at 63, at para 127.
[67] Ibid., at para 128.

outside the country to get access to abortion by failing to hold Ireland accountable for its obligation under the right to private life and, by delegating the task to the neighboring states, fails to demand a consistent application of human rights principles shared among the Council of Europe member states. The question is, is the prohibition of abortion for health and well-being reasons necessary to protect moral values in a democratic society like Ireland?

The Court had to assess if this provision could have been regarded as an interference by the State, amounting to a violation of the right to private life (Article 8), or if this interference was justified under the margin of appreciation accorded to Ireland. Here we find a critical aspect in the abortion discourse: the private nature of pregnancy. The Court, and previously the Commission, has left the question open by saying that pregnancy cannot be said to pertain uniquely to the sphere of a woman's private life and must be regarded as an aspect of it, implying that not any regulation of abortion amounted to an interference with Article 8. This approach was already expressed in Tysiac v Poland and Vo v France before reiterating it in A, B, C v Ireland case, in which the Court held that "Article 8 cannot be interpreted as meaning that pregnancy and its termination pertain uniquely to the woman's private life as, whenever a woman is pregnant, her private life becomes closely connected with the developing foetus".[68] Although not crucial to the outcome of the A, B, C case, this highlight the wider problem of drawing the distinction between what is private and what is public. Government must have a strong justification to interfere in its citizens' private lives. While the Court stated that not every regulation of termination of pregnancy would amount to an interference to the right to respect for private life, it concluded that such an interference occurred in the case of the first two applicants, even though it promptly determined the legitimate aim of the protection of morals prescribed by the law.

The remaining issue for the Court in the cases of the first two applicants and clearly the most challenging one, was whether the prohibition on abortion in Ireland is necessary in a democratic society, as required by Article 8(2). The Court relied on the matter of the margin of appreciation in formulating its decision, which became the focus of the reasoning behind the unexpected outcome that sees the restrictive Irish abortion law justifiable. A wide margin of appreciation was accorded to Ireland based "on the profound moral views of the Irish people as to the nature of life ... and as to the consequent protection to be accorded to the right to life of unborn ...". In balancing the right to respect for their private lives and the rooted belief behind the need to protect the life of the unborn, the Court

[68] Ibid., at para 213.

sought to define what was the entity and the extent of the "margin of appreciation" to accord to the State in order to assess if there was a violation of State's obligations in a restrictive abortion law as the one of Ireland.

The margin of appreciation allowed to member states, as stated by the Court, is narrower where an important aspect of a person's identity is at stake or where a consensus among member states of the Council of Europe exists.[69] A broad consensus among the Council Member States that permits abortion on broader grounds compared to the ones granted under Irish law exists. The European Court did not fail in recognizing that "the first applicant could have obtained an abortion justified on health and well-being grounds in approximately 40 member States and the second applicant could have obtained an abortion justified on well-being grounds in 35 member States."[70] However, the Court examined if this wide margin of appreciation needed to be narrowed by the existence of a relevant European consensus on the matter of abortion. The Court assessed that a European consensus does not exists on whether the right to life begins before or after birth and, since the life of the woman and the unborn child are inextricably interconnected, the margin of appreciation necessarily translate on how it balances the conflicting rights of the mother and the unborn.

As we have already seen, in order to meet the needs of women seeking a termination of pregnancy for health and well-being reasons, as in the cases of applicants A and B, Ireland allows women to lawfully travel to another State to get access to abortion and allegedly grants also the possibility to obtain information and medical care in Ireland. On this matter, the judges Rozakis, Tulkens, Fura, Hirvelä, Malinverni and Poalelungi has issued their partly dissenting opinion in which they explained why Ireland should have been held in violation of article 8 in the case of the first two applicants. They contested the decision of the Court to focus on the lack of consensus on when life begins; they made it clear that the "issue before the Court was whether, regardless of when life begins – before birth or not – the right to life of the foetus can be balanced against the right to life of the mother, or her right to personal autonomy and development, and possibly found to weigh less than the latter rights or interests. And the answer seems to be clear: there is an undeniably strong consensus among European States – and we will come back to this below – to the effect that, regardless of the answer to be given to the scientific, religious or philosophical question of the beginning of life, the right to life of the mother, and, in most countries' legislation, her well-being and health, are considered more valuable than the right to life of the foetus." and therefore that it was not pertinent to this case.

[69] Ibid., paras. 232, 234.

[70] Ibid.

What surprises the most is that, as emphasized by the dissenters, this constitutes the first time that the Court has disregarded the existence of a European consensus on the basis of "profound moral views" and that "according to the Convention case-law, in situations where the Court finds that a consensus exists among European States on a matter touching upon a human right, it usually concludes that that consensus decisively narrows the margin of appreciation which might otherwise exist if no such consensus were demonstrated."[71]

The dissenting opinion was quite concerned for the departure from the Court's previous jurisprudence in dismissing a prevailing European consensus on the basis of a morals and ethical values. This point is reinforced by the position taken by the majority who failed to explain the reasons why the apparent lack of a consensus on when life begins should prevail, even in this specific case, over the acknowledged consensus to adopt more liberal abortion laws than those existing in Ireland.[72]

Furthermore, recognizing the existence of the consensus and then choosing to ignore it when defining Ireland's margin of appreciation is an undesirable approach that undermine the core of the Convention's obligations, which are evolutive by nature. The case of applicant C challenges the Irish abortion law from a different side, hence it was treated separately by the Court in its decision. Applicant C's complaint concerned the failure by the Irish State to implement Article 40.3.3. and to define a procedure according to which a woman whose life was at risk could establish if she qualifies for a lawful abortion within the Irish borders. The Court noted that there were no clear criteria or directives, neither derived from legislation nor from case law, to determine how to measure the risks threatening the woman's life. The absence of transparency in the system led the Court to effortlessly recognize the chilling effect that arise for both women and medical practitioners, the same chilling effect that would take place for the criminal penalties imposed on abortion services which can amount to life imprisonment.

The outcome of the reasoning of the Court has resulted in a confirmation of the allegation made by applicant C. Ireland was found in violation of its positive obligations under Article 8 for failing to implement the constitutional law that guarantees a lawful abortion, more precisely it noted that the

> "lack of legislative implementation of Article 40.3.3, and more particularly... the lack of effective and accessible procedures to establish a right to an abortion under that provision, ... has resulted in a striking discordance between the theoretical right to a lawful abortion in Ireland on grounds of a relevant risk to a woman's life and the reality of its practical implementation."

[71] A, B and C, Partly Dissenting Opinion at para 5.
[72] A, B and C v Ireland, Center for reproductive rights, p. 5.

In conclusion, what we can deduce is that abortion, contrary to what could be a globally shared aspiration, is not concretely a human right. Unfortunately, the fact that a right to abortion does not exists in the major international human rights documents has various consequences that cannot be ignored. The most evident is that a right to abortion, and therefore a violation of the same, can be invoked only when it is enshrined in the national legislation of the single State. States are called to comply with their obligations under human rights instruments but are considered in violation of them only when other more justiciable rights, such as the right to life, the right to privacy and family life, the right to be free from inhuman and degrading treatment etc., are violated. The reason is that a right to abortion is not yet perceived as a human right and its value is not immediate perception, not on the same depth of what happen when every other consolidated human right is violated. Numerous considerations can be made in light of the case-law we have just analyzed. First of all, the gendered stereotypes at the base of the discrimination matrix behind the abortion discourse, primarily in the reluctance in recognizing a right to abortion, go often unnoticed or are not considered one of the main factors in the Courts' reasoning.

1.3.2 General Comments, Recommendations and opinions on reproductive health and abortion

I have shown so far that a direct right to abortion does not exists in international and regional human rights systems, aside from the case of the Optional Protocol of the African Charter which legitimise abortion under specific circumstances. Provisions about abortion are interpreted and expressed in General Comments, Recommendations and opinion juris or in the jurisprudence of the human rights bodies monitoring the application of the same human rights instruments examined so far. Abortion is a highly safe and reliable medical procedure when performed by skilled health care providers and is certainly more common than what we might assume. It follows the need to discuss the matter in order to provide instructions to guarantee the respect of women's reproductive rights and secure their bodily autonomy.

- General comment No. 22 (2016) on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)

The UN treaty body of the ICESCR, the ESC Committee, has issued a detailed General Recommendation that tackle the matter of abortion. General Recommendation No. 22,[73] dated 2016, identified sexual and reproductive health as an integral part of the right to health and recognize the linkage with civil and political rights. As we have previously seen, an important merit of the Covenant is that it acknowledges to every person the right of enjoyment of scientifically accurate and most recent information concerning health procedures, among which abortion, and recognize that medical procedures to procure abortion, as well as pre- and post-abortion care, should be available to every person in need.

Although the CESCR has previously treated the issue of sexual and reproductive health in General Comment No. 14 on the right to the highest attainable standard of health, the Committee was of the idea to express its stance separately in a new comment, in light of the ongoing severe violations of the right to sexual and reproductive health care, addressing also the various practical barriers to the enjoyment of this right. In its work of monitoring the application of the Covenant by Member States, the Committee has found necessary to indicate, in General Comment 14 on the right to health and now in General Comment 22, the following interrelated characteristics of health care services[74]:

- availability (health care services and professional providers have to be available in sufficient quantity);
- accessibility (services, including information, have to be physically and economically accessible to everyone without discrimination);
- acceptability (services have to be culturally appropriate, that is, respectful of the cultures of individuals, minorities and communities, and sensitive to gender and life-cycle requirements); and
- adequate quality (services have to be scientifically appropriate and of sufficient quality).[75]

According to the Committee, laws and policies that obstinately limit safe abortion procedures are not compatible and do not comply with the performance standard proposed in the Covenant. Based on this performance standard, laws or national policies requiring extremely high qualifications for health providers will limit the availability of safe services, as well as a scarce territorial coverage of medical

[73] UN Document: E/C.12/GC/22

[74] R Cook. (2003). Human Rights Dynamics of Abortion Law Reform. *Human Rights Quarterly*, p.16.

[75] General Comment on Article 12, General Comment No. 14 UN CEDSCR Comm. Econ., Soc. & Cultural Rts., 22d Sess., at 12, UN Doc. E/C. 12/2000/4 (2000). Soc. & Cultural Rts., 22d Sess., at 1 12, UN Doc. E/C.12/2000/4 (2000).

centers providing abortion would result in expensive transportation costs for whom live far from the area, which in turn would not respect the parameter of accessibility.

The Committee also describes domestic laws which criminalize abortion as a violation of the right to health. Denial of legal and safe abortion services may lead to maternal mortality and morbidity, which in turn constitutes a violation of the right to life and security and in certain circumstances may amount to torture, inhuman and degrading treatment. Sexual and reproductive health is to be considered as interrelated with other human rights, including education and the right to non-discrimination. The Comment underlines that reproductive and sexual rights are disproportionately and discriminatorily denied to certain vulnerable groups, among those we can find persons with disabilities, and we can identify a gender base matrix of discrimination which affect indistinctly individuals of the LGBTQI+ community. For this reason, the General Comment requires States to respect the right to reproductive autonomy and the right to make decisions about one's sexual and reproductive health without coercion nor discrimination and exhorts States to liberalize restrictive abortion laws in order to guarantee access to safe abortions and post-abortion healthcare.

The general comment then lays out States' legal obligations, identifies examples of violations, and reiterates the duty to provide remedies for abuses. Lastly, the Committee furnish a new interpretation of denial of access to safe abortion as a form of gender discrimination:

> "Due to women's reproductive capacities, the realization of the right of women to sexual and reproductive health is essential to the realization of the full range of their human rights. The right of women to sexual and reproductive health is indispensable to their autonomy and their right to make meaningful decisions about their lives and health. Gender equality requires that the health needs of women, different from those of men, be taken into account and appropriate services provided for women in accordance with their life cycles."[76]

- General Comment No. 36 of International Covenant on Civil and Political Rights

There is no doubt about the impact of unsafe abortion on maternal mortality and morbidity. The World Health Organization has confirmed that the legal status abortion does not affect the number of induced abortions, since women will seek the procedure regardless of its lawful availability. Given

[76] UN Human Rights Committee (HRC), *CCPR General Comment No. 22: Article 18 (Freedom of Thought, Conscience or Religion)*, 30 July 1993, CCPR/C/21/Rev.1/Add.4, at para 25.

the circumstances, the availability of safe, legal access to abortion is crucial to women's enjoyment of their human rights, including in particular the right to health and, more fundamentally, the right to life. Consistent with its customary practice and in light of the experience gained through reviews of compliance by States Members as well as its jurisprudence on the issue, the UN Human Rights Committee decided to review the previous General Comments, to date in 1982 and 1984, on the right to life, and to elaborate a new General Comment (No. 36) on article 6 of the International Covenant on Civil and Political Rights. The event was perceived as an opportunity by the ICJ, jointly with organizations working on the reproductive rights field, to put pressure on the Committee to continue with the implementation of its stance on the issue by elaborating obligations to protect women's right to life from the risks they face when reproductive autonomy is at stake. The Committee had already expressed its concern for the fate of women's health and lives resulting from poor maternal health services, from State's negligence in guaranteeing access to reproductive-related services, among which there is contraception, and from restricting abortion.

After a first draft, in which the issue of extending the applicability of the right to life to the unborn was proposed, there followed a joint statement delivered by the ICJ coalition requiring that article 6 does not extend its applicability prenatally, hence reaffirming the right to life at birth. The Committee acknowledged that "proposals to include the right to life of the unborn within the scope of article 6 were considered and rejected…",[77] consistently with what article 1 of the Universal Declaration establishes and in line with the position of the CEDAW, which affirmed "under international law, analysis of major international human rights treaties on the right to life confirm that it does not extend to fetuses".[78] The compelling need was to not give any possibility of invoking a prenatal right to justify exceptions to women's rights protected under the ICCPR. In this connection, if States Parties recognize a right to life prior to birth and have measures designed to protect it in their national legal system, they must ensure that such provisions do not impede the enjoyment of the rights of pregnant women under the Convention, and therefor they must avoid incurring in violations of the right to life and to freedom from ill treatment. States must act in compliance with the law so, even in cases where access to abortion is legally restricted, women and girls' health and lives must not be put at risk and they must not be subjected to severe physical and mental suffering. The Committee officially adopted its General Comment no. 36 on article 6 of the ICCPR on the right to life on 30 October 2018, that read as follows:

[77] Livio Zilli. (2019). The UN Human Rights Committee's General Comment 36 on the Right to Life and the Right to Abortion. OpinioJuris.
[78] Ibid., supra note at 76, p. 20.

> "Although States parties may adopt measures designed to regulate voluntary terminations of pregnancy, such measures must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant. Thus, restrictions on the ability of women or girls to seek abortion must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering which violates article 7, discriminate against them or arbitrarily interfere with their privacy. States parties must provide safe, legal and effective access to abortion where the life and health of the pregnant woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or is not viable. In addition, States parties may not regulate pregnancy or abortion in all other cases in a manner that runs contrary to their duty to ensure that women and girls do not have to undertake unsafe abortions, and they should revise their abortion laws accordingly. For example, they should not take measures such as criminalizing pregnancies by unmarried women or apply criminal sanctions against women and girls undergoing abortion or against medical service providers assisting them in doing so, since taking such measures compel women and girls to resort to unsafe abortion. States parties should not introduce new barriers and should remove existing barriers that deny effective access by women and girls to safe and legal abortion, including barriers caused as a result of the exercise of conscientious objection by individual medical providers. States parties should also effectively protect the lives of women and girls against the mental and physical health risks associated with unsafe abortions. In particular, they should ensure access for women and men, and, especially, girls and boys, to quality and evidence-based information and education about sexual and reproductive health and to a wide range of affordable contraceptive methods, and prevent the stigmatization of women and girls seeking abortion. States parties should ensure the availability of, and effective access to, quality prenatal and post-abortion health care for women and girls, in all circumstances, and on a confidential basis."

With General Comment no. 36, the Committee intends to provide States with clear instructions on how to respect their obligations under the Convention. States, in fact, must give effect to women's right to life by providing safe, legal and effective access to abortion, by removing restrictions to abortion that might endanger women's lives or discriminate against them, but also dismantle existing barriers that would deny effective access to legal abortion (such as the ones placed by health care providers) and prohibit to set new ones and, to conclude, to revise laws that criminalize abortion taking into account the aforementioned requirements.

To sum up, the Human Rights Committee reaffirmed its stance by stating that safe, legal and affective access to abortion is a human right protected under the Convention which falls specifically within the scope of the right to life, asserted that preventable maternal mortality and morbidity constitute violations of the right to life under the ICCPR, right that under the Convention begins at birth.

- General recommendation of the Committee on the Elimination of Discrimination against Women

The Convention on the Elimination of Discrimination against Women, as we have seen, does not include a direct right to abortion. However, the Committee has expressed its stance on abortion in multiples recommendations and, at the same time, has been delineating more specific lines on how reproductive health is pivotal in women's equal enjoyment of human rights. In General Recommendation No. 14, concerning female circumcision, the Committee recommends that State Parties take all the appropriate measures to eradicate all other traditional practices that harm women's health, requiring States to report to the Committee their actions in eliminating those practices. General Recommendation No. 21, regarding "equality in marriage and family relations", puts on the spotlight what is the cornerstone of women's equality and reproduction autonomy paradigm.

The CEDAW highlights how the stereotyped role that depict women in the position of persons in charge of raising children affect disproportionately women's right to access to education, employment and other activities related to personal development. Similarly, the number and spacing of children have the same influence on women's physical and mental health, placing inequitably burdens of work on women. In this respect, decisions to have children or not "… must not be limited by spouse, parent, partner or government".[79] CEDAW's specification of the prohibition of involvement by the government in matters relating to family planning is quite important when enforcing women's right.

However, it is only with General Recommendation No.19, and later with General Recommendation No.35, that the CEDAW presents women's reproductive and sexual health in a different, powerful light. General Recommendation 19 highlights how violence against women "includes acts that inflict physical, mental or sexual harm of suffering, threats of such acts, coercion and other deprivations of liberty". These acts mentioned in article 19 put at stake women's health and impair their ability to play their role in family and public life and, at the same time, to enjoy of the principle of equality.

In some States, these acts, are part of traditional practices perpetuated by cultural assets that might harm the health of both women and children. In this context, States should prevent and refrain from using coercion in the sphere of fertility control and reproduction and must ensure that women are not

[79] UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No. 21: Equality in Marriage and Family Relations*, 1994, art. 16(1)(e).

forced to seek unsafe medical services, such as illegal abortion, to make up with a lack of appropriate fertility control methods or to obviate to an unavailable healthcare service.

In updating Recommendation No. 19, the General Recommendation No. 35 the CEDAW Committee has presented a very progressive approach toward the matter of abortion. It acknowledges that criminalization of abortion is a form of gender-based violence. Acts that are in violation of women's sexual and reproductive health rights, for example forced sterilization, forced abortion or denial/delaying access to safe abortions, are considered to constitute forms of gender-based violence. Under certain circumstances, these acts may amount to torture, cruel, inhuman or degrading treatment, as stated in paragraph 18 of General Recommendation 35. More interesting, we can read in the introduction of the same recommendation, that

> "For more than 25 years, in their practice, States parties have endorsed the Committee's interpretation. The *opinio juris* and State practice suggest that the prohibition of gender-based violence against women has evolved into a principle of customary international law. General recommendation No. 19 has been a key catalyst for that process."[80]

Women's right to be free from gender-based violence is indivisible from and, as recognized also by other human rights instruments, is also interdependent with other human rights, encompassing the right to life, health, liberty and security, the right to equality, freedom from torture, cruel, inhumane or degrading treatment, it applies also when talking about freedom of expression or any other fundamental human right.

It is also important to note the CEDAW Committee has established obligations for its Member States. In General Comment No.24, the Committee has noted that where systems fail to provide health services that only women need, such as emergency contraception and safe and lawful abortion services, it is a form of discrimination that States Parties are obliged to remedy. Acts or omission by private actors acting under governmental authority, under this category we can find also private bodies providing public services such as health care, are considered acts attributable to the State itself, as provided in General Recommendation No. 35.[81] Thanks to the work of the CEDAW Committee, women's rights are object of a more and more conscious space, laid down by necessities that are hard to ignore and that must find answers.

[80] UN Committee on the Elimination of Discrimination Against Women (CEDAW), *CEDAW General Recommendation No 35 on gender-based violence against women, updating general recommendation No.19*, 2017, Introduction.
[81] Ibid., B (1).

Chapter 2 - Neglecting women's right to reproductive health: recognizing a systemic inequality

The structure of the international legal order reflects a male perspective and ensures its continued dominance. International law has as primary subjects States themselves and is extending its interest also in international organizations. In both these cases the position of women is invisible. Power structures and high valued positions within governments are indisputably masculine: women in key position of power can be found in very few States and, where they do, their numbers are low. Women are unrepresented or underrepresented in the national and global decision-making processes, that's undeniable[82].

We constantly face a contradiction, despite the common acceptance of human rights as an area in which is recognized the need to direct the attention toward women, they are widely underrepresented also in context such as the UN human rights bodies. The only Committee that in its composition sees only women members, the Committee on the Elimination of Discrimination against Women[83], the monitoring body of the CEDAW, has been object of criticism precisely because of its "disproportionate" representation of women by the UN Economic and Social Council.[84]

ECOSOC, when considering the CEDAW Committee's sixth report, called upon states members to appoint both male and female experts for the election to the Committee[85], which is absurd considering that the focus of the Committee is to advance women's rights. There followed an attempt of diminishing the representation of women in a committee dedicated to women's interests, where fortunately women are well and justly represented, while the much more common dominant participation of men in other UN bodies goes unremarked. The covert problem behind this long-term male domination of all political bodies detaining decisional power, both nationally and internationally, is that issues traditionally of concern to men are considered as general human concerns while women's reality are relegated to a special sphere and a limited category.[86]

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[82] H. Charlesworth et al. (1991). Feminists approaches to International Law. *The American Journal of International Law*, p. 621.

[83] GA Res. 34/180 (Dec. 18, 1979) (entered into force Sept. 3, 1981). See also Declaration on the Elimination of Discrimination against Women, GA Res. 2263 (XXII) (Nov. 7, 1967).

[84] H. Charlesworth et al. (1991), supra note at 82, p. 624.

[85] A. Byrnes. Report on the seventh session of the Committee on the Elimination of Discrimination against women and the Fourth meeting of States Parties to the Convention on the Elimination of All Forms of Discrimination against Women (February-March 1988), at 13 (International Women's Rights Action Watch 1988).

[86] H. Charlesworth et al. (1991), supra note at 82, p. 625.

This approach fails to recognize that men generally are not victims of sex discrimination, domestic violence or sexual violence and these matters, precisely because they do not affect men, can be ascribed to a separate sphere that tend to be ignored in the law-making process[87]. At the basis there is the assumption that international law norms directed at individuals are universally applicable and neutral, but it ignores that such principles affect women and men differently.

Charlesworth and Chinkin have elaborated the same view for what concerns jus cogens.[88] According to their theory, jus cogens norms reflect a male perspective of what is fundamental to international society that may not be shared by women or supported by women's experience of life. They assert that fundamental aspirations attributed to communities and assumptions at the basis of the notion of jus cogens are essentially male. The development of human rights law has challenged the primacy of the state in international law and has given individuals a significant legal status. It has, however, developed in an unbalanced and partial manner promising much more to men than women.

International law still reflects the dichotomy between the public and the private sphere. Generally, the distinction sees the international as what concerns the relations between States, and therefore "public", and what concerns the domestic level as "private", as in the case of the jurisdiction of States.[89] As we have already seen, women's lives are commonly considered to pertain to the private sphere and therefore outside the scope of international law[90]. Human rights law is often considered as a development in international law because it challenges this traditional dichotomy. However, the major human rights treaties have reiterated rights that have been defined according to the point of view of men and are directed towards the protection of them, may it be in an unconscious way, but without taking into consideration of what this entails for women. This does not mean that women are not accorded the same protection, but it means that this approach does not consider the harms from which women most need protection.

While the seriousness of the human rights typically included in the jus cogens norms, such as murder, torture, slavery etc., is not discussed, it is evident that women's experiences have not contributed to their definition. This can be noted if we look at race discrimination, that appears consistently in jus cogens norms, in contrast to discrimination on the basis of sex, which is not included. At the same time sex discrimination is included in every human rights treaty, but sexual equality does not enjoy

[87] Ibid.
[88] H. Charlesworth and C. Chinkin. (1993). The gender of jus cogens. *Human Rights Quarterly.*
[89] Ibid., p. 69.
[90] R. J. Cook. (1993). Gender, Health and Human Rights. *Health and Human Rights*, p. 364.

the status of fundamental tenet of a world order. What differs is the way norms have been defined, obscuring the most commonly pervasive harms from which women suffer.

The right to life is one of the most extreme examples, as set out in Article 6 of the Civil and Political Covenant[91]. As I have previously shown, this article focuses on the voluntary and arbitrary deprivation of life perpetrated by public agents but lacks a fundamental interpretation that results in an inadequate formulation of the same right.[92] The reason is that prohibition of arbitrary deprivation of liberty and life does not consider the ways in which being a woman is life-threatening in itself and the special protection women need to be able to enjoy the right to life in an equal way.[93]

To make a short and non-exhaustive list of cases of unequal enjoyment of the right to life, in some areas being a woman may be dangerous from before birth due to ongoing practices of aborting female fetuses driven by socio-economic pressures to have sons, during childhood in various communities girls are breast-fed for shorter periods and later fed less so they suffer mental and physical effects of malnutrition.[94] In both developing and developed countries the so called "feminization" of poverty causes women to have a much lower quality of life compared to men under different aspects.[9596] Violence against women is endemic, pervasive and globally spread. Although the strong scientific evidence, violence against women has not been reflected in the development of international law and of the doctrine of jus cogens and has gone unaddressed by the international legal concept of the right to life precisely because the legal system is directed toward the "public" actions by the state. The same reasoning can be applied to the prohibition of torture as intended in international law, where the concept identifies the public agent as the perpetrator of the violation.[97]

Evidence shows that women are victims of torture to a great degree in the "private" sphere, to such an extent that many scholars have directed the focus of their analysis towards the understanding of the structural explanation of the universal subordination of women.[98] Through the analysis of the

[91] See also Universal Declaration on Human Rights, signed 10 Dec. 1948, G.A. Res. 217A (III), art. 3, U.N. Doc. A/810, at 71 (1948); European Convention for the Protection of Human Rights and Fundamental Freedoms, 213 U.N.T.S. 221, art. 2 (1950).
[92] Y. Dinstein. (1981). The Right to Life, Physical Integrity and Liberty, in The International Bill of Rights: The Covenant on Civil and Political Rights (L. Henkin ed., 198), *Columbia University Press,* p. 114.
[93] H. Charlesworth and C. Chinkin.(1993), supra note at 88, p. 70.
[94] United Nations, The World's Women, 1970-1990: Trends and Statistics 1 n.2 (1991); Charlotte Bunch, Women's Rights as Human Rights: Towards a Re-Vision of Human Rights, 12. Hum. Rts. Q. 486, 488-89 n 3. (1990).
[95] H. Charlesworth and C. Chinkin. (1993), supra note at 88, p. 71.
[96] See, e.g., Women are Poorer, 27 (3) U.N. Chronicle 47 (1990)
[97] United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, G.A. Res. 39/46 (Dec. 10, 1984), art. 1(1), draft reprinted in 23 I.L.M. 1027 (1984), substantive changes noted in 24 I.L.M. 535 (1985), also reprinted in Human Rights: A Compilation of International Instruments, at 212, U.N. Doc. ST/HR/1/Rev.3.
[98] H. Charlesworth et al. (1991), supra note at 82, p. 629.

different intersecting factors that play a role in women's reproductive health rights, it will be demonstrated how women's health is still the object of a systemic inequality that do not recognize women's autonomy and decision-making power in their reproductive life.

2.1 "My body, Not my choice!": how to conceptualize women's denied reproductive autonomy as a form of violence

Every individual has sexual and reproductive health care needs. Nevertheless, it exists an enormous discrepancy in the implications of a lack of ready access to reproductive and sexual health care services between women and men, that sees women in a far more disadvantaged position.[99] Women's ability to make choices about their own lives, to have a voice on their own civic and economic lives, their autonomy and equality depends significantly on their ability to obtain reproductive health care; men do not have the same necessity nor the same related problems.[100]

Women's economic, social and political circumstances are dependent on their ability to exert some degree of control over their own sexuality and reproductive choices. Every form of violation of women's reproductive health rights has serious and connected consequences on their lives, on their self-determination, on their self-esteem, that denying women the power to decide over their own life and over their own body cannot be seen otherwise than a form of violence.

2.1.1 Women's health in a male-oriented international legislation

Once it is recognized that laws that are neutral, or better to say male-based, posit serious consequences for the equal enjoyment of women's rights, what are the implications if this applies to one of the spheres that differ the most between women and men? As we have previously seen, the concept of health is defined by the WHO as the "physical, mental and social well-being and not merely the absence of disease or infirmity". A similar definition emphasizes the significance of a concept that does not stop on the medicalization of a disease but takes into consideration the social welfare of populations, because health is the result of a combination of factors that encompass biological, genetic, environmental and socio-economic aspects of every human being.[101]

[99] E. Nelson. (2017). Autonomy, equality, and access to sexual and reproductive health care. *Alberta Law Review*, p. 708.
[100] Ibid.
[101] R. J., Cook. (1994). Women's Health and Human Rights: The Promotion and Protection of Women's Health through International Human Rights Law. *World Health Organization*, p. 5.

As Rebecca Cook has underlined,

> "the cumulative impact of women's multifaceted disadvantages and their devaluation within legal, religious and cultural traditions and socioeconomic systems result in many women being denied health as understood by WHO. Their disadvantages spiral downwards, in that their liability to death in pregnancy or to infertility contributes to their devaluation, while their devaluation contributes to poor health and greater liability to illness and premature death."[102][103]

While the obvious, immediate and structural causes that lead to maternal morbidity and mortality can change from country to country, from disease to disease or can differ based on the socioeconomic status and ethnicity, the most striking difference we observe is the one between men and women.[104] This precise difference has not properly been identified by research and consequently is not present into considerations at the basis of the law-making process. Research on populations tended to be undifferentiated by sex and has excluded proper studies of women, apart from addressing the most obvious differences in reproductive functions.

Returning to the WHO definition of health, it is evident that neglect of women's health is pervasive. Women's health is neglected on grounds of both sex and gender. While sex is determined by biology and genes, gender is commonly understood as a social construct that comprehend personality traits, feelings, attitudes, values, behaviors and activities that are socially ascribed to the two sexes on a differential basis.[105] Women are subject to discrimination in health and other fields because of sex, for example in cases of stereotypes and taboos related to menstruation, on the other hand they suffer discrimination also because of the roles identified with the female gender that are typically under evaluated in socio-economic terms.

Women have been excluded for a long time from clinical and physiological research,[106] the reason behind this choice has been explained on the grounds that the menstrual cycle influences the analysis of data by introducing a potentially confounding variable.[107] Another reason for the exclusion of women from research is that experimental use of products and therapies might expose the foetus to various risks but excluding pregnant women from the research sample might involve indelicate

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[102] Ibid., p. 6.
[103] M., Koblinsky et al. (1993). The health of women: a global perspective. *Boulder, CO, Westview Press*.
[104] Hamilton JA. (1985). Guidelines for avoiding methodological and policy-making biases in gender-related health research in public health service. In: *Women's health: report of the public health taskforce on women'shealth issues.* Washington, DC, Department of Health and Human Services.
[105] R. J. Cook and S. Cusack. (2010). Gender Stereotyping: Transnational legal perspectives. *Philadelphia, University of Pennsylvania Press*, p. 20.
[106] Ibid., p. 352.
[107] M., Soderstrom. (2001). Why researchers excluded women from their trial populations. *Lakartidningen.*

questioning or testing.[108] Extending the discourse to all medical research, the differences between women and men have not been reflected accurately in this field, women's health has unfortunately been considered a niche area or to be examined preferably under the reproductive sphere, even though it involves more than 50% of the world's population.[109]

The results are clear: women's health is under-researched and medical diseases that affect mostly women are under-diagnosed. Suffice it to say that autoimmune diseases affect roughly 8% of the global population but 78% of the individuals affected are women. Two-thirds of people affected from Alzheimer's disease are women, like they are three times more likely to have a fatal heart attack than men or they are twice more likely to suffer chronic panic conditions.

Paula Johnson, a pioneer in gender biology and in the challenge to ignite a change in women's health research, confirmed that every human body cell has its gene. This means that women and men's bodies are different also at cellular level. Women are less likely to experience the "classical" heart attack symptoms, symptoms that were discovered relying on research in which most participants were men and led by men.[110][111] Diagnosis methods still favor male biology and physiology; therefore, many women experience a delay in receiving a diagnosis or even misdiagnosis.[112] Historically male-only studies were justified by the idea that what would have worked for men would have surely worked also for women. This wrong assumption had severe results, to the point that between 1997 and 2000 eight out of ten of the drugs removed from the US pharmaceutical market were removed because the side effects affected mostly or exclusively women. It was only in 1994 that the US National Institutes of Health (NIH) issued a guideline for studies and research to evaluate gender differences in clinical trials in order to ensure that the safety and efficacy of drugs would be guaranteed for every patient who would have to use it[113].

The goal of NIH was to recruit enough women to evaluate the risks and benefits for women and to give them the opportunity to actively contribute to clinical trials without exposing the foetus to toxic drugs.[114] From that moment, women have been able to participate in different phases of clinical trials.

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[108] J.A., Hamilton. (1985). Guidelines for avoiding methodological and policy-making biases in gender-related health research in public health service in Women's Health: report of the public health task force on women's health issues.
[109] T. D. Keville. (1994). The Invisible Woman: Gender Bias in Medical Research. *Women's rights law reporter*.
[110] Ted Blog. "How a TED Talk helped out put women's health research on the political agenda". https://blog.ted.com/how-a-ted-talk-helped-create-a-wider-understanding-of-gender-differences-in-health/
[111] Rochon PA et al. (1998). Reporting of gender-related information in clinical trials of drug therapy for myocardial infarction. *CMAJ*.
[112] Soderstrom. (2001). Supra note at 107.
[113] A. Holdcroft. (2007). Gender bias in research: how does it affect evidence based medicine?. *Journal of the Royal Society of Medicine*, p. 2.
[114] D.J., Harris and P.S.,Douglas. (2000). Enrollment of women in cardiovascular clinical trials funded by the National Heart, Lung, and Blood Institute. *The New England journal of medicine*.

Unfortunately, on a practical level the recruitment of women to participate in research have not come to the desired result. One important barrier to the recruitment has been reported to be, as we have already said, hormonal contraceptives but, aside from this reason, women were subjected to discriminatory practices as they were required to provide four counter-signatures in some studies to confirm contraceptive use, whereas men were not subjected to the same treatment.[115][116] To include women had become so troublesome that it was more convenient to include only men.

In addition, lack of funding for women's health remained a huge problem. A study in Sweden highlighted as economic costs to include women in research constituted a big deterrent[117], which have been uphold recently in a publication by the Society for Women's Health Research that suggested that for research into sex differences the best standards for women would be to use different hormonal states and it would entail an economic expenditure four time higher.[118] Another flaw of research is the lack of incorporation of gender data into evidence-based medicine; it fails to recognize different factors contributing to women's health such as economic means and social deprivation, that would surely not be the same for men and that reflect the social context of disease.[119]

On this point, Article 12 of the Women's Anti-Discrimination Convention requires states to eliminate all forms of discrimination against women in the specific context of health.[120] The Convention has required states to address in their reports the distinctive features of health that differ for women or subgroup of women in contrast with those of men, by taking into account biological factors, socioeconomic factors, unequal power relations in access to health services, psychosocial factors such as stigmatization and health systems factors such as lack of protection of confidentiality or report on stigmatizing treatment in conditions such as unintended pregnancy.[121] The Convention stressed that states cannot refuse or fail to provide health services that only women need, such as emergency contraception, cervical cancer tests or safe abortion services, precisely because it is a form of discrimination[122]. The concept of equality in the sphere of reproductive health sphere requires that

[115] J.B. Becker et al. (2005). Strategies and methods for research on sex differences in brain and behaviour. *Endocrinology*.
[116] M. Anthony and M.J. Berg. (2002). Biologic and molecular mechanisms for sex differences in pharmacokinetics, pharmacodynamics, and pharmacogenetics: part II. *J Health Gend Based Med.*
[117] Soderstrom. (2001), supra note at 107.
[118] B. A. Brown et al. (2000). Challenges of recruitment: focus groups with research study recruiters. Women & Health.
[119] R., Raine et al. (2002). Influence of patient gender on admission to intensive care. *J Epidemiol Community Health.*
[120] Comm. on the Elimination of Discrimination Against Women (CEDAW), *General Recommendation No 24: Women and Health*, U.N. Doc A/54/38 Rev.1. (1999).
[121] R. J. Cook and S. Howard. (2007). Accommodating Women's Differences Under the Women's Anti-Discrimination Convention. *Emory Law Journal*, p. 1051.
[122] Ibid.

women should be no more advantaged or disadvantaged than men. This means that where physiological differences exist, they should be accommodated.

2.1.2 From the principle of non-discrimination to the importance of addressing intersectionality when talking about women's health

The problem behind the non-representation of women's perspectives in human rights is characterized by the inability of societies to identify and recognize women's biological differences, and consequently to the failure of addressing the social discrimination women face based on those differences. States have failed to address how women's physiological differences have contributed to justify discrimination against women and have created the circumstances for a pervasive neglect of health services that only women need by perpetrating stereotypes of women as mothers and on the sole role of care givers.[123] To adequately address the differences in women's reproductive function means to treat women as they have the same right to be treated as equals with men, as to say being treated with the same respect, dignity and as persons with the same entitlement to reproductive autonomy.[124]

In the context of abortion, to apply the principle of equality means to consider how women experience access to abortion services, the treatment they face in the clinical context, the discriminatory and stereotyped determination of their life options, that include their right to decide if and when become pregnant.[125] Active on this matter is, as expected, the CEDAW Committee, which has developed a concept of equality through the application of principles of nondiscrimination to states' practices, laws and policies. The Committee has defined discrimination against women every distinction, exclusion or restriction made on the basis of sex that has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women on a basis of equality of women and men of human rights in any field.[126]

Every law or policy that is discriminatory or is sex neutral on its face but have the opposite effect of discriminating against women, is in contravention of this definition of equality.[127] Women's equality necessitates the acknowledgment of women's actual differences and the elimination of the treatment

[123] R. J. Cook and S. Howard. (2007), p. 1040.
[124] E. V. Fegan. (2002). Recovering Women: Intimate Images and Legal Strategy. *Social & Legal Studies.*
[125] R. J. Cook and S. Howard. (2007). Supra note 121, p. 1041.
[126] CEDAW, Art. 1.
[127] R. J. Cook and S. Cusack. (2010). Gender Stereotyping: Transnational legal perspectives. *Philadelphia, University of Pennsylvania Press* Gender Stereotyping, p. 115.

based on gender stereotypes, like the naturalness of motherhood. It is not enough to guarantee women a treatment that is identical to that of men, but it is necessary to consider biological and socio-cultural constructed differences between women and men.[128]

Abortion laws and practices need to be reconceptualized under this concept of equality, freeing them of the pressure of involuntary pregnancy, childbearing, childrearing and by freeing women by the eventuality of jeopardizing their lives or health when these services are denied[129]. We have already seen that according to the Recommendation on the Convention on the Elimination of All Forms of Discrimination against Women, where health systems refuse or fail to provide health services that only women need like pregnancy related services, emergency contraception and safe abortion services, it is a form of discrimination against women that states need to remedy.

Sex discrimination in access to services is often aggravated by discrimination on other grounds, such as women's age and race that usually sees as the victims of this intersectional discrimination young women of disadvantaged racial groups and/or of lower socio-economic status.[130][131] These categories of women are the most vulnerable to risks of maternal death from unsafe abortion and unsafe delivery. Scientific evidence demonstrates that poor women in rural areas have less access to contraceptives and safe abortion providers, and that the denial of reproductive health needs between young and adolescent women, victims of the stereotype of pregnancy outside marriage, is pervasive and lead women to resort to unsafe abortion practices.

Young women must also face the burden of obtaining parental consent to have access to reproductive health services, seeing their reproductive autonomy denied again. Women are exposed to various forms of discrimination based on their sex, race, age, poverty and rural status[132]. In contrast to "age-related men, whose mortality and morbidity are associated with lifestyle choices of violence,[133] alcohol consumption[134] and, particularly in more developed countries, motor vehicle accidents,[135]

[128] Cook and Howard. (2007). Supra note at 121, p. 1044.
[129] Comm. on the Elimination of Discrimination Against Women (CEDAW), General Recommendation No. 25: On Article 4, Paragraph 1, of the Convention on the Elimination of All Forms of Discrimination Against Women, on Temporary Measures, U.N. Doc. A/59/38 (2004).
[130] Cook et al. Abortion Law in Transnational Perspective Cases and Controversies, p. 281.
[131] Mieke C. W. Eeckhaut. Intersecting Inequalities: Education, Race/Ethnicity, and Sterilization.
[132] R. J. Cook. (2007). Supra note at 121, p. 1060.
[133] World Health Organization. (2002). The injury chart book 61*, Department of Injuries and Violence Prevention Noncommunicable Diseases and Mental Health Cluster*.
[134] R. Doyle. (1996). Death caused by alcohol. *SCI.AM*, p. 30.
[135] World Health Organization. (2002), supra note 133.

women's death and disability are associated with their inherent biological status as vulnerable to unplanned pregnancy."[136]

The concepts of equality and of non-discrimination requires that women should not be more advantaged or disadvantaged in the sphere of reproduction that men. This means that where physiological differences exist, they should be accommodated rather than used to construct and reinforce gender stereotypes.[137] The accommodation of men and women's differences in the context of reproduction, from a perspective of equality, would require that states engage in a variety of activities that seek to discredit the stereotypical norms surrounding pregnancy and motherhood.

A discrepancy in treatment is also detected in cases where women are subjected to procedures to assess if they are entitled to require an abortion. In States where abortion is permitted on health grounds, a panel of physicians is commonly required to certify if the woman is facing serious risks to her physical or mental health or her life is in danger in order to proceed with the practice. In cases of presumed suicidal risks, it is also required a psychiatric evaluation to assess if the woman if eligible for an abortion.

The same treatment is reserved to women who declare to have become pregnant as a result of rape; they are obliged to file a complaint to the police authorities and undergo an examination to demonstrate the sexual assault. Women's reproductive choices are subjected to examination not only by these figures but also by social workers, reproductive counselors and, in some cases, also by religious leaders that have the duty to make sure that women are aware of the consequences of their choice of interrupting the pregnancy. Paradoxically, men who seek medical treatment for sexually transmitted infections are promptly treated without the need to assess their responsibilities in procuring those medical conditions.

Patterns of discrimination are identifiable also in the medical context where medical personnel or counselors deliver misleading information to women requiring reproductive or sexual health services.[138] This aspect will be discussed more in depth, but cases have been reported of States being the actors behind the decision to deliver wrong or incomplete information. This practice is common also in medical personnel which autonomously misinform women due to their religious or ethical believes. Stereotypes that depict the woman as the one that has to decide to protect her fetus or risk

[136] R. J., Cook. (2007) Supra note at 121.
[137] Ibid., p. 2007.
[138] S., De Vido. (2020). Violence against women's health in international law. *Manchester University Press,* p. 141.

her life to save the one of the unborn no matter what the medical treatment she has to undergo are at the basis of those behaviors and are dangerously widespread.

Social and economic conditions of women requiring access to abortion are often factors that contribute to shaping those discrimination patterns. Health services that are not available because the clinics performing abortion are not present in the territory or because the medical practitioners invoke conscientious objection or, as we have seen in the case law, because the national law does not permit abortion and force women to travel, are clear examples of violence against women's health and of discrimination, that disadvantage in a much more severe way women who do not have the means to afford abortion-related costs and indirectly force them to resort to unsafe practices. The concept of intersectionality has emerged in connection with involuntary sterilization, but it can be identified in each type of violence. It was coined by legal scholar Kimberlé Crenshaw in a 1989 publication to underscore "the conception of structured social inequalities as interdependent, mutually constituted, integrally connected systems of inequality"[139]

Intersectionality theory draws attention to power dynamics and to the ways in which multiple dimensions of inequality combine, overlap, and intersect to shape individuals' unique social positions and experiences[140]. The framework focuses on the complex, or intersecting, effects of different forms of oppression, such as racism, sexism, and classism. It is asserted, for example, that black women's experiences tend to be qualitatively different than those of white women and those of black men, differences that cannot be fully captured by the additive or independent effects of being black and being female.[141] Courts are not keen on invoking the concept of intersectionality even though, for example, the CEDAW Committee in its General Recommendation no. 35 "acknowledged that 'because women experience varying and intersecting forms of discrimination' violence against women 'may affect some women to different degrees, or in different ways, so appropriate legal and policy responses are needed'".[142]

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[139] Weber, L. (2006). Reconstructing the landscape of health disparities research. Promoting dialogue and collaboration between intersectional and biomedical paradigms. Jossey-Bass, p. 40.

[140] Ibid.

[141] Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum*, p. 139.

[142] S., De Vido. (2020 Supra note at 138, p. 144.

Importantly, the lack of attention to interaction effects likely impedes our recognition of power dynamics and of the ways in which interacting systems of power structure reliance on violence against women's health by either enabling or impeding women's reproductive autonomy. The need to take account of the interactions between multiple dimensions of inequality is the key tenet of intersectionality theory. Once again, women's reproductive autonomy is disregarded by a predominant assumption that women are incapable of making their own conscious decisions about their bodies, their future and their lives. This is a clear form of discrimination based on socio-cultural stereotypes that States members are obliged to eliminate from abortion regulations.

2.2 *De jure* prohibition of abortion

Human rights standards recognize to States the autonomy to establish criminal abortions laws, even if highly criticized, if it can serve legitimate ends, such as the protection of morals or the protection of public interests.[143] Many human rights bodies have condemned the recourse to criminal laws, as it is a highly intrusive power that has serious impacts on human rights and fundamental freedoms of pregnant women, by imposing limits on the state power. Hence, human rights standards require states to guarantee abortion at least on three grounds: where the pregnancy poses serious risks to the woman's life or health, where the pregnancy is the result of rape or incest and when there is a risk of fetal impairment. However, the WHO Safe Abortion Guidance, many other authoritative source and countless studies, have demonstrated that criminal abortion laws do not decrease in any way the rate of abortions but rather tend only to increase the request for clandestine and unsafe abortion.[144]

2.2.1 Criminalizing abortion as an instrument of demographic control

Probably the most evident example of what are the consequences of abortions regulations imposed to control the demographic growth is the one of Romania. Before 1966 Romania, as other neighbor countries, had quite liberal abortion policies that permitted women to get access to safe abortion through the country's health system. President Ceaucescu introduced a pronatalist policy that established mandatory pelvic examinations at places of employment to women of reproductive age, doctors could be prosecuted for performing abortions without authorization and nurses were entitled to make unannounced visit to see if new mothers were taking care of their babies. Data shows that

[143] J. N., Erdman et al. (2020). Decriminalization of abortion: a human rights imperative. *Clinical obsterstrics & gynaecology.*
[144] World Health Organization. (2012). Safe abortion: technical and policy guidance for health systems. second ed. Geneva: *World Health Organization*.

after a brief rise, the birth rate fell and continued to fall, while the purpose of the policy was intended to be the exact opposite.

After the entry into effect of this new policy, Romanian abortion-related maternal mortality rate increased to a level 10 times higher that of the other Eastern European countries (before it was at the same level).[145] The immediate effect was that many women resorted to illegal abortion practices and every year approximately 500 otherwise-healthy women died from post-abortion hemorrhage, sepsis, abdominal trauma and poisoning.[146] Regarding the social impact of the restrictive abortion policy, approximately 150.000 to 200.000 children ended in institutional care, which in turn overwhelmed the health care system and reduced the standard of the overall care.[147]

The first act of the provisional government in 1989 was to abrogate the law banning abortion and contraception as an emergency public health measure in order to decrease the worrying number of cases of maternal mortality due to unsafe abortion. The most striking effect of the abolition of the abortion ban was the 50% decrease in the maternal mortality rate only in the first year following the change, which continued to decrease as women availed themselves of safe abortion procedures.[148] At the same time, also the numbers of institutionalized children drastically fell, demonstrating that, together with the other indicators, restricting or prohibiting access to abortion is a counter-productive way to control demographic trend and that controlling reproductive behavior through legislation is never useful. In 23 years of enforcement, the Romanian anti-abortion law resulted in over 10,000 maternal deaths due to unsafe abortion.[149]

Another explicatory case of abortion legislation introduced for demographic control purposes is the one of South Korea. Only recently was the abortion ban declared unconstitutional, a ban that was in force since 1953 and was introduced to reduce the fertility rate so that the country could receive international economic aid for economic development.[150] This case is particularly emblematic because until 2010 the abortion issue was not considered an urgent issue on the feminist agenda

[145] Stephenson et al. (1992). Commentary: The public health consequences of restricted induced abortion- lessons from Romania. *American Journal of Public Health*, p. 1329.

[146] Ibid.

[147] Report of a UNICEF Mission to Develop Emergency Assistance Programme for Institutionalized Children in Romania. New York, NY: United Nations Children's Fund.

[148] The Children's Health Care Collaborative Study Group. The Causes of Institutionalization in Romanian Leagane and Sectii de Distrofici: Report of Population-based Study with Recommendations.
[149] Ibid., supra note at 64, p. 1329.
[150] S. Kim et al. (2019). The Role of Reproductive Justice Movements in Challenging South Korea's Abortion Ban. *Health and human rights*, p. 98.

because the country's abortion ban was largely unenforced until the mid 2000s. The government in this period adopted a strong anti-natalist policy, to the point that abortion, contraception and sterilization were largely encouraged, in some cases even with coercive methods among certain populations, for example towards women with disabilities.[151]

The government established family planning clinics nationwide to provide abortion services under the false name of menstrual regulation and offered incentives like health insurance benefits and public housing to families with less than two children. The situation was so serious that people with disabilities, single and poor mothers were subjected to forced abortions, while the social stigma about abortion was still pervasive. As a result, South Koreas's Family Planning Program was evaluated as the most successful example of population control project as the fertility rate dropped from 6.0 to 1.6 in the 1990s. the number of abortions during this period (1989-2009) was estimated to be around 30-50 million annually, which is a proof of the government's limited enforcement of the anti-abortion law. At the same time, barriers to the de jure illegal services, such as male partners' permission and barriers to abortion services information, were still in force.

When the fertility rate dropped to 1.8, the lowest rate in the world, the government decided to actually enforce the abortion ban, hence the abortion issue was finally perceived as a social problem.[152] The first provision adopted was to report obstetrics and gynecology clinics that performed abortion which had immediate effects on women who tried to access abortion services but couldn't find any. The fear of being prosecuted discouraged any medical practitioner that until now was performing abortions. While a network of associations was beginning to shift the focus and challenge the criminal codes on abortion, the first Constitutional Court review occurred in 2010, when a midwife charged of performing an abortion decided to appeal to the Constitutional Court to challenge the abortion law. The Court ruled that the ban was constitutional and declared that the foetus' right to life was in the public interest while the woman's right to opt for abortion was an individual and private interest.[153] The public/private dichotomy is, as we can see, a constant.

After this decision, a teenage girl died during a complicated abortion procedure in 2012. When the abortion procedure did not go smoothly, instead of transferring the patient to the hospital, which could have potentially saved her life, the doctor did not do so because he was afraid of being prosecuted for

[151] Ibid.

[152] Korean Statistical Information Service, Total fertility rates (1970–2016) (Daejeon: KOSIS, 2018).

[153] S. Kim et al. (2019), Supra note at 150.

engaging in an illegal abortion procedure, and he was in fact condemned to a year of imprisonment.[154][155]

As the abolition of the criminal codes on abortion became an urgent item on the feminist agenda in South Korea, it was proposed a new solidarity group, the Joint Action for Reproductive Justice, for full-scale activism. Since the hegemonic discourse around abortion in South Korea had previously focused on young, hetero- sexual, cisgender, able-bodied women, Joint Action wanted to enlarge the movement to include a broad range of individuals to be part of the inaugural ceremony, and thus, many different stories related to abortion and childbirth were shared by a diverse group of women, including girls, women living with HIV/AIDS, women with disabilities, queer and transgender women, and sex workers.[156] They aimed to expose the historical contexts and intersectionality of abortion issues, and in doing so, they intended to establish the decriminalization of abortion as a matter of social justice rather than just a narrow concept of reproductive freedom.

As the day of the court ruling approached, Joint Action held a large protest in 2019 to publicize their demands that the government fully legalize abortion for the safe termination of pregnancy, expand comprehensive sex education and access to contraceptives, completely revise the eugenic elements of the law, and guarantee reproductive rights without stigma or discrimination. Finally, on April 11, 2019, the Constitutional Court ruled that the current abortion ban was unconstitutional.[157] The Joint Action efforts were effective in persuading people that the Korean anti-abortion law was not a matter of "life versus choice" but instead a governmental and social tool that allowed the state to control reproductive rights and regulate women's sexuality and behavior.[158]

Interestingly, the main slogan in the recent reproductive justice campaign to abolish the criminal abortion law in the country was "If abortion is a crime, the state is the criminal." The reproductive justice movement, collectively represented by the activities and actions of Joint Action, has debunked

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[154] Sexual and Reproductive Rights Forum (Ed.) (2018). Battleground: Sexual and reproductive politics around the criminal codes on abortion law in South Korea, p. 115.

[155] K. Kim, mi-seong-nyeon im-sin-bu nag-tae-su-sul hu sa-mang ... ui-sa jib-haeng-yu-ye hwag-jeong" [a teen pregnant woman died after an abortion ... The doctor has been given a suspended prison sentence

[156] S. Kwak, "Yeo-seong-deul-i 'im-sin jung-dan'eul seon-taeg-han ja-sin-ui gyeong-heom-eul i-ya-gi-ha-da (hwa-bo)". Women talk about their abortion experiences.

[157] 2017Hun-Ba127, decided on April 11, 2019.

[158] S. Kim et al. (2019) Supra note at 150.

the notion that seeking abortion care makes women criminals; on the contrary, it places the responsibility on the government for defending and for engaging in the progress of reproductive rights in South Korea. Historically, restrictions on abortion were introduced for three main reasons: as a public health mission to protect women from a dangerous practice, as a punitive act towards women who were considered to commit a sin or an immoral act and, as a mean to protect the foetus' life in all or some circumstances.

Since the practice of abortion has become safer, laws against abortion make sense only if intended as punitive measures or to protect fetal life over women's lives. Instead of focusing on practitioners who perform unsafe abortions, the laws focus on punishing who provide safe abortions outside the law itself. As we have already seen in chapter 1, are restrictive abortions legislations that cause maternal deaths and millions of injuries to women who cannot afford to pay for a safe abortion. Since progressive abortion laws have been introduced, justified on public health and human rights grounds, collected data shows that countries with almost no death from unsafe abortion are those who allow abortion on request and without restrictions. Despite years and years of campaigns for safe abortion, the use of contraception has been completely decriminalized but abortion has not, despite the evidence demonstrating that abortion is one of the safest medical procedure if performed following the directives of the World Health Organization.

2.2.2 Total prohibition of abortion is a form of torture, inhuman and degrading treatment

The right to be free from torture is regarded as a norm of customary international law, like the prohibition on slavery, as a norm of jus cogens.[159] The basis for the right is traced to "the inherent dignity of the human person."[160] Behavior constituting torture is defined in the Convention against Torture as:

> "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or

[159] See Filartiga v. Pena-Irala, 630 F.2d 876 (2d Cir.)

[160] United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, GA Res. 39/46 (Dec. 10, 1984), draft reprinted in 23 ILM 1027 (1984), substantive changes noted in 24 ILM 535 (1985) [hereinafter Torture Convention]; Inter-American Convention to Prevent and Punish Torture, Dec. 9, 1985, reprinted in 25 ILM 519 (1986); European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, Nov. 26, 1987, Council of Europe Doc. H (87) 4, reprinted in 27 ILM 1152 (1988), Preamble.

> a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity."[161]

This definition has been considered sufficiently broad because it covers mental suffering and behavior "at the instigation of" a public official. However, despite the use of the term "human person" in the preamble, the use of the masculine pronoun alone in the definition immediately gives the definition a male context, rather than conveying a neutral point of view identifying every human being. Clearly, the description of the prohibited conduct is based on the distinction between public and private actions that ignore injuries to the dignity typically sustained by women.[162]

The traditional canon of human rights law, as we I have already argued, does not take into consideration categories that fit the experiences of women. It is focused on violations of rights that offer little redress in cases where there is a pervasive, structural denial of rights.[163] A crucial aspect of torture and cruel, inhuman or degrading treatment, as defined, is that they take place in the public sphere: a public official or a person acting officially must be the one perpetrating the pain and suffering. This dynamic rests in that "private acts (of brutality) would usually be ordinary criminal offenses which national law enforcement is expected to repress. However, many women suffer from torture in this limited sense.

The international jurisprudence on the notion of torture arguably extends to sexual violence and psychological coercion if the perpetrator is an official actor.[164] It is to note that human rights bodies often define CIDT by distinguishing it from torture. In part, this distinction is based on the severity of the pain, suffering, or humiliation inflicted on the victim, with a higher threshold of suffering needed for an act to amount to torture. However, severe pain and suffering that is inflicted outside the most public context of the state, for example within the home or by private persons, which is the

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[161] Ibid, art. 1.

[162] H. Charlesworth et al. (1991). Feminist Approaches to International Law. *The American Journal of International Law*, p. 628.

[163] Ibid.

[164] N. S., Rodley. (1988). The Evolution of the International Prohibition of Torture, in Amnesty Intern Universal Declaration of Human Rights 1948 – 1988: Human Rights, the United Nations and Amnesty International 55, 63.

most pervasive and significant violence faced by women, does not qualify as torture despite its impact on the inherent dignity of the human person.[165]

Indeed, some forms of violence are attributed to cultural tradition. States are responsible for torture only when their agents have direct responsibility for such acts and in that case the responsibility is imputed to the state. Arguably States are not considered responsible if they have enforced a legal and social system in which violations of physical and mental integrity are endemic. A perspective that is conscious of women's reality would require a rethinking of the human rights notions of state responsibility and in this sense would challenge the most basic assumptions of international law. If violence against women were to be considered by the international legal system to be as shocking as violence against people for their political ideas, women would have considerable support in their struggle. Absolute criminal prohibitions on abortion are in conflict with these principles, precisely because they constitute an arbitrary deprivation of the rights to life and health in their absolute negation of these rights through the denial of health care that could potentially save women's lives. Human rights standards thus require the repeal of laws that criminalize all forms of abortion or their reform through the introduction or broadening of legal grounds for abortion.

Criminalization of abortion is considered arbitrary and disproportionate because it fails to give due consideration to the hardships of those who seek to end their pregnancies in circumstances such as risks to health, integrity, and well-being. At the same time, any law likely to result in bodily harm, unnecessary morbidity, or preventable mortality including through the denial of health care constitutes a violation of rights to life and health and any law that criminalizes or limit access to health care disproportionately needed by women, constitutes discrimination, and violates the right to equality. According to human rights standards States are required to decriminalize abortion, at a minimum, on three grounds: where pregnancy presents a risk to the life or health of the pregnant person, where pregnancy results from sexual crime (i.e., rape, sexual assault, or incest), and where there is a risk of serious fetal impairment.

What we have observed until now is that human rights bodies, in particular the European Court of Human Rights, have concluded in different cases that cruel, inhuman and degrading treatment can arise in situations where women are denied access to, or are obstructed in, their attempts to obtain abortions or related health services that are legally available under national law. In these cases, human rights bodies have not recognized a right to abortion under international law but have urged States to

[165] H. Charlesworth et al. (1991), supra note at 162, p. 629.

address the procedural barriers in their own laws that make women subject to abuse when seeking an abortion.

The UN Human Rights Committee and the UN Committee Against Torture "have found that States have an international legal obligation to reform particularly restrictive abortion laws or risk inflicting CIDT on women when these laws are applied".[166] Importantly, human rights experts like the Special Rapporteur on Torture have also recognized that health care settings can be sites of mistreatment that amounts to CIDT and that women are particularly vulnerable to abuse in the healthcare context.[167]

The European Court has declared that, under an "evolutive interpretation" of the European Convention on Human Rights, an act that at one time was considered to be a form of inhuman or degrading treatment might in the future be classified as torture due to changes in the social context.[168] The European Court has further elaborated this definition extending the concept of degrading treatment as conduct that humiliates and debases the victim, either in his own eyes or in the eyes of others.[169] As we have seen, the majority of human rights bodies have not found an explicit "right to choose" in human rights law but have concluded that certain restrictions or barriers to access to abortion services may seriously undermine women's human rights, including their rights to life, health, privacy, and non-discrimination, and that fulfillment of these right may therefore require reforms to domestic laws.[170]

In this context, framing women's experiences of pain or suffering as forms of cruel and inhuman treatment underlines the necessity of addressing women's suffering as a human rights issue and requires greater accountability from States for their role in procuring such suffering. About the Court's jurisprudence on the matter, in delivering its decision in *A, B, & C v. Ireland,* it signals that the Court will be unwilling to abolish even extremely restrictive abortion laws as long as some measures are

[166] A. Zureick. (2015). (En)gendering suffering: Denial of abortion as a form of cruel, inhuman, or degrading treatment, p. 105.

[167] U.N. Human Rights Council, Report of the Special Rapporteur on Torture, Cruel, Inhuman and Degrading Treatment: Torture and Ill-Treatment in Health Facilities, U.N. Doc A/22/53 (Feb. 1, 2013) (describing forms of torture of ill-treatment that have been documented in healthcare facilities); U.N. Gen. Assembly, Report of the Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, U.N. Doc. A/66/254 (Aug. 3, 2011) (describing the rights violations that women suffer when reproductive healthcare is criminalized).

[168] Kanstantsin Dzehtsiarou, *European Consensus and the Evolutive Interpretation of the European Convention on Human Rights,* 12 GER. L.J. 1731 (2011) (describing the use of evolutive interpretation by the European Court of Human Rights); *accord* Selmouni v. France, Eur. Ct. H.R. No. 25803/94, 101 (1999). Other human rights bodies have also used dynamic interpretive techniques. *See* Birgit Schlitter, *Aspects of Human Rights Interpretation by the UN Treaty Bodies, in* UN HUMAN RIGHTS TREATY BODIES: LAW AND LEGTITMACY 261, 282 (Helen Keller & Geir Ulfstein eds., 2012).

[169] A. Zureick. (2015) supra note at. 166, p. 108.

[170] *See, e.g.,* Comm. on the Elimination of Discrimination Against Women, Commc'n No. 22/2009, L.C. v. Peru, 17 Oct. 2011, U.N. Doc. CEDAW/C/50/D/22/2009 (2011).

still technically available to women to safeguard their well-being, such as travelling to England for an abortion, even though it did not investigate into the difficulties Irish women face when trying to resort to these options.[171] Neglecting a woman autonomy over her body and her reproduction choices can have other social consequences that inflict severe pain and suffering on her. Human rights bodies have already recognized this type of autonomy-based harm in the reproductive rights context, in particular with respect to coercive sterilization.[172]

The same European Court, in two cases of VC. v. Slovakia[173] and N.B. v. Slovakia, have found that sterilizing a woman without her informed consent, a practice that is still widespread, amount to degrading treatment precisely because it interferes with a woman's autonomy in her reproductive choices. The abortion context is not so different and raises similar autonomy issues. While coercive sterilization may be distinguished from abortion in that it involves the doctor is directly intruding on her patient's body, this is a relatively minor difference. Bodily intrusion itself is denigrating, but it is ultimately the fact that the doctor, the society or the law deprive women of their reproductive decision-making that transforms both coercive sterilization and denial of abortion into acts that cause feelings of anguish, fear, inferiority and inadequacy in women. Moreover, the personal and social consequences that the European Court recognized in the coercive sterilization context, such as depression and social isolation, often emerge in situations when women are denied an abortion, especially in contexts where abortion is heavily restricted and where attempting to access abortion is stigmatized.[174]

Human rights bodies have not failed in recognizing that restrictive abortion laws contribute to social conditions that stigmatize women for seeking an abortion, regardless of the reason, therefore they should improve human rights protections for women seeking to exercise their reproductive autonomy. With regard to the UN Human Rights Committee's jurisprudence, the Committee noted in the K.L. case, that the applicant had endured pain and distress from being forced to carry her pregnancy to term and then witnessing her daughter's impairment, all while knowing the child would die shortly after birth. Given the early diagnosis of the fetus's condition, the Committee concluded that K.L.'s

[171] A. Zureick. (2015) supra note at. 166, p. 122.
[172] Ibid., p. 137.

[173] *See* V.C. v. Slovakia, Eur. Ct. H.R. No. 18968/07, 106-20 (2012); N.B. v. Slovakia, Eur. Ct. H.R. No. 29518/10, 71-88 (2012).

[174] For a case study of how restrictive abortion laws can lead to stigma, discrimination, and abuse against women seeking abortions, see *ForsakenLives: The HarmfulImpact of the Philippine Criminal Abortion Ban,* CENTER FOR REPRODUCTIVE RIGHTS (2010).

mental suffering was foreseeable and that the State's refusal to allow the abortion was the cause of K.L.'s suffering. The *K.L.* decision, the first international decision to find that denial of abortion amounted to cruel, inhuman and degrading treatment, was particularly notable for recognizing the severity of the mental suffering K.L. experienced as the result of carrying a seriously impaired fetus to term and for placing this suffering at the center of its analysis.[175] This reasoning suggests that the Committee understood K.L.'s suffering as arising from being compelled to continue with her pregnancy, not from being denied a right recognized under domestic law.

The same was acknowledged by the European Court in R.R. v. Poland[176] and P &S v. Poland[177]. Pain and suffering did not stem only or primarily from the fact that the services they required were legally available, but rather stemmed from the applicants' impossibility to exercise their ability to make important decisions over their bodies and future. However, human rights bodies are more likely to find that the denial of abortion exceed the margin of appreciation of States when the pregnancy is the result of a situation that impair the woman's ability to consent to the sexual intercourse. States identify a particular vulnerability in women who are minors, victims of rape or disabled, all conditions that would diminish their ability to exercise their consent to sexual intercourse. According to this view, women who become pregnant but did not consent to sex may be seen as suffering because of their lost innocence and not because their autonomy over their bodies and reproductive choices has been denied. The recognition that it can be cruel to force a woman to continue with a pregnancy resulting from an autonomy deficit is a significant development in human rights law, but it risks excluding from this view all the women who choose to have sex as underserving of the same access.[178]

In this context, States must ensure that women do not suffer from cruel, inhuman and degrading treatment in the process of seeking reproductive health care by creating the conditions in which their rights are guaranteed under domestic law not only on the paper but that they can properly get access to those services and exercise their reproductive autonomy through a mechanism that reduces the risk of abuse in the health care system. States that have a legislation that criminalize abortion in all circumstances must revise their law to guarantee access to abortion at least in cases in which the

[175]A. Zureick. (2015) supra note at. 166, p. 128.

[176] See R.R. v. Poland, Eur. Ct. H.R. No. 2767/04, 12 (2011).

[177] P & S v. Poland, No. *57375/08,* Eur. Ct. H.R., (2012).

[178] L. M. Kelly. (2014). Reckoning with Narratives of Innocent Suffering in Transnational Abortion Litigation, in Abortion Law in Transnational, 303, 317-18 (Rebecca J. Cook, Joanna N. Erdman & Bernard M. Dickens eds., 2014).

pregnancy poses serious risks to women's lives and health, in case of rape or physical and mental harm and in case of fetal abnormalities.

This approach reflects the understanding that restrictive abortion laws are unjustifiable and disproportionate to lawful State goals. We can conclude that there is an ever-growing recognition by human rights bodies that deprivation of women's reproductive autonomy can lead to serious pain and suffering, in some cases comparable to cruel, inhuman and degrading treatment, that is unacceptable in modern societies.

2.2.3 Women have abortions: women's practices for safe abortion in radical States

Brazil, Argentina and Chile are the most suitable examples of how women overcome and react to the difficulties of having an abortion in radical States where abortion is a criminalized practice. Abortion in Brazil was considered legal only in case of rape and in case the woman's life was in danger, according to the penal code of 1940. The situation worsened with the election of President Bolsonaro in 2018 who adopted an even more radical approach with a draft proposal to modify the Constitution in order to prohibit abortion in all circumstances.[179] In such a context, women do not stop fighting for the recognition of their human rights and have resorted to other measures to have abortions. With the introduction on the market of misoprostol, women have turned to pharmacological abortion. The only way to get access to misoprostol was, and at some extent still is, through clandestine channels and drug dealers.[180] Abortion with misoprostol is considered one of the safest abortion procedures if taken following the OMS guidelines, easily accessible on internet, that explain how to autonomously have an abortion at home. This method offers a safe procedure in which women are free from harassment or stigmatized behaviours by the medical personnel and offer a certain degree of security of not being reported to the authorities. The widespread use of misoprostol might have contributed to the lowering in numbers of maternal death due to abortion complications. Unfortunately access to safe abortion vary on grounds such as race, income and region. It is demonstrated that white women who have the economic resources to have an abortion usually go to private clinics to undergo the procedure while women in poor economic conditions are forced to go to clandestine clinics, where

[179]V. Ribeiro Corossacz (2019). Brasile: criminalizzazione dell'aborto, razzismo e pratiche politiche delle donne in Dai nostri corpi sotto attacco: Aborto e Politica. *Ediesse,* p. 170.
[180] D. Diniz et al. (2012). Pesquisa Nacional de Aborto 2016. *Ciencia e saude coletiva*, p. 653.

sanitary conditions are precarious and the abortifacient used are often herbal medicines or invasive procedures that put at risk the woman's life.[181]

In Argentina a wide channel of feminists' organizations fights for the regulation and depenalization of abortion, among these organizations the most famous and active is the Socorritas en Red: Feministas que Abortamos. The Socorritas is a web of fifty feminists organizations that operates in the whole country giving information on the safe use of abortifacients and giving decisional support to women who want to have abortions through a policy that articulates in four steps: 1) a public telephone number for everyone who wants to have information about abortion; 2) a meeting during which Socorritas furnish detailed information on abortifacients according to the OMS guidelines; 3) assistance during the assumption of the abortifacient and in the post-abortion process; 4) establishment of formal and informal alliances between activists and health workers in each of the territories.[182] The meeting they organize are collective and have the goal to create a space where people who want to have an abortion and/or people who already had one share their worries, anxieties and experiences in order to create a familiar and caring environment to fight loneliness and social confinement. The Socorritas are in charge of giving medical information by handing out and explaining brochures with abortion guidelines, expected symptoms and worrying signs that must be taken care of in hospital. The impact of the work of the Socorritas is extremely strong. They have collected documents of every person who turned to them for help in having an abortion to create annual statistics in order to have an important instrument at political level that shows sociodemographic, gynaecological and obstetrical information. In the period from 2014 to 2018 they have provided information to 23,214 women, 19,361 of whom have been assisted in all the phases of abortion. [183] An important contribution they have given is having challenged the stereotyped narrative of abortion as a necessarily painful, terrifying and unpleasant experience and replacing it with the more realistic conception of abortion as a relief and to social redemption.

The context surrounding abortion in Chile is not different from the one we previously mentioned. The strategy adopted is similar to the one provided by the Socorritas, to the point that exists a collaboration with them, to create "solidarity webs" that in origins had the sole purpose to provide information about how to have a safe abortion but, with time, has extended their goals to include also the direct assistance by phone during the process of abortion. The service of phone assistance follows a carefully studied protocol in order to not violate abortion regulations, in fact phone operators cannot

[181] L. M. Kelly. (2014) Supra note at 178, p. 175.
[182] J. Burton et al. (2019). Argentina e Cile: aborto libero, sicuro e legale a casa e in ospedale in I. Boiano and C. Botti. (2019). Dai nostri corpi sotto attacco. Aborto e politica. *Ediesse*, p. 188.
[183] I. Boiano and C. Botti. (2019). Dai nostri corpi sotto attacco. Aborto e politica. *Ediesse*, p. 191.

in any way provide information on how and where obtain misoprostol. The wide web of feminists' organizations has a specific and defined plan of action which is articulated in monitoring of the application of the law, the regulation of every case in which abortion is allowed and importantly, the ultimate goal is to "socially depanelize" abortion by eliminating the social stigma attached to women who have abortions and to physicians who perform them.[184]

Telemedicine abortion is a procedure in expansion that sees its most famous and innovating example in the Women on Web movement. The origins of Women on Web and of telemedicine abortion, the voluntary interruption of pregnancy through pharmaceutical medicine at home and assistance by phone, sees its beginning with another project that goes by the name Women on Waves, by the same founder of Women on Web, Rebecca Gomperts. The organization Women on Waves provided abortion on international sea in a gynaecological clinic on board of a ship that fled the Dutch flag. When the ship arrived in a State with abortion restrictions or with a total criminalization of abortion, women who arranged an appointment with the organization were brought into international waters (on board of the Women on Waves' ship the Dutch laws were in force) to have abortions under the assistance of the Ong's medical personnel.

A specific event changed the approach of the organization when, during a mission in Portugal in 2004, Women on Wave's ship was blocked by two military ships of the Portuguese government that at the time was carrying out a highly restrictive campaign against abortion. This blockage lasted few days and granted quite a visibility to the organization, to the point that Gomperts was invited in a talk show where, to face the problem of the women who were waiting for the organization to assist them in the abortion procedure, she explained publicly how women can have an abortion on their own in the safest way. This was the event that led to the revolution of the Ong's method.

Women on Waves continued with its mission while the role of daily assistance was taken by Women on Web. While pharmaceutical abortion is considered one of the safest procedures if performed according to OMS's guidelines, what may worry women is rather the consequences they might face in cases of complications in States where abortifacients are also prohibited. Women on Web provide advice to get round the law by taking the misoprostol pill by letting it dissolve under the tongue and spitting out the remains after about thirty minutes, in order to eliminate any traces of the drug if the woman were to require emergency assistance at the hospital. What is interesting to note is that Women on Web do not receive requests exclusively from women residing in criminalizing States, "the policy of Women on Web has changed. Previously, no drugs were sent to countries where abortion is legal.

[184] Ibid., p. 192.

But then we realized that there are realities, in Italy as in France, Spain or England, where abortion is legal but, in reality, access is not always guaranteed ".[185]

The work of organizations like Women on Web has been demonstrated to be essential in a situation like the Covid-19 pandemic. WoW's site has registered an increase in demands from every place in Europe. A survey realized by a group of researchers from the University of Texas has shown that between January 2019 and June 2020 in eight European five European countries (Hungary, Italy, Malta, Portugal and North Ireland) the number of requests has increased exponentially since the entry into force of the pandemic restrictions.[186]

The data from Italy has shown an increase of 67.9% of requests, demonstrating the extent of existing barriers to abortion and how the government has amplified those barriers by interrupting the pharmacological abortion, that would require four meeting at the hospital. This already complex situation has exacerbated the difficulties in obtaining an abortion and explains why an ever-growing number of women are turning to organizations like Women on Web to claim their reproductive rights. Unfortunately, the power of these organizations is limited. Women on Web have been object of blockages campaign in different States. In this moment, the site is in shutdown in Turkey, South Korea and Saudi Arabia. In Spain, at the beginning of the last year, WoW's site was also in shutdown without having been noticed from the local authorities of the measure. Has been found out that the Ministry of Health itself asked to the different internet companies to block the site due to violations of the prohibition to sell abortifacients in the territory. Gomperts has submitted a complaint to the UN Human Rights Council, and with the joint effort of several ONGs, the restrictions have been removed.[187]

2.2 *De facto* obstacles to lawful abortion

The improvement of women's reproductive health care has recently been at the centre of worldwide goals. The Millennium Development Goals itself has set the goal of achieving a general improvement in the ability to access sexual and reproductive health care services for women. Although over the last decades there has been a global tendency towards the adoption of liberalizing abortion regulations, mainly by democratically-accountable legislatures, access to abortion is still not

[185] Il Post. "La coraggiosa storia di 'Women on Web'". https://www.ilpost.it/2021/03/29/women-on-web/
[186] A. R. A. Aiken et al. (2021). Demand for Self-Managed Online Telemedicine Abortion in Eight European Countries During the COVID-19 Pandemic: A regression discontinuity analysis. *BMJ sexual & reproductive health.*
[187] Ibid., supra note at 185.

guaranteed.[188] Women, again, find themselves in the disadvantaged and discriminatory position of not having full access to health care services they are lawfully entitled to. De facto barriers to reproductive health care services, and specifically to abortion, are multiple and often interconnected but they lead to the same conclusion: the discrimination of women.[189]

2.3.1 The vicious circle of conscientious objection: when doctors' beliefs result in closed doors to abortion

Physicians have the right to refuse to take part in medical procedures that are in conflict with their own conscience, religious beliefs or moral principles. This right may be incompatible with every patient's right to receive lawful medical treatment.[190] A conflict of interest can arise when the physician's beliefs are in contraposition to the medical procedures to perform, the most common circumstances being abortion, sterilization, in vitro fertilization or euthanasia.[191] The medical specialty of gynecology and obstetrics are the field in which conscientious objection is more frequently claimed due to its coverage of medical procedures that can involve religious convictions. Medical practitioners pledge, as the Declaration of Geneva provides, that "the health of my patient will be my first consideration".[192] However, practitioners who feel uncomfortable to perform any medical procedure are required, both on a legal and ethical ground, to refer their patients to practitioners who do not declare to be conscientious objectors. Not only, objectors have the right to decide whom to treat and patients have the same right to decide from whom they will be treated.[193] The ethical duty of referral, which reflects legal duties that arise in the patient-physician relationship, is made clear in the World Medical Association's 1970 Declaration on Therapeutic Abortion, which provides in article 6 that:

[188] R. J. Cook et al. (2009). Healthcare responsibilities and conscientious objection. *International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics.*
[189] S. De Vido. (2020). Violence against women's health in international law. Manchester University Press, p. 60.
[190] Cook, R. J. and Bernard M. Dickens. (2006). The Growing abuse of conscientious objection. *Virtual Mentor: Ethics Journal of the American Medical Association.*
[191] B. M. Dickens and R. J. Cook. (2000). The scope and limits of conscientious objection. *International journal of gynaecology and obstetrics: the official organ of the International Federation of Gynaecology and Obstetrics,* p. 72.

[192] World Medical Association. *Declaration of Geneva.* Available at: www.wma.net/e/policy/c8.htm. Accessed April 5, 2006.
[193]R. J. Cook et al. (2009), Supra note at 188, p. 337.

> "If the physician considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of medical care by a qualified colleague".[194]

The duty of appropriate referral has strong ethical, legal and human rights support. The ethical duty arises from the principle of respect for patients, particularly their right to self-determination or autonomy, in fact physicians' protection of their religious and ethical convictions should not be at the cost of patients' health or other interests, nor subordinate patients' religious convictions to their own.[195] Theoretically, the rights protecting conscientious objection should be recognized where patients' rights to lawful care are equally granted, if this is not the case practitioners' interests should not prevail over patients' health.

Physicians have the responsibility to declare in advance which health-care service or medical procedure they object to perform but they do not share the same responsibilities over persons they have not accepted as their patients. Nevertheless, physicians are expected to undertake the transfer of health care of the patients they cannot treat, for example because of excessive work load or because the indicated diagnosis or care is beyond their specialty, and of patients they will not treat on grounds of their own conscience.[196] It is to be noted that the possibility to invoke conscientious objection does not apply when the indicated care is a life-saving procedure, in this case practitioners are obliged to perform those procedures even if against their conscience.

The State can also be found in violation of its legal duties under international human rights law when the health care departments or agencies under State's control deny lawful access due to physicians' conscientious objections. As we have previously analyzed, the State has the duty to guarantee to every person full access to legal health care services also under article 12(1) of the Covenant on Economic, Social and Cultural Rights, which protect the right to the enjoyment of the highest attainable standard of physical and mental health.

Nurses are in a different position due to their auxiliary work, but most laws allow them to invoke conscientious objection in cases where they are required to give direct assistance in the performance of abortion or sterilization or when they are given directives to give immediate pre-operative care for

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[194] World Medical Association. *World Medical Association Declaration on Therapeutic Abortion*. Available at: www.wma.net/e/policy/a1.htm. Accessed April 5, 2006.

[195] L., Doyal. (1994). Needs, rights and the moral duties of clinicians. In: Gillon R, editor. Principles of health care ethics. *Chichester: Wiley*.

[196] B. M. Dickens and R. J. Cook. (2000), Supra note at 191, p. 73.

these medical procedures. Adherence to religious convictions about the issue of fetal life "may also allow nurses to object to cleaning operating theaters, particularly after second trimester abortions, although many other nurses may also find this distasteful and distressing, and be unsympathetic to an exemption for colleagues whose objections have a religious base."[197] In the process of seeking employment in clinics or hospitals where abortion is undertaken, aspiring nurses can be asked if they oppose to participate in the procedures performed. Hospitals and clinics cannot discriminate in the recruitment of medical personnel on religious or other grounds but must guarantee a certain standard of health care, which inevitably comprehends reproductive health services, by ensuring the availability of competent medical staff.[198]

The primary aim of hospitals and clinics must always be to promote patients' interests; therefore, if their medical staff reach such a high number of objectors that the services they offer are not accessible, the requirement of non-objectors become an undisputable necessity to meet the legal responsibilities they have towards their patients. Conscientious dilemma can be faced also by other service providers such as social workers committed to counselling and assistance, whose professionalism presume a non-judgmental fulfillment of their work and a non-religious biased counseling. It is quite common to encounter counseling providers who refuse to give advice to patients who are opting for a procedure they object or that provide opinions based on their religious conviction irrespective of the patient's interests. The problem of conscientious objection extends to non-surgical abortion by pharmaceutical products, such as mifepristone RU 486, methotrexate, misoprostol and emergency contraception birth control drugs, that pharmacists often refuse to prescribe invoking their conscientious objection.[199] While pharmacists who own their pharmacy can decide which pharmaceutical products make available, pharmacists that work in clinics or hospitals may have to submit to general principles we have mentioned earlier, such as non-discrimination and employment contracts which may require they are not objectors.[200]

Considering that physicians and nurses may invoke their conscientious objection, the issue that arise from this scenario is whether medical and nursing students must be trained to perform abortions regardless of their convictions. Conscientious objection may be invoked in the context of practical training that consist in performing specific procedures under supervision but not in case of academic

[197] Ibid.
[198] Ibid., p. 75.
[199] S.,Christin-Maitre et al. (2000). Medical termination of pregnancy. *New Engl J Med*.

[200] B. D., Weinstein. (1992). Do pharmacists have a right to refuse to fill prescriptions for abortifacient drugs?. *Law Med Health Care*.

knowledge, precisely because medical professionals must be ready to perform emergency abortions in life-threatening cases and they are obliged to give preventive and post-abortion care.[201]

Most western countries allow healthcare professionals some degree of CO through medical policies or codes of ethics — often called ‘‘refusal clauses’’ or ‘‘conscience clauses’’.[202] Reproductive health is the only field in medicine where societies worldwide accept freedom of conscience as an argument to limit a patient‘s right to a legal medical treatment. However, CO in medicine is still largely unregulated across Europe (as in the rest of the world) and abuses remain systemic.[203] The concept of “conscientious objection” has its origins in the refusal to perform mandatory military service because of one’s personal religious or ethical beliefs that are in contrast with the act of killing. The concept has recently been extended to the medical profession that in providing conscientious services might entail a moral dilemma, even though the moral principle guiding these professions is supposed to be the subordination of their own principles in order to serve and help others.[204] This applies even in the most extreme situations, for instance to defend or provide health care to criminals.

Historically, people in the military service that refused to participate in killing missions were harshly penalized; nowadays conscientious objection is protected in military contexts, but objectors still must justify their stance through a rigorous review.[205] On the contrary, the possibility to invoke conscientious objection in the reproductive health care sphere is widely accepted, to the point that usually health care professionals do not face any disciplinary measure, nor they have to justify their stance, even though the refusal to provide abortion for a woman in the situation of an unwanted pregnancy posit serious consequences for her and not the objector.

Conscientious objection in the military context is generally invoked when military service is compulsory; in contrast, healthcare professionals choose to be a doctor, a nurse, a gynecologist knowing in advance that they will be expected to perform a wide range of duties on which patients will depend on. As we have seen, reproductive healthcare is the field where conscientious objection

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[201] R.S., Dresser. (1994). Freedom of conscience, professional responsibility, and access to abortion. *J Law Med Ethics.*

[202] C., Fiala and J. H. Arthur. “Dishonorable disobedience”: why refusal to treat in reproductive healthcare is not conscientious objection. *Woman-Psychosomatic Gynaecology and Obstestrics*, p. 13.

[203] Center for Reproductive Rights. Abortion opponents undercut council of Europe resolution on conscientious objection; 2010, http://reproductiverights.org/en/press-room/abortion- opponents-undercut-council-of-europe-resolution-on-conscientious-objection.

[204] B. D., Weinstein. (1992) Supra note at 200.

[205] National Peace Museum. (2006). The history of conscientious objection, http://www.nationalpeacemuseum.org/history.html

is worldwide accepted but it is also the field of healthcare that is mostly delivered to women. Women constantly face the weight of the motherhood role stereotype, so they are exposed to a series of biased behaviors of disapproval and hostility when requesting an abortion, birth control pills or emergency contraception, which paradoxically force them into an unwanted pregnancy.[206] As with abortion, refusals to provide contraception are not a "mere inconvenience to women, but cause genuine harm to their reproductive autonomy, their sense of security, and their moral identity as people who deserve to be treated respectfully when requesting sexual and reproductive health services."[207]

The erroneous presumption that only a small number of healthcare professionals may invoke conscientious objection and that health services will still be guaranteed is a dangerous and non-realistic assumption that entail serious consequences. Indeed, conscientious objection is a highly widespread practice, to the point that in some countries like Italy, the number of objectors has reached 92.3% in Molise. This case is emblematic in depicting the whole situation surrounding abortion, where in an entire region there was only one physician performing the service. The situation escalated quickly when the doctor, after 40 years of performing abortion, reached pensionable age but could not retire because no one was willing to take his place and perform a practice that is permitted under domestic law[208]. The refusal to perform or assist with abortion is often not driven by personal beliefs, most pro-choice medical professionals who could perform abortions may refuse to perform them because they fear for their reputation or their career because of the social stigma attached to it. The abortionist doctor of Molise stated: "who perform abortion do not advance in career: find a head physician who perform abortion. In Italy there is the Church, and until there is the Vatican to dictate the law this problem will last forever".[209]

Physicians who nevertheless are willing to perform abortions denounce obstacles such as anti-choice climate in workplaces and no-abortion policies in private healthcare facilities, which may discourage healthcare providers from performing these services with threats like immediate dismissal. When access to abortion care is limited and stigmatized in so many ways, even allowing any degree of conscientious objection adds further pressure to the already serious abrogation of patients' rights and medical ethics. The accommodation of conscientious objection in reproductive healthcare is quite

[206] B. D., Weinstein. (1992) Supra note at 200, p. 15.

[207] Ibid.

[208] Il Post, "Il problema del Molise con l'obiezione di coscienza". https://www.ilpost.it/2021/07/27/molise-obiezione-coscienza-aborto/

[209] Ibid.

inappropriate and unprofessional because it clearly violates women's right to lawful healthcare and discriminate against them because this conscious refusal is invoked mainly when women's reproductive choices are involved.[210] By forcing women to continue an unwanted pregnancy, the exercise of conscientious objection undermines women's reproductive autonomy and self-determination and put their health and lives at stake.

2.3.2 Non exhaustive territorial coverage of abortion clinics and travel-related issues

The issue of conscientious objection has serious consequences that causes also more practical and logistic problems. We have already analyzed in chapter one a case in which women did not have easy access to abortion and had been forced to travel to another State to have access to a lawful practice, that is the case of Northern Ireland that limit access to abortion under certain grounds, such as risk to woman's life and health or in case of rape. In States or regions where conscientious objection is a highly widespread practice and the percentage of objectors reach a considerable rate, women's right to a lawful abortion is dangerously impaired.

The case of Austria gives us a different point of view which unfortunately leads to the same consequences. Abortion providers practicing in Vienna are required to travel to Salzburg once a week to perform abortions at one public hospital because gynecologists and obstetrics in the region have invoked conscientious objection after an intense pressure from the Church and anti-choice groups to the point that access to abortion in Salzburg or in the surroundings was nearly impossible.[211]

Among various barriers to abortion care that may hinder accessibility to those services, travel related issues are the most common one. While previous research on the matter has focused on analyzing what negative consequences emerge from one specific restriction deriving from state abortion policy, little is known about what experience women who travel for abortion. An interesting survey focused on "the breadth of barriers, beyond those related to individual state-level abortion restrictions, that such women encounter and any associated consequences."[212] The survey, in describing the context in which it takes place, highlighted that in 2014 around 90% of US counties lacked an abortion clinic

[210] B. D., Weinstein. (1992) Supra note at 200, p. 18.
[211] C., Fiala and J. H. Arthur. "Dishonorable disobedience": why refusal to treat in reproductive healthcare is not conscientious objection. *Woman-Psychosomatic Gynaecology and Obstestrics*, p. 15.

[212] J. Jerman et al. (2017). Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States. *Perspectives on Sexual and Reproductive Health,* p. 95.

and five states had only one. Seven percent of individuals who underwent an abortion in the same year reported living in a state different from the one where they underwent an abortion and to have traveled to obtain one, while 75% of abortion patients were low income or poor so, any additional barrier to abortion - for instance travel-related expenses, lost wages and expenses for childcare, accommodations expenses - may be a significant burden for women.

Differences in service availability based on the gestation limits may lead to the creation of additional financial barriers for women who cannot travel, for instance "among a group of women denied an abortion because of gestational age limits, 85% reported procedure and travel costs as the primary reason for not obtaining an abortion elsewhere."[213] In this survey emerged from women's narratives that travel is a factor that exacerbate the negative effects of the barriers they encountered. Some women reported that the distance itself was not the main problem but rather external factors such as the need to use multiple ways of transportation, the fact that sometimes transportations may not be reliable or, as emerged from an interview, the idea of having to cross state lines itself was a stigmatizing factor that intensified the feeling of guilt.

Another interesting perspective that emerged is the testimony of a woman who had to travel 320 miles to get access to abortion that declared "... it made me go through so much extra stress and money… It didn't hinder me from doing it".[214] For many women, having to travel long distances or travel abroad to get access to abortion, simply intensify the negative effects of the multiple barriers they face but do not stop them from doing it. Being forced to travel to have an abortion has several practical consequences; women may find it difficult to arrange the appointment because they have other children that cannot be left alone, they must find someone to take care of them when they have to travel, they may need company during the trip in case they may suffer from post-abortion health consequences, they have to take the day off from work, they may need to find the money to afford travel expenses. This extremely complex and burdensome situation of encountering barriers to abortion emerges also in the narratives of women who find themselves in later gestations than desired because they experience delays in access to the services.

The extreme stress that stems from barriers to abortion bears with it also negative mental health outcomes that led women to even consider ending the pregnancy by their own using medications such as misoprostol or by resolving to the dangerous practice of self-inflicted physical trauma. The survey shows that each barrier faced by women requiring abortion complicated the process, even though it

[213] Ibid.
[214] Ibid., 98.

was not possible to discern the effects of each barrier. What emerged is that every woman experienced negative feelings from more than one barrier at the time and that the impact of these barriers, when encountered simultaneously, have a cumulative effect. This cumulative effect "also manifested in the often circular and sometimes overlapping nature of barriers", for instance in cases where women encounter a lack of information regarding the procedure or the healthcare services where to obtain a lawful abortion putting them in a situation of having to "jump through hoops" that necessarily lead to the delay in having access of abortion and aggravating the problem of gestational limits.[215]

2.3.3 Mandatory pre-abortion counselling and waiting periods

Every State requires that the patient requiring abortion consent to the medical procedure they are eventually going to undertake, this consent must be "informed". For consent to be informed there must be three interrelated factors: patients must possess the capacity to make decisions about their care, their participation in these decisions must be voluntary and they must receive adequate and appropriate information about the different and best options at disposal.

The whole process that takes place before obtaining an abortion is full of flaws. Starting from mandatory counselling, which was introduced to give support to the woman in making the decision for her unintended pregnancy, to help her implement her decision with the most accurate information at disposal and to give assistance in controlling her fertility. However, findings from empirical research show that most women do not need, nor do they want, a counselling session, highlighting that this procedure is contrary to women's wishes. Despite the enormous gains that a pre-abortion counselling session might have for a woman, the counselling must be voluntary to have meaningful effects such as reinforcing the idea that the decision must be autonomously taken in order to be a trustworthy and respectful service. That is precisely the reason why if the counselling must be mandatory, women have described it as being more detrimental than helpful.

Abortion care is not in any way different from other medical conditions so, women seeking abortion should be treated as moral decision-makers able to autonomously decide for their own healthcare by giving them the same respect accorded to every other patient making decisions about other medical procedures. To be effectively valuable, the counselling process must be non-judgemental in order to positively affect women by clarifying their concerns, but the ultimate premise is that pre-abortion

[215] Ibid.

counselling must be voluntary to be truly ethical. Mandatory pre-abortion counselling in most cases implies that the patient must make two or more visits to the health care facility. It has been demonstrated that extending the waiting period to 72 hours or more, as in the case of Utah, is associated with a reduction of women carrying on the process of requiring an abortion. Aside from being a time-consuming step, it bears with it an economic cost that not everyone can afford and, more importantly, might have serious consequences on the availability of abortion services because it can lead women to go past gestational ages that qualify them for the legal procedure.

All these barriers may lead women to resort to either unsafe abortions or force them to carry to term an unwanted pregnancy against their will. Some States have recently adopted laws and policies regulating abortion that compel women to receive counselling and information prior to obtaining an abortion that are intentionally biased and directive. In Russia in 2010, the Ministry of Health, have issued guidelines on psychological pre-abortion counselling that required to portray women as irresponsible for having an unwanted pregnancy and to describe abortion as the act of murdering a living child.[216] Counsellors were specifically instructed to convince women that they have a maternal feeling and to not ignore it, but they were also incited to portray abortion as an immoral and cruel act in order to lead women into reaching to an "independent" conclusion that they must continue with the pregnancy.[217]

Another practice widely adopted is to expose women to mandatory ultrasound examination in pre-abortion counselling sessions. In these kind of counselling sessions women are shown ultrasound images of the foetus while the physician informs the woman of all the anatomical features of the foetus at that precise gestational age and the harm abortion will have on the it, as well as the harmful effects the procedure will have on her body and health.[218] Notwithstanding the controversial reason behind the practice of mandatory pre-abortion ultrasound, a study of Wisconsin's ultrasound law found that 93% of women were certain of their decision to obtain an abortion, and that the results did not change before and after the introduction of the law.[219]

These practices of forcing women to undergo counselling or receive information that they do not seem to need nor want, undermines women's human rights. This approach is in clear contravention

[216] L., Hoctor and A., Lamačková. (2017). Mandatory waiting periods and biased counseling in Central and Eastern Europe. *Int J Gynecol Obstet*, p. 3.
[217] Ibid.
[218] Law on Termination of Pregnancy (Nos. 87/2013 & 164/2013) (Maced.); Ministry of Health, Rulebook on the Content and the Manner of Counseling for the Pregnant Woman Prior to the Termination of Pregnancy: Based on Article 6 Paragraph 4 of the Law on Termination of Pregnancy (Official Gazette of the Republic of Macedonia Nos. 87/13 & 164/13) (Oct. 6, 2014).
[219] Guttmacher Institute. "Mandatory Counseling For Abortion". https://www.guttmacher.org/evidence-you-can-use/mandatory-counseling-abortion#

of some human rights we have previously seen, such as the right to enjoy of the highest attainable standards of healthcare and scientific progress that presupposes that the information they receive are non-biased, that physicians or counsellors refrain from censoring or misrepresenting information but also that the information they provide are scientifically proven.[220] More importantly, "women's rights to privacy, personal autonomy and integrity require that women be able to exercise agency and make autonomous choices about their bodies and their health free from arbitrary restrictions".[221] This is why, counselling services that provide good quality, non-biased information must be offered by States to women who are in need but cannot be imposed on women because it would undermine their autonomy and decision-making capacity ignoring their wishes, necessities or even economic possibilities. While it may be a useful service for some women, the majority declare to have made up their minds before seeking care or that they don't want to discuss their reasons for requiring an abortion.

Mandatory counselling is also criticized in the WHO Safe Abortion Guidelines, which reinforces the idea that many women have already taken a decision about their abortion and that their decision must be respected, as it would be natural to do in any other case involving other medical procedures, without questioning their certainty by obliging them to undergo mandatory counselling. The International Federation of Gynecology and Obstetrics (FIGO) has also expressed its stance on the matter by declaring that "neither society, nor members of the health care team responsible for counselling women, have the right to impose their religious or cultural convictions regarding abortion on those whose attitudes are different".[222] The mandatory counselling often includes also obligatory waiting periods that must elapse before women can actually obtain an abortion. This provision consists in a particular period of time that must pass between the counselling sessions or the moment a woman requests an abortion and the scheduled time in which the procedure can be carried out. The length of the mandatory waiting period varies from country to country or may depend on the clinic's specific provisions.

Mandatory waiting periods, as other abortion barriers, jeopardize women's rights to timely access to health and can cause serious physical and mental harm to women requesting lawful abortion. Resulting delays can prevent women from obtaining legal abortions by pushing women beyond gestational limits and may result in the necessity to turn to other clinics that have different gestational

[220] Committee on Economic, Social and Cultural Rights, General Comment 14: The Right to the Highest Attainable Standard of Health (Art. 12), E/C.12/2000/4 (2000).
[221] J. Jerman et al. 2017). Barriers to Abortion Care and Their Consequences For Patients Traveling for Services: Qualitative Findings from Two States. *Perspectives on Sexual and Reproductive Health.*
[222] Ibid, 5.

limits stipulated, which usually are fewer in numbers, limited in the territory and would compel women with higher costs to travel.

When mandatory waiting periods and biased counselling intersect, the negative effects on women grow exponentially. Aside from practical time-related problems, the theme of time has been addressed as central in the abortion experience by women themselves. Wait time for an appointment and wait time in clinic have been considered only nerve-wrecking.[223] Women have expressed their opinion and their perception of time during the abortion procedure; once they have made a decision, they wanted to happen as quickly as possible, "the wait time because once you have made up your mind to have the abortion you want it over as soon as possible".[224] In general, waiting time has been described as a factor contributing to their anxiety, mainly wait time for the appointment but also the wait in the clinic. The idea behind the introduction of these barriers to abortion is that without the mandatory counselling and the required waiting period of "reflection" women would make rash decisions or would not consider thoroughly the consequences of their decision. This approach dangerously promotes harmful gender stereotypes and discriminatory beliefs about women's capabilities. For instance, women are considered to be emotional and reactive, therefore they need assistance to take rational decisions about their fertility and abortions. Additionally, women are stereotypically portrayed as "natural mothers", for that reason they need assistance to take decisions they would otherwise regret, which explains the reason why biased counseling often project disapproval and shame for the decision of terminating the pregnancy.

2.4. The role of positive and negative obligations of the State

2.4.1 State obligation to respect, to protect and to fulfil to eradicate gender stereotypes in the field of women's reproductive health

States' obligations with regard women's human rights varies according to the scope of the right in question. A distinction is commonly made between positive and negative duties. Negative duties are State's obligations to refrain from intervening in the exercise of individual's rights; a violation of which occurs when a State has directly acted, or a government agent has acted in the name of the

[223] M. R., McLemore et at. (2014). Women Know Best. Findings from a Thematic Analysis of 5,214 Surveys of Abortion Care Experience. *Women's Health Issues*, p. 598.
[224]Ibid., p. 597.

State, intervening or obstructing an individual's effort to enjoy of his rights. Positive duties, on the contrary, require States to provide individuals of the means to achieve their rights, for example by making general provision of health services.

A violation of positive obligations occurs when the state creates barriers to the enjoyment of individuals' rights. In some cases, a specific right might require to States only to not intervene, to positively act in order to provide individuals with the means to enjoy their right or might require both positive and negative obligations from States. An example is the right to health protection against HIV infection that entail negative duties not to obstruct access to information about how to contravene the infection and information about prevention but also positive duties to employ resources in public education about the risks and prevention.[225] A State's compliance with its obligations depends on the legal interpretation of the scope and nature of the right in question that can be found in the treaty and can be evidenced looking at events and statistics. The correct observance or the breach of a duty can be evidenced by individual's report of occurrence of an event but also by referring to internationally determined standards demonstrating conformity with the treaty.

The role of gender stereotypes in harming women is widely recognized, but making the harms explicit by identifying them, naming them and understanding the context in which they operate is a responsibility pertaining to states and is necessary to expose its cruel nature.[226] It helps to better understand the legal and other means that might be useful to treat or eliminate gender stereotyping. When the negative effects are acknowledged, it becomes clear why is essential to combat such stereotyping in order to eradicate all forms of discrimination against women and achieve real equality.

Jurisprudence and literature on gender stereotyping show that the application or perpetuation of gender stereotypes can harm women, or even subgroups of women, in profound ways that result in different kinds of damage. Women may be damaged because they are denied recognition of their dignity and worth or fair allocation of public goods and services; sometimes these forms of damage can be consequential or even overlap. An example is the parental/husband's consent in authorizing women's access to health care services that portray the stereotype of women as less capable of making rational medical decisions, therefore neglecting their moral and autonomous agency. A woman can

[225] R. J., Cook & World Health Organization. Adviser on Health and Development Policies. (1993). Human rights in relation to women's health: the promotion and protection of women's health through international human rights law / prepared by Rebecca J. Cook. *World Health Organization*., 22.

[226] R. J. Cook and S. Cusack. (2010). Gender stereotyping: Transnational legal perspectives. Philadelphia, PA: *University of Pennsylvania Press,* p. 59.

be harmed when she is denied a benefit because of the application, enforcement, or perpetuation of a gender stereotype in a law, policy, or practice that does not correspond to her actual needs.[227]

To eliminate discrimination and achieve substantial equality is therefore important that states refrain from treating women according to generalized attributes, characteristics, or roles that might have been wrongly ascribed to them by virtue of them being women, or that do not consider their actual needs, abilities, and circumstances. In other words, where a law, policy, or practice makes a difference in treatment based on a gender stereotype in any sector that has the purpose or effect of impairing or nullifying women's equal rights and fundamental freedoms, it is a form of discrimination that States Parties are obligated to eliminate.

The Preamble to the Women's Convention underlines an important aspect that often goes unnoticed: gender stereotypes of men can, aside from harming men, affect also women. Therefore, it is important to tackle gender stereotypes of both if we want to challenge and change the traditional roles of women and men in the family as well as in society. The Convention continues by requiring the modification of "the social and cultural patterns of conduct of men and women" with a view to eliminating "prejudices and . . . practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women."[228]

Under the Women's Convention, States have the obligation to take all the measures to eliminate, modify or abolish existing laws, customs and practices that discriminate against women. Where a law, policy or practice is discriminatory on a gender-stereotyped basis and results in a different treatment that has the aim or effect of denying women's rights, it is States' duty to eliminate that form of discrimination. The approach widely applied by international and regional human rights bodies to address the content of the obligations of States Parties to eliminate gender stereotyping is structured in: obligation to respect, obligation to protect and obligation to fulfill human rights. States and all states' agents, according to the obligation to respect, must refrain from wrongful gender stereotyping that would, both directly and indirectly, impair or deny the equal human rights and freedoms of men and women. This implies naming the stereotype, identifying the harmful effects and addressing how it affects the equal enjoyment of a right deriving from a law, policy or practice.

States have the obligation to refrain from implementing the stereotyping laws, regulations or practices and must modify or eliminate them accordingly. Importantly, the judiciary is also an organ of the state, thus is subject to the same obligation to respect. The judiciary too must refrain from gender

[227] Ibid., p. 61.
[228] CEDAW, art. 5(a).

stereotyping in delivering its reasoning,[229] even though it is common to assist to biased reasoning that reflects generalizations about women that do not correspond to women's actual realities.[230] Court's decisions that contribute to perpetrating gender stereotypes create harms not only to the individual; therefore, courts decisions dismantling and eliminating stereotypes benefit the whole community and people who suffer from similar disadvantages. The obligation to protect instead, requires States to take all appropriate measures to address violations by non-state actors in context like the community and the family.

States have the duty to protect women against forms of wrongful gender stereotyping by non-state actors by raising awareness of common biases and prejudices that affect women and to establish effective mechanism in response to complaints. Article 2(e) of the CEDAW, requires the adoption of "all appropriate measures to eliminate discrimination against women by any person, organization or enterprise", therefore a State Party is responsible for acts or omissions of its own agents but can be held responsible also for failing to act with due diligence to prevent, investigate, punish and remedy for wrongful gender stereotyping by non-state actors. The family is considered a non-state actor that might engage in or take part in domestic violence, "honor" killing, forced marriage etc.[231] The State have obligations with regards also these stereotyped manifestations, as well as those occurring in other contexts such as religious, educational and traditional institutions that perpetrate a rooted code of conduct attributed to women such as chastity, obedience, emotionality. In the market, non-state actors' stereotyping actions can include hiring practices that reflect socially attributed roles to women such as more suitable jobs like the one of secretary and, at the same time, denying them of the equal possibility to cover typically male job positions.[232]

The importance of addressing gender stereotyping by non-state actors is equally relevant because they also play an indisputable role in creating and institutionalizing wrongful stereotypes. In assessing if the measures to adopt to eliminate gender stereotyping are appropriate, states will have to carefully weigh those measures in order to respect both victims of stereotypes and the right of individuals who apply gender stereotypes claiming legitimate freedom of thought, expression or religion.

[229] S. Cusack and R. J., Cook. (2009). Stereotyping Women in the Health Sector: Lessons from CEDAW. *Wash & Lee K. Civ. Rts & Soc. Jus*t., p. 74.
[230] Ibid., supra note at 143, p. 76.

[231] M. W. Wright. (1999). The Dialectics of Still Life: Murder, Women, and Maquiladoras. *Public Culture.*

[232] R. J. Cook and S. Cusack. (2010). Gender stereotyping: Transnational legal perspectives. Philadelphia, PA: *University of Pennsylvania Press*, p. 89.

There is an important distinction to make, individuals are entitled of having their own stereotypical opinions about women, but States have the duty to modify or eliminate those measures or stereotypical thinking by non-state actors that impair or lead to the denial of benefits to a qualified woman, such as preventing access to employment or access to a lawful health care service.

There are several cases in which court decisions have circumscribed manifestation of religion, for instance the European Court of Human Rights declared it was justifiable to invoke conscientious objection when acting in their professional capacity when those acts denied access to emergency contraception.[233] The last duty is the obligation to fulfill, which addresses the problem more deeply. As we have said, under international human rights law, States Parties must do more than refraining from interfering with human rights, they also must adopt positive measures to ensure that people can enjoy their rights in practice.[234]

In concrete terms, States might be required to address and show how gender stereotypes affect women in specific sectors and provide appropriate measures to break stereotypes with the promotion of education and training for public officials to build a collective awareness. Training programs for the judiciary could address the ways in which women are in a disadvantaged position within the process, how negative stereotypes are reflected in some reasoning and in specific areas of the law.[235] Judges might be encouraged to analyze to what degree and how wrongful gender stereotypes have become embedded in court decisions and reasoning and what they can do to dismantle them.

Wrongful gender stereotypes have practical consequences; in the reproductive health field often impede women's access to essential health services and reproductive information. Stereotypes prescribe one or more roles and behaviors to women even against their will, for instance the role of the mother. This specific stereotype can impede women from having access to reproductive health information and/or services in order to fulfill their imposed role of mothers and continue with the pregnancy.[236]

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[233] Ibid., p. 92.
[234] Ibid., p. 82.

[235] See, e.g., Sheilah L. Martin and Kathleen E. Mahoney, eds., *Equality and Judicial Neutrality* (Toronto: Carswell, 1987); Kathleen Mahoney, "Canadian Approaches to Equality Rights and Gender Equity in the Courts," in Cook, ed., note 49, 436–61, at 449–56.

[236] S. Cusack and R. J., Cook. (2009). Stereotyping Women in the Health Sector: Lessons from CEDAW. *Wash & Lee K. Civ. Rts & Soc. Jus*t, p. 85.

As we have already said, wrongful stereotypes find a fertile ground in the reproductive health sphere. It proves to be necessary to establish effective remedies when harming gender stereotyping are involved if the ultimate goal is to eradicate them, precisely because ineffective or non-existent remedies encourage a climate of devaluation of women and women's need in all sectors. The idea of impunity exacerbates prejudices and generalizations, which is why sanctions, even if they do not necessarily correct a wrong behavior, help in deterring its repetition or continuation.

States are obliged, under the Women's Convention, to provide individual and structural remedies. Individual remedies must be established to protect and compensate the victim of the specific wrong for the application, enforcement or perpetuation of the gender stereotype, while structural measures are aimed at deinstitutionalizing wrongful gender stereotyping in structure, that is to say that aim at modifying or eliminating stereotypes from laws, practices or policies of States to prevent future harms against women.

Recognition of wrongful gender stereotyping uncover the underlying conditions that jeopardize women's health. As we have said, health is not to be intended as merely the absence of diseases, but a broad concept that comprise the socio-economic well-being as well. International human rights law requires States to positively engage in the elimination of gender stereotypes that affect women's status, role and health. While achieving the full recognition of each person's right to the highest attainable standard of health is the first step to achieve women's equality, it is important to understand, and act accordingly, that the right to health is interdependent with other equally important human rights. "Good health is the precondition to individuals' exercise of rights to equal participation in communal and social life. At the same time, an individual's capacity for participation in activities of their choice enhances their health status".[237]

[237] R. J. Cook. (1995). Gender, Health and Human Rights. *Health and human rights*, p. 364.

Chapter 3 - Abortion and its denial: a psycho-social perspective

Abortion is a controversial and morally divisive issue. Even in contexts where the practice is legally permitted, in Western Europe countries for instance, abortion is often socially prohibited, stigmatized and harshly condemned from a moral and religious point of view.[238] The debate on abortion and related psychological consequences has been central in political, legal, medical and religious discourses, often to discredit the validity of the practice itself as well as to discourage women from requiring abortion and practitioners from providing it.

The debate was generating so much controversy to the point that, in the US in 1987, President Ronald Reagan designated the then-Surgeon General C. Everett Koop to prepare a report on the public health effects of abortion, analysing both psychological and physical elements. Koop conducted a comprehensive review of the scientific literature at disposal and declined to issue a report, instead he sent a letter to President Reagan in which he concluded that the existing research was inadequate to support any scientific findings about the psychological consequences caused by abortion.[239] Later, Koop stated before the Congress that "obstetricians and gynaecologists had long since concluded that the physical sequelae of abortion were no different than those found in women who carried to term or who had never been pregnant"[240] and also that there might be the case that psychological responses following abortion can be "overwhelming to a given individual" but the psychological risks following abortion were "minuscule" if considered from a public health perspective.[241]

Koop's report has been cited by pro-abortionists and anti-abortionists to claim both the presence and the absence of scientific evidence supporting the detrimental effects of abortion on women's physical and mental health. It turned out to be necessary to re-examine the issue and therefore the American Psychological Association (APA) in 1989 convoked a panel of scientific experts to review the scientific literature on psychological responses to abortion in order to deliver a conclusive report on the pernicious, but of undeniable importance, matter. Recognizing that a great number of studies presented different methodological flaws, the panel selected studies with the most rigorous research

[238] M. G. Pacilli et al. (2018). Elective abortion predicts the dehumanization of women and men through the mediation of moral outrage. *Social Psychology*.
[239] Report of the APA Task Force on Mental Health and Abortion, 5. (2008)
[240] S. A. Cohen. (2006). Abortion and Mental Health: Myths and Realities. *Guttmacher Policy Review*, p. 9.
[241] Ibid, p. 10.

designs focusing on studies on legal, elective, first-trimester abortions and analysing the psychological status of women belonging to this category. The conclusion of the panel reinforced the outcome of the research previously conducted by Koop: the most methodologically reliable studies indicated that "severe negative reactions to legal, non-restrictive, first-trimester abortion are rare and can be better understood in the framework of coping with a normal life stress".[242] The task force reached the important conclusion that obviously some individual can experience severe forms of distress or psychologically relevant disorders following abortion, but it cannot be assessed if these symptoms are a direct cause of it.

After these two important reviews of scientific literature, which have been regarded as the definitive proof on the matter, several new studies were conducted to address the link between abortion and women's mental health. These new studies are divided on those supporting the outcome of the 1989 Task Force report (to cite some, Cohan, Dunkel-Schetter, & Lydon, 1993; Gilchrist, Hannaford, Frank, & Kay, 1995; Russo & Dabul, 1997; Russo & Zierk, 1992) and those supporting the existence of psychological negative consequences of abortion (Cougle, Reardon, & Coleman, 2003; Fergusson, Horwood, & Ridder; 2006; Gissler, Kauppila, Meri- lainen, Toukomaa, & Hemminki, 1997; Reardon & Cougle, 2002a).

A new critical review of the recent literature was imperative, therefore the Council of Representatives of APA convened a new Task Force on Mental Health and Abortion (TFMHA) in 2006, this time composed of scientific experts in areas such as stigma, coping, methodology, women's health and reproductive health. This report represents the most complete, thorough, and critical evaluation of the literature currently available since the APA report of 1989.[243] Important to note is the mission of the TFMHA, which was to critically evaluate in an objective way the quality of the scientific evidence with the premises of conducting the review without regard to the direction of its findings. The ultimate goal of the task force was to deliver an unbiased conclusion based on the best scientific evidence available; in order to do so, the members of the APA have a wide range of differing personal views on abortion.[244]

[242]Report of the APA Task Force on Mental Health and Abortion. (2008), p. 5.
[243] Ibid.
[244] Ibid., 6.

Several other studies have investigated the attitudes toward abortion intended as a social matter,[245] concluding that several factors generate changes in the attitudes according to people's education,[246] religiosity,[247] political orientation and gender-role attitudes.[248]

At the basis of the discourse on abortion and related psychological experiences, is the assumption that the term abortion encompasses a multitude of experiences and that it inevitably assumes different meanings to different women.[249] Defining women's abortion experiences is a highly difficult task. Aside from the fact that many circumstantial factors influence women's emotional perception of the abortion experience, women obtain abortions for a variety of reasons, at different times in their lives, at different times of gestation and recur to different medical procedures to obtain abortion, all of which contribute to creating a whole personal perception of the experience. How women cope with the voluntary interruption of pregnancy depends also on what abortion means to them but also on their value of motherhood and pregnancy, which varies among women and among women in different socio-cultural and religious contexts or simply in different time period of their lives.[250]

The widely different personal, social, economic, religious and cultural context of every woman who decides to have an abortion undeniably shapes the cultural role of abortion and the associated stigma to the practice, but also to the woman who have an abortion. For these reasons, it is important to be careful in delivering global statements about the psychological impact abortion might have on women.

Women require abortions for different reasons. An interesting research has been conducted by Biggs and al.[251] on the reasons behind the choice of seeking abortion in the US. Being a conscientious topic, women try to maintain a certain degree of privacy about their abortion, often in attempt to protect themselves from stigma, which explains why the majority of American women in the US (approximately 1.2 million women per year) do not disclose their experiences.[252] The research focused on qualitative and quantitative articles concerning reasons for abortion among women in 26

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[245] Arisi, 2003; Huang, Davies, Sibley, & Osborne, 2016; Rosenheck, Feigal, Brown, Barcellos, & Bender, 2016.

[246] Wang & Buffalo, 2004.
[247] Esposito & Basow, 1995; Jelen, Damore, & Lamatsch, 2002; Misra & Hohman, 2000; Strickler & Danigelis, 2002
[248] Huang et al., 2016; Osborne & Davies, 2009, 2012; Wang & Buffalo, 2004.
[249] Edna Astbury-Ward. (2008). Emotional and psychological impact of abortion: a critique of the literature. F*amily Planning and Reproductive Health Care* ,p. 181.
[250] B. Major and others. (2009). Abortion and mental health: Evaluating the evidence. *The American psychologist*, p. 866.
[251] M. A. Biggs and others. (2013). Understanding why women seek abortions in the US. *BMC Women's Health*, p. 4.
[252] Ibid., p. 1.

"high-income" countries. The participants agreed to complete semi-annual telephone interviews for a period of five years. From this research emerged that most women gave only reasons that fell under one theme (36%) or two (29%) reasons, while a minority (13%) mentioned four or more themes.[253]

Financial reasons were the most frequently mentioned, among which appear a small proportion of women that mentioned the lack of employment or underemployment as a reason to seek abortion and six women that declared to have required abortion also because of a lack of insurance of the inability to get government assistance.[254] More than one third (36%) of women stated that the reason for requesting an abortion was because it wasn't the right time to have a baby.[255]

One third of respondents gave partner-related reasons for seeking an abortion, both as their only reason or together with other reasons, such as not having a good or stable relationship with the partner, wanting to get married first, not having a supportive partner, being with the "wrong guy" and having an abusive partner[256]. The need to focus on other children was also mentioned as a reason by 29%[257]. The reasons among this theme include feeling overextended with current children or simply not wanting other children, while a small proportion felt that having a baby at that time would have an adverse impact on the other children.

One in five women (20%) stated that having a baby at that time would have interfered with future plans and opportunities, for instance with school or career plans[258]. Some declared the impossibility to take time from work to adequately raise a child. Younger women perceived that having a baby would negatively impact on multiple aspects of their future lives. Nineteen percent of women declared to be emotionally and mentally unprepared to raise a child at that time, a feeling of inability or a lack of mental strength to have a baby. Twelve percent mentioned the desire to give the baby a better life than they could provide at that moment. Less than seven percent of respondents reported a lack of maturity as a reason for seeking abortion while someone felt to be too young[259]. The lack independence was also perceived as a reason for choosing an abortion, as well as influences from family and friends. Others mentioned not wanting a baby or not wanting to place the baby for adoption[260].

[253] Ibid., p. 4.
[254] Ibid., p. 5.
[255] Ibid.
[256] Ibid., 6.
[257] Ibid.
[258] Ibid.
[259] Ibid.
[260] Ibid., 8.

Reasons related to timing, partners and concerns about the possibility to adequately support the child and other financially and emotionally reasons were the most common mentioned for seeking an abortion, demonstrating that abortion is a choice driven by women's concerns for current and/or future children, family as well as commitments[261]. Some women instead demonstrated to have internalized gendered norms about motherhood that lead to self-denial over the best interests of children[262].

Stigma about abortion generally affect at a major degree women who chose to have an abortion for self-fulfilling reasons, to secure themselves a better life and a good education, because they don't fall into the category of women whose best interest is the well-being of the baby or that do not sacrifice themselves to fulfil the gendered stereotyped "natural" role of the mother.

Denying women access to abortion may have a significant impact on their health,[263] their future plans[264][265] and their existing children[266] or on the family more in general. It is necessary to consider every case of request of abortion because, as we have seen, women require the procedure for a variety of reasons. Policies that restrict abortion must take into consideration that some women will need governmental support to raise a child or might be in a dangerous environment such as an abusive relationship that might be aggravated by a pregnancy, instead of depicting abortion as a sign of irresponsibility by immature women who must be helped in the process of decision-making from people who are unaware of their life's conditions.[267]

[261] Ibid., 11.
[262] Ibid., 12.
[263] C., Gerdts et al. (2016). Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy. *Women's health issues: official publication of the Jacobs Institute of Women's Health*.
[264] D. G., Foster and al. (2018). Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States. *American Journal of Public Health.*
[265] U. D., Upadhyay and al. (2015). The effect of abortion on having and achieving aspirational one-year plans. *BMC Women's Health.*
[266] D. G., Foster and al. Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children. *The Journal of pediatrics.*
[267] M. A. Biggs et al. (2013). Understanding why women seek abortions in the US. *BMC Women's Health*, 13.

3.1. Stigma and myths: attitudes towards women who chose abortion

3.1.1 False myths about abortion

Some state-mandated abortion counselling intentionally includes inaccurate information about abortion. The practice has often been linked to various physical and mental consequences to discourage women from requiring an abortion,[268] as it is because of a profound religious belief or because of mere misinformation in reproductive health policy debates.[269] Clearly, this practice infringes the principles of informed consent which should put the patient in the position to receive accurate and unbiased information in order to take the best decision about the medical treatment. According to ethical principles, the role of abortion providers comprises the duty to ascertain, before providing an abortion, that the patient has freely chosen to end her pregnancy without coercion and after having received adequate information of what the practice entails.

Myths surrounding abortion are numerous. First to mention are the inaccurate information on fetal pain. Some states require to deliver information on the ability of the fetus to feel pain at 20 weeks' gestation, which is a highly inaccurate and disputed assertion. It is highly unlikely that the fetus might feel pain during the abortion procedure before the third semester. The University of California has conducted a comprehensive literature review on the matter, coming to the conclusion that the fetus does not develop cortical function (the one required for conscious perception of pain) until 29-30 weeks' gestation. The explanation is that, without a psychological understanding of pain, a fetus cannot experience pain.[270]

Other inaccurate information circulating about abortion regards the possibility to reverse a medication abortion. Few States, starting from 2015, have begun to deliver information during the counselling meetings about the possibility to reverse the abortion procedure by taking a high dose of progesterone after the administration of mifepristone.[271] However, the practice of reversal is not supported by any scientific evidence and do not adhere on to clinical standards, therefore doctors refuse to rely on this practice and also consider damaging to include information about a medical experimental treatment

[268] Guttmacher Institute. Mandatory Counseling For Abortion.

[269] A. Sonfield. The Uses and Abuses of Science in Sexual and Reproductive Health Policy Debates. *Guttmacher Insititute*.

[270] S.J., Lee et al. (2005). Fetal pain: a systematic multidisciplinary review of the evidence, *Journal of the American Medical Association*.

[271] Guttmacher Institute. Mandatory Counseling for Abortion.

whose safety and efficacy is not scientifically proven, as stated the American College of Obstetricians and Gynecologists' (ACOG) vice president.[272]

Antiabortion activists, however, oppose abortion for moral and religious reasons. To validate their position often asserts that abortion is not only morally wrong, but that it harms women both physically and mostly psychologically[273]. While is more difficult to challenge the validity of scientific research confirming the safety of the abortion procedure, they appeal on what they allege are the negative mental health consequences of abortion. At the basis of their allegations there is the assumption that abortion causes mental instability and may even lead to suicidal thoughts, despite the continuous dismissals from the major professional mental health associations such as the American Psychological Association.[274] To defend their positions, they often cite numerous studies that present serious methodological flaws or draw conclusions that are not backed up by scientific evidence.

So far, there is not scientifically relevant proof that having an abortion causes more mental health damage than delivering and parenting a child born from an unintended pregnancy or placing a child for adoption.[275]

3.1.1.1 Post-abortion syndrome, depression and suicidal ideation

Women's experiences of abortion are often depicted as extremely stressful and difficult to cope with. According to theories of stress and coping, abortion might be a potentially stressful life event comparable to other normal life stressors. Since abortion occurs in the context of an already stressful life event, an unwanted or unintended pregnancy, it might be difficult to differentiate between psychological experiences associated with abortion from the ones associated with the other aspects of the unintended pregnancy.[276]

Abortion can be a way to relieve the stress from the unwanted pregnancy but can also engender additional stress. A woman's perception of her abortion experience will necessarily be mediated by the value she gives to pregnancy and abortion, her ability to deal with these events, and the way she

[272] Sherman C. Medical community slams study pushing "abortion reversal" procedure.
[273] S. A. Cohen. (2006). Abortion and Mental Health: Myths and Realities. *Guttmacher Institute*.
[274] American Psychological Association, Task Force on Mental Health and Abortion. Report of the Task Force on Mental Health and Abortion. (2008).
[275] Major and al. (2019). Abortion and Mental Health: Evaluating the evidence. *The American psychologist*s.
[276] Ibid., p. 10.

interprets her emotions related to the experience. Abortion might be interpreted as being in conflict with personal and family's religious beliefs or cultural background even by a woman who decide to proceed with the abortion procedure; in this case the experience might be perceived as more stressful in comparison to the perception of a woman who does not share the same conflicting values or does not live in a stigmatizing social context.

According to the stress-and-coping perspective's research there are different factors connected with the development of more negative psychological reactions among women who chose abortion.[277] Generally these include terminating a pregnancy that is wanted; real or perceived pressure from others to terminate a pregnancy; lack of support from others and perceived opposition to the abortion from family, partners, friends and the society; personality traits as low self-esteem and, lastly, a history of pre-existing mental health problems. It is important to note that the same risk factors that might lead to negative psychological reactions to abortion can be risk factors for negative reactions to its alternatives.

This is the case where abortion is considered within the range of normal life stressors, but abortion is often depicted as an extremely traumatic experience. Women who choose to require an abortion are expected to feel guilt, remorse, pain and depression because the experience involves the intentional termination of one's unborn life by their hand and the witnessing of a "violent death", as well as the lack of parental instinct and the expected maternal bond.[278]

Speckhard and Rue, who asserted that the traumatic experience of abortion can lead to severe forms of mental health suffering, coined for the first time the term *post-abortion syndrome*. They developed the concept of postabortion syndrome as a specific form of posttraumatic stress disorder (PTSD), similar in the symptomatology to the posttraumatic stress disorder experienced by war veterans, including symptoms such as trauma, flashbacks and denial, severe form of depression, anger, shame, survivor guilt and the tendency to substance abuse. The study conducted by Speckhard and Rue presents evident methodological flaws considering that she selected a sample of women specifically recruited because they declared to have had a highly stressful abortion experience, among which women who had illegal abortions or exceeded the gestational period allowed.[279]

[277] Ibid., p. 11.
[278] D. C. Reardon. (2018). The abortion and mental health controversy: A comprehensive literature review of common ground agreements, disagreements, actionable recommendations, and research opportunities. *SAGE Open Medicine.*
[279] American Psychological Association, Task Force on Mental Health and Abortion. Report of the Task Force on Mental Health and Abortion. (2008), p. 11.

Scientific research examining the link between abortion and subsequent PTSD have excluded this hypothesis in cases where abortion is voluntary, safe and legal, to the point that postabortion syndrome is not recognized as a diagnosis in the Diagnostic and Statistical Manual of the American Psychiatric Association.[280] Nevertheless, it has emerged the need to examine in depth and rigorously the factors that may engender a PTSD response, such as risk factors, prior mental health conditions and history of abuse or violence.

The review of studies on abortion and mental health outcomes that found a causal relationship between abortion and PTSD has highlighted several common mistakes, among which the lack of control of pre-existing disorders, but more importantly has highlighted the absence of appropriate comparison groups. Often studies compare women who have abortions to women who miscarriage or terminate a wanted pregnancy. This is extremely problematic and invalidate the reliability of these studies, precisely because the reasons that lead women to terminate their pregnancies are inherently different. To be scientifically valid, the recommended comparison group is one where women who have an abortion are compared to women wanting an abortion but are unable to get one.[281]

A study conducted by Biggs and al. have assessed women's risk of experiencing PTSS and PTSD over 4 years after seeking abortion, trying to find if women who receive an abortion are more likely to experience PTSS than women who are denied abortions and whether the source of PTSS is attributed to abortion, to pregnancy, to birth or other events in women's lives.[282] Women reported various causes to their PTSS, among which the most often mentioned are violence, abuse or criminal activity, followed by non-violent relationship issues, index pregnancy-related event, non-violent death or illness of a loved one and personal health-related issues.

Among those who attributed their symptoms to the pregnancy experience, many declared that the source of their symptoms was "the abortion", but others mentioned the experience of getting the abortion or the abortion procedure itself (the abortion clinic experience, seeing anti-abortion activists outside the clinic). Finding out to be pregnant was also mentioned as the cause of the development of

[280] American Psychiatric Association. (2002). Diagnostic and statistical manual of mental disorders (4th ed., text revision) (DSM-IV-TR). *Arlington, VA*: Author.

[281] M. A., Biggs and al. (2016). Does abortion increase women's risk for post- traumatic stress? Findings from a prospective longitudinal cohort study. *BMJ Open*, p. 2.
[282] Ibid., p. 4.

PTSS symptoms, as well as other people's reaction to abortion or the feel of guilt women are expected to feel for having done "something bad" or being victims of rape.

Regarding the index of violence, abuse or criminal activity, what emerged from the respondents' interviews is an history of sexual, physical or emotional abuse, such as being raped by a non-partner and having being victims of childhood sexual, emotional or physical abuse. To witness a violent event experienced by a loved one, such as unlawful deaths or attempted suicide, have been demonstrated to cause such symptoms, as well as violent events unrelated to closed one like being part of have assisted to an attack, a robbery or a fight. Relationship problems, personal health-related reasons, concerns about existing children or the fear they might be victims of abuse, financial problems and car or other accidents may also trigger PTSS symptoms according to women's interviews.

Significantly, both first-trimester abortion and near-limits groups who reported pregnancy-related PTSS felt that having the abortion was the right decision. This study demonstrates that the hypothesis that women who obtain abortions are more likely to experience posttraumatic stress syndrome than women who are denied abortions or that must carry the pregnancies to term, is not supported by scientific research. Women themselves have indicated a range of traumatic life experiences as the source of their symptoms. These findings show that exposure to sexual and physical violence are rather the cause or are strongly associated with PTSS and PTSD following abortion, that lack of significant difference between the women who had an abortion and those who were denied one demonstrates that the circumstances around the time of pregnancy were the source of stress rather than the procedure itself.[283]

The postabortion syndrome is not the only extreme reaction identified as related to abortion. The notion that women who have an abortion are at higher risk of suicide has been used as a ground to discourage women from having abortions, to the point that this assumption has been used during mandated counselling to warn women of the possibility to develop suicidal thoughts if they choose abortion.[284]

This view is supported by several studies that suffer from some serious methodological shortcomings, the same that appear in the studies about postabortion syndrome, failing to assess the existence of

[283] Ibid., p. 11.
[284] M. A. Biggs and al. (2018). Five-Year Suicidal Ideation Trajectories Among Women Receiving or Being Denied an Abortion. *American Journal of Psychiatry*, p. 845.

pre-existing risk factors. When studies fail to identify these pre-existing risk factor, they may wrongly attribute all these adverse mental health outcomes to abortion rather than to those factors.[285]

Another frequent methodological flaw, as we have already seen, is the use of inappropriate comparison groups that analyse the experiences of women who have abortions and the experiences of those who have never had an abortion or who choose to give birth.[286][287]

A U.K. study focused on analysing deliberate self-harm by comparing women who gave birth with women who received an abortion and women who were denied abortions. From this study emerged that, while women requiring abortion were at high risks of self-harm, rates were the highest among women who were denied an abortion, even though the researchers who conducted the study did not test whether the differences between women who had or were denied an abortion were statistically significantly.[288]

Consistently with previous review of literature on psychological effects of abortion, also studies on the effects of abortion on suicidal ideation have highlighted the conclusion that abortion does not place women at higher risk of experiencing suicidal tendency than being denied access to abortion. From this review, even when accounting for the factors that predispose women to experiencing suicidal ideation, having an abortion have been demonstrated that do not increase women's risk of developing suicidal ideation compared with women who are denied abortion or carry the pregnancy to term.[289]

Paradoxically, from this study it emerges that, rates of suicidal ideation were lower compared with other studies of pregnant and postpartum women. Gestational age when seeking an abortion has been demonstrated to have no significant effect of suicidal ideation, therefore policies that limit access to abortion on gestational age period with the motive of higher possibilities of developing suicidal thoughts are not evidence-based.

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[285] Ibid.

[286] N. P., Mota et al. (2010). Associations between abortion, mental disorders, and suicidal behaviour in a nationally representative sample. *Can J Psychiatry*.

[287] M., Gissler et al. (1996). Suicides after pregnancy in Finland, 1987–94: register linkage study. *BMJ*.

[288] A.C., Gilchrist et al. (1995). Termination of pregnancy and psychiatric morbidity. *Br J Psychiatry*.

[289] M. A., Biggs and al. (2016). Does abortion increase women's risk for post- traumatic stress? Findings from a prospective longitudinal cohort study. *BMJ Open*, p. 851.

Women who have an abortion are expected to experience feelings of regret and, according to Reardon and Cougle[290], women who abort an unintended first pregnancy are at higher risk of clinical depression compared to women who carry an unintended first pregnancy to term. They stress the importance to include this information in pre-abortion counselling in order to guarantee informed consent warning women of the possibility to develop a serious form of depression if they choose to proceed with the abortion.

Evidence that choosing to terminate rather than deliver an unwanted first pregnancy expose women to higher risk of depression is inconclusive.[291] Schmiege and Russo have examined the relation between the outcome of an unwanted pregnancy and depression, testing the same hypotheses of Reardon and Cougle but with more accurate coding of variables and appropriate samples. Pregnancy outcome did not predict depression in either the samples, indeed the data confirms similar scores for depression across the delivery and abortion groups, on the contrary, depression scores were slightly higher in the delivery group.[292]

It has been observed, consistently with other studies on the negative effects of early and unwanted childbearing[293][294], that the association of abortion with education and income-social variables have profound implications for mental health.

All these literature reviews and studies demonstrate that there is no credible evidence that choosing to terminate an unwanted pregnancy puts women at higher risk of subsequent depression, postabortion syndrome or suicidal ideation than does choosing to deliver an unwanted pregnancy. On the contrary, delivering an unwanted pregnancy has severe consequences on future plans and is associated with lower education and income, which, in turn, have been demonstrated to be risk factors for depression and other forms of mental distress.[295]

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[290] D.C., Reardon and J.R., Cougle. (2002). Depression and unintended pregnancy in the National Longitudinal Survey of Youth: a cohort study. *BMJ.*
[291] S. Schmiege and F. Russo. (2005). Depression And Unwanted First Pregnancy: Longitudinal Cohort Study. *BMJ: British Medical Journal.*
[292] Ibid., p. 3.
[293] S.B., Campbell et al. (1992). Course and correlates of post-partum depression during the transition to parenthood. *Dev Psychopath.*
[294] S.P., Cowan et al. (2000). Transition to parenthood: is, hers, and there's. *J Fam Issues*,

[295] M., Gissler et al. (1996). Suicides after pregnancy in Finland, 1987–94: register linkage study. *BMJ*., p. 5.

3.1.1.2 Abortion is the cause of breast cancer

Giving birth to a baby is said to reduce the chances to develop breast cancer in the future but having an induced abortion does not provide the same protection against it. This information has been included in informed-consent booklets for pregnant women by the Texas Department of Health Services since 2003. In this booklet, we can read that there is research showing that having an abortion "will not provide the increased protection against breast cancer"[296], aside from delivering a series of information that find no support in scientific evidence such as fetal pain and expose women to illustrations showing the stages of development of the "baby" inside the womb, the booklet include also misleading information about death, physical risks, mental health risks and reduction of future fertility as a complication associated to abortion. The theory of abortion-related breast cancer dates back to the 1950s and was widely promoted in the wake of the famous case Roe v. Wade decision, naming it the "ABC Link".[297]

The National Cancer Institute has examined the hypothetical link between abortion and the development of breast cancer and reported that a few retrospective studies suggested an actual increased risk of breast cancer. However, the Institute, which held a workshop in 2003 with more than 100 experts from around the world, has promptly recognized that these studies had important design limitations that could have affected the results.[298]

Prospective studies, which do not present the same bias and are more rigorous in design, have shown no association between induced abortion and breast cancer.[299][300] Furthermore, the Committee on Gynaecologic Practice of the American College of Obstetricians and Gynaecologists have concluded that "more rigorous recent studies demonstrate no causal relationship between induced abortion and a subsequent increase in breast cancer risk".[301]

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[296] A Woman's Right to Know. *Texas Department of State Health Services*, https://www.hhs.texas.gov/sites/default/files/documents/services/health/women-children/womans-right-to-know.pdf.
[297] The Washington Post. Texas state booklet misleads women on abortions and their risk of breast cancer, https://www.washingtonpost.com/news/fact-checker/wp/2016/12/14/texas-state-booklet-misleads-women-on-abortions-and-their-risk-of-breast-cancer/.
[298] Reproductive History and Cancer Risk. *The National Cancer Institute (NIH)*, https://www.cancer.gov/about-cancer/causes-prevention/risk/hormones/reproductive-history-fact-sheet#is-abortion-linked-to-breast-cancer-risk.
[299] G.K., Reeves et al. (2016). Breast cancer risk in relation to abortion: results from the EPIC study. *International Journal of Cancer*.
[300] V., Beral et al. (2014). Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and abortion: collaborative reanalysis of data from 53 epidemiological studies, including 83,000 women with breast cancer from 16 countries. *Lancet*.
[301] Committee on Gynecologic Practice. ACOG Committee Opinion No. 434: induced abortion and breast cancer risk.

From these studies it emerges that women who have had an induced abortion have the same risk of breast cancer as other women, women who have had a spontaneous abortion have the same risk of breast cancer as other women and other types of cancers also appear to be unrelated to a history of induced or spontaneous abortion.[302]

There are many risk factors for breast cancer, including ones that relate to a women's pregnancy history. In fact, women who have their first baby at 30 years or younger have decreased possibilities to be exposed to risk of developing breast cancer than women who have their first baby over 35 years or who never deliver a baby at all. However, having a baby does provide a greater protection against breast cancer but it doesn't mean that abortion affects the risk of developing it. Texas' booklet is voluntarily deceiving and misleading. A woman who delivers a child before 30, but have an abortion after the first child, continue to have a decreased risk of breast cancer.[303]

When reading a section like the one of the Texas' booklet is easy to deduce that abortion may be the cause of breast cancer and may actually dissuade women from resorting to a highly safe procedure; however, information about how much the risk of developing breast cancer can be associated to the age of the first pregnancy do not appear in the booklet.

Other studies have come to similar conclusions. The Lancet have has also reviewed data from 53 studies that included 83,000 women with breast cancer and found no correlation with spontaneous or induced abortion.[304] In 2008 a similar research has been conducted by Archives of Internal Medicine, examining the history of more than 100,000 women, and demonstrated that there is no link between induced or spontaneous abortions and breast cancer incidence.[305]

3.1.1.3 Abortion leads to infertility

Do abortions make you less fertile? Misleading and inaccurate information may appear when making a research on abortion on the internet. Data shows there is no link between abortion and fertility when abortion is safe, only abortions that are associated with complications can lead to future fertility

[302] Reproductive History and Cancer Risk. *The National Cancer Institute (NIH*).
[303] Ibid.
[304] V., Beral et al. (2014), supra note at 300.
[305] K. B., Michels et al. (2007). Induced and spontaneous abortion and incidence of breast cancer among young women: a prospective cohort study. *Archives of internal medicine*.

problems.[306] Abortion complications that might lead to developing difficulties in getting pregnant in the future, include uterine injury from the procedure, infection and serious bleeding requiring surgery.[307] A safely performed abortion is ten times safer than pregnancy that continues to term.[308]

The risk of complication with a safe and legal abortion that might hypothetically lead to infertility in the US has been demonstrated to be 0.23 percent. Contrary to the idea that second trimester and later procedure are highly more dangerous, it has been demonstrated that the risk in these cases are only 0.41 percent.

The risk of complications that could lead to infertility is much higher in case of delivering, either vaginal or C-section, while the risk of dying from giving birth in the US is 14 times higher than the risk of dying from an abortion.[309] Infertility is rather influenced by other factors that can have a much bigger effect than having an abortion, such as age, health conditions like endometriosis or sexually transmitted infections or even smoking.[310]

3.1.2 Features of abortion stigma

Stigma is a complex concept because it is both a cause and a consequence of inequality.[311] The first concrete definition of stigma related to abortion was formulated by Kumar, Hessini and Mitchell in 2009. They conceptualized abortion stigma as "a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood".[312] This definition, in turn, derives from Goffman's conceptualisation of stigma as an "attribute that is deeply discrediting", reducing the stigmatised "from a whole and usual person to a tainted, discounted one".[313]

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[306] The American College of Obstetricians and Gynecologists. https://www.acog.org/womens-health/faqs/induced-abortion?utm_source=redirect&utm_medium=web&utm_campaign=otn.
[307] The New York Times. Can an abortion affect your fertility? https://www.nytimes.com/2019/05/30/well/can-an-abortion-affect-your-fertility.html.

[308] Victorian State Government. Abortion – some misconceptions. *Better Health Victoria.*

[309] U. D. Upadhyay. (2015). The effect of abortion on having and achieving aspirational one-year plans. *BMC Women's Health*, p. 175.
[310] Mayo Clinic. Female Infertility. https://www.mayoclinic.org/diseases-conditions/female-infertility/symptoms-causes/syc-20354308.
[311] A. Kumar. (2013). Everything is Not Abortion Stigma. *Women's Health Issues*, p. 330.
[312] A. Kumar et al. (2009). Conceptualizing abortion stigma. *Culture, Health & Sexuality*.

[313] E. Goffman. (1963). Stigma: Notes on the management of spoiled identity. *Englewood Cliffs, New Jersey: Prentice-Hall Inc.*

According to Kumar, Hessini and Mitchell there are three specific ideologies of femininity that see women who require an abortion as failing: the idea of female sexuality pertaining solely to procreation, the inevitability of motherhood and the inherent and instinctual vulnerability of women. The definition of abortion stigma proposed by Kumar, Hessini and Mitchell is the most commonly cited in literature, from which have been created other definitions, broadening its scope to include a greater number of manifestations.[314] Applying Herek's theory of three manifestation of sexual stigma, Cokrill and Nack identify three forms of abortion stigma: *internalized stigma* which results from a woman's acceptance of negative cultural valuations of abortion; *felt stigma* that encompasses a woman's assessments of other's abortion attitudes, as well as her expectations about how attitudes might concretize in actions and lastly, enacted abortion stigma, which translates in a woman's experience of clear or subtle actions that reveal prejudice against those involved in the abortion (physical or emotional abuse, discrimination, hate speech, judgments etc).[315]

Abortion stigma is rooted in gender-specific archetypes that shape the cultural meaning of voluntary interruption of pregnancy, together with archetypal constructs of the "feminine" of procreative female sexuality and women's "natural" desire to be a mother.[316]

These different sexual and/or reproductive experiences have the potential to infringe these archetypes. Throughout life, women's experiences break these archetypes multiple times: with premarital sex and use of contraception, infidelity, infertility, by contracting sexually transmitted infection, doing sex work and having an abortion.[317] In particular, abortion include different transgressions within the same experience, such as participating in sex without desire to procreate, the unwillingness of becoming a mother and/or a lack of maternal bonding.

Abortion stigma affects not only women who terminate a pregnancy; its objects have expanded beyond the women who require the procedure to include service providers,[318] support networks,[319] advocates of abortion rights,[320] women's sexual partners and even abortion clinics.[321]

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[314] Ibid., supra note at 311.
[315] K., Cockrill and A., Nack. (2013). "I'm Not That Type of Person": Managing the Stigma of Having an Abortion. *Deviant Behavior,* p. 974.
[316] A. Kumar et al. (2009). Conceptualizing abortion stigma. *Culture, Health & Sexuality*.
[317] Ibid.
[318] Harris et al. (2011). Dynamics of stigma in abortion work: Findings from a pilot study of the providers share workshop. *Social Science & Medicine.*
[319] K., Cockrill et al. 2013). The stigma of having an abortion: Development of a scale and characteristics of women experiencing abortion stigma. *Perspectives on Sexual and Reproductive Health.*
[320] A., Norris et al. (2011). Abortion stigma: a Reconceptualization of Constituents, Causes, and Consequences. *Women's health issues: official publication of the Jacobs Institute of Women's Health.*
[321] S. K. Cowan. (2017). Enacted abortion stigma in the United States. *Social Science & Medicine.*

Abortion stigma has a wide range of consequences. The most commonly cited negative impacts of stigma on women's psychological and emotional wellbeing are emotions or psychological states such as guilt, shame and the incorporation of a negative self-concept.[322] These emotions are exacerbated by the psychological and emotional costs of secrecy about one's abortion (the most common strategy for coping with abortion stigma), which is said to be particularly onerous in terms of stress.[323]

While abortion stigma research has been usually directed toward understanding the individual, their attitudes, their coping strategies, lately the attention has been shifted to a concept that sees abortion stigma as socio-cultural in origin. The lack of attention given to the social production of stigma perpetuates the view of stigma as an individual action, "as what some individuals do to other individuals"[324] or "as primarily a problem of individual beliefs and actions that stigmatisers push onto the stigmatised".[325]

Intervention strategies to eliminate abortion stigma are generally designed to change beliefs and prejudices around abortion or to induce empathy into people who have or provide abortion.[326] This approach is criticized because it could never achieve large-scale change across populations. Targeting abortion stigma through specific individual-level values is bound to fail because it would be necessary to call into question the most basic principles of social life. The ideas, the beliefs behind one's idea of abortion are attached to systems that sustain relationship of power, privilege and disadvantage.[327]

Among the groups affected by abortion stigma, the first to mention are obviously women who have abortions. Not every woman feels stigmatized by abortion, but research indicates that two out of three women having abortion anticipate stigma if others were to know about it while 58% felt the need to keep their abortion secret from their loved one. [328] The experience of stigma depends on and varies according to individuals' religious beliefs, cultural values and socio-economic status. The more a woman perceive other stigmatizing her, the more she will feel the need to keep the abortion

[322] K., Cockrill and A., Nack. (2013). "I'm Not That Type of Person": Managing the Stigma of Having an Abortion. *Deviant Behavior*, supra note at 315.
[323] E. Millar. (2020). Abortion stigma as a social process. *Women's Studies International Forum, 78*, p. 2. See also Schellenberg et al. Social stigma and disclosure about induced abortion: Results from an explanatory study.
[324] Parker R. and Aggleton P. HIV and aids-related stigma and discrimination: A conceptual framework and implications for action.
[325] Tyler I. and Slater T. Rethinking the sociology of stigma.
[326] Ibid., supra note at 83, p. 5.
[327] Millar E. Happy abortions: Our bodies in the era of choice.
[328] Schellenberg et al. Social stigma and disclosure about induced abortion.

experience secret,[329] moreover women who perceive support from the community for the right to end a pregnancy are less likely to feel guilt and shame.

Stigma surrounding abortion may also keep women from seeking social support, which is highly valuable and useful in mitigating effects of abortion stigma,[330] and may also have an economic cost for women who feel to travel or who decide not to use private insurance by privileging the option to pay out of their pocket in order to conceal their abortion.[331] This explains, for instance, why medical self-induced abortion, which allow to maintain a certain degree of secrecy, is still so widespread in the United States.

Abortion providers and individuals who work in abortion clinics are also subjected to stigmatization and marginalization. We have already seen that abortion is not provided in many regions or counties because the procedure itself is stigmatized, leading to a situation in which abortion providers are few and are usually channelled by structural forces to become abortion specialists. Physicians report both explicit and subtle practice restrictions and fear repercussions from colleagues, harassment and marginalization, leading them to refusing to perform abortions or to perform some types of abortion usually perceived as extraordinary circumstances, such as second-trimester abortions, usually more stigmatized than first-trimester abortions.

An important difference between abortion stigma perceived by women who have abortion and abortion providers is that women may not be continuously exposed to stigma, rather they can perceive stigma during the procedure and in situations when the abortion discourse is brought up in discussions, but abortion providers are exposed to stigma on a daily basis. The hypothesized effects of stigma on abortion providers include stress, marginalisation by anti-abortion colleagues, difficulties in advancing in career, fear about disclosing one's work in social circumstances and burnout. Usually, abortion providers cope with negative effects of abortion stigma engaging in positive thoughts and beliefs that their work is highly valuable and that they help people in reaching their well-being, difficult to achieve if not with their work.[332]

Among the victims of abortion stigma there are also abortion supporters, including partners, family, friends as well abortion advocates and researchers that may experience what has been defined

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[329] B., Major and R. H., Gramzow. (1999). Abortion as stigma: Cognitive and emotional implications of concealment. Journal of Personality and Social Psychology.

[330] A., Kumar et al. (2009). Conceptualizing abortion stigma. *Culture, Health & Sexuality.*

[331] R. K., Jones et al. (2010). Characteristics of U.S. abortion patients, 2008. New York: Guttmacher Institute.

[332] L. H. Harris. (2008). Second trimester abortion providers: Breaking the silence and changing the discourse. *Reproductive Health Matters*.

"courtesy stigma", that arises from being associated with women who have had abortions or with abortion providers.[333] Partners of people who have abortions experience complex emotions like those experiences by the partner requiring the procedure, these are ambivalence, guilt, sadness, anxiety and a feel of powerlessness.[334]

There are several reasons why abortion is stigmatized. Abortion violates two fundamental ideals of womanhood, the natural predisposition to motherhood and sexual purity. The idea that women have sex for pleasure and not to procreate is in contrast with the idea of "good woman" who should feel a profound desire to be a mother, although is acceptable for men. Kumar and colleagues have asserted that abortion is stigmatized because it is the evidence that women had "nonprocreative" sex and they were trying to exert control over their reproduction and sexuality, challenging existing gender norms. These circumstances give rise to feelings of shame about one's sexual practices, sexual attitudes, failure to an efficient use of contraceptives, shaping abortion as a consequence of several "bad choices" about sex and partners and putting the blame on women's shoulders.

Abortion stigma is reinforced by attributing personhood to the fetus; a view that has been increasingly proposed through fetal photography, ultrasound, fetal surgery and that have put in the corner women, decontextualizing the fetus, erasing the boundary between fetus and infant, exaggerating the independence of the fetus from the woman who carries it and helping in shaping the idea that abortion is equivalent to murder. Legal restrictions that impose parental consent, that set gestational limits, mandatory counselling, ultrasound and waiting periods, play a central role in perpetuating abortion stigma so that stigma is an actual barrier to changing abortion laws.

Furthermore, abortion stigma might encourage behaviours associated with reproductive coercion and might influence women in their decision-making process, particularly by discouraging them from having abortions.[335]

Before analysing the strategies of stigma management, it is important to further discuss the manifestations of abortion stigma. Many women learn negative stereotypes about girl/women who have abortion, often seen as unintelligent, uneducated, promiscuous, irresponsible, cruel and selfish.

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[333] E. Goffman. (1963). Stigma: Notes on the management of spoiled identity. Englewood Cliffs, New Jersey: Prentice-Hall Inc.

[334] A. B. Shostak et al. (2006). Abortion clinics and waiting room men: Sociological Insights.

[335] I., Tyler and T., Slater. (2018). Rethinking the sociology of stigma. London, England: *SAGE Publications Sage* UK.
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Women who learn these stereotypes usually tend to internalize abortion stigma which translates in prejudice and self-stigma.[336]

Self-stigma manifests when a woman has been exposed to negative discourses about abortion and women who have abortion, when she believes these discourses are legitimate and/or believes the discourse can apply to her. Evidence shows that self-stigma appears most frequently in contexts where women are exposed to strong and negative attitudes towards abortion in families or communities. These women tend to have harsher self-judgement and feelings of guilt than women who grow up in less condemning contexts. Women who imagined unsupportive reactions at the idea of disclosing an unplanned pregnancy, an abortion history or the decision to require an abortion, reported felt stigma; they feared that disclosing their abortion would result in attitudes like condemnation, ostracism, unwanted advice and guilt trips from religious families, friends who struggled to have a child or significant others who are anti-abortionists. Some women feared disclosing information about their abortion would lead to double or triple stigma if others knew abortion was linked to pre- or extra- marital sex, rape, being poor or not wanting to become a mother.[337]

Most women in Cockrill and Nack's study still chose to talk about their pregnancy at least to their partner and, to a less degree, to friends and parents, even though they responded to felt stigma choosing information to disclose. Enacted stigma is also quite common, particularly in contexts where confrontation between patients and protestors take place or when women have interactions with anti-abortion practitioners.

Medical practitioners often reflect the role of the ones in charge of moral surveillance that put themselves in the dominant role and transmit the feeling of moral condemnation to their patients who have abortions, unintended pregnancies or sexual intercourses outside marriage.[338] As the authors note, a woman who expects non-judgmental treatment from an abortion practitioner and instead receives enacted stigma is expected to fear negative reactions also from other people in her life. However, the most devastating manifestation of enacted stigma is the one received from one's sexual partner that might lead women to reinforce negative feelings about herself and to engage strategies like secrecy and information-control.

To cope with stigma effects, women who experienced internalized stigma rationalized why the abortion occurred and why it was a legitimate behaviour. Two ways of rationalizing include: excuses

[336] K., Cockrill and A., Nack. (2013). "I'm Not That Type of Person": Managing the Stigma of Having an Abortion. *Deviant Behavior*, p. 979.
[337] Ibid., p. 980.
[338] Ibid., p. 981.

to avoid the label of irresponsible women and justification that help women who accept responsibility for their abortion but, at the same time, deny the wrongfulness of the act. [339] Scientific research has found that excuses contribute to the acceptability of abortion; the most evident case is when abortion is requested by rape victims that receive great support and are easily excused from moral condemnation in contrast to women who have abortion for educational and financial reasons.[340] Some women manage internalizes stigma with stigma transference, which implies transferring the burden of stigma to others or to abstract subjects, for instance onto clinic staff. Another strategy is appealing to higher loyalties associated with gendered expectations, an example of this strategy is when women "justify" themselves saying they were meeting the need of existing children or that it was the best decision to have an abortion after finding out the baby had Downs Syndrome. When women have a negative conception about abortion or about women who choose to terminate the pregnancy, they may experience cognitive dissonance when the one having an abortion are themselves; others may instead take distance from the "label" of women who have abortion as a mechanism of self-protection.

Some women may have difficulties in disclosing their abortion because it may affect their reputation negatively, therefore when they anticipate stigmatizing attitudes, they may use deceptive cover stories by creating fictional explanations. Major and Gramzow found that women who keep their abortion secret are more likely to need to suppress thoughts about the experience, to experience intrusive thoughts and distress.[341] In order to cope with the damaged reputation, some women begin to name and critique the stigma they experienced or to direct judgments at those who had stigmatized them using the strategy of "condemnation of the condemners".[342]

By condemning the condemners, women are able to put the blame and the sin onto who have judged abortion as a deplorable act and who fight to limit access to abortion, constructing a view that sees the anti-abortion discourse as more immoral than having an abortion. An interesting research conducted by Pacilli and colleagues has investigated whether "the perceived humanness of the social actors involved in abortion could be affected by their decision to abort through the mediation of moral outrage".[343] The research has also examined how the counter-stereotypical decision to abort would

[339] Ibid., p. 982.

[340] L. B., Finer et al. (2005). ''Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives.'' *Perspectives on Sexual and Reproductive Healt*h.

[341] Ibid., supra note at 336.
[342] G. M., Sykes and D., Matza. (1957). ''Techniques of Neutralization: A Theory of Delinquency.'' *American Sociological Review.*

[343] M. G. Pacilli et al. (2018). Elective abortion predicts the dehumanization of women and men through the mediation of moral outrage. *Social Psychology.*

affect the perception of women's competence in professional life and specifically in traditional versus non-traditional female professions. From this study it has emerged that participants perceived women who have abortions to be "moral animal and machine-like", and that the decision to abort affected the perception of a woman's professional competence considering her as less able to perform traditional female jobs. The decision to abort increased participants' moral outrage and decreased the degree of humanness attributed to women, confirming the existence of a dehumanizing stigma towards people who have abortions and, consequently, the lowering of perceived competence on traditional jobs because the decision to have an abortion is in deep contrast with the gender stereotype of motherhood.[344]

The study analysed how the decision to have an abortion affects also the male partner, revealing that when the choice was taken by both partners, participants expressed higher moral outrage to both the woman and the man compared to non-abortion condition; when the responsibility was on the man, participants attributed a greater competence in traditional female professions to the woman.

As a matter of fact, the study showed that those participants that hold the most positive attitudes towards abortion do not feel moral outrage toward the man and only slightly dehumanize him more compared to the woman who decide not to have an abortion, demonstrating that participants hold a double standard making harsher judgments toward the woman compared to the man.[345] This ambivalence can lead to moral outrage and dehumanized perceptions toward women who have abortions also in pro-choice people. As the authors highlight, this choice of having an abortion demonstrates to have potential consequences also in terms of discrimination in the professional life.

The manifestations and strategies used to manage abortion stigma may occur in different stages of life, may occur in the process of obtaining the abortion, may happen immediately after and/or at specific moments throughout a woman's life. Stigma affects disproportionally women because it is deeply entangled with social constructions and stereotypes that depict women as naturally "good" and incentivizes secrecy about their abortion, which explains why some women may perceive their abortions as they have failed to live up to expectations of others and/or to their own moral code.

[344] Ibid., p. 293.
[345] Ibid., p. 298.

3.2. Psychological consequences

3.2.1 Impact of voluntary interruption of pregnancy on women's mental health: is abortion or its denial the cause of negative consequences?

Despite the prevalence of elective abortion, which should be an indicator of the will of ending a pregnancy per se because considered the best choice, controversy exists about the mental health risks associated with the abortion procedure. We have already seen that several myths are attached to the abortion procedure, including claims of mental health consequences and psychological distress following abortion. Studies affirming these claims are hampered by methodological problems, in particular by choosing biased sample targeting women that have sought professional help for psychological problems after abortions. Several studies have also failed to distinguish between clinically significant mental disorders and feelings of sadness, loss, regret and remorse that, although unpleasant, do not fall into the category of psychiatric disorders.

Major and colleagues have examined women's mental health and abortion-related emotions following a first-trimester abortion of an unintended pregnancy, they have evaluated if there are changes over time and if exist predictors of these psychological responses.[346] They focused on pre-abortion and post-abortion distress, the level of well-being, post abortion emotions, PTSD and decision satisfaction in a time period of two years after having an abortion. Women reported feeling more relief than negative emotions post abortion but the level of declined over time. However, the majority of women felt they had definitely benefitted from their abortion more than they had been harmed by it, most of them confirmed they made the right decision and to be satisfied of their choice, which is in line with the number of women who have said they would definitely have the abortion again if they had to make the decision over. Depression scores were lower at all different times after having the abortion compared to pre-abortion levels; on the contrary, self-esteem increased over time and was higher post abortion than pre abortion.[347]

Notably, the rate of "post-abortion syndrome" (1%) was significantly lower than the rate of PTSD in the general population of women and compared to rates following traumas such as childhood physical abuse (48.5%) or rape (46%).[348]

[346] B., Major et al. (2000). Psychological responses of women after first-trimester abortion. *Archives of general psychiatry*.
[347] Ibid., p. 780.
[348] Ibid., p. 781.

This study proves the claims that women usually regret their decision of having the abortion wrong. Additionally, it confirmed the findings of prior research that identified in pre-abortion mental health condition the best predictor of post-abortion mental health and feelings. According to these findings, women with a prior history of psychological disorders, for instance depression, may be predisposed to experiencing depression episodes and regret, regardless of whether they have an unintended pregnancy or not and what they decide to do with it.

As the authors have highlighted, the psychological risks of abortion must be confronted with the psychological risks of its alternatives. When women have an unintentional and unplanned pregnancy, often do not have many alternatives and the few alternatives at their disposal could be a source of distress or regret. For instance, giving up a child for adoption has been demonstrated to lead to feelings of sadness.

The Turnaway Study, a 5-year longitudinal study, the most cited study on abortion consequences, was designed to investigate different effects of unwanted pregnancy on women's lives. Women were recruited from 30 different facilities throughout the U.S. with the aim of describing the mental health, physical health and socioeconomic consequences of receiving an abortion (first-trimester abortion group and near-limit abortion comparison group) compared to carrying an unwanted pregnancy to term due to past gestational limits (turnaway group).[349]

The main objective was to assess women's psychological well-being 5 years after receiving or being denied an abortion to disprove the idea that abortion leads to adverse psychological outcomes and that shape both mandatory counselling and restrictive abortion policies.[350] The outcomes of the study confirmed that depressive symptoms declined over time for all groups except the turnaway-birth group; women in the turnaway-birth and turnaway-no-birth groups held significant level of anxiety that declined for all groups except the turnaway-birth group and with regard well-being, baseline self-esteem was lower among women in the turnaway birth and no-birth groups, even though improved over time.[351]

These findings demonstrated that women who had an abortion showed more positive outcomes initially compared to women who were denied the termination of pregnancy. Those women who were denied an abortion, in particular who later had a miscarriage or had to require an abortion elsewhere, had the most elevated levels of anxiety, lower self-esteem and life satisfaction right after being denied

[349] The Turnaway Study. University of California San Francisco. https://www.ansirh.org/research/ongoing/turnaway-study.
[350] M. A. Biggs et al. (2017). Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study. *JAMA Psychiatry.*
[351] Ibid., p. 6.

an abortion. These elevated levels of distress might be explained as a reaction to being denied an abortion, as well as other emotional challenges experienced on discovering the unwanted pregnancy and in having to seek an abortion. An unintended pregnancy forces women to confront themselves with their circumstances and reflect on their possibilities at that precise moment of their lives; this, along with the stress of trying to obtain an abortion, may be the causes of lowered mental health conditions. The situation is even more severe for those women of the turnaway-no-birth group that have experienced additional stress from being denied the abortion and having to raise additional money, find and travel to another place to have the practice done. The effects of being denied an abortion may be more damaging to women's psychological well-being than simply allowing women to obtain a legal and safe abortion.[352]

The Turnaway Study has been useful also in assessing what are the effects of carrying an unwanted pregnancy to term on women's existing children. As we have already seen, among the reasons mentioned by women for requesting an abortion there is also concern for other existing children, in fact approximately 60% of women in the US who have an abortion are already mothers.[353] It emerged a situation of slightly lower child development scores and lower socioeconomic well-being for the existing child of women who have been denied an abortion compared with children whose mother received the wanted abortion.

Since existing children of women denied abortion were likely to live in poor contexts, it has been observed that limited resources may entail a slowed development. Furthermore, a mother who is stressed for the whole socio-economic and financial situation may invest less in her children both emotionally and financially.[354] Having been denied a wanted abortion may cause greater stress during the pregnancy, the perinatal period or beyond, impacting not only on the woman but also on her existing children via lower quality of mother-child relationship.[355]

Many women seeking abortion face economic hardship, suffice it to say that the most common reasons for requesting an abortion are financial difficulties - in particular, not having enough money to raise a child or support another child -, to the point that half of these women live below the federal poverty level, struggle to pay for food, housing and transportation.[356] Denial of abortion clearly exacerbates these difficulties, indeed there are large and statistically significant differences in the

[352] Ibid., p. 9.
[353] D. G., Foster et al. (2019). Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children. *The Journal of pediatrics.*
[354] Ibid., p. 187.
[355] Ibid., p. 188.
[356] D. G. Foster et al. (2018). Socioeconomic outcomes of women who receive and women who are denied wanted abortions in the United States. *American Journal of Public Health.*

socioeconomic conditions of women who were denied an abortion with women who received abortion. For instance, public assistance usually play an important role in mitigating the loss of employment for women who have no other choice than to carry to term the unwanted pregnancy but is not sufficient to support the increase of family size and do not prevent women denied an abortion from living in poor conditions.[357] It is important to note that a great number of women seeking an abortion live in an household as the only adult with children, in particular women who were denied abortions and having to endure the burden of raising a child in poor conditions, often after having lost job and without any help from partners or extended family.[358]

So far, I have examined different factors concurring to a good health and well-being, therefore I will now examine the side effects and physical health consequences associated with abortion and birth after an unplanned pregnancy. The safety of abortion has been questioned and still is, but it has been extensively documented that the practice is among the safest procedures.[359] On the contrary, data shows that the risk of mortality from childbirth is estimated to be fourteen times higher than the risk from induced abortion.[360] In fact, women in the Turnaway Study who were denied an abortion and gave birth reported more life-threatening complications like eclampsia and postpartum haemorrhage compared to those women who received wanted abortions.[361] Physical long term effects such as chronic headaches or migraines, joint pain and gestational hypertension were also reported more frequently from women who were denied an abortion and gave birth.[362]

Experiencing violence from intimate partners is unfortunately also quite common among women who want to have abortions. 6% to 22% women who reported violence from intimate partners assessed that concern about violence was a reason for pregnant women to decide to terminate their pregnancies, not only for themselves but also for fear to expose their children to the same violence.[363] Among women requiring abortion, terminating the pregnancy is associated with a reduction over time in physical violence from the man involved with the pregnancy, while carrying the pregnancy to term is not.[364] It has been demonstrated that having a baby from an unwanted pregnancy resulted in

[357] Ibid., p. 412.
[358] Ibid.
[359] WHO. Safe abortion: technical and policy guidance for health systems.
[360] E. G. Raymond and D. A. Grimes. (2012). The comparative safety of legal induced abortion and childbirth in the United States. *Obstetrics & Gynecology*.
[361] C. Gerdts et al. 2016). Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy. *Women's health issues: official publication of the Jacobs Institute of Women's Health*.
[362] L. J. Ralph et al. (2019). Self-reported physical health of women who did and did not terminate pregnancy after seeking abortion services: A cohort study. *Annals of Internal Medicine*,
[363] C.C., Pallito et al. (2005). Community level effects of gender inequality on intimate partner violence and unintended pregnancy in Colombia: Testing the feminist perspective. *Social Science and Medicine*.
[364] S. C., Roberts et al. (2014). Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Med.*

sustained physical violence over time; women denied abortions have an hard time in leaving their partner, are slower to end their romantic relationship with their violent partners and are likely to maintain contact with the man involved. Remarkably, both women who were initially denied abortions but who did not end up giving birth experienced similar reduction in violence of those women who obtained a first-trimester abortion or those having near-limit abortions.[365] As any form of violence, intimate partners violence has serious consequences for women ranging from physical injuries, chronic pain, sexually transmitted infections to depression and post-traumatic stress disorder.

The possibility to decide whether to have an abortion or terminating a pregnancy, as well as the spacing of childbirth, is highly connected also with educational attainment and workforce participation. Early childbearing have been demonstrated to diminish the likelihood of competing high school, in fact teen mothers are less likely to graduate than women who delay childbearing into their 20s and beyond.[366] Young women who had the possibility to control their fertility through legal access to the pill and abortion contributed significantly to increases of young women who obtained at least college education.[367] The same possibility to exercise decisional power over one's body has been demonstrated to be a driving force behind the societal change to more young women participating in paid jobs, including professional occupations requiring higher education and training.[368] This is particularly important since women who have children experience a significant earning loss compared with their employed, childless counterparts. Having a child creates an immediate drop in women's earnings and also a long-term decrease in their earnings trajectories.[369]

3.2.2 Risk factors of negative psychological responses

Pre-abortion mental health has been demonstrated to be the strongest predictor of eventual post-abortion mental health.[370] Scientific evidence demonstrates that depressive, anxiety and stress

[365] Ibid., p. 5.
[366] A. Sonfield et al. (2013). The Social and Economic Benefits of Women's Ability To Determine Whether and When to Have Children. *Guttmacher Institute*.
[367] Ibid., p. 9 and 30.
[368] Ibid., p. 12.
[369] E.T. Wilde et al. (2010). The mommy track divides: the impact of childbearing on wages of women of differing skill levels, *NBER Working Paper*.

[370] B., Major et al. (2009). Abortion and mental health: Evaluating the evidence. *The American psychologist.*

symptoms are higher before an abortion but decline significantly after the procedure, therefore what is highly recommended to do is to examine and understand what contributes to pre-abortion psychological health, specifically because it is a strong indicator of strategies employed to cope with the abortion.[371]

The common risk factors approach argues that a correlation between abortion and mental health, although spurious, is driven by factors that are common, identifying factors such as pre-existing mental health problems, violence, sexual abuse and social disadvantages. Additionally, this approach-based studies find that confounding factors like childhood adversities, violence perpetuated by intimate partners and prior mental health problems are associated with a poorer post-pregnancy and post-abortion mental health well-being.[372]

Another approach, the stress and coping perspective, argues that if an individual perceive a specific situation as stressful, that person will enact coping strategies that will lead him to a better or worse psychological health.[373] Major and colleagues have assessed that women's personal characteristics such as the level of self-esteem, relationship context or other contextual factors (value of pregnancy, anti-abortionists exposure) influence coping strategies and consequently have implications on psychological health after an abortion.

Stigma and hostile socio-cultural contexts also play a fundamental role in coping strategies influencing post-abortion adjustments. Among the psychosocial predictors that have been identified, perceived abortion stigma appeared to explain the most amount of additional change in depressive and stress symptoms, therefore engaging in fighting abortion stigma and helping women feel less stigmatized is an important step in lowering these risk factors.[374] Other factors identified as contributing to post-abortion psychological health were "number of childhood adversities, age and education, with more adversities, younger age and higher education" which predict more pre-abortion mental health problems. Importantly, being victim of reproductive coercion predicted more pre-abortion anxiety and stress symptoms, while more acute depression symptoms are consequences of intimate partner violence.[375]

Moreover, substantial research literature has demonstrated that systemic and personal characteristics that predispose women to have an unintended and unplanned pregnancy also predispose them to

[371] Ibid.
[372] D. G., Foster et al. (2015). A comparison of depression and anxiety symptom trajectories between women who had an abortion and women denied one. *Psychological medicine*.
[373] R.S., Lazarus and S., Folkman. (1984). Stress, Appraisal, and Coping. *Springer,* New York.
[374] J. R., Steinberg et al. (2014). Psychological Aspects of Contraception, Unintended Pregnancy, and Abortion. *Policy insights from the behavioral and brain sciences*.
[375] Ibid., p. 73.

develop psychological and behavioural problems. Among systemic risk factors, poverty has been identified as concurring into mental health problems and a predicting factor of increased likelihood of psychiatric disorder per se.[376] It has been noted that women at particularly hight risk for unintentional pregnancy and women who have abortions tend to be unmarried, young and poor.

In fact, children who grow up in poor neighbourhoods are at higher risk for teen pregnancy, substance abuse, obesity, smoking, dropping out of school, which are all risk factors for psychological problems.[377]

From the co-occurring risks perspective, the greater exposure to adverse and difficult life circumstances, exposure to intimate partner physical and/or psychological abuse and exposure to rape are also associated with greater likelihood for both unintended pregnancy and abortion.[378] The more violent experiences a woman has faced and the more stressful life events she has experienced in general, the greater the risk for developing mental disorders.

In addition to systemic risk factors, personality and behavioural factors may predispose a woman to unplanned pregnancy and abortion, and consequently to mental health problems. There is an ever-growing tendency to acknowledge that problem behaviours tend to co-occur among the same individual, so students that engage in early sexual activity are more likely to report alcohol abuse, smoking, drug use, delinquency etc.[379] Women who have unintended pregnancies and abortions are more likely to have previously engaged in behaviours like smoking, using alcohol and drugs, early sexual intercourse and having unprotected sexual intercourses than other women.[380]

One explanation for this phenomenon is that the involvement in problem behaviours trigger the involvement in other risky patterns, therefore one person that has an history of drug use is more at risk of engaging in early sexual activity which, in turn, put that person at risk for another risky event such as unintended pregnancy and abortion.[381]

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[376] B., Major et al. APA Report on Mental health and abortion.

[377]B., Major et al. (2009). Abortion and mental health: Evaluating the evidence. *The American psychologist*.

[378] C.C., Pallito and P., O'Campo. (2005). Community level effects of gender inequality on intimate partner violence and unintended pregnancy in Colombia: Testing the feminist perspective. *Social Science and Medcine.*

[379] T., Willounghby et al. (2004). Where is the syndrome? Examining co-occurrence among multiple problem behaviors in adolescence. *Journal of Consulting and Clinical Psychology.*

[380] F., Costa et al. (1987). Psychosocial correlates and antecedents of abortion: An exploratory study. *Population and Environment: A Journal of Interdisciplinary Studies.*

[381] B., Major et al. (2009). Abortion and mental health: Evaluating the evidence. *The American psychologist*, p. 14.

An alternative explanation for the co-occurrence of problem behaviours is that who engage in problem behaviours like alcohol and drug use share a set of personality features that predispose them to engage in other risky attitudes that increasingly translate in other problems.

Personality factors diminishing individuals' ability to cope with negative emotions may also put them at risk of engaging in problem behaviours. Has have been demonstrated, high impulsivity and a coping strategy as avoidance were risk factors for a further involvement in a wide range of problem behaviours as the one previously mentioned.[382]Many of these personal characteristics that put women at risk for problem behaviours and unplanned pregnancy, also put them at risk of developing mental or physical health problems, independently from the carrying a pregnancy to term or having an abortion.[383]

Since every person cope in different ways with stressful life events, these perspectives do not exclude the possibility that some women may experience severe negative psychological experiences after an abortion but recognize such reactions in women's coping processes and the personal and social determinants that shape those as the causes, rather than abortion itself. Women's psychological experiences of abortion are shaped by sociocultural contexts within abortion occurs. Social and cultural messages that stigmatize abortion and all the actors involved in the experience suggest that women having an abortion will feel necessarily bad and may engender negative psychological consequences. If we recognize the role of pre-existing conditions, life conditions, problem behaviours and personality characteristics, it is difficult to ignore the profound and long-lasting negative effects these can have on mental health.

In summary, mental health problems that arise after an abortion may not be caused by abortion per se but instead might reflect other factors associated with having an unwanted pregnancy or even other factors unrelated to pregnancy or abortion, such as poverty, a history of mental health problems or intimate partner violence.

[382] M. L.,Cooper et al. (2003). Personality and the predisposition to engage in risky or problem behaviors during adolescence. *Journal of Personality and Social Psychology*.
[383]Ibid., supra note at 381.

3.2.3 Social changes for a better understanding of women's perspectives

As we have seen above, enacted stigma undermines the sustainability of abortion regulations at domestic level engaging in two main mechanisms: by marking abortion as deviant, it normalizes the idea of abortion as being outside the mainstream medical institutions; and by normalizing anti-abortion discourses it reinforces discrimination, harassment and even violence against people who require abortion and people who provide abortion.[384] Abortion is stigmatized even in the medical environment, to the point that the same American Congress of Obstetricians and Gynaecologists perceive the need to destigmatize abortion training in medical education.[385]

Public health researchers have asserted that the language of abortion is a powerful instrument in perpetuating stigma and creating barriers to optimal care. Specifically, language is also fundamental in medical education reform, in particular if we examine a phenomenon now commonly called the hidden curriculum, which is "a set of cultural and organizational forces, outside of the explicit learning agenda, that influence how students develop professional identities during medical training."[386] Since abortion is often excluded from formal medical school curricula, the role of language may have particular significance in conversations about abortion amongst medical professionals. Smith et al. have conducted an interesting qualitative research examining intention to provide abortions in cases of "elective" abortion, how this was conceived and the role of language in perpetuating enacted stigma.[387]

Most participants used the term "elective" to define a unique subset of abortions characterized, according to the majority of participants, as lacking maternal or fetal medical indications, differentiating it from "medically necessary" or "medically recommended" abortions. Some participants distinguished it from those for fetal anomalies or maternal morbidity, others asserted that an elective abortion is when other than a lack of medical indication, neither the pregnancy nor the parenting were desired or intended. The recurring definitions of "elective abortion" comprehend abortion as sought for "usually a lot of social reasons", sought by "young healthy women for social reasons", for "convenience reasons" that contrasted with "induced abortion for medically necessary reasons". Some participants considered rape and incest the only social reasons for which abortion is

[384] L. Freedman. (2010). Willing and Unable. *Vanderbilt University Press*.
[385] Committee on Health Care for Underserved Women, 2014.
[386] F. W. Hafferty and J. F. O'Donnell. (2015). The Hidden Curriculum in Health Professional Education. *Dartmouth College Press*.
[387] B. E. Y. Smith et al. (2018). "Without any indication": stigma and a hidden curriculum within medical students' discussion of elective abortion. *Social Science & Medicine.*

not considered elective.[388] Generally, the participants' use of the term "elective" implied a hierarchy privileging medical over psychosocial indications, reinforcing the reason behind the isolation of this "category" of abortion and perpetuating the stigma.

However, most participants used the term when describing their personal concerns about having to provide elective abortion, underlining how they would probably experience an "internal conflict". Someone declared that as a doctor they have sworn to help people and with elective abortions they would have to hurt a potential future person; others expressed their interest in learning how to perform an abortion but felt reluctant at the idea of having to perform it.

When asked to describe the provision of elective abortion, participants highlighted the isolation of the practice, sometimes describing it as a consequence of hospital policies against providing abortions that fall into the category of elective. As the authors state, "the structural isolation of elective abortions withing medical education facilitates informal messaging about abortion. In the absence of formal teaching to the contrary, these messages contribute to a hidden curriculum for abortion training in medical education".[389]

From this research it emerged that this term is deeply connected with a process of creation and perpetuation of stigma. Enacted abortion stigma is not inherent to the procedure itself but rather created by individuals through identification of differences, linking this identification to wrongful stereotypes and placing negatively marked individuals into a distinct category.[390]

It has been recognized that professional jargon and informal speech contribute to the foundation of the hidden curriculum, that by categorizing abortions in this way reinforces the false idea that medical and psycho-social reasons for terminating a pregnancy are distinct, that do not overlap. Maintaining this firm distinction between medically necessary abortions and elective ones, perpetuates the idea that elective abortion is a dishonourable practice and obscures the voluntary nature of abortion in all circumstances. The result is a commonly shared discourse mirroring the broad societal phenomenon of women being acknowledged a higher moral status if they desire motherhood and that in case of elective abortions give up their higher status.

Stigmatizing language can result in inferior care, limited access to high quality health services, biased policy-level manifestations of enacted stigma, therefore is important to take action in eliminating gender stereotyped discourses from the medical environment.

[388] Ibid., p. 29.
[389] Ibid., p. 30.
[390] B. G. Link and J. C., Phelan. (2001). Conceptualizing stigma. *Annu. Rev. Sociol*.

Myths about reproductive health in general, and about abortion more specifically, continue to circulate and result in widespread misinformation also among psychology graduate students and psychologists. Several studies have tried to assess the level of abortion knowledge and found that is often limited. There are no differences in abortion knowledge dependent on whether the participants lived in conservative, liberal or mixed states; misinformation about abortion and birth control are pervasive and have also been observed among women seeking abortions.[391]

This is utterly important if we consider that lack of knowledge was related to overestimating risks of abortion and contraception, which favour abortion restrictions,[392] and that having less accurate knowledge on the matter is associated with lower support.[393]

Considering that psychology is of particular importance when talking about abortion, since practitioners play a significant role in assessing if women need psychologic support to cope with the abortion experience or, in cases of mandatory counselling, to assess if the woman is eligible for the abortion, understanding psychologists' knowledge of and attitudes toward the legality of abortion is fundamental, particularly among those who practice or are involved with training practitioners.[394]

In a study conducted by Mollen and colleagues, participants stated that training programs were doing a poor job discussing abortion but, despite a lack of formal training, most of them stated their basic counselling skills prepared them for working with people who may consider abortion.[395] However, most participants felt they needed more training than they were receiving or received. For that reason, a great number of them supplemented their training on an independent basis before starting practicum or through different working experiences in contexts like abortion clinics and sexual and reproductive health services. Overwhelmingly, most participants declared to be pro-choice but that their conviction contrasted with the disclosure of their views in academia because of the controversies surrounding abortion.[396]

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[391] E. R., Wiebe et al. (2014). Misperceptions about the risks of abortion in women presenting for abortion. *Journal of Obstetrics and Gynaecology*.

[392] Ibid.

[393] M. L., Kavanaugh et al. (2013). Connecting knowledge about abortion and sexual and reproductive health to belief about abortion restrictions: findings from an online survey. *Women's health issues: official publication of the Jacobs Institute of Women's Health*.

[394] D., Mollen et al. (2018). Abortion Knowledge and Attitudes Among Psychologists and Graduate Students. *The Counseling Psychologis*t.

[395] Ibid., p. 747.

[396] Ibid., p. 746.

Consistent with previous research,[397] most participants endorsed pro-choice attitudes and support for legal access to abortion in any circumstances. Despite endorsing attitudes in support of legal access to abortion, from this research emerges an inadequate level of knowledge of abortion, even though they accurately understood the fallacy of different arguments like the relationship between abortion and breast cancer, that abortion decrease where abortion is illegal and other myths surrounding abortion.[398] Inaccurate information regarding the number of abortion providers in the US and the number of women who will seek abortion may lead some psychologists to overestimate abortion's accessibility and to simultaneously underestimate its prevalence, which may result inadvertently in misguiding and preventing clients from accurate information about abortion during counselling experiences.

People who come for health services deserve a well-prepared, informed workforce. In the case of psychologic support, psychology students also deserve thoughtfully inclusive curriculum that accurately addresses experiences like the one of abortion that, being permeated by stigma, are likely to be raised by clients in therapy sessions.

At the same time, the whole community deserves abortion practitioners and psychologists who defend and support access to abortion on behalf of those who are stigmatized and prevented from accessing services.

[397] Inbar, Y. and Lammers, J. (2012). Political diversity in social and personality psychology. *Perspectives on Psychological Science*.
[398] Ibid., supra note at 154, p. 752.

Conclusion

International legal systems have the duty to reflect on and answer to the necessities of the people they represent. While reproductive and sexual health have found no difficulty in being recognized as extremely valuable and entitled to protection, the same cannot be assessed regarding the right to abortion. The right to abortion is too controversial to be recognized in international legal instruments as an alone-standing right, precisely due to the different cultural and religious background of every single State.

Notwithstanding, international and regional human rights norms have indeed evolved to recognize at least that the criminalization of abortion and the denial of abortion care violates women's and girls' fundamental human rights. Several States already had a legislation on abortion in their national legal system; whereas in contexts where abortion was not included in the domestic legislation, these progressive standards have played a crucial role in influencing, and in some cases even in revolutionizing, national abortion laws and domestic high court decisions, eventually leading toward a policy reform. Treaty bodies have condemned absolute bans on abortion as being in violation of international human rights and have urged states to eliminate punitive measures for women and girls who undergo abortions and for health care providers who deliver abortion services.

This shift is a demonstration of an ever-growing recognition that limited exceptions to abortion bans do not protect women's and girls' reproductive rights but rather impede a process of empowerment of women who only want to exercise their reproductive autonomy.[399] While the progress made in jurisprudence, laws and policies is an important achievement of states' compliance with their obligations and duties under human rights perspectives, including these rights in the law is an essential step toward the full realization and implementation of such rights that can help in fulfilling the accountability of States when laws are violated.

Even though some important goals have been achieved, international legal instruments still fail to concretize women's right to decide whether to carry a pregnancy to term as a fundamental aspect of women's equality, self-determination and reproductive autonomy.

The establishment of a minimum standard in international law that obliges States to ensure access to legal abortion services at least on certain grounds, for example when the woman's life is at risk, stigmatizes women who seek abortion for other reasons, perpetrating discriminatory and stereotyped norms about women's role and paving the way for seeking unsafe abortions.

[399] Fine, J.B. and others. "The Role of International Human Rights Norms in the Liberalization of Abortion Laws Globally". Health and Human Rights Journal.

Women's reproductive autonomy is still object of governments' policies. Women's agency over their own bodies is not completely respected and the underlying mechanisms behind these, often intersecting, discriminatory patterns are often ignored. Women's reproductive health has continuously been proposed as a delicate matter that needs to be protected; this perspective generates a system that swings between a hypersensitive attention towards women's different reproductive needs and a parallel system that completely ignores women's perspectives. States must do more than accommodate women's biological differences, they also must guarantee that women are not subjected to dignity-denying treatment in their various journeys to obtain an abortion. States must no longer embrace policies that are based on the idea that women's reproductive capacities are the most important among their attributes.

A truth is easily detectable though, everyone other than the woman herself seem to be more capable of taking decisions about her reproductive autonomy. Clear examples of this phenomenon are all the *de jure* and *de facto* barriers to abortion, as well as the pervasive stigma surrounding the abortion experience that stereotypically depict women who choose to terminate their pregnancies as irresponsible, selfish and lacking in maternal instinct. Discouraging women through false myths about abortion to exercise their right to reproductive autonomy, scaring them about mental and physical health outcomes that are not supported by scientific evidence and suggesting they need to feel sadness, remorse and guilt if they choose to have an abortion is deeply deceptive.

These are the causes that may potentially trigger negative psychological consequences, not abortion. The impossibility to autonomously evaluate one's personal life circumstances, to make future plans, to invest in one's education, to simply decide how to live one's life and the socially induced idea that it would be wrong to have an abortion and be satisfied of the choice made, is what harms women the most.

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