

RESTRICTIVE REGULATION OF ABORTION AND THE RIGHT TO HEALTH

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I. INTRODUCTION

Women have always had abortions and will always continue to do so, irrespective of prevailing laws, religious proscriptions, or social norms. Although the ethical debate over abortion will continue, the public-health record is clear and incontrovertible: access to safe, legal abortion on request improves health.¹

The issue of whether a woman should have the right to choose whether to terminate a pregnancy and, if so, the content of such a right has been analysed, considered and discussed from a myriad of perspectives. It is a topic about which fields as diverse as religion, philosophy, human rights, health law, and feminist theory all have something to contribute. It is an issue that gives rise to passionate advocacy and heartfelt deliberations. This article considers the question of abortion through the lens of the international right to health. I argue that laws which restrict access to abortion services violate the international right to health.

The understanding of what constitutes restrictive regulation of abortion differs significantly between various people, groups, and organisations. For example, ‘pro-choice’ groups typically have a different conception of what constitutes restrictive regulation of abortion as compared with ‘anti-choice’ groups. For the purposes of constructing the argument presented in this article, which adopts a right to health approach to the issue of abortion, I will assume that a law that restrictively regulates access to abortion is a law which prohibits abortion with

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¹ DA Grimes and others, ‘Unsafe Abortion: The Preventable Pandemic’ (2006) 368 *Lancet* 1908, 1917 (citations omitted). <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673606694816.pdf?id=0e96c9e6421f9512:7a2f0723:123a11c858d:efa1252541835984> accessed 10 September 2009.

no exception for circumstances in which the pregnancy poses a threat to the physical or mental health of the woman. The World Health Organization defines 'health' as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.² On this basis, a mental health exception to a general prohibition on abortion should 'include psychological distress caused by, for example, rape or incest, or by diagnosis of foetal impairment' as well as 'distress caused by detrimental socio-economic circumstances'.³

It should be noted that the question of whether a foetus has rights and, if so, whether those rights should ever trump those of the woman is an extremely complex question which has been the subject of extensive debate and which is beyond the scope of this article.⁴ This article is restricted to a consideration of the way in which restrictions on abortion violate a woman's right to health, and I do not address the question of whether the rights of the foetus should ever prevail over the rights of the woman.

Part II of this article positions the right to health in the context of the other human rights, which may be invoked to protect a woman's right to terminate a pregnancy. Part III discusses the right to health in international law, specifically considering the right to reproductive health. In Part IV, I develop the argument that restricting access to abortion violates the right to health given the consequential damage to both physical and mental health and, further, violates the anti-discrimination principle, which is an integral component of the right to health.

II. THE RIGHT TO HEALTH IN CONTEXT

International law has not yet clearly recognised a right to abortion. Consequently, advocates of such a right have framed the abortion right as falling within a number of existing, clearly recognised human rights. For example, it has been argued that restricting a woman's access to

² World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems* (Geneva, 2003) at 86.

³ *Ibid.*

⁴ R Dworkin, for example, has posited the view that a woman has a right to choose to terminate a pregnancy until the point of foetal viability. His view is that at the point of foetal viability, a foetus may be regarded as having its own interests that should be protected and that a State does not unduly burden a woman's right to choose to terminate a pregnancy if it insists that a woman decides before the point of viability. See: R Dworkin, *Life's Dominion* (Alfred A Knopf, Inc., New York 1993). Another example is Judith Jarvis Thompson's argument that, even assuming a foetus has a right to life, that right does not prevail over the rights of a woman who becomes pregnant through no voluntary action of her own (for example through rape). See: JJ Thomson, 'A Defense of Abortion' (1971) 1 *Phil Pub Affairs* 47.

safe and legal abortion services constitutes a violation of the: right to life,⁵ right to health,⁶ right to privacy/autonomy,⁷ right to equality/freedom from discrimination,⁸ right to be free from torture or cruelty, inhuman or degrading treatment or punishment.⁹ Radhika Coomaraswamy, in her capacity as United Nations Special Rapporteur on Violence Against Women, has categorised restrictions on abortion as a form of violence against women and has positioned violence against

⁵ See for example: Human Rights Committee, *General Comment No 28: Article 3 (Equality of Rights between Men and Women)*, UN Doc CCPR/C/21/Rev.1/Add.10 (2000); Human Rights Committee, *Concluding Observations on Chile*, 65th session, UN Doc CCPR/C/79/Add.104 (March 30 1999) [15]; Human Rights Committee, *Concluding Observations on Colombia*, UN Doc CCPR/C/79/Add.76 (May 5 1997) [24]; Human Rights Committee, *Concluding Observations on Ecuador*, 63rd session, UN Doc CCPR/C/79/Add.92 (18 August 1998) [11]; Human Rights Committee, *Concluding Observations on Guatemala*, 72nd session, UN Doc CCPR/CO/72/GTM (August 27 2001) [19]; Human Rights Committee, *Concluding Observations on Mali*, 77th session, UN Doc CCPR/CO/77/MLI (April 16 2003) [14]; Human Rights Committee, *Concluding Observations on Mongolia*, 68th session, UN Doc CCPR/C/79/Add.120 (May 25 2000) [8(b)]; Human Rights Committee, *Concluding Observations on Peru*, 70th session, UN Doc CCPR/CO/70/PER (November 15 2000) [20].

⁶ See for example: United Nations Population Division, *Report of the International Conference on Population and Development*, UN Doc A/CONF.171/13 (October 18 1994) [8.25]; Human Rights Committee, *Concluding Observations on Mali*, 77th session, UN Doc CCPR/CO/77/MLI (April 16 2003) [14]; Human Rights Committee, *Concluding Observations on Poland*, 82nd session, UN Doc CCPR/CO/82/POL (December 2 2004) [8]; Committee on the Elimination of All Forms of Discrimination against Women, *Concluding Observations on Ireland*, UN Doc CEDAW/A/60/38 (July 22 2005) [397]; Committee on the Elimination of All Forms of Discrimination against Women, *Concluding Observations on Andorra*, 25th session, UN Doc A/56/38 (July 31 2001) [48]; Committee on the Elimination of All Forms of Discrimination against Women, *Concluding Observations on Argentina*, UN Doc A/52/38 Rev.1 (July 23 1997) [319].

⁷ See for example, *Karen Noelia Llantoy Huamán v Peru*, Human Rights Committee, Communication No 1153/2003, UN Doc CCPR/C/85/D/1153/2003 (November 22 2005). In the context of the European regional system, see for example: *Tysiac v Poland* (2007) Eur Court HR 5410/03.

⁸ There has been a notable absence of explicit discussion in the international legal arena addressing the right to abortion in the context of the prohibition of discrimination. However, scholarly material has emerged out of domestic jurisdictions (particularly the USA), which powerfully advocates for a discrimination-based approach to restrictions on access to abortion services. See for example: RB Ginsburg, 'Some Thoughts on Autonomy and Equality in Relation to *Roe v Wade*' (1985) 63 NCL Rev 375; R Siegel, 'Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection' (1992) 44 Stan L Rev 261; CA MacKinnon, 'Reflections on Sex Equality Under Law' (1991) 100 Yale LJ 1281.

⁹ See for example, *Karen Noelia Llantoy Huamán v Peru*, Human Rights Committee, Communication No 1153/2003, UN Doc CCPR/C/85/D/1153/2003 (22 November 2005); M Nowak, *Report of the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/HRC/7/3 (January 15 2008).

women as directly related to the right to life, right to be free from gender-based discrimination, and right to be free from torture.¹⁰

The relationship between unsafe abortion and high rates of maternal mortality forms the basis for the argument that restrictions on abortion violate the right to life.¹¹ It is also argued that a woman's right to decide matters relating to her own body (such as the right to terminate a pregnancy) form a part of the right to privacy, right to autonomy, right to liberty, right to physical integrity, and right to decide the number and spacing of one's children.¹² The view that laws restricting access to abortion are frequently informed by discriminatory assumptions about women, and that the effect of such laws is to further entrench women's unequal status in society and increase discrimination against women, forms the basis for the argument that laws restricting abortion violate a woman's right to be free from gender-based discrimination.¹³ The argument that restrictions on abortion constitute torture or cruel, inhuman or degrading treatment is based on the suffering experienced by a woman who is denied access to abortion services or who accesses unsafe abortion services.¹⁴

Many of these arguments are interrelated. For example, the arguments that restrictions on abortion violate the right to life, right to health, or right to be free from torture are all based on the notion that a woman who is denied access to abortion services may suffer in a way which is damaging to her physical or mental health (or both) as a result of such denial.¹⁵ The right to autonomy is intimately connected with the right to equality given that women will not obtain equal social status until they are free to determine their own 'life's course' to the

¹⁰ R Coomaraswamy, *Report of the Special Rapporteur on Violence Against Women*, UN Doc E/CN.4/1999/68/Add.4 (January 21 1999).

¹¹ Center for Reproductive Rights, 'Safe and Legal Abortion is a Woman's Human Right' (August 2004) 1; C Zampas and JM Gher, 'Abortion as a Human Right—International and Regional Standards' (2008) 8 Human Rights L Rev 249, 255–256; RJ Cook, 'Reproductive Health Law: Where Next, After Cairo and Beijing?' (1997) 16 Med L 169; RJ Cook and MF Fathalla, 'Advancing Reproductive Rights Beyond Cairo and Beijing' in KD Askin and DM Koenig (eds), *Women and International Human Rights Law* (Volume 3) (Transnational Publishers Inc., New York 2001) 78–80.

¹² Center for Reproductive Rights (n 11) at 3; Cook and Fathalla (n 11) at 80–82. It should be noted that imposing criminal sanctions on a woman who aborts her foetus may be conceptualised as a separate violation of the right to liberty. See Cook (n 11) at 172.

¹³ Center for Reproductive Rights (n 11) at 3; Siegel (n 8); MacKinnon (n 8).

¹⁴ See for example: *Karen Noelia Llantoy Huamán v Peru*, Human Rights Committee, Communication No 1153/2003, UN Doc CCPR/C/85/D/1153/2003 (November 22 2005).

¹⁵ The negative health effects of restrictions on abortion are discussed in Part IV(A) of this article.

same extent as men.¹⁶ Both of these rights are connected with the right to health. For example, restricting a woman's right to bodily autonomy clearly has the potential to damage a woman's health and wellbeing and the understanding that every person has a right to make decisions relating to his or her health is widespread.¹⁷ Further, under international law the right to be free from discrimination forms an integral component of the right to health.¹⁸ A fully comprehensive discussion of the way in which restrictions on abortion violate women's rights would consider each of these basic human rights (and possibly others) as well as the ways in which they all intersect. It is inadequate to only consider restrictions on abortion through the lens of one particular fundamental right as such, a one-dimensional approach invariably results in an oversimplification of the ways in which women experience a denial of legal abortion services. For example, a consideration of restrictions on abortion only in terms of a violation of the right to life and right to health frequently results in a focus on the physiological/biological effects of denying access to abortion but fails to consider the social context in which laws restricting access to abortion are formulated and implemented.¹⁹ Similarly, a focus on the right to privacy, autonomy,

¹⁶ See the opening paragraph from the dissenting judgement of Justices Ginsburg, Breyer, Souter, and Stevens in the US Supreme Court decision of *Gonzales v Carhart* 127 S Ct 1610, 1641 (2007).

¹⁷ The seminal US Supreme Court decision of *Roe v Wade*, which based its reasoning for the decision upholding the constitutional right to abortion in certain circumstances on the right to privacy and personal liberty, clearly recognised the link between unduly restricting a woman's choice to terminate a pregnancy and negative health ramifications. As part of the majority judgement Justice Blackmun states: 'This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved.' See *Roe v Wade* 410 US 113, 153 (1973). See also the 2006 Colombian Constitutional Court decision, which declared Colombia's restrictive abortion laws unconstitutional: Sentencia C-355 de 2006 Corte Constitucional.

¹⁸ Part IV(B) of this article specifically considers the right to be free from discrimination as a component of the right to health.

¹⁹ Reva Siegel is particularly critical of an approach to reproduction that views reproduction entirely in physiological/biological terms and which fails to recognise the social context in which reproduction occurs. See Siegel (n 8).

and liberty which fails to include a focus on equality involves a consideration of a woman's right as an individual but fails to consider the implications of restrictions on abortion on women as a marginalised group that suffers various forms of discrimination.²⁰ On the other hand, a consideration of the right to abortion through an equality lens that fails to also include an autonomy lens may result in generalisations and stereotypes, which fail to adequately take account of the individual woman.²¹ Further, while labelling restrictions on abortion as torture or cruel, inhuman or degrading treatment has the benefit of stigmatising such restrictions and emphasising the gravity of their effects, in practice a sole focus on this right may result in a focus on extraordinary scenarios at the expense of the 'ordinary' experiences of women dealing with an unwanted pregnancy. Consequently, while the objective of this article is comprehensively and persuasively to construct an argument supporting the position that restrictions on abortion violate the right to health, I acknowledge that this is merely one facet of the multi-faceted lens through which restrictions on abortion can and should be viewed. Only a multi-faceted approach can adequately take account of the numerous ways in which women who are denied access to abortion may suffer.

III. THE RIGHT TO HEALTH

A. *General Overview of the Right to Health*

According to Henri Frederic Amiel, '[i]n health there is freedom. Health is the first of all liberties'.²² The notion of a right to health is not a new notion. However, the enshrining of this right into law; its formulation as a legal right, is a relatively new phenomenon that can be traced to the Universal Declaration of Human Rights, which has subsequently been incorporated into numerous international and regional documents.²³

²⁰ See for example, E Kingdom, 'Legal Recognition of a Woman's Right to Choose' in J Brophy and C Smart (eds), *Women in Law* (Routledge, London 1985); RP Petchesky, *Abortion and Woman's Choice: The State, Sexuality, and Reproductive Freedom* (2nd edn Northeastern University Press, Boston 1990) xxi–xxvi.

²¹ According to RP Petchesky, 'reproductive freedom—indeed, the very nature of reproduction—is social and individual at the same time; it operates "at the core of social life" as well as within and upon women's individual bodies'. See Petchesky (n 20) at 2.

²² HF Amiel, *Amiel's Journal: The Journal Intime of Henri Frédéric Amiel* (Humphry Ward, trans., MacMillan, London 1889) 104.

²³ It should be noted that while the Universal Declaration of Human Rights is technically a declaration and not a legal document, there is substantial debate as to whether it has evolved to become a part of customary international law: See for example, O Schachter, *International Law in Theory and Practice* (Martinus Nijhoff, Dordrecht/Boston/London 1991) Ch XV.

The Universal Declaration of Human Rights affirms that ‘everyone has the right to a standard of living adequate for the health and well-being of himself [or herself] and of his [or her] family, including food, clothing, housing, medical care, and necessary social services’.²⁴ Following the Declaration, the International Covenant on Economic, Social, and Cultural Rights (ICESCR) enshrined what is now regarded as the seminal international law articulation of the right to health. Pursuant to Article 12(1) of the ICESCR ‘[t]he States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.²⁵

In addition to being included in this general human rights treaty, a number of specific human rights treaties also include the right to health. For example, Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination specifies the right of everyone ‘to public health, medical care, social security and social services’²⁶ and under Article 24 of the Convention on the Rights of the Child States Parties recognise ‘the right of the child to the enjoyment of the highest attainable standard of health’.²⁷ Article 25 of the Convention on the Rights of Persons with Disabilities states that ‘persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability’.²⁸ Of particular relevance to this discussion is the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which obliges States Parties to ‘take all appropriate measures to eliminate discrimination against women in the field of health care’.²⁹ In addition to the treaties mentioned above, the right to health has been expressed in numerous other treaties, declarations, and statements of principle. According to Mary Robinson (former United Nations High Commissioner for Human Rights), the Millennium Development Goals that relate to health ‘will be implemented

²⁴ *Universal Declaration of Human Rights*, UN Doc A/810 (December 10 1948) art 25(1).

²⁵ *International Covenant on Economic, Social and Cultural Rights*, opened for signature December 16 1966, 999 UNTS 3 (entered into force January 3 1976) art 12(1) (emphasis added).

²⁶ *International Convention on the Elimination of All Forms of Racial Discrimination*, opened for signature December 21 1965, 660 UNTS 195 (entered into force January 4 1969) art 5(e)(iv).

²⁷ *Convention on the Rights of the Child*, opened for signature November 20 1989, 1577 UNTS 3 (**entered into force September 2 1990**) art 24(1).

²⁸ *Convention on the Rights of Persons with Disabilities*, opened for signature (30 March 2007), 993 UNTS 3 (entered into force April 3 2008) art 25.

²⁹ *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force September 3 1981) art 12(1).

only if there is a strong focus on the right to health'.³⁰ In addition to the international documents enshrining the right to health, it should be noted that this right has also been expressly articulated at the regional level³¹ and, in many countries, at the domestic level.³²

It is clear that there is an international legal right to health; slightly more murky is the scope and content of this right. What is meant by the statement that everyone has the right 'to the enjoyment of the highest attainable standard of physical and mental health'? The scope of the right to health may be conceptualised as encompassing both health care and the underlying preconditions for health. Depending on which legal instrument is being considered, health care may include medical care, preventive health care, primary health care, child health care, family planning services, pre- and post-natal health services and mental healthcare services. Underlying preconditions for health may include clean drinking water, adequate sanitation, adequate nutritious foods, environmental health, occupational health, health-related information, and the abolishment of harmful traditional practices.³³ According to the General Comment No 14 of the Committee on Economic, Social, and Cultural Rights:

The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.³⁴

Thus, it seems that the scope of the right to health is fairly broad. This article will not explore every element of the freedoms, entitlements and obligations inherent in the concept. Rather, the purpose of this article is

³⁰ M Robinson, 'Conference on World Law and World Health: Women's Right to Health: A Conversation' (2008) 22 Emory Int'l L Rev 29, 30.

³¹ See for example: African Charter on Human and Peoples' Rights (art 16); African Charter on the Rights and Welfare of the Child (art 14); Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights (art 10); European Social Charter (art 11).

³² P Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc E/CN.4/2003/58 (February 13 2003) [20].

³³ BCA Toebe, *The Right to Health as a Human Right in International Law* (Intersentia, Antwerp 1999) 245–246.

³⁴ Committee on Economic, Social, and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, UN Doc E/C.12/2000/4 (August 11 2000) [8].

to explore one specific sub-category of the right to health: the right to reproductive health.

B. The Right to Reproductive Health

International law, like domestic law, was formulated and developed predominantly by men for men. In Hilary Charlesworth's words, '[m]asculinity has so permeated the mainstream of international law that it has become the norm'³⁵ and '[i]nternational law might be said to have a gender in the sense that it is constructed upon the particular assumptions and experiences of life where men and the male are taken to represent the human experience'.³⁶ However, unlike domestic law, which has been the subject of significant feminist critique and advocacy, feminists have been slow to attack the male centric nature of international law. Consequently, many areas of international law remain male centric in their approach and address female issues insofar as they are also male issues but frequently fail to address female issues, which are relevant to women only.³⁷ Therefore, while to most women it seems obvious that reproductive health is an essential component of the right to health, this is not obvious in the context of a system that has traditionally sidelined women's issues.

The phrase 'reproductive health' has only recently been incorporated into international legal discourse. CEDAW, the only convention to deal specifically with women's issues, discusses reproductive rights in various contexts yet never uses the phrase 'reproductive health'. Thus while seemingly obvious, the widespread conceptualisation of health problems stemming from women's reproductive capacity as forming an integral component of the universal right to health seems to be a relatively recent phenomenon. The 1994 United Nations Report of the International Conference on Population and Development brought the issue of reproductive health to the fore when it dedicated an entire chapter to 'reproductive rights and reproductive health'. The report defines reproductive health as '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'.³⁸ The 1995 United Nations Report of the Fourth World

³⁵ H Charlesworth, 'Feminist Ambivalence about International Law' (2005) 11 Int'l Legal Theor 1, 1.

³⁶ H Charlesworth, 'The Hidden Gender of International Law' (2002) 16 Temp Int'l & Comp LJ 93, 96.

³⁷ H Charlesworth, C Chinkin and S Wright, 'Feminist Approaches to International Law' (1991) 85 AJIL 613.

³⁸ United Nations Department of Economic and Social Affairs, *Report of the International Conference on Population and Development*, UN Doc A/CONF.171/13 (October 19 1994) [7.2].

Conference on Women reiterates this definition of reproductive health.³⁹ In 1999, the Committee on the Elimination of Discrimination against Women issued a General Recommendation on women and health, specifically clarifying in the introduction that ‘access to health care, including reproductive health, is a basic right under the Convention’.⁴⁰ At the turn of the century, the Committee on Economic, Social, and Cultural Rights released its most comprehensive explanation to date of the right to health enshrined in the Covenant. As part of this General Comment No 14, the Committee discusses the meaning of Article 12.2(a), which provides for ‘the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child’ and states that:

The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child” (art. 12.2 (a)) may be understood as requiring measures to improve child and maternal health, sexual and *reproductive health* services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.⁴¹

Further, in his 2003 report, Special Rapporteur Paul Hunt specifically included maternal, child, and reproductive health in his assessment of the specific entitlements included in the right to health.⁴² It should be noted that the discourse surrounding reproductive health has evolved such that there are those who advocate for a framing of the right to reproductive health, and reproductive rights in general, as a sub-category of sexual rights.⁴³ However, conceptualising the right to reproductive health as part of a broader sexual rights approach is complex and this discourse is still in its early stages. Even those who advocate a sexual rights approach in this context acknowledge that ‘it is perhaps necessary to encourage a trial separation of [reproductive rights and sexual rights] to provide the necessary time and space to do

³⁹ United Nations Department for Policy Coordination and Sustainable Development, *Report of the Fourth World Conference on Women*, UN Doc A/CONF.177/20 (October 17 1995) [94].

⁴⁰ Committee on the Elimination of Discrimination against Women, *General Recommendation No 24: Women and Health (Article 12)*, 20th session, UN Doc A/54/38/Rev.1 (1999) [1].

⁴¹ Committee on Economic, Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Article 12)*, 22nd session, UN Doc E/C.12/2000/4 (August 11 2000) [14] (emphasis added, citations omitted).

⁴² Hunt (n 32) at [25].

⁴³ S Corrêa, R Petchesky, and R Parker, *Sexuality, Health and Human Rights* (Routledge, London/New York 2008) 164–180.

the hard work of analysing their differences as well as their interlinkages.⁴⁴ While acknowledging that this conceptual framework has much to commend it, given that the concept of reproductive health as an integral part of the general right to health is now firmly ensconced in international legal discourse, it makes sense (for the purposes of this article) to view the right to reproductive health through the lens of the general right to health. Consequently, the remaining question is, does the right to reproductive health include that most controversial of 'rights'—the right to choose to terminate a pregnancy?

IV. DO RESTRICTIONS ON ABORTION VIOLATE THE RIGHT TO HEALTH?

In recent years, there has been an increasing acknowledgment in the international realm of the connection between restrictions on abortion and serious health problems. For example, while couched in diplomatic language, the 1994 United Nations Report of the International Conference on Population and Development categorises unsafe abortion as 'a major public health concern'.⁴⁵ The 1995 United Nations Report of the Fourth World Conference on Women states that unsafe abortion is 'a grave public health problem' as well as a 'major public health concern'.⁴⁶ In its 2004 concluding observations on Poland, the Human Rights Committee 'reiterates its deep concern about restrictive abortion laws in Poland, which may incite women to seek unsafe, illegal abortions, with attendant risks to their life and health'.⁴⁷ However, many States with restrictive abortion laws continue to insist that restrictions on abortion do not violate the right to health. For example, in the reservations section of the 1995 United Nations Report of the Fourth World Conference on Women, many States objected to the report's allusions to the view that restrictions on abortion constitute a human rights violation.⁴⁸ Consequently, this article seeks to explain in detail why the right to reproductive health includes

⁴⁴ *Ibid.* at 178.

⁴⁵ United Nations Department of Economic and Social Affairs, *Report of the International Conference on Population and Development*, UN Doc A/CONF.171/13 (October 19 1994) [8.25].

⁴⁶ United Nations Department for Policy Coordination and Sustainable Development, *Report of the Fourth World Conference on Women*, UN Doc A/CONF.177/20 (October 17 1995) [97, 106].

⁴⁷ Human Rights Committee, *Concluding Observations of the Human Rights Committee: Poland*, 82nd session, UN Doc CCPR/C/SR.2251 (November 5 2004) [8].

⁴⁸ United Nations Department for Policy Coordination and Sustainable Development, *Report of the Fourth World Conference on Women*, UN Doc A/CONF.177/20 (October 17 1995) Chapter V.

the right to abortion and, concomitantly, why restrictions on abortion violate the right to health.

A. The Negative Health Effects of Restrictive Regulation of Abortion

1. Physical Health

(a) The Physical Effects of Unsafe Abortion

He used a syringe to squirt something into me. I suspect it was soapy water—I later learned that that is what was often used. I paid him £150 and he was going to go. Then the pain began and it was frightful, just terrible. I jack-knifed and screamed in pain and the girl who was with me came rushing in.⁴⁹

According to the World Health Organization, nearly 20 million unsafe abortions took place globally in the year 2003 and 98% of them took place in developing countries with restrictive abortion laws. As a result of this high global rate of unsafe abortion, every year approximately 70 000 women die and close to five million women suffer from temporary or permanent disability.⁵⁰ Further, unsafe abortion accounts for 13% of maternal deaths and 20% of the total mortality and disability burden due to pregnancy and childbirth in terms of disability-adjusted life years.⁵¹

Unsafe abortion may be defined as ‘a procedure for terminating an unintended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both’.⁵² Common mechanisms for effecting an unsafe abortion include treatments taken by mouth (such as quinine, turpentine or acid); treatments placed in the vagina or cervix (such as herbal preparations); intramuscular injections; foreign objects placed into the uterus through the cervix (such as a knitting needle or coat hanger); enemas and direct trauma.⁵³ Common medical complications associated with unsafe abortions include haemorrhage, sepsis, peritonitis, and trauma.⁵⁴ The most common cause of death is septic shock with multi-organ failure, with or without

⁴⁹ A Neustatter and G Newson, *Mixed Feelings: The Experience of Abortion* (Pluto Press Limited, London 1986) 85.

⁵⁰ World Health Organization, *Unsafe Abortion: Global and Regional Estimates of Incidence of Unsafe Abortion and Associated Mortality in 2003*, World Health Organization (2007) 5.

⁵¹ *Ibid.*

⁵² Grimes (n 1) at 1908.

⁵³ *Ibid* at 1911.

⁵⁴ *Ibid* at 1910.

haemorrhage.⁵⁵ Other potential consequences of unsafe abortions include bowel injury and acute renal failure.⁵⁶ Long-term complications of survivors of severe morbidity include infertility and chronic pelvic pain.⁵⁷ When a woman suffers sepsis or haemorrhage, a hysterectomy may be necessary to save her life, gas gangrene is common when foreign objects have been inserted as part of the abortion process and tetanus is a real risk for women who have not been immunised.⁵⁸ According to Susan Fawcus,

The most common morbidities associated with unsafe abortion are sepsis and haemorrhage. In addition, trauma from foreign bodies and metabolic complications associated with renal failure can arise from ingestion of chemicals for abortion. The sepsis results from a combination of retained products, trauma and non-sterile techniques. It can be compounded by late presentation at a health facility because of fear of criminal investigations. Uterine sepsis, if not treated or if treated inadequately, can lead to uterine necrosis with peritonitis, septic shock, and various organ failures (paralytic ileus, disseminated intravascular coagulopathy, adult respiratory distress syndrome, liver dysfunction and renal failure). Severe haemorrhage can result in death from hypovolemic shock and coagulopathy. Trauma of the genital tract can cause death by sepsis or haemorrhage. It can result from bowel trauma from sharp objects passed through the cervix, which perforate the uterus and damage the bowel.⁵⁹

The serious public health problem posed by unsafe abortion practices is increasingly recognised on the world stage. The 1994 Report of the International Conference on Population and Development specifically urges all States 'to strengthen their commitment to women's health' and to 'deal with the health impact of unsafe abortion as a major public health concern'.⁶⁰ It goes on to state in the same paragraph that 'where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion.'⁶¹ The 1995 Report of the Fourth World Conference on Women states that 'unsafe

⁵⁵ SR Fawcus, 'Maternal Mortality and Unsafe Abortion' (2008) 22 *Best Pract Res Cl Ob* 533, 533.

⁵⁶ DA Grimes, 'The Role of Medical Technology' in IK Warriner and IH Shah (eds), *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (Guttmacher Institute, New York 2006) 73, 84.

⁵⁷ Fawcus (n 55) at 537.

⁵⁸ Grimes (n 1) at 1910.

⁵⁹ Fawcus (n 55) at 537.

⁶⁰ United Nations, *Report of the International Conference on Population and Development*, UN Doc A/CONF.171/13 (October 18 1994) [8.25].

⁶¹ *Ibid.*

abortions threaten the lives of a large number of women, representing a grave public health problem as it is primarily the poorest and youngest who take the highest risk'.⁶² It further calls on States to '[r]ecognize and deal with the health impact of unsafe abortion as a major public health concern'.⁶³ In the same paragraph, the report acknowledges the link between laws prohibiting abortion and unsafe abortions.

(b) The Link between Safety and Legality

Legal restrictions on abortion drive abortion underground, thereby creating the space for unsafe abortions to flourish.⁶⁴ While there are numerous factors that contribute to the incidence of unsafe abortion in any given country (including service factors, social factors, economic factors, religious factors, and policy factors) legal restrictions have been categorised as the main determinant of unsafe abortion.⁶⁵ According to the World Health Organization, the 'incidence of unsafe abortion is influenced by the legal provisions governing access to safe abortion, as well as the availability and quality of legal abortion services. *Restrictive legislation is associated with a high incidence of unsafe abortion*'.⁶⁶ (emphasis added) Susheela Singh extrapolates on this notion, stating that:

... it is also true that all abortions that occur where the procedure is highly restricted by law, are to some extent 'unsafe' – even those that are performed by a medically trained professional are clandestine and unregulated; for example, should there be any medical problem or malpractice, a woman would have little or no chance of recourse.⁶⁷

⁶² United Nations, *Report of the Fourth World Conference on Women*, UN Doc A/CONF.177/20 17 October 1995) [97].

⁶³ *Ibid.* at 106.

⁶⁴ 'Abortion bans increase the number of women dying but do not decrease the number of abortions': N Cahn and AT Goldstein, 'The Legacy of Roe: The Constitution, Reproductive Rights, and Feminism: Roe and its Global Impact' (2004) 6 U Pa J Const L 695, 701.

⁶⁵ AI Mundigo, 'Determinants of Unsafe Induced Abortion in Developing Countries' in IK Warriner and IH Shah (eds), *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (Guttmacher Institute, New York 2006) 51, 52–54.

⁶⁶ World Health Organization (n 50) at 2. See also Grimes (n 1) at 1908; IK Warriner, 'Unsafe Abortion: An Overview of Priorities and Needs' in IK Warriner and IH Shah (eds), *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (Guttmacher Institute, New York 2006); M Berer, 'National Laws and Unsafe Abortion: The Parameters of Change' (2004) 12 RHM 1, 2.

⁶⁷ S Singh, 'The Incidence of Unsafe Abortion: A Global Review' in IK Warriner and IH Shah (eds), *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (Guttmacher Institute, New York 2006) 35, 38–40. See also G Sedgh and others, 'Induced Abortion: Estimated Rates and Trends Worldwide' (2007) 370 Lancet 1338, 1339 <http://www.thelancet>.

The link between legality and safety is demonstrated by empirical evidence. Many countries retain extremely restrictive abortion laws. For example, in approximately 70 countries, abortion is not legally permitted where necessary to preserve the physical health of the woman.⁶⁸ Data from 165 countries demonstrate that the incidence of unsafe abortion is highest in countries with restrictive abortion legislation.⁶⁹ Romania provides a clear example of the link between legality and safety. From 1957 to 1966, access to abortion was legal and widespread. In 1960, the abortion mortality ratio was 20 per 100 000 live births. In 1966, access to abortion was legally restricted and by 1989 mortality ratios had risen to 148 deaths per 100 000 live births with abortion accounting for 87% of the deaths. In 1989, the law was once again changed to provide for easier and safer access to abortion services. Within a year the mortality ratio fell by more than half and by 2002 mortality from unsafe abortions was as low as nine per 100 000 live births.⁷⁰ Another example is the USA where the rate of abortion-related deaths decreased by 85% in the five years following *Roe v Wade*,⁷¹ the decision, which held that a woman has a constitutional right to access abortion services (subject to certain limitations).⁷²

2. Mental Health

(a) The Negative Mental Health Effects of Restrictions on Abortion

The physical health effects of restricting access to abortion are frequently discussed and acknowledged; in contrast, the mental health effects often fall under the radar, despite the fact that they may also be serious and warrant considered attention. Women's experiences of abortion differ markedly—for some the process may be positive, for some it may be emotionally benign, for others it may be emotionally difficult.⁷³ While acknowledging that for some women abortion may itself amount to a difficult mental and emotional experience, restricting a woman's capacity to exercise a difficult choice is fraught with the potential for untold mental health consequences. Any negative emotional responses to an

com/journals/lancet/article/PIIS0140-6736(07)61575-X/fulltext accessed 10 September 2009.

⁶⁸ World Health Organization (n 50) at 2; Center for Reproductive Rights, *The World's Abortion Laws*, (2008).

⁶⁹ Fawcus (n 55) at 539; Berer (n 66).

⁷⁰ Grimes (n 1) at 1913.

⁷¹ 410 US 113, 153 (1973).

⁷² Cahn and Goldstein (n 64) at 701.

⁷³ For an interesting discussion of women's varied reactions to abortion see: C Gilligan, *In a Different Voice* (Harvard University Press, Cambridge 1982).

unwanted pregnancy are significantly exacerbated in a climate where access to abortion services is restricted.

Even leaving aside the obvious trauma inherent in experiencing an unsafe abortion, the notion that forcing a woman to carry an unwanted pregnancy to term gives rise to negative mental health consequences, is not novel. Many domestic legal systems, which continue to prohibit abortion generally nevertheless include a 'mental health exception' to that prohibition. For example, the following countries prohibit abortion, but provide exceptions where an abortion is deemed necessary to save a woman's life or to protect a woman's physical or mental health: Algeria, Botswana, Colombia, Gambia, Ghana, Hong Kong, Israel, Jamaica, Liberia, Malaysia, Namibia, Nauru, New Zealand, Northern Ireland, Saint Kitts & Nevis Saint Lucia, Samoa, Seychelles, Sierra Leone, Spain, Swaziland, Thailand, and Trinidad & Tobago.⁷⁴ Each country's law provides a different prescription for when the mental health exception will be established. The very fact that countries which maintain long-standing legal opposition to abortion provide for a mental health exception to such laws is indicative of the extent to which it is generally acknowledged that forcing a woman to continue with an unwanted pregnancy may damage her mental health.⁷⁵ As well as being recognised in the domestic realm, the extent of this potential for mental disorder has also been recognised in the international realm. For example, in the 2005, Human Rights Committee decision of *Karen Noelia Llantoy Huamán v Peru*⁷⁶ the Human Rights Committee decided that Peru's refusal to allow the complainant to terminate her pregnancy caused severe psychological harm to the complainant and resulted in her suffering from clinical depression.

Women who are denied abortion and consequently are forced to carry a pregnancy to term bear the mental health consequences even after the birth of the child. A study of over 500 mothers found that mothers with unwanted children were 'substantially more depressed' than other mothers.⁷⁷ When women are forced to carry an unwanted pregnancy to term, it is not only the woman who suffers the consequences, the resulting child is also disadvantaged. Dagg's review of the literature found that a large percentage of women who raise a child after being denied access to abortion services experience long-term negative feelings

⁷⁴ Center for Reproductive Rights (n 68).

⁷⁵ For a discussion about mental health indications for abortion see: RJ Cook and others, 'Legal Abortion for Mental Health Indications' (2006) 95 Int J Gynecol Obstet 185.

⁷⁶ Human Rights Committee, Communication No 1153/2003, UN Doc CCPR/C/85/D/1153/2003 (November 22 2005).

⁷⁷ JS Barber, WG Axinn and A Thornton, 'Unwanted Childbearing and Mother-Child Relationships' (1999) 40 J Health Soc Behav 231.

towards that child and difficulty adjusting to motherhood.⁷⁸ Henry David found that differences in psychosocial development between children born of an unwanted pregnancy and other children widened over time, but lessened at around age 30. All the differences disfavoured those born of unwanted pregnancies; for example, they became psychiatric patients more frequently than the controls. Overall, the findings indicate that denial of abortion for unwanted pregnancy increases the risk that the child born as a result of the pregnancy will be disadvantaged with respect to psychosocial development and mental wellbeing.⁷⁹

Those who advocate restricting access to abortion services frequently present adoption as a way to avoid the damaging consequences of forcing a woman to raise a child resulting from an unwanted pregnancy. However, adoption is not quite the panacea that it is frequently presented to be. Many women who place a child for adoption suffer enduring mental health consequences as a result. For example, studies indicate that a birth mother may experience a long-term sense of loss, depression, and difficulties in adjustment after placing a child for adoption.⁸⁰ The following testimony of a woman who elected to terminate her pregnancy aptly illustrates this point:

I am doing it because I have to do it. I am not doing it the least bit because I want to . . . psychologically there was no way that I could hack another adoption. It took me about four and a half years to get my head on straight. There was just no way I was going to go through it again.⁸¹

Thus, it must be acknowledged that, irrespective of one's view of the morality of abortion, forcing a woman to carry an unwanted pregnancy to term is detrimental to that woman's wellbeing and possibly also to the wellbeing of the resulting child.

⁷⁸ PKB Dagg, 'The Psychological Sequelae of Therapeutic Abortion—Denied and Completed' (1991) 148 *Am J Psychiat* 578. For example, Dagg refers to a study by Pare and Raven that focused on 73 women 1–3 years after their request for abortion was denied, 34% reported that the child was a burden that they frequently resented.

⁷⁹ HP David, 'Born Unwanted: Long-Term Developmental Effects of Denied Abortion' (1992) 48 *J Soc Issues* 163; Henry P David, 'Born Unwanted, 35 Years Later: The Prague Study' (2006) 14 *RHM* 181. See also HP David and others (ed) *Born Unwanted: Developmental Effects of Denied Abortion* (Springer Publishing Company, New York 1988) for a discussion of other studies that have focused on the effects of denied abortion on the resulting child.

⁸⁰ MP Sobol and KJ Daly, 'The Adoption Alternative for Pregnant Adolescents: Decision Making, Consequences, and Policy Implications' (1992) 48 *J Soc Issues* 143.

⁸¹ Gilligan (n 73) at 85.

(b) Negating Post-Abortion Syndrome (PAS)

In the words of Reva Siegel:

Since the 1990s, increasing numbers of anti abortion advocates have decided that the public's willingness to restrict abortion crucially turns on judgments about women. The movement has devised a way of arguing its case that is designed to quell these concerns. It has transformed PAS [Post Abortion Syndrome] – a therapeutic discourse initially employed to recruit women to the anti-abortion movement – into WPAA [woman-protective anti-abortion argument] – a political discourse designed to persuade audiences outside the movement's ranks who are ambivalent about restricting abortion because of their concerns about women. To meet the concerns of this audience, the anti-abortion movement is now arguing that restricting abortion promotes the health and freedom of women.⁸²

Speckhard and Rue are well-known proponents of the notion of PAS.⁸³ They coined the term and defined it as 'a type of post-traumatic stress disorder that is characterised by the chronic or delayed development of symptoms resulting from impacted emotional reactions to the perceived physical and mental trauma of abortion'.⁸⁴ David Reardon is another prominent advocate of PAS.⁸⁵ He has conducted numerous studies, which he claims demonstrate the existence of such a syndrome; for example, by revealing that women who access abortion services have higher rates of subsequent death, outpatient admissions, inpatient admissions, and sleep disturbances than women who continue their pregnancies to term.⁸⁶ Fergusson has suggested that there is a link between abortion and mental health problems such as depression and anxiety.⁸⁷ Acceptance of this argument has begun to move into the legal domain. In its recent

⁸² RB Siegel, 'The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument' (2008) 57 Duke LJ 1641, 1688. In this article, Siegel chronicles the growth of this movement in the USA and thoroughly discredits it.

⁸³ See for example, AC Speckhard and VM Rue, 'Post-abortion Syndrome: An Emerging Public Health Concern' (1992) 48 J Soc Issues 95.

⁸⁴ *Ibid.*

⁸⁵ See for example, DC Reardon, *Making Abortion Rare: A Healing Strategy for a Divided Nation* (Acorn Books, Michigan 1996).

⁸⁶ See American Psychological Association Task Force, Report of the APA Task Force on Mental Health and Abortion, American Psychological Association (2008) 22.

⁸⁷ See for example, DM Fergusson, JM Boden and LJ Horwood, 'Abortion among Young Women and Subsequent Life Outcomes' (2007) 39(1) Perspect Sex Reprod Health 6; DM Fergusson, LJ Horwood and EM Ridder, 'Abortion in Young Women and Subsequent Mental Health' (2006) 47 J Child Psychol Psyc 16.

decision of *Gonzales v Carhart*⁸⁸, the United States Supreme Court upheld the Partial-Birth Abortion Ban Act⁸⁹ and in doing so cited an *amicus* brief that argued that women should be protected from making a decision that they might regret.⁹⁰ In other words, in its most recent abortion-related decision, the majority of the Supreme Court seemed to accept the woman-protective rationale for restricting abortion.⁹¹

However, the studies supporting the existence of PAS have been criticised by the American Psychological Association⁹² and the American Psychiatric Association does not recognise PAS as a diagnosis.⁹³ Further, in its 2008 report on mental health and abortion, the American Psychological Association concluded that 'the most methodologically sound research indicates that among women who have a single, legal, first-trimester abortion of an unplanned pregnancy for non-therapeutic reasons, the relative risks of mental health problems are no greater than the risks among women who deliver an unplanned pregnancy.'⁹⁴ Similarly, a recent review of studies conducted by researchers at the John Hopkins Bloomberg School of Public Health found that 'the highest quality studies had findings that were mostly neutral, suggesting few, if any, differences between women who had abortions and their respective comparison groups in terms of mental health sequelae. Conversely, studies with the most flawed methodology found negative mental health sequelae of abortion.'⁹⁵

There are numerous studies that negate the existence of PAS. For example, in a study of 1,247 women who elected to either abort or deliver an unwanted first pregnancy, it was found that terminating compared with delivering an unwanted first pregnancy was not directly related to the risk of clinically significant depression.⁹⁶ A study of approximately 13 000 women (which has been lauded for its methodological rigour)⁹⁷ was conducted jointly by the Royal College of General Practitioners and the Royal College of Obstetricians and Gynecologists in the UK. This study compared those who chose to abort an unplanned

⁸⁸ 127 S Ct 1610 (2007).

⁸⁹ Partial Birth Abortion Ban Act of 2003, 18 USC § 1531 (Supp V 2005).

⁹⁰ *Gonzales v Carhart* 127 S Ct 1610, 1634 (2007).

⁹¹ For a detailed discussion of this aspect of the Supreme Court's decision see: Siegel (n 82).

⁹² American Psychological Association Task Force (n 86) at 22, 24, 46.

⁹³ American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* (4th edn, Arlington 2002).

⁹⁴ American Psychological Association Task Force (n 86) at 22, 71.

⁹⁵ VE Charles and others, 'Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence' (2008) 78 *Contraception* 436.

⁹⁶ S Schmiede and NF Russo, 'Depression and Unwanted First Pregnancy: Longitudinal Cohort Study' (2005) 331 *Brit Med J* 1303.

⁹⁷ American Psychological Association Task Force (n 86) at 66.

pregnancy with those who chose to give birth and found that there were equivalent rates of psychological disorders among the two groups.⁹⁸ In addition, in light of the high rates of post-partum depression among the general population there is little basis for suggesting that the potential negative psychological effects of abortion are any greater than the potential negative psychological effects of giving birth.⁹⁹

Some research indicates that some women actually experience positive psychological effects as a consequence of an abortion experience. For example, in an eight year study of over 5,000 women, Russo and Zierk found that 'women who had had one abortion had higher self-esteem in general, and greater feelings of worth and capableness and fewer feelings of failure in particular, than did women who had had no abortions—despite the fact that they had experienced the stress of an unwanted pregnancy'.¹⁰⁰ In his 1991 review of the literature, Dagg found that most women express positive reactions to having an abortion, and only a small minority express any degree of regret. Similarly negative feelings present before the abortion disappear, with normalisation of various scores.¹⁰¹ Likewise, Sit, Rothschild, Creinin, Hanusa, and Wisner found that most patients experienced post-abortion mood improvement.¹⁰² The following quote of one woman's experience provides some insight into the way in which some women describe the termination of a pregnancy as an empowering experience:

Because now that you are going to take control of your life, you don't feel like you are a pawn in other people's hands. You have to accept the fact that you have done something wrong, and it also gives you a little more integrity, because you are not fighting off these things in yourself all the time. A lot of conflicts are resolved, and you have a sense of a new beginning, based on a kind of conviction that you can act in a situation.¹⁰³

⁹⁸ AC Gilchrist and others, 'Termination of Pregnancy and Psychiatric Morbidity' (1995) 167 *Brit J Psychiat* 243. See also Royal Australian and New Zealand College of Obstetricians and Gynaecologists, *Termination of Pregnancy: A Resource for Health Professionals* (2005); Royal College of Obstetricians and Gynaecologists, *The Care of Women Requesting Induced Abortion*, Evidence-Based Clinical Guideline No 7 (2004) 9.

⁹⁹ GH Wilmoth, 'Abortion, Public Health Policy, and Informed Consent Legislation' (1992) 48 *J Soc Issues* 1, 10, 11.

¹⁰⁰ NF Russo and KL Zierk, 'Abortion, Childbearing, and Women's Well-Being' (1992) 23 *Prof Psychol-Res Pr* 269.

¹⁰¹ Dagg (n 78).

¹⁰² D Sit and others, 'Psychiatric Outcomes Following Medical and Surgical Abortion' (2006) 22(3) *Human Reproduction* 878. See also Royal Australian and New Zealand College of Obstetricians and Gynaecologists (n 98) at 4.

¹⁰³ Gilligan (n 73) at 133.

Further, many women describe feelings of relief following an abortion:

A year later, I can say with certainty that I made the right decision. I have suffered no sorrow, no guilt, no pain . . . only relief that I was able to correct a mistake that would have altered my life forever . . . Was the embryo inside me life in some form? Yes, of-course. Was it the equivalent of an adult life such that its rights should have exceeded mine? No. Do I believe that I committed murder? No. Do I regret it? Am I sorry? No.¹⁰⁴

(c) Negative Societal Attitudes, Negative Mental Health Effects, and the Law

Despite the research negating the existence of PAS and despite the reality that terminating a pregnancy may have positive mental health consequences for some women, it is undeniable that for other women terminating a pregnancy is an emotionally difficult process. Whether a woman's experience of abortion is predominantly positive or negative will to a large extent depend on a variety of factors, including the 'want-edness' of the child and the woman's own attitude towards the morality of abortion.¹⁰⁵ Some studies suggest that broader societal attitudes and values affect women's responses to abortion. A study by Major, Cozzarelli, Sciacchitano, Cooper, Testa, and Mueller found that women who told close others (such as a partner, family or friends) of their abortion but perceived them as less than completely supportive had poorer post-abortion psychological adjustment than either women who did not tell or women who told and perceived complete support.¹⁰⁶ Cozzarelli, Major, Karrasch, and Fuegen found that women who encountered anti-abortion picketers when entering a clinic to have an abortion were negatively affected by those picketers in the short-term.¹⁰⁷

On a more macro level, Major and Gramzow researched the effect of the stigmatising aspect of abortion. They found that women who felt stigmatised by abortion were more likely to feel a need to keep it a secret from family and friends. Secrecy was related positively to suppressing thoughts of the abortion and negatively to disclosing abortion-related emotions to others. Greater thought suppression was associated with experiencing more intrusive thoughts of the abortion. Both suppression and intrusive thoughts, in turn, were positively related to

¹⁰⁴ Berer (n 66) at 6.

¹⁰⁵ NE Adler, 'Unwanted Pregnancy and Abortion: Definitional and Research Issues' (1992) 48 J Soc Issues 19.

¹⁰⁶ B Major and others, 'Perceived Social Support, Self-Efficacy, and Adjustment to Abortion' (1990) 59 J Pers Soc Psychol 452.

¹⁰⁷ C Cozzarelli and others, 'Women's Experiences of and Reactions to Anti-abortion Picketing' (2000) 22 Basic Appl Soc Psych 265.

increases in psychological distress over time.¹⁰⁸ In general, it seems that stigmatisation gives rise to an increased risk of numerous health problems, including depression, hypertension, coronary heart disease, and stroke.¹⁰⁹ Boyle discusses the reality that society's negative construction of abortion influences the way in which women experience abortion; the reality that cultural constructions of abortion position it as a secret in many women's lives.¹¹⁰ For example, research has predominantly focused on the negative effects of abortion, social discourses still link femininity to motherhood and cast abortion in a deviant light, counselors often lead women preparing for an abortion to anticipate feelings of grief, and medical professionals frequently seem judgemental when discussing abortion.¹¹¹ Therefore, in light of the fact that women who terminate their pregnancies often feel the weight of stigma attaching to their actions, it is reasonable to presume that even if a woman suffers negative mental health consequences from terminating her pregnancy, such consequences may be attributable to the social and cultural construction of abortion and to the fact that she feels stigmatised.

The question may be posed—even if it is accepted that there is a direct correlation between stigma and negative mental health consequences, what does stigma have to do with the law? How do legal restrictions on abortion exacerbate the stigma attached to abortion? While this is not the appropriate point to engage in a comprehensive discussion of the relationship between legal change and social change, it is clear that (at least to some extent) the law has the capacity to affect changes in social values, behaviour, and expectations. The law is capable of aiding in the stigmatisation of certain behaviour or characteristics and, conversely, of aiding in the removal of stigmatisation. Eric Posner illustrates this point when he states that:

Symbolism and stigma play a role in every major piece of legislation. Flag desecration bills are designed to rebut the symbolism of destroying flags. Affirmative action enhances the stigma of belonging to a minority, according to its opponents, or weakens that stigma, according to its defenders. Modern social welfare and bankruptcy legislation was intended to eliminate the stigma against people who are poor and cannot pay their debts, and

¹⁰⁸ B Major and RH Gramzow, 'Abortion as Stigma: Cognitive and Emotional Implications of Concealment' (1999) 77 J Pers Soc Psychol 735. See also Grimes (n 1) at 1914 on the link between stigma related to abortion and negative health consequences.

¹⁰⁹ B Major and LT O'Brien, 'The Social Psychology of Stigma' (2005) 56 Annu Rev Psychol 393.

¹¹⁰ M Boyle, *Re-thinking Abortion* (Routledge, London/New York 1997) 118.

¹¹¹ *Ibid.* at 102–113.

against aliens and illegitimate children, yet earlier versions of this legislation were intended to strengthen the stigma. Expungement laws that erase criminal convictions from offenders' records, reduce the stigma of the ex-convict. And debates over issues as diverse as the sale of organs, surrogate motherhood, the legalisation of prostitution, cost-benefit analysis, and pornography invariably raise questions about the symbolism of the practice in question and the use of law to control it.¹¹²

Thus, if it is accepted that the law plays a role in exacerbating or removing social stigma, then it must be accepted that prohibitions on abortion exacerbate the stigma attached to abortion. Consequently, if it is accepted that individuals who feel stigmatised suffer negative mental health consequences as a result of such stigmatisation, then it must be accepted that there is a connection between restrictions on abortion and psychological/psychiatric disorder.

The above discussion demonstrates that restrictive regulation of abortion violates the right to health at both the physical and mental level. The next section of this article takes this argument one step further and explains that not only does restrictive regulation of abortion violate the right to health per se, but it also violates the anti-discrimination principle, which is an integral component of the right to health.

B. Restrictions on Abortion Infringe Upon the Non-Discrimination Component of the Right to Health

The principle of non-discrimination applies to all rights enshrined in the ICESCR. Article 2(2) of the ICESCR specifically calls on States Parties 'to guarantee that the rights enunciated in the ... Covenant will be exercised without discrimination of any kind as to ... sex ...' and Article 3 requires States Parties to 'undertake to ensure the equal right of men and women to the enjoyment of all economic, social, and cultural rights set forth in the present Covenant'.¹¹³ Consequently, it is clear that the right to health (as one of the rights included in the ICESCR) is to be applied without discrimination.¹¹⁴ Amartya Sen has recently articulated this link between the right to health and the right to be free from

¹¹² EA Posner, *Law and Social Norms* (Harvard University Press, Cambridge 2000) 2–3.

¹¹³ *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 999 UNTS 3 (entered into force 3 January 1976) arts 2(2), 3.

¹¹⁴ It should be noted that the Human Rights Committee has also stated that article 26 of the International Covenant on Civil and Political Rights not only prohibits discrimination with respect to the rights set out in that Covenant but also applies to other human rights (such as economic and social rights). See: *Broeks v Netherlands* (172/1984), UN Doc A/42/40 (1987).

discrimination, stating that 'good health does not depend only on health care. It also depends on nutrition, lifestyle, education, women's empowerment, and the extent of inequality, and unfreedom in a society.'¹¹⁵ In its resolution on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, the Commission on Human Rights specifically called upon States to implement the right to health without discrimination and invited the Special Rapporteur to invoke a gendered perspective in the implementation of his mandate.¹¹⁶ According to the Special Rapporteur on the right to health, 'non-discrimination is among the most fundamental principles of international human rights law' and 'discrimination on grounds of gender, race, ethnicity, and other social factors is a social determinant of health'.¹¹⁷

Thus the question remains, what is the meaning of gender-based discrimination in the context of the right to health? Human rights violations in general are often the product of 'deep rooted patterns of gender discrimination' and female-specific concerns have frequently been neglected in the international human rights realm.¹¹⁸ Women's reproductive health is a sphere of health care, which specifically affects women as women. Consequently, there has been increased recognition that for the right to health to be implemented on the basis of equality and non-discrimination, it is essential that the non-discrimination principle be specifically applied in the context of reproductive health. This is not to say that reproductive health is the only component of the right to health, which gives rise to issues of gender-based discrimination – there are many other components of the right to health, which also give rise to concerns of gender-based discrimination. However, the combating of discrimination in the context of reproductive health is a logical starting point.

¹¹⁵ A Sen, 'Why and How is Health a Human Right?' (2008) 372 *The Lancet* 2010, 2010 <http://download.thelancet.com/pdfs/journals/lancet/PIIS0140673608617845.pdf?id=aeaa5a245ca1fddb:-3eff16a0:123a19fa63f:-6291252550109988> accessed 10 September 2009.

¹¹⁶ Commission on Human Rights *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, 2002/31, 49th meeting, UN Doc E/2002/23-E/CN.4/2002/200 (22 April 2002) [59–60]. It should be noted that the Commission on Human Rights no longer exists and has been replaced by the Human Rights Council.

¹¹⁷ Hunt (n 32) at [20]. See also P Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/HRC/7/11 31 January 2008 [42] for an additional statement of the application of the non-discrimination principle to the right to health.

¹¹⁸ A Hendriks, 'The Right to Health: Promotion and Protection of Women's Right to Sexual and Reproductive Health under International Law: The Economic Covenant and the Women's Convention' (1995) 44 *Am U L Rev* 1123, 1126.

In his 2006 report, the Special Rapporteur focused on reproductive health, reiterating the application of the non-discrimination principle to the right to health and specifically stating that women are entitled to good quality reproductive health care that is available and accessible as part of the general right to health.¹¹⁹ In its General Recommendation on violence against women, the Committee on the Elimination of Discrimination against Women stated that the 'definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental, or sexual harm or suffering'.¹²⁰ The negative health consequences of restricting access to abortion services affect women as women given that the state of being pregnant is an exclusively female state of being. Further, the incidents of unsafe abortions, a logical consequence of legally restricting access to abortion, constitute acts that inflict physical, mental, and sexual harm and suffering. Consequently, it seems that restrictions on abortion fall within the Committee's definition of gender-based discrimination. The Committee on Economic, Social, and Cultural Rights unambiguously included obstacles to the attainment of reproductive health in its discussion of the elimination of discrimination against women in the implementation of the right to health. In a thinly veiled reference to unsafe abortion, the Committee stated that:

To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for *promoting women's right to health throughout their life span*. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, *including sexual and reproductive services*. A major goal should be reducing women's health risks, particularly *lowering rates of maternal mortality* and protecting women from domestic violence. The realization of women's right to health requires the *removal of all barriers interfering with access to health services*, education and information, *including in the area of sexual and reproductive health*.¹²¹

¹¹⁹ P Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc A/61/338 13 September 2006 [17, 28].

¹²⁰ Committee on the Elimination of Discrimination against Women, *General Recommendation No 19: Violence against Women*, 11th session, UN Doc A/47/38 (1992) [6].

¹²¹ Committee on Economic, Social, and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health*, UN Doc E/C.12/2000/4 (11 August 2000) [21] (emphasis added).

Restrictions on abortion constitute sex-based discrimination given that 'regulation concerning women's capacity to gestate categorically differentiates on the basis of sex' as only women become pregnant. Further, aside from the obvious physiological distinctions between men and women, the point must be made that the sex roles of men and women are only defined by physiology to a limited extent. For the most part, gender roles are social constructs, reflective of socially constructed values and beliefs.¹²² Abortion restrictive regulation is frequently based on stereotypes about a woman's role as child-bearer and child-rearer. In other words, restrictive regulation of abortion is frequently intrinsically connected to misogynist views of women and women's "roles". Where such an approach informs restrictive regulation of abortion, such regulation should be viewed as discriminatory.¹²³

This is not to say that restrictions on abortion are only discriminatory when they are based on stereotypes of gender roles. The negative impact of laws that restrict access to abortion on the women who are denied access is demonstrative of the discriminatory effect of restrictions on abortion. The negative health implications of restricting access to abortion are clearly demonstrated in section Article (2) of this Part. The negative health effects of forced motherhood were expressly recognised in 1973 in the seminal United States Supreme Court decision of *Roe v Wade*.¹²⁴ Yet it is not only women's health that is negatively affected by restrictions on abortion. Women's professional and financial prospects are also negatively affected. When women are compelled to bear children, they are in practice compelled to raise those children given that many women feel emotionally unable to 'give up' a child and given the social pressure on women to raise the children who they bear.¹²⁵ As a consequence, women engage in the 'work' of motherhood, which is largely uncompensated and undervalued. In Reva Siegel's words, 'it is the institution of motherhood that gives a gendered structure to the economics of family life, and a gendered face to poverty in the nation's life.'¹²⁶ A similar view is expressed in the opening paragraph from the dissenting judgement of Justices Ginsburg, Breyer, Souter, and Stevens in the United States Supreme Court decision of *Gonzales v Carhart*:¹²⁷

¹²² RB Siegel, 'Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression' (2007) 56 Emory LJ 815, 817.

¹²³ R Siegel (n 8).

¹²⁴ 410 US 113, 153 (1973).

¹²⁵ R Siegel (n 8), 371–72.

¹²⁶ R Siegel (n 8), 376–77.

¹²⁷ 127 s Ct 1610, 1641 (2007).

As *Casey* comprehended, at stake in cases challenging abortion restrictions is a woman's 'control over her [own] destiny'... 'There was a time, not so long ago', when women were 'regarded as the center of home and family life, with attendant special responsibilities that precluded full and independent legal status under the Constitution'. Those views, this Court made clear in *Casey*, 'are no longer consistent with our understanding of the family, the individual, or the Constitution'. Women, it is now acknowledged, have the talent, capacity, and right to *participate equally in the economic and social life of the Nation. Their ability to realise their full potential, the Court recognised, is intimately connected to their ability to control their reproductive lives.* Thus, legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalised notion of privacy; rather, they centre on *a woman's autonomy to determine her life's course, and thus to enjoy equal citizenship stature.* (emphasis added; citations omitted)

According to this view, laws which restrict access to abortion services are intrinsically discriminatory—they are discriminatory in that they disproportionately affect women and they are discriminatory in that they force women to engage in the work of child-bearing and child-rearing with the concomitant negative financial and status implications (as well as health implications) that is frequently the predictable consequence of such work. Therefore, not only do such laws *prima facie* violate the right to health; they also violate the requirement that this right be implemented without discrimination of any kind.

V. CONCLUSION

One may persuasively argue that restrictions on abortion violate numerous rights including the right to life, right to health, right to autonomy, right to equality, right to be free from torture and perhaps also sexuality rights, this article focuses on restrictive regulation of abortion as a violation of the right to health. According to David A Grimes et al, '[w]hen abortion is made legal, safe, and easily accessible, women's health rapidly improves. By contrast, women's health deteriorates when access to safe abortion is made more difficult or illegal'.¹²⁸

It is generally accepted that international law enshrines the right to health and that the right to reproductive health forms a sub-category of the right to health. I argue that restrictions on abortion violate the right to reproductive health, as part of the general right to health. Legal restrictions on abortion drive abortion practices underground,

¹²⁸ Grimes (n 1), 1908.

resulting in increased incidence of unsafe abortion and the consequential physical health ramifications. The nature and extent of the potential physical health consequences of unsafe abortions are increasingly being recognised on the world stage leading to a growing acknowledgment of the connection between the right to health and the need for safe and legal access to abortion.

Further, the growing awareness of the reality that health includes both physical and mental health has resulted in an increased recognition of the potential mental health consequences of forcing a woman to continue with an unwanted pregnancy. Thus, while an abortion procedure itself may constitute a negative experience for some women, such negative effects are in many cases intrinsically connected with the stigma that society attaches to abortion (through mechanisms such as restrictive regulation of abortion) and are outweighed by the potential mental health damage resulting from coerced pregnancy. Finally, it should be noted (as argued above) that as well as violating the right to health *per se*, restrictions on abortion also constitute a form of gender-based discrimination. The anti-discrimination principle is an integral component of the right to health. Therefore, restrictive regulation of abortion violates the right to health as well as the requirement that this right be implemented free of discrimination.

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