

ACCOMMODATING WOMEN'S DIFFERENCES UNDER THE WOMEN'S ANTI-DISCRIMINATION CONVENTION

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INTRODUCTION

States worldwide have failed to eliminate the many specific forms of discrimination against women that contribute to maternal death and disability. This is nowhere more apparent than in the estimated nineteen million women compelled to resort to unsafe abortions¹ resulting in the premature, preventable deaths of 68,000 women worldwide.² Criminal law restrictions on abortion contribute to these deaths³ and channel women into unsafe procedures, resulting in emergency hospital care.⁴

The human problem of abortion can be characterized as societies' inability to accommodate women's biological differences and to redress the social discrimination women face based on those differences. That is, states have not adequately addressed how the differences in women's physiology have been used over the centuries to justify discrimination against women, neglect of health services that only women need, and discriminatory state enforcement of traditional roles for women as mothers and self-sacrificing caregivers. Accommodating differences in the abortion context requires learning how to reframe law and policies to construct an inclusive standard of equality that values sex and gender distinctions.

An antidiscrimination theory that adequately addresses the differences in women's reproductive functions, and the differences in the construction of women's life choices arising out of those functions, has yet to be developed. Nondiscrimination serves the ethic of justice that requires that the *same* interests are treated equally without discrimination. For example, women have the right to be treated as equals with men. This means being treated with the same respect, dignity, and responsibility as moral agents.⁵ It also requires that

¹ Elisabeth Ahman & Iqbal Shah, *Unsafe Abortions: Worldwide Estimates for 2000*, REPROD. HEALTH MATTERS, May 2002, at 13, 14–15.

² WORLD HEALTH ORG., UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY IN 2000, at 13 tbl.3 (2004), http://www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/estimates.pdf.

³ Marge Berer, *National Laws and Unsafe Abortion: The Parameters of Change*, REPROD. HEALTH MATTERS, Nov. 2004 (Supp. 1), at 1, 1–4; David Grimes et al., *Unsafe Abortion: The Preventable Pandemic*, 368 LANCET 1908, 1912, 1916 (2006).

⁴ Susheela Singh, *Hospital Admissions Resulting from Unsafe Abortion: Estimates from 13 Developing Countries*, 368 LANCET 1887 (2006).

⁵ Moral agency refers to the capacity to make and execute decisions about our lives. It “enables the expression of our ‘selves.’” Eileen V. Fegan, *Recovering Women: Intimate Images and Legal Strategy*, 11 SOC. & LEGAL STUD. 155, 156 (2002).

we treat *different* interests in ways that adequately respect those differences. For example, women have a distinct interest in not being compelled to gestate and deliver children.

Developing an adequate antidiscrimination theory to address abortion restrictions concerns not only abortion per se, but also overall patterns of neglect of women's reproductive health and the detrimental impact of that neglect on women's status in society. Literature on the legal construction of norms, policies, and standards regarding abortion,⁶ the epidemiological data on unsafe abortions,⁷ and the social science literature on barriers women face in accessing safe abortion⁸ are all instructive in demonstrating systemic patterns of neglect. These patterns also offer important insights into women's experience of discrimination in the abortion context.⁹

The purpose of this Article is to explore how the Convention on the Elimination of All Forms of Discrimination Against Women (the "Convention")¹⁰ can be more effectively applied in the abortion context. This Article aims to step back from the judicial rationale for resolution of particular abortion cases and to examine how the rights of women to equality can be advanced through the Convention. The application of the right to equality in the abortion context requires examining how women experience different pathways to abortion services, the dignity-denying treatment in the clinical provision of services, and the discriminatory constructions of their life options, including their choices as to whether and when to found their families.

⁶ VIOLETA BERMUDEZ, *LA REGULACION JUDICA DEL ABORTIO EN AMERICA LATINA Y EL CARIBE* (1997); Rebecca J. Cook & Bernard M. Dickens, *Human Rights Dynamics of Abortion Law Reform*, 25 HUM. RTS. Q. 1 (2003); Charles Ngwena, *Access to Legal Abortion: Developments in Africa from a Reproductive and Sexual Health Rights Perspective*, 19 S. AFR. PUB. L. 328 (2004).

⁷ WORLD HEALTH ORG., *supra* note 2.

⁸ PREVENTING UNSAFE ABORTION AND ITS CONSEQUENCES: PRIORITIES FOR RESEARCH AND ACTION (Ina K. Warriner & Iqbal H. Shah eds., 2006), <http://www.guttmacher.com/pubs/2006/07/10/PreventingUnsafeAbortion.pdf>.

⁹ TIMOTHY MACKLEM, BEYOND COMPARISON: SEX AND DISCRIMINATION 109–12 (2003); WOUTER VANDENHOLE, NON-DISCRIMINATION AND EQUALITY IN THE VIEW OF THE UN HUMAN RIGHTS TREATY BODIES 70–79, 147–52, 240–72 (2005); PAUL LEMMENS & WOUTER VANDENHOLE, PROTOCOL NO. 14 AND THE REFORM OF THE EUROPEAN COURT OF HUMAN RIGHTS (2005). See generally MAGDA KRZYZANOWSKA-MIERZEWSKA, HOW TO USE THE EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS IN MATTERS OF REPRODUCTIVE LAW: THE CASE LAW OF THE EUROPEAN COURT OF HUMAN RIGHTS, http://www.astra.org.pl/astra_guide.htm (giving an overview of case law of the European Convention concerned with reproductive rights).

¹⁰ Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13 [hereinafter *Convention*].

I. EQUALITY UNDER THE WOMEN'S ANTI-DISCRIMINATION CONVENTION

The Committee on the Elimination of Discrimination Against Women (“the Committee”), which monitors states’ compliance with the Convention, has developed the concept of equality through the application of principles of nondiscrimination to the laws, policies, and practices of states. One of the Committee’s means include publication of Concluding Observations on the periodic reports of states parties to the Convention in which states explain the extent of their compliance.¹¹ Another is the issuance of General Recommendations on articles of the Convention, which guide states parties in discharge of their periodic reporting duties.¹² Although the normative development of equality can be derived from both Concluding Observations and General Recommendations, this Article primarily addresses General Recommendations.

The principal General Recommendations relating to restrictive abortion laws and their consequences are *Violence Against Women*,¹³ *Equality in Marriage and Family Relations*,¹⁴ *Women and Health*,¹⁵ and *Temporary Special Measures*.¹⁶ General Recommendations develop the content and meaning of equality by elaborating the obligations of states to eliminate all forms of discrimination against women in particular contexts, including in health, marriage, and family life.

The starting point for understanding equality under the Convention is Article 1, which defines “discrimination against women” as

any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human

¹¹ *Id.* art. 18.

¹² *Id.* art. 21.

¹³ Comm. on the Elimination of Discrimination Against Women [CEDAW], *General Recommendation No. 19: Violence Against Women*, U.N. Doc. A/47/38 (1992) [hereinafter *General Recommendation No. 19*].

¹⁴ Comm. on the Elimination of Discrimination Against Women [CEDAW], *General Recommendation No. 21: Equality in Marriage and Family Relations*, U.N. Doc. A/49/38 (1994) [hereinafter *General Recommendation No. 21*].

¹⁵ 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) [hereinafter *General Recommendation No. 24*].

¹⁶ 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 Special Measures*, U.N. Doc. A/59/38 (2004) [hereinafter *General Recommendation No. 25*].

rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.¹⁷

Laws and policies that are discriminatory on their face, as well as laws and policies that are sex neutral on their face but have the effect of discriminating against women, offend this definition. States are obligated to achieve formal and substantive equality through elimination of de jure and de facto discrimination.¹⁸

The definition of discrimination has to be seen in the context of the overall purpose of the Convention, which is apparent in its title, preamble, and foundational Articles 1 to 5 and 24.¹⁹ The title underscores the obligation of states not only to prohibit discrimination on grounds of sex, but also to eliminate all forms of discrimination against women. In the context of international human rights law, the Convention moves from a norm of nondiscrimination on grounds of sex to a norm of the elimination of all forms of discrimination against women. The preamble states that “extensive discrimination against women continues to exist” despite various U.N. resolutions, declarations, and recommendations to prohibit sex discrimination.²⁰

“All forms of discrimination” include stereotypes about women’s sex and physiology and those that are based on female gender. Article 5(a) of the Convention requires states parties to eliminate prejudices and practices that are “based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.”²¹

A state’s decision to deny benefits to or impose burdens on women in reliance on gender stereotypes amounts to gender discrimination. Stereotypes generalize certain attributes to an entire class of persons and preclude assessment of individual needs and circumstances. Accordingly, they suggest limits to individual autonomy in a manner that is arbitrary and unfair. The use

¹⁷ *Convention*, *supra* note 10, art. 1.

¹⁸ *General Recommendation No. 25*, *supra* note 16, ¶ 4.

¹⁹ See Andrew Byrnes, *The Convention on the Elimination of All Forms of Discrimination Against Women*, in HUMAN RIGHTS OF WOMEN: INTERNATIONAL INSTRUMENTS AND AFRICAN EXPERIENCES 119 (Wolfgang Benedek et al. eds., 2002).

²⁰ *Convention*, *supra* note 10, pmb. ¶ 6.

²¹ *Id.* art. 5(a); see RIKKI HOLTMAAT, TOWARDS DIFFERENT LAW AND PUBLIC POLICY: THE SIGNIFICANCE OF ARTICLE 5A CEDAW FOR THE ELIMINATION OF STRUCTURAL GENDER DISCRIMINATION 31–45 (2004), http://www.emancipatieweb.nl/uploads/947/Towards_Different_Law_and_Public_Policy.pdf (reviewing the Committee’s work on Article 5(a)).

of stereotypes is discriminatory when the generalization implies that those persons subject to the stereotype are in some way inferior as human beings.²²

The notion that motherhood is women's ultimate and ideal role is a discriminatory stereotype that serves to disadvantage women when it is incorporated into state policies or reflected in the implementation of government programs, such as the delivery of health services. The application of this stereotype limits the ability of individual women to make decisions about their lives that may conflict with their role as mothers or future mothers. More profoundly, it insinuates that women are by nature less capable of autonomous action than men. This results in a denial of women's status as moral agents and restricts their full participation in social, political, and economic activities.

Transforming this stereotype does not mean that women's role as mothers should not be taken into account. Rather, the fact that women may at some point become mothers cannot be relied upon to prioritize motherhood for all women to the exclusion of other goals and priorities. The Committee's General Recommendation on Equality in Marriage and Family Relations explains that "[t]he responsibilities that women have to bear and raise children affect their right of access to education, employment, and other activities related to their personal development. They also impose inequitable burdens of work on women."²³

The perceived "naturalness" of motherhood reinforces women's inequality by minimizing the effort involved in bearing and caring for children. Likewise, it reduces motherhood to a natural function that is not equal to the work performed by men, which requires training and skill and is worthy of financial compensation. Motherhood, however, serves as a barrier to women's participation in other activities, such as paid work and education, because it is perceived as a natural "trump" that will always take priority.

Women's equality requires both the acknowledgment and accommodation of women's actual differences, as well as the elimination of discriminatory treatment based on gender stereotypes. Both efforts are required in light of the overall object and purpose of the Convention. The Committee's General Recommendation on Temporary Special Measures requires states parties "to eliminate all forms of discrimination against women with a view to achieving

²² Sophia R. Moreau, *The Wrongs of Unequal Treatment*, 54 U. TORONTO L.J. 291, 299-300 (2004).

²³ *General Recommendation No. 21*, *supra* note 14, ¶ 21.

women's *de jure* and *de facto* equality with men in the enjoyment of their human rights and fundamental freedoms."²⁴ As the Committee further explained,

[T]he Convention requires that women be given an equal start and that they be empowered by an enabling environment to achieve equality of results. It is not enough to guarantee women treatment that is identical to that of men. Rather, biological as well as socially and culturally constructed differences between women and men must be taken into account. Under certain circumstances, non-identical treatment of women and men will be required in order to address such differences.²⁵

Especially instructive in the context of unwanted pregnancy and its consequences is the following explanation:

The position of women will not be improved as long as the underlying causes of discrimination against women, and of their inequality, are not effectively addressed. The lives of women and men must be considered in a contextual way, and measures adopted towards a real transformation of opportunities, institutions and systems so that they are no longer grounded in historically determined male paradigms of power and life patterns.²⁶

It is argued that "real transformation" in the abortion context requires that women are able to make their own reproductive decisions with dignity and freedom from stereotypes and stigma. It also requires that women have access to safe abortion services at the earliest possible stage of pregnancy, free of judgment about their sexuality, and punishment for their failure to conform to the norms of motherhood.

Transformative equality requires rethinking unintended pregnancy from the perspective of the women affected, recognizing and remedying the disadvantages that women face in making decisions to terminate or continue pregnancy, and removing the barriers faced in seeking services. Sandra Fredman observed that

[e]quality as transformation does not aim at a gender neutral future, but one that appropriately takes gender into account. The future is not simply one of allowing women into a male-defined world. Instead, equality for women entails re-structuring society so that it is

²⁴ *General Recommendation No. 25, supra* note 16, ¶ 4 (emphasis added).

²⁵ *Id.* ¶ 8.

²⁶ *Id.* ¶ 10.

no longer male-defined. Transformation requires a redistribution of power and resources and a change in the institutional structures which perpetuate women's oppression.²⁷

A challenge in determining discrimination against women concerns the definitional phrase "on a basis of equality of men and women" in Article 1 of the Convention.²⁸ The General Recommendation on Temporary Special Measures proposes evolution beyond the male comparator or reference point as the standard for determining equality.²⁹ The male comparator clearly fails when women's physiology is at issue because differences in physiology and reproductive function are verifiable. The challenge remains to identify how laws, policies, customs, religions, and other influences discriminate against women, and in so doing, create inequality.

The preamble to the Convention explains that "a change in the traditional role of men as well as the role of women in society and in the family is needed to achieve full equality between men and women."³⁰ As a result, the Convention requires that states achieve equal rights and empowerment of women in light of their physiological differences from men, affording them, for instance, the same security in life, health, and dignity regarding reproductive choices that men expect in the activities of their lives.³¹

Transformative equality requires concrete analyses of the context to ensure that "opportunities, institutions and systems are no longer grounded in historically determined male paradigms of power and life patterns."³² Transformative equality requires that abortion laws and practices neither compel involuntary pregnancy, childbearing, and childrearing, nor direct women to jeopardize their lives or health when denied access to safe, dignified services. It also requires that states address the influences that force women who were denied safe, dignified abortion services to resort to unsafe, humiliating services. These influences include perceptions of dishonor to families when women engage in sex outside marriage³³ and the stigma of

²⁷ Sandra Fredman, *Beyond the Dichotomy of Formal and Substantive Equality: Towards a New Definition of Equal Rights*, in TEMPORARY SPECIAL MEASURES 111, 115 (Ineke Boerefijn et al. eds., 2003).

²⁸ *Convention*, *supra* note 10, art. 1.

²⁹ *General Recommendation No. 25*, *supra* note 16, ¶ 3–14.

³⁰ *Convention*, *supra* note 10, pmb. ¶ 14.

³¹ *Id.* arts. 3, 12.

³² *General Recommendation No. 25*, *supra* note 16, ¶ 10; see *supra* text accompanying note 26 for full quotation from ¶ 10.

³³ HONOUR: CRIMES, PARADIGMS, AND VIOLENCE AGAINST WOMEN (Lynn Welchman & Sara Hossain eds., 2005).

pregnancy out of wedlock,³⁴ which is sometimes due to young girls being forced to have sex without consent.³⁵ The stigmatization of having children outside of marriage denies the mother the ability to register the birth of the child,³⁶ obtain citizenship for the child,³⁷ or seek education³⁸ or employment opportunities.³⁹ Moreover, it creates an economic prejudice in combining employment with rearing of dependent children.⁴⁰

States parties to the Convention are obligated to overcome the many prejudices women face throughout their childbearing and childrearing lives in order to reduce the barriers to meaningful reproductive choice.⁴¹ The challenge of transformative equality is to liberate women as moral agents equal to men and let them decide for themselves how to manage their sexuality and family life. This must be done without subjecting women to the social controls

³⁴ This is referred to in *Roe v. Wade*, 410 U.S. 113, 153 (1973), as a potential cause of psychological harm should a woman be forced to carry her pregnancy to term. See also Paulina Makinwa-Adebusoye, Susheela Singh & Suzette Audam, *Nigerian Health Professionals' Perceptions About Abortion Practice*, 23 INT'L FAM. PLAN. PERSP. 155, 159 (1997), available at <http://www.guttmacher.org/pubs/journals/2315597.pdf>.

³⁵ SEX WITHOUT CONSENT: YOUNG PEOPLE IN DEVELOPING COUNTRIES (Shireen J. Jejeebhoy et al. eds., 2005).

³⁶ See *Marckx v. Belgium*, 31 Eur. Crt H.R. (ser. A) (1979) (an unmarried mother successfully challenged the Belgian law requiring her to register and officially adopt her own child as contrary to her right to family life (Article 8), her right to nondiscrimination (Article 14) in conjunction with the right to family life, and the right to dispose of one's property (Protocol 1) under the European Convention on Human Rights).

³⁷ See, e.g., Article 9(1) of the Constitution of Nepal, 1990, which provides only for citizenship through the father. Compare Proposed Amendments to the Naturalization Provisions of the Constitution of Costa Rica, Advisory Opinion No. OC-4/84 of Jan. 19, 1984, Inter-Am. Ct. H.R. 43, OEA/Ser. L IV/III. 10, doc. 13 Ser. A: No. 4 (1984), with *Unity Dow v. Attorney General*, (1992) 103 I.L.R. 128 (Bots. Ct. App.). See generally COMM. ON FEMINISM & INT'L LAW, INT'L LAW ASS'N, WOMEN'S EQUALITY AND NATIONALITY IN INTERNATIONAL LAW (2000).

³⁸ Luisa Cabal et al., *What Role Can International Litigation Play in the Promotion and Advancement of Reproductive Rights in Latin America?*, 7 HEALTH & HUM. RTS. 51, 61 (2003) (discussing case of a fifteen-year-old Chilean girl who was denied enrollment in school because she was pregnant).

³⁹ Comm. on the Elimination of Racial Discrimination [CERD], *Yilmaz-Dogan v. The Netherlands*, Communication No. 001/1984, U.N. Doc. CERD/C/36/D/1/1984 (Sept. 29, 1988).

⁴⁰ *Id.*

⁴¹ *General Recommendation No. 24*, *supra* note 15, ¶ 12.

of sexuality, dress, and behavior through chastity, virginity,⁴² modesty, and obedience codes.⁴³

II. DISCRIMINATION IN THE ABORTION CONTEXT

The abortion issue is unavoidably contentious because it implicates many social values and goals. Restrictions on access to abortion are commonly defended as a necessary means to protect the sanctity of human life and to preserve the sexual morals of a community. These values and goals are often and intentionally articulated in sex and gender-neutral terms. A law will not be saved, however, merely because it is expressed or defended in neutral terms. Laws and policies that are based, even in part, on “the idea of [women’s] . . . inferiority,” or that reinforce women’s existing inequality in effect violate the Women’s Anti-Discrimination Convention.⁴⁴ Moreover, where laws and policies are “based on the idea of . . . the superiority” of men—such as laws treating men with impunity for the unwanted pregnancies they helped to cause—they can also be shown to violate states’ obligations under the Convention.⁴⁵

Restrictive abortion laws are frequently justified by appealing to the value of and the need to protect unborn life. As Reva Siegel has effectively demonstrated, however, the manner in which the goal of protecting fetal life is implemented is reflective of attitudes towards women that reduce them to their physiological capacity to bear children:

A latent assumption that motherhood is women’s “normal” condition can easily render state actors oblivious to the life-consuming consequences of forcing women to perform its work—just as a latent assumption that motherhood is women’s “deserved” condition will cause indifference to the burdens the legislation will inflict. In short, a legislature may not decide that it is reasonable to save unborn life

⁴² REBECCA J. COOK, BERNARD M. DICKENS & MAHMOUD F. FATHALLA, *REPRODUCTIVE HEALTH AND HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS, AND LAW* 299 (2003) (examining the background, ethics, and medical aspects associated with hymen reconstruction); Nadera Shalhoub-Kevorkian, *Imposition of Virginity Testing: A Life-Saver or a License to Kill?*, 60 *SOC. SCI. & MED.* 1187 (2005) (a case study of the effect on law and medicine by imposing virginity testing on women in Palestine).

⁴³ Courtney W. Howland, *Safeguarding Women’s Political Freedoms Under the International Covenant on Civil and Political Rights in the Face of Religious Fundamentalism*, in *RELIGIOUS FUNDAMENTALISMS AND THE HUMAN RIGHTS OF WOMEN* 93, 94 (Courtney W. Howland ed., 1999).

⁴⁴ *Convention*, *supra* note 10, art. 5(a).

⁴⁵ *Id.*

by compelling pregnancy, “but for” the archaic or stereotypic assumptions about women it holds.⁴⁶

Such an assumption becomes apparent through an examination of the common exceptions to laws criminalizing abortion, which include scenarios where the continuation of a pregnancy would result in death or serious damage to a woman’s health.⁴⁷ Siegel explains, “The therapeutic exception indicates that the state *is* willing to subordinate the welfare of the unborn to that of the pregnant woman, but *only* when women will sustain physical injuries bearing children.”⁴⁸ Women can only escape the imposition of motherhood “when they are physically incapable of the act.”⁴⁹ Siegel explains that the state’s concern in women’s liberty is

an interest in brute physical survival—reasoning about women as if they had no social, intellectual, or emotional identity that transcended their physiological capacity to bear children. . . . [T]he state has promulgated a code of conduct for pregnant women that distinguishes “good” abortions from “bad” abortions—whose very reasonableness depends on unarticulated sex-role assumptions about women.⁵⁰

It is likely that laws that allow abortion only on certain conditions, for instance, obtaining parental or spousal permission, are themselves discriminatory under the Convention because these restrictions serve to limit women’s agency. Eliminating such restrictions in order to promote and protect women’s agency is required under the Convention as a means “to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on the basis of equality with men.”⁵¹ Eileen Fegan and Rachel Rebouche explain that “[w]hen women are considered first and foremost in relation to others their own

⁴⁶ Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV 261, 362–63 (1992).

⁴⁷ CTR. FOR REPROD. RIGHTS, THE WORLD’S ABORTION LAWS (2005), http://www.reproductiverights.org/pub_fac_abortion_laws.html (explaining indications for lawful abortions); see also ALBIN ESER & HANS-GEORG KOCH, ABORTION AND THE LAW: FROM INTERNATIONAL COMPARISON TO LEGAL POLICY 72–88 (2005).

⁴⁸ Siegel, *supra* note 46, at 365.

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Convention, supra* note 10, art. 3.

individual needs and future potential are in danger of being neglected by wider society.”⁵²

Protecting prenatal and newborn life can be accomplished through nondiscrimination policies that are compatible with women’s rights. Such policies include

- clinical interventions to reduce miscarriages, including recurrent miscarriages, of wanted pregnancies;⁵³
- health systems measures to reduce maternal mortality, now estimated at 529,000 deaths of pregnant women annually,⁵⁴ including increasing the availability of and access to intrapartum care—care before, during, and after childbirth;⁵⁵
- health systems measures to reduce maternal morbidity, such as obstetric fistula resulting from prolonged obstructed labor, usually causing the death of the fetus, and a hole between the woman’s bladder and the vagina resulting in urinary incontinence;⁵⁶
- health systems measures to decrease the 4 million neonatal deaths (deaths to infants in the first 4 weeks of life) annually;⁵⁷ and
- measures that address underlying socioeconomic and sociocultural conditions, such as reduction of economic and social vulnerabilities of pregnant women.⁵⁸

These policies arguably go much further in protecting life than restrictive abortion policies because they increase the resources available for intrapartum care, rather than merely seeking to assure the birth of children, irrespective of their condition and their prospects for survival. Implementing restrictive abortion laws rather than seeking to address the underlying issues that

⁵² Eileen V. Fegan & Rachel Rebouche, *Northern Ireland’s Abortion Law: The Morality of Silence and the Censure of Agency*, 11 FEMINIST LEGAL STUD. 221, 226 (2003).

⁵³ Raj Rai & Lesley Regan, *Recurrent Miscarriage*, 368 LANCET 601 (2006).

⁵⁴ WORLD HEALTH ORG., MATERNAL MORTALITY IN 2000: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA (2004), http://www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf.

⁵⁵ Oona M.R. Campbell & Wendy J. Graham, *Strategies for Reducing Maternal Mortality: Getting on with What Works*, 368 LANCET 1284 (2006).

⁵⁶ L. Lewis Wall, *Obstetric Vesicovaginal Fistula as an International Public-Health Problem*, 368 LANCET 1201 (2006).

⁵⁷ Joy E. Lawn et al., *4 Million Neonatal Deaths: When? Where? Why?*, 365 LANCET 891 (2005); Gary L. Darmstadt et al., *Evidence-Based, Cost-Effective Interventions: How Many Newborn Babies Can We Save?*, 365 LANCET 977 (2005).

⁵⁸ Véronique Filippi et al., *Maternal Health in Poor Countries: The Broader Context and a Call for Action*, 368 LANCET 1535 (2006).

influence reproductive decision making imposes the costs of reproduction on women, and reinforces the stereotype that women are defined by their reproductive capacity and that they are therefore ultimately responsible for human reproduction.

Discrimination against women on the basis of their reproductive capacity, and the way in which it reinforces women's broader social and economic inequality, can be analyzed in many ways.⁵⁹ The following Section examines discrimination in the abortion context through the neglect of health care that only women need, the expropriation of women's bodies as gestational instruments, and the denial of women's moral agency that enforces male-dominated values on women.

A. *Neglecting Health Care that Only Women Need*

Article 12 of the Women's Anti-Discrimination Convention requires governments to eliminate all forms of discrimination against women in the context of health. The content and meaning of this right has been amplified by the Committee on the Elimination of Discrimination Against Women in its General Recommendation on Women and Health.⁶⁰ The Recommendation clarifies that where health systems refuse or fail to provide health services that only women need, such as obstetric care, treatment of cervical cancer, emergency contraception, and safe abortion services, it is a form of discrimination that states are obligated to remedy.⁶¹

The Convention requires that states address in their periodic reports the distinctive features of health and life that differ for women, or subgroups of women, in contrast with those of men. The Recommendation takes account of the following:

- biological factors, such as women's reproductive functions;⁶²
- socioeconomic factors, including unequal power relations in provision of and access to health services;⁶³

⁵⁹ Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1033 (1984) ("Confronting the myth and reality of biological differences may enable us to create a stronger equality concept in relation both to laws premised on cultural stereotypes and to laws that regulate reproductive biology."); Siegel, *supra* note 46, at 362.

⁶⁰ *General Recommendation No. 24*, *supra* note 15.

⁶¹ *Id.* ¶ 11.

⁶² *Id.* ¶ 12(a).

⁶³ *Id.* ¶ 12(b).

- psychosocial factors, encompassing stigmatization of unwed motherhood;⁶⁴ and
- health system factors, such as a lack of protection of confidentiality, particularly for the treatment of stigmatizing conditions such as unintended pregnancy.⁶⁵

In discharging states' legal obligations to periodically report under the Convention, the Recommendation mandates an account of the impact of health policies and laws on women including, among other things, the mortality and morbidity resulting from pregnancy, childbirth, and unsafe abortion.⁶⁶

⁶⁴ *Id.* ¶ 12(c).

⁶⁵ *Id.* ¶ 12(d).

⁶⁶ *Id.* ¶ 19. This obligation is reinforced by the Human Rights Committee, acting under the International Covenant on Civil and Political Rights, which, through its General Comment on Equality Between Men and Women, specified that states are now required to provide data on "pregnancy and childbirth-related deaths of women." U.N. Human Rights Comm. [HRC], *Report of the Human Rights Committee*, ¶ 10, U.N. Doc. A/55/40 (2000). The Committee on Economic, Social, and Cultural Rights, established pursuant to Economic and Social Council res. 1985/17, U.N. Doc. E/RES/1985/17 (May 28, 1985), has developed General Comment 14 on the Right to Health, which explains that discrimination in access to services violates the right to health. U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. & Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social, and Cultural Rights: General Comment No. 14 (2000)*, ¶ 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000). In regard to women's health, General comment 14 explains that

"[t]he 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.*

....

... A gender-based approach recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women.

... 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. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

....

... In particular, States are under the obligation to *respect* the right to health by, *inter alia*, . . . abstaining from imposing discriminatory practices relating to women's health status and needs.

Additionally, the Recommendation explains states' obligations to respect, protect, and fulfill women's rights to health care. The Recommendation explains that the general obligation "[t]o repeal all national penal provisions which constitute discrimination against women"⁶⁷ includes the removal of barriers to care, including "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures."⁶⁸ Laws that criminalize medical procedures to which only women need access by definition include criminal abortion laws. The obligation to protect rights relating to women's health

requires States parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons or organizations . . . [including] the enactment and effective enforcement of laws and the formulation of policies, including health care protocols and hospital procedures to address violence against women and abuse of girl children and the provision of appropriate health services.⁶⁹

Services that are appropriate for women often overlap with those that are appropriate for men, such as the treatment of violence-based infection. Sexual violence, however, often presents women with the distinctive risk of sexually transmitted infections, including HIV/AIDS, as well as pregnancy.⁷⁰ Appropriate treatment is increasingly recognized to include emergency contraception for pregnancy⁷¹ and postexposure prophylaxis for HIV.⁷²

Id. ¶¶ 14, 20–21, 34 (emphasis added); *see also* ECOSOC, Comm. on Econ., Soc. & Cultural Rights, *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social, and Cultural Rights: General Comment No. 16 (2005)*, ¶ 29, U.N. Doc. E/C.12/2005/4 (Aug. 11, 2005) (requiring states to examine "the ways in which gender roles affect access to determinants of health, such as water and food; the removal of legal restrictions on reproductive health provisions; the prohibition of female genital mutilation; and the provision of adequate training for health-care workers to deal with women's health issues").

⁶⁷ *Convention*, *supra* note 10, art. 2(g).

⁶⁸ *General Recommendation No. 24*, *supra* note 15, ¶ 14. The Colombian Constitutional Court relied on this provision to decide that their criminal law prohibiting abortion in all circumstances violates a bundle of rights held by pregnant women, including the right to sexual and gender equality. *Sentencia C-355/06*, Corte Constitucional (May 10, 2006) (Colum.).

⁶⁹ *General Recommendation No. 24*, *supra* note 15, ¶ 15.

⁷⁰ Marge Berer, *HIV/AIDS, Sexual and Reproductive Health: Intimately Related*, 11 REPROD. HEALTH MATTERS 6, 8 (2003).

⁷¹ Sheila Dunn & Edith Guilbert, *Emergency Contraception Guidelines*, 25 J. OBSTETRICS & GYNECOLOGY CAN. 1, 2 (2003).

⁷² GOV'T OF S. AFR., DEP'T OF HEALTH, POLICY GUIDELINE FOR MANAGEMENT OF TRANSMISSION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND SEXUALLY TRANSMITTED INFECTIONS IN SEXUAL ASSAULT (2003), <http://www.doh.gov.za/aids/docs/rape-protocol.html>.

However, some hospitals, both public and private, maintain religious-denominational affiliations that deny women emergency contraceptive means.⁷³ Others allow the abuse of conscientious objection provisions that delay or deny access to services.⁷⁴

Where states rely on private clinics to provide legal abortion services, they are obligated to ensure that services are made fairly available, including geographically and financially accessible, and that services are delivered in ways that are respectful of women's rights, including dignitary rights.

The Recommendation further explains that "the duty to fulfill rights places an obligation" on states to "take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their right to health care."⁷⁵ For example, studies that show high rates of maternal mortality and morbidity put governments on notice that they might be in breach of their obligations.⁷⁶

The thrust of the Convention and accompanying General Recommendations is to establish that the human right of equal access to health services is not only a negative right, which individuals can enjoy by their own means and initiatives, but that it is also a positive right that states have a legal duty to provide. Unfortunately, governments have yet to adequately facilitate access to services in public health facilities or to cover the cost of abortions through publicly or privately mandated health insurance plans. Similarly, the lack of necessary training in the delivery of abortion services for both public and private sector physicians as well as associated health service providers is a failure of states' duty to ensure that legal abortion services are sufficiently available.

Beyond the health systems issues of ensuring availability and access to services are the steps that governments must take to help "construct and

⁷³ Susan E. Rubin et al., *Hospital Religious Affiliation and Emergency Contraceptive Prescribing Practices*, 96 AM. J. PUB. HEALTH 1398, 1400 (2006).

⁷⁴ R. Alta Charo, *The Celestial Fire of Conscience – Refusing to Deliver Medical Care*, 352 NEW ENG. J. MED. 2471 (2005); Bernard M. Dickens, *Conscientious Objection: A Shield or a Sword?*, in FIRST DO NO HARM: LAW, ETHICS AND HEALTHCARE 337, 339–43 (Sheila A.M. McLean ed., 2006); Bernard M. Dickens & Rebecca J. Cook, *The Scope and Limits of Conscientious Objection*, 71 INT'L J. OF GYNECOLOGY & OBSTETRICS 71, 73, 76–77 (2000); Charles Ngwena, *Conscientious Objection and Legal Abortion in South Africa: Delineating the Parameters*, 28 J. JURID. SCI. 1 (2003). For further discussion, see *infra* Part II.C.2.

⁷⁵ *General Recommendation No. 24*, *supra* note 15, ¶ 17.

⁷⁶ *See id.*

reinforce women's agency."⁷⁷ Few governments "take all appropriate measures . . . [t]o modify the . . . stereotyped roles for . . . women"⁷⁸ that inhibit women's exercise of their agency in making personal and life-changing decisions. For example, most governments have yet to

- adopt measures to ensure the timeliness of services, including prompt referral in the case of providers' objections on grounds of conscience;
- respect women's decision-making role in the abortion services by adopting policies or ethical guidelines explaining the necessary elements of women's autonomous decision making; and
- institute procedures for the appeal or review of medical decisions denying a woman's request for abortion.⁷⁹

Governments are further in breach of their legal obligations to ensure equal access to health services when the provisions they offer for delivery of abortion services are subject to excessively burdensome, arbitrary, or unreasonable requirements. Such requirements include mandating excessive certification requirements for facilities, as well as requiring medical specializations and bureaucratic approval procedures, such as multi-specialist therapeutic abortion committees.⁸⁰ As a matter of competent administration, governments should not establish procedures that function to obstruct delivery of the services they claim to offer. Negotiating a pathway through bureaucratic obstacles is disproportionately prejudicial to women seeking prompt access to safe abortion services, particularly when they suffer the disadvantages of being poor, uneducated, young, and ethnically marginalized. Governments have yet to adequately operationalize the legal grounds for abortion through the development of protocols, guidelines, and regulations that are clear to both the

⁷⁷ Fegan & Rebouche, *supra* note 52, at 226.

⁷⁸ *Convention*, *supra* note 10, art. 5.

⁷⁹ Brief for Tysiac as Amici Curiae Supporting Petitioner at 3–11, *Tysiac v. Poland*, App. No. 5410/03 (Eur. Ct. H.R. Sept. 21, 2005), *available at* http://www.reproductiverights.org/pdf/crt_092105POLANDamicibrief1.pdf. The European Court of Human Rights recently decided this case, holding that the Polish government had a positive obligation to put in place effective mechanisms capable of determining whether the conditions for obtaining a lawful abortion had been met. *Tysiac v. Poland*, App. No. 5410/03 (Eur. Ct. H.R. Mar. 20, 2007). Failure to do so caused the applicant in a situation of severe distress, amounting to a violation of her right to private life. ¶¶ 124, 130. The Court dismissed the claim of violation of equality in conjunction with private life, stating that it was not necessary to examine this claim. ¶ 144.

⁸⁰ Penal Law, 5737–1977 (Isr.). For further commentary, see Delila Amir & Orly Biniamin, *Abortion Approval as a Ritual of Symbolic Control*, in *THE CRIMINALIZATION OF A WOMAN'S BODY 5* (Clarice Feinman ed., 1992).

providers and the women eligible for services, as is required by the Convention.⁸¹

The Recommendation specifies that states parties “report on their understanding of how policies and measures on health care address the health rights of women from the perspective of women’s needs and interests.”⁸² Policies that impose excessive and arbitrary burdens on access to abortion and that reinforce stereotypical attitudes toward women do not take women’s actual needs and interests into account. Failing to account for women’s distinct reproductive health needs within national health policies reinforces women’s vulnerability and inferior social status. In other words, where states neglect to ensure that their laws and policies are evidence based, transparent, and fair, it is a form of discrimination against women that states are obligated to remedy.

1. Discriminatory Access

The necessary rethinking of equality requires that unintended pregnancy and its consequences be approached from the perspective of not only women in general, but of different subgroups of women, particularly those who are marginalized due to income, age, or race. As a general matter, a great deal is known about patterns of discrimination in the abortion context.⁸³ Strategies to inhibit women’s equal access to services, to instrumentalize their bodies, and to compromise their capacity for moral agency are moving around the world in systematic ways. Challenges to restrict the availability of and access to services emerge in countries that have reformed their laws, such as attempts to impose spousal or partner authorization requirements⁸⁴ and refusal to provide services on grounds of conscience.⁸⁵ Only some of these challenges reach the courts.

⁸¹ CEDAW, *supra* note 15, ¶¶ 14–15. For further discussion see *infra* notes 86–99 and accompanying text.

⁸² *Id.* ¶ 12.

⁸³ See Cook & Dickens, *supra* note 6, at 34–43.

⁸⁴ See *infra* Part II.C.1.

⁸⁵ See Dickens & Cook, *supra* note 74, at 76–77; see also discussion *infra* Part II.C.2.

Governmental⁸⁶ and nongovernmental⁸⁷ reports from countries show inequitable and unsafe access to abortion services in countries with restrictive laws, in contrast to some countries with permissive laws.⁸⁸ For example, in 1976, following a series of jury acquittals of Dr. Henry Morgentaler, a Canadian physician who admitted performing many abortions,⁸⁹ the Canadian government appointed a Committee, chaired by Professor Robin Badgley, a social scientist, to look into the operation of the abortion law.⁹⁰ Canada has a universal, publicly funded health care system under which provincial governments, with federal financial support, undertake to provide reasonable access to necessary medical services for all residents, without regard to their individual means to pay. Such services include safe abortion care, which was filtered through provisions of the Criminal Code to distinguish lawful from unlawful services.

The Badgley Committee's mandate was "to conduct a study to determine whether the procedure provided in the Criminal Code for obtaining therapeutic abortions is operating equitably across Canada."⁹¹ The more specific directives included the following:

⁸⁶ MINISTRY OF HEALTH, REPORT OF THE INTER-DEPARTMENTAL COMMITTEE ON ABORTION (1939); 1-3 ELIZABETH KATHLEEN LANE, COMM. ON THE WORKING OF THE ABORTION ACT, REPORT OF THE COMMITTEE ON THE WORKING OF THE ABORTION ACT (1974) (U.K.); ROBIN F. BADGLEY ET AL., CAN. COMM. ON THE OPERATION OF THE ABORTION LAW, REPORT OF THE COMMITTEE ON THE OPERATION OF THE ABORTION LAW (1977); DUNCAN WALLACE McMULLIN, N.Z. ROYAL COMM'N OF INQUIRY, CONTRACEPTION, STERILISATION AND ABORTION IN NEW ZEALAND (1977); MARION POWELL, REPORT ON THERAPEUTIC ABORTION SERVICES IN ONTARIO (1987); B.C. TASK FORCE ON ACCESS TO CONTRACEPTION & ABORTION SERV., REALIZING CHOICES: THE REPORT OF THE BRITISH COLUMBIA TASK FORCE ON ACCESS TO CONTRACEPTION AND ABORTION SERVICES (1994).

⁸⁷ See generally CAN. ABORTION RIGHTS ACTION LEAGUE, PROTECTING ABORTION RIGHTS IN CANADA (2003), <http://www.caral.ca/PDF/caralreport14.pdf>; MARIANNE MOLLMAN, HUMAN RIGHTS WATCH, DECISIONS DENIED: WOMEN'S ACCESS TO CONTRACEPTIVES AND ABORTION IN ARGENTINA (2005), <http://hrw.org/reports/2005/argentina0605/argentina0605.pdf> [hereinafter MOLLMAN, DECISIONS DENIED]; MARIANNE MOLLMAN, HUMAN RIGHTS WATCH, THE SECOND ASSAULT: OBSTRUCTING ACCESS TO LEGAL ABORTION AFTER RAPE IN MEXICO (2006), <http://www.hrw.org/reports/2006/mexico0306/mexico0306webwcover.pdf> [hereinafter MOLLMAN, SECOND ASSAULT]; CHARLES NGWENA ET AL., CTR. FOR HEALTH SYS. RESEARCH & DEV., ACCESSING TERMINATION OF PREGNANCY BY MINORS IN THE FREE STATE: IDENTIFYING BARRIERS AND POSSIBLE INTERVENTIONS 9-27 (2005).

⁸⁸ M.R.M. VISSER ET AL., EVALUATIE VAN DE WET AFBREKING ZWANGERSCHAP, (ZonMw 2005) (summarised in English in Sjef Gevers, *Abortion Legislation and the Future of the 'Counseling Model,'* 13 EUR. J. HEALTH L. 27, 34-37 (2006)).

⁸⁹ Bernard M. Dickens, *The Morgentaler Case: Criminal Process and Abortion Law*, 14 OSGOODE HALL L.J. 229, 234-41 (1976).

⁹⁰ BADGLEY ET AL., *supra* note 86, at 3.

⁹¹ *Id.* at 27.

- the determination of the availability of the procedure by location and type of institution;⁹²
- the timeliness of the procedure in light of what is desirable for the safety of the applicant;⁹³
- the views of the health care providers and those of members of the hospital abortion committees;⁹⁴
- patient pathways to obtaining abortions within Canada and outside of Canada;⁹⁵ and
- the cost of abortion and related services.⁹⁶

The criminal abortion law that prevailed at the time in Canada allowed abortion if, in the opinion of a majority of members of a therapeutic abortion committee composed of at least three physicians, “the continuation of the pregnancy would or would be likely to endanger the life or health of the female person.”⁹⁷

The extensive findings of the Badgley Committee were that “[t]here was no uniformity across the nation involving the standards of medical care relating to the quality of services of the requisite facilities required to undertake the abortion procedure in general hospitals.”⁹⁸ Furthermore, “On average women took 2.8 weeks after they first suspected they had become pregnant to visit a physician. After this contact had been made there was an average interval of 8.0 weeks until the induced abortion operation was done.”⁹⁹

The Badgley Committee’s overall conclusion was that the law operated inequitably and that the delay in authorizing lawful services caused unnecessary risks to women’s health.¹⁰⁰ While men had prompt access to necessary medical services, women whose lives or health depended on abortion were dependent on approval by hospital committees. Moreover, none of the hospitals were mandated to create a committee, many of the hospitals were ineligible to constitute a committee, and many of the eligible hospitals chose not to create a committee.¹⁰¹ Further, constituted committees often set

⁹² *Id.*

⁹³ *Id.* at 28.

⁹⁴ *Id.* at 30.

⁹⁵ *Id.* at 143–76.

⁹⁶ *Id.* at 379–420.

⁹⁷ Canada Criminal Code, R.S.C., ch. C 34, § 251(4) (1970).

⁹⁸ BADGLEY ET AL., *supra* note 86, at 28.

⁹⁹ *Id.* at 146.

¹⁰⁰ *Id.* at 17–26.

¹⁰¹ *Id.* at 22. For further discussion on distribution and availability, see *id.* at 107–42.

quotas and refused to accommodate women residents outside the hospitals' catchment areas.¹⁰² It was found that forty percent of Canadian resident women lived outside areas whose local hospitals were eligible to create committees.¹⁰³

These and other findings were not debated in the federal Parliament to which the Badgley Committee's report was submitted, and they were ignored by the provincial health authorities responsible for the delivery of health care. More than ten years after the report's submission, the Supreme Court of Canada assessed the Badgley evidence and declared that in denying women's security of the person, as protected by the Canadian Charter of Rights and Freedoms, the Criminal Code provisions were unconstitutional and therefore of no legal effect.¹⁰⁴ In the words of the then-Chief Justice of Canada, the Court found that "[f]orcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person."¹⁰⁵

Creation of the Badgley Committee is consistent with the obligation of Article 12 of the Convention, which Canada had ratified, to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services" by examining and exposing inequitable access.¹⁰⁶ The national failure was that neither federal nor provincial governments responded to the findings. In its 1988 judgment, the Canadian Supreme Court noted that governmental statistics demonstrated that since the ten years after the 1976 Badgley Report, the number of accessible therapeutic abortion committees in the country had fallen.

The only female justice of the seven presiding in the Supreme Court, Justice Bertha Wilson, broadened her reasoning in support of the judgment beyond security of the person to address women's liberty.¹⁰⁷ At the time of the

¹⁰² *Id.* at 259–63.

¹⁰³ *See id.* at 30.

¹⁰⁴ *See Morgentaler v. Queen*, [1988] 44 D.L.R. 419.

¹⁰⁵ *Id.* at 402.

¹⁰⁶ *Convention*, *supra* note 10, art. 12.

¹⁰⁷ *See Morgentaler*, [1988] 44 D.L.R. at 490. Upon concluding that the right to liberty contained in section 7 of the Canadian Charter of Rights and Freedoms "guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives," Justice Wilson stated:

decision, Canadian equality jurisprudence was underdeveloped; however, Justice Wilson characterized the liberty interest at stake as falling within broader efforts to eliminate gender discrimination, as well “as an integral part of modern woman’s struggle to assert *her* dignity and worth as a human being.”¹⁰⁸ The Supreme Court subsequently ruled that men cannot veto the abortion decisions of women whom they have impregnated.¹⁰⁹

Sex discrimination in access to services is often aggravated by discrimination on the grounds of women’s age and race, usually leaving young women of disadvantaged racial groups and of lower socioeconomic status the most vulnerable to the risk of maternal death from unsafe pregnancy and unsafe abortion.

Epidemiological data shows that the neglect of reproductive health needs of young and adolescent women and the stigmatization of pregnancy outside marriage is pervasive, especially in the developing world, and disproportionately burdens this age cohort with unsafe abortion. “Two-thirds of unsafe abortion occur among women aged 15–30, and 14% among women under age 20.”¹¹⁰ The age patterns vary among regions, with 60% and 30% of unsafe abortions occurring among women under 25 in Africa and Asia, respectively, while in Latin America and the Caribbean, over half occur to women aged 20–29.¹¹¹ There have been some successful attempts by national legislatures,¹¹² and before that, national courts, to ensure that mature minors

The question then becomes whether the decision of a woman to terminate her pregnancy falls within this class of protected decisions. I have no doubt that it does. This decision is one that will have profound psychological, economic and social consequences for the pregnant woman. The circumstances giving rise to it can be complex and varied and there may be, and usually are, powerful considerations militating in opposite directions. It is a decision that deeply reflects the way the woman thinks about herself and her relationship to others and to society at large. It is not just a medical decision; it is a profound social and ethical one as well. Her response to it will be the response of the whole person.

Id.

¹⁰⁸ *Id.* at 491. For an examination of abortion in the context of Canadian equality jurisprudence, see Joanna Erdman, *The Dignity of Equality: Abortion in the Health Care Context*, 56 EMORY L.J. 1093 (2007); Sanda Rodgers, *Women’s Reproductive Equality and the Supreme Court of Canada*, in HEALTH LAW AT THE SUPREME COURT OF CANADA (Jocelyn Downie & Elaine Gibson eds., forthcoming 2007).

¹⁰⁹ Tremblay v. Daigle, [1989] D.L.R. 665.

¹¹⁰ Iqbal Shah & Elisabeth Ahman, *Age Patterns of Unsafe Abortion in Developing Regions*, 12 REPROD. HEALTH MATTERS 9 (2004).

¹¹¹ *Id.*

¹¹² Under the 2004 Ethiopian penal code, abortion is not punishable when “a pregnant woman lacks the capacity to care for a child *because of her age* or physical or mental health.” Proclamation No. 414/2004, Criminal Code of the Federal Democratic Republic of Ethiopia, bk. V, tit. 1, ch. 1, sec. 1, art. 551. The 2006

can access reproductive health services without the need to obtain parental consent¹¹³ or before they have reached a certain age.¹¹⁴ However, many countries have yet to ensure that adolescents can access health services on the basis of their capacity to understand the nature of the health service instead of on the basis of an arbitrary age limit.¹¹⁵

Epidemiological evidence also demonstrates that poor women in rural areas have less access to contraceptives and safe abortion providers. In Uganda, 86% of the population lives in rural areas, where the health infrastructure is sparse.¹¹⁶ The vast majority of poor women are concentrated in these areas.¹¹⁷ A recent report explains that 50% of poor women in Uganda who sought abortion services relied upon a less costly and less safe¹¹⁸ provider such as a pharmacist, traditional healer, traditional birth attendant, herbalist, or other lay practitioner, or even herself.¹¹⁹ In contrast, 68% of women not classified as poor were able to rely on the safer services provided by medically trained professionals.¹²⁰

The evidence related to sex, race, age, poverty, and rural status illustrates the compound forms of discrimination to which young, poor, or rural women are exposed. In contrast to age-related men—whose mortality and morbidity are associated with lifestyle choices of violence,¹²¹ alcohol consumption,¹²²

Guidelines, established pursuant to the 2004 code, explains that “a woman seeking an abortion on the grounds that she is a minor and unable to care for a child is not required to present proof of age.” FED. DEMOCRATIC REPUBLIC OF ETH., FAMILY HEALTH DEP'T, TECHNICAL AND PROCEDURAL GUIDELINES FOR SAFE ABORTION SERVICES IN ETHIOPIA (2006).

¹¹³ See, e.g., *Carey v. Population Servs. Int'l*, 431 U.S. 678 (1977); *Gillick v. W. Norfolk & Wisbech Area Health Auth.*, [1986] A.C. 112 (H.L.) (appeal taken from Eng.) (U.K.); *J.S.C. & C.H.C. v. Wren*, [1986] A.R. 118; *Christian Lawyers Ass'n v. Minister of Health & Others* 2005 (1) SA 509 (T) at 528 (S. Afr.); *R. (Axon) v. Sec'y of State for Health*, [2006] EWHC (Admin) 37, 2006 Q.B. 539 (Eng.).

¹¹⁴ Sentencia C-355/06, Corte Constitucional (May 10, 2006) (Colum.); see WOMEN'S LINK WORLDWIDE, C-355/2006: EXCERPTS FROM THE CONSTITUTIONAL COURT'S RULING THAT LIBERALIZED ABORTION IN COLUMBIA (2007), http://www.womenslinkworldwide.org/pdf/pub_c355.pdf.

¹¹⁵ Rebecca Cook & Bernard M. Dickens, *Recognizing Adolescents' "Evolving Capacities" to Exercise Choice in Reproductive Healthcare*, 70 INT'L J. OF GYNECOLOGY & OBSTETRICS 13, 13–21 (2000).

¹¹⁶ SUSHEELA SINGH ET AL., ALAN GUTTMACHER INST., UNINTENDED PREGNANCY AND INDUCED ABORTION IN UGANDA: CAUSES AND CONSEQUENCES 7 (2006), <http://www.guttmacher.org/pubs/2006/11/27/UgandaUPIA.pdf>.

¹¹⁷ See *id.*

¹¹⁸ *Id.* at 11.

¹¹⁹ *Id.* at 12.

¹²⁰ *Id.* at 11.

¹²¹ WORLD HEALTH ORG., THE INJURY CHART BOOK 61 (2002), <http://whqlibdoc.who.int/publications/924156220X.pdf>.

¹²² Rodger Doyle, *Deaths Caused by Alcohol*, SCI. AM., Dec. 1996, at 30, 31.

and, particularly in more developed economies, motor vehicle accidents¹²³—women's death and disability are associated with their inherent biological status as vulnerable to unplanned pregnancy. The men who impregnate their partners face no comparably discriminatory, stigmatizing health or social consequences.

The South African example illustrates how restrictive abortion laws discriminate on grounds of both race and sex, which compounds the burdens that poor African women face. South Africa changed its restrictive Abortion and Sterilization Act of 1975 to the Choice of Termination of Pregnancy Act of 1996 because of its disproportionately harmful impact on the morbidity and mortality of black South African women.¹²⁴ Excessive certification procedures for women seeking abortion under the 1975 Act confined access to socioeconomically advantaged women, who were disproportionately white.¹²⁵ A study undertaken by the Medical Research Council explained that an average of 800 to 1,200 women per year qualified for abortion under the old law.¹²⁶ Of these, 66% were white and from urban middle-class backgrounds, at a time when whites constituted only 16% of the general population.¹²⁷ According to official estimates, “[A]nnually, upwards of 44,000 mainly black women had recourse to backstreet abortion, with the consequent toll on health and mortality. About 33,000 such women would require surgery to treat the residue of septic abortion” with abortion-related deaths amounting to over 400 a year.¹²⁸

The Preamble to the 1996 Act recognized the discriminatory aspects of the 1975 Act in stating that its provisions were enacted “[r]ecognizing the values of human dignity, the achievement of equality, security of the person, non-racialism and non-sexism, and the advancement of human rights and freedoms which underlie a democratic South Africa.”¹²⁹ Given the responsibility of states to eliminate all forms of discrimination against women, including discrimination on the grounds of race and ethnicity, countries enacting abortion laws that disproportionately affect women of distinct racial or ethnic status

¹²³ WORLD HEALTH ORG., *supra* note 121, at 21.

¹²⁴ Charles Ngwena, *South Africa's New Abortion Law: A Break with the Past*, IAB NEWS (Int'l Ass'n of Bioethics, Quezon City, Phil.), Autumn 1997, at 3, 4.

¹²⁵ *Id.* at 3.

¹²⁶ *Id.*

¹²⁷ *Id.*

¹²⁸ *Id.* at 4.

¹²⁹ Choice on Termination of Pregnancy Act, 1996 pmb1.

could well be held accountable under the Convention and be forced to reform their laws to ensure equality for all women.

2. *Dysfunctional Regulations*

Legislatures that retain the historical mindset of abortion being immoral and therefore criminal often establish exceptions apprehensively, fearing that women will exploit a concession to legality in manipulative ways. Regulations have therefore emerged in response to the relaxation of criminal prohibitions in order to guard against abuse. Where abortions are permitted on health grounds, states commonly require that at least two physicians, acting independently and in good faith, certify that the woman is at risk of death or of suffering severe, long-term physical injury or mental health injury if denied an abortion.¹³⁰ Because general practitioners may be fearful and too easily persuaded that a woman who is denied an abortion will commit suicide, it has become general practice in some states to require that an accredited psychiatrist verify the mental health indication for a lawful abortion.¹³¹ The Committee on the Elimination of Discrimination Against Women has reported the unfairly restrictive practice in Namibia, where only psychiatrists are recognized as legally entitled to authorize therapeutic abortion on the basis of mental health, noting that there is only one psychiatrist in all of Namibia.¹³²

Similarly, fearful that women can easily accuse their sexual partners of rape, as a precondition to medical termination on a rape indication, states have required that women file a complaint to local police authorities and receive an examination by a forensic specialist in sexual assault to demonstrate that the woman is a bona fide victim of sexual assault.¹³³ The forensic specialist

¹³⁰ See, e.g., Comm. on the Elimination of Discrimination Against Women [CEDAW], *Consideration of Reports Submitted by States Parties Under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women; Initial Reports of States Parties: Namibia*, at 138, U.N. Doc. CEDAW/C/NAM/1 (Feb. 10, 1997).

¹³¹ See, e.g., *id.*

¹³² See *id.* at 139; Comm. on the Elimination of Discrimination Against Women [CEDAW], *Consideration of Reports Submitted by States Parties Under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women; Combined Second and Third Periodic Reports of States Parties: Namibia*, at 29, U.N. Doc. CEDAW/C/NAM/2-3 (Sept. 2, 2005).

¹³³ K.I. Teklehaimanot & C. Hord Smith, *Rape as a Legal Indication for Abortion: Implications and Consequences of the Medical Examination Requirement*, 23 MED. & L. 91, 94-98 (2004). It has been explained that the old 1975 South African abortion law, which did permit abortion on grounds of rape and incest,

is of little value to all but the most economically and racially privileged pregnant rape and incest survivors.

examines for evidence of assault, such as lacerations and bruising consistent with the woman's vigorous resistance to an assailant. Eliminating all forms of discrimination against women in the health care context requires treating women according to their medical needs and not according to forensic requirements.¹³⁴ Some countries, consistent with the Convention, no longer require forensic exams for proof of rape¹³⁵ or prompt treatment.¹³⁶

The Committee on the Elimination of Discrimination Against Women has questioned the advisability of the formal legal requirements and informal practices of multi-member committees to review the applications for services submitted by women and their general medical practitioners.¹³⁷ These committees often include an obstetrician-gynecologist to ensure that pregnancy has not advanced beyond a legislated or institutionally imposed gestational limit, a psychiatrist to ensure stability of the woman's mental health, a social worker or other counselor to ensure that she understands the social implications of her choice, and perhaps a hospital chaplain to counsel her on spiritual implications of her request.¹³⁸ In contrast, men seeking medical treatment for sexually transmitted infections, injuries due to violence, or motor vehicle accidents are treated promptly without excessive bureaucratic regulation inquiring into their own responsibility for the conditions they present and the medically indicated treatment they request. States' obligations under Article 5(a) of the Convention to eliminate discriminatory stereotypes include the obligation to amend abortion service regulations that reflect

Legislation that grants the notional option of legal abortion, while effectively blocking access in practice, is ineffective. It is thus important to analyse *how* the existing abortion law manages severely to restrict women's access to abortion even in the few exceptional circumstances in which abortion is legally permitted.

Desirée Hansson & Diana E. H. Russell, *Made to Fail: The Mythical Option of Legal Abortion for Survivors of Rape and Incest*, 9 S. AFR. J. ON HUM. RTS. 500, 506 (1993). Even where rape had been certified, it has been reported in some countries, such as Brazil, that doctors refused to perform the procedure. Leila de Andrade Linhares Barsted (Christopher Peterson trans.), *Legalization and Decriminalization of Abortion in Brazil: Ten Years of Feminist Struggle*, 7 ESTUDOS FEMINISTAS (Special Issue) 7, 15 (1999).

¹³⁴ COOK, DICKENS & FATHALLA, *supra* note 42, at 296.

¹³⁵ Suprema Corte de Justicia de la Nación, 1995, Apendix, Séptima Época, 2005.II. Tesis 37 at 206 (Mex.).

¹³⁶ CENTRO NACIONAL DE EQUIDAD DE GÉNERO Y SALUD REPRODUCTIVA [Mexico Ministry of Health and National Center for Gender Equality and Reproductive Health], MODELO INTEGRADO PARA LA PREVENCIÓN Y ATENCIÓN DE LA VIOLENCIA FAMILIAR Y SEXUAL 52–54 (2004).

¹³⁷ Rebecca J. Cook & Bernard M. Dickens, *Human Rights Dynamics of Abortion Law Reform*, 25 HUM. RTS. Q. 1, 56 (2003).

¹³⁸ *See supra* notes 101–02 and accompanying text.

characterizations of women as incapable of making their own decisions or as duplicitous, manipulative, and deceitful in alleging rape.

Even where burdensome, highly qualified, multi-member committees are not required, many women live outside the reach of routinely qualified general medical practitioners who are competent to perform safe abortions.¹³⁹ For example, the Indian Medical Termination of Pregnancy Act of 1971 leaves many women outside the geographical and financial reach of services and exposed to unqualified practitioners or to the continuation of unhealthy pregnancy, endangering women's life or health.¹⁴⁰

Little attention is afforded to the evidence that adequately qualified nurses and midwives are able to undertake safe procedures in hygienic local surroundings for termination of early pregnancies. Evidence also shows that many safe abortions are nonetheless conducted unlawfully by such personnel and that women's health and well-being would be advanced by bringing these abortion practices within a legal framework. For example, an English case from the House of Lords shows how doctors can act along extended lines of authority to be only nominally in charge of abortion procedures, the critical elements of which are performed by nursing personnel.¹⁴¹ Also, the Ethiopian law was amended to permit midlevel providers, such as nurses and midwives, to perform abortion in cases where the pregnancy was less than twelve weeks old.¹⁴² The formal incorporation into law of the authority to delegate certain procedures, as in the British case, or the authority of nurses to provide treatment, as in the Ethiopian case, would enable wider availability of services and thus advance women's equal access to abortion services.

Where noncompliance with dysfunctional regulations will not lead to criminal liability for abortion, compliance may reappear as a condition of public funding. For instance, although therapeutic abortion committee approval for exemption from criminal liability has been ruled unconstitutional in Canada, provincial health plans may require medical committee agreement

¹³⁹ SINGH ET AL., *supra* note 116.

¹⁴⁰ Bela Ganatra, *Unsafe Abortion in South and South-East Asia: A Review of the Evidence, in PREVENTING UNSAFE ABORTION AND ITS CONSEQUENCES: PRIORITIES FOR RESEARCH AND ACTION* 151, 155–56 (Ina K. Warriner & Iqbal H. Shah eds., 2006).

¹⁴¹ Royal Coll. of Nursing of the U.K. v. Dep't of Health & Soc. Sec. [1981] 1 All E.R. 545, 545–46.

¹⁴² Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No. 414/2004, arts. 551–52, *translation available at* <http://mail.mu.edu.et/~ethiopia/laws/criminalcode/criminalcodepage.htm>; FED. DEMOCRATIC REPUBLIC OF ETH., *supra* note 112, at 8, 22–29.

that procedures are medically necessary, as opposed to elective, as a condition of public coverage of services.¹⁴³

3. *Lack of Transparency*

The medical profession and its supporting specialist and intergovernmental agencies have been conscientious in developing policies and guidelines to determine when medical interventions are indicated and which interventions are most appropriate for particular conditions. However, many modern physicians, medical associations, and governmental health agencies will state as a generality that abortion is illegal. Nevertheless, they may be persuaded to recognize narrow exceptions, such as one based on the concept of Double Effect¹⁴⁴ to classify life-saving abortion as legitimate intervention to preserve life and not simply as performance of abortion for its own sake. Against this background of illegality, it has been considered incongruous, and perhaps criminal conduct, to specify indications and appropriate techniques for termination of pregnancy.

The criminal context to which permissive laws and policies on abortion are exceptions is reflected in governmental disinclination to probe the experiences of abortion within their jurisdiction, including the need for safe services and follow-up care for those obtaining abortions outside of the legal framework. An egregious form of governmental neglect is the lack of reliable statistics in many countries on the incidence of abortion-related mortality and morbidity; governments have left both their laws and the need for governmental abortion-related services unaddressed. In 2004, the Court of Appeal for the United Kingdom provided judicial redress for such disregard within the U.K. province of Northern Ireland, holding that the Department of Health, Social Services, and Public Safety of Northern Ireland (“the Department”) had deliberately neglected to address the need for abortion services to which women were lawfully entitled.¹⁴⁵

¹⁴³ Medical Services Payments Act, N.B. Reg. 84-20, Schedule 2(a.1), available at <http://www.gnb.ca/0062/PDF-regs/84-20.pdf>.

¹⁴⁴ TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 128–32 (5th ed. 2001).

¹⁴⁵ Family Planning Ass’n of N. Ir. v. Minister for Health, Soc. Services & Pub. Safety, [2004] NICA 37–39 (Civ), [2005] N. Ir. L.R. 188 (Civ). See generally Ruth Fletcher, *Abortion Needs or Abortion Rights? Claiming State Accountability for Women’s Reproductive Welfare: Family Planning Association of Northern Ireland v. Minister for Health, Social Services and Public Safety*, 13 FEMINIST LEGAL STUD. 123, 123–34 (2005); Fegan & Rebouche, *supra* note 52, at 221–54.

The judgment of the Court of Appeal underscores the importance of the legal principle of equality before the law (or equal protection of the law), including women's fair and transparent access to abortion services to which they are legally entitled. In 2001, the fpaNI (formerly the Family Planning Association of Northern Ireland) initiated legal action against the Department.¹⁴⁶ It sought a declaration that the Department had acted unlawfully in failing both to issue clarifying guidelines on the circumstances for legal abortion in the jurisdiction and to investigate whether women were receiving satisfactory services for actual or potential abortions, including those lawfully obtained in Britain or elsewhere.¹⁴⁷ The fpaNI argued that women who were legally entitled to abortion services in Northern Ireland were unable to access the service fairly due to widespread uncertainty about the legal criteria for abortion.¹⁴⁸

The British Abortion Act of 1967,¹⁴⁹ which clarified and liberalized the grounds upon which women could lawfully obtain an abortion, had not been extended to Northern Ireland. Instead, Northern Irish law was governed by an English statute from 1861¹⁵⁰ as well as the Criminal Justice Act of Northern Ireland,¹⁵¹ which, together, criminalized abortion with a maximum punishment of life imprisonment except where performed in good faith to save the mother's life.¹⁵² Prior case law had established that "life" referred to both a woman's physical and mental health;¹⁵³ however, this still left open a wide margin of discretion for individual physicians. Despite the fact that it was precisely this scope of discretion that had led to the uncertainty complained of by fpaNI, the trial judge denied the declaration on the ground that prior judgments provided clear explanation of the law.¹⁵⁴

The Court of Appeal unanimously reversed this judgment based on evidence that lack of clarity regarding the application of the law remained

¹⁴⁶ *In re an Application by the Family Planning Ass'n of N. Ir. for Judicial Review*, [2003] NIQB 48, [2005] N. Ir. L.R. 188.

¹⁴⁷ *Id.* ¶ 3.

¹⁴⁸ *Id.* ¶¶ 1–3.

¹⁴⁹ Abortion Act 1967, 1967, c. 87 (U.K.).

¹⁵⁰ Offences Against the Person Act, 1861, 24 & 25 Vict., c. 100, §§ 58–59 (U.K.).

¹⁵¹ Criminal Justice Act (Northern Ireland), 1945, c. 15, § 25(1).

¹⁵² *In re an Application by the Family Planning Ass'n of N. Ir. for Judicial Review*, [2003] NIQB 48, [2005] N. Ir. L.R. 188, ¶¶ 16, 30–31.

¹⁵³ *Id.* ¶¶ 32–36 (citing *R. v. Bourne*, [1939] 1 K.B. 687; *N. Health & Soc. Services Bd. v. F and G*, [1993] N.I. 268; *N. Health & Soc. Servs. Bd. v. A & others*, [1994] N.I.J.B. 1; *W. Health & Soc. Services Bd. v. CMB & the Official Solicitor*, [1995] (unreported)).

¹⁵⁴ *Id.* ¶ 39.

widespread, which resulted in inconsistent medical practice.¹⁵⁵ Access to abortion services was limited by many practitioners' fear of prosecution and imprisonment. Due to the unavailability of legal abortion services in Northern Ireland, over 1,500 women from Northern Ireland traveled to Britain in 2005 to access abortion services at private clinics.¹⁵⁶ These Northern Irish women do not qualify for publicly funded abortion services conducted in Britain and they must pay £500 to £1,200 in medical fees and travel expenses, which many women cannot afford.¹⁵⁷ The inequity is that, as the trial judge interpreted the local law, many of these services could have been lawfully provided in Northern Ireland under the prevailing law.¹⁵⁸

The Court of Appeal further held that the Department had failed to perform its statutory duties to secure the provision of integrated health and personal social services to women entitled to lawful termination of pregnancy in Northern Ireland.¹⁵⁹ The Department failed to investigate whether women were receiving satisfactory abortion services and *whether* guidance as to the local availability of legal services *should be issued*.¹⁶⁰ The Court found that, as a consequence of the lack of transparency, women were denied access to abortion services to which they were lawfully entitled.¹⁶¹ The Department's failure to provide aftercare to women who returned from having abortions lawfully performed in Britain constituted an additional breach of statutory duty.¹⁶²

Where ministries of health fail to track the delivery of women's health services, and where women are unable to access health services to which they are legally entitled, governments may be in breach not only of their local laws, but of international human rights duties, particularly under the Convention. The Convention provides not only for equal entitlements to health care, but

¹⁵⁵ Family Planning Ass'n of N. Ir. v. Minister for Health, Soc. Services and Pub. Safety, [2004] NICA 37-39, [2005] N. Ir. L.R. 188, ¶¶ 115-16, 171, 186.

¹⁵⁶ Family Planning Association, FPA Campaigns for Abortion Services in Northern Ireland, <http://www.fpa.org.uk/news/policy/policy%5Fpapers/detail.cfm?contentid=310> (last visited Feb. 18, 2007).

¹⁵⁷ *Id.*

¹⁵⁸ *In re* an Application by the Family Planning Ass'n of N. Ir. for Judicial Review, ¶¶ 37-38.

¹⁵⁹ *Family Planning Ass'n of N. Ir.*, [2004] NICA 37-39, [2005] N. Ir. L.R. 188, ¶¶ 42, 44, 115.

¹⁶⁰ *Id.* In January, 2007, the Department issued draft guidelines for comment, DEP'T OF HEALTH, SOC. SERVS. & PUB. SAFETY OF N. IR., GUIDANCE ON THE TERMINATION OF PREGNANCY IN NORTHERN IRELAND (2007), <http://www.dhsspsni.gov.uk/guidance-termination-of-pregnancy-ni-draft-jan07.pdf>.

¹⁶¹ *Family Planning Ass'n of N. Ir.*, [2004] NICA 37-39, [2005] N. Ir. L.R. 188.

¹⁶² *Id.*

also more broadly for equal protection of the law.¹⁶³ Both equality and equal protection of the law is denied when the law lacks transparency. Failure of a government to clarify when abortion services are legally indicated is an injustice to those who are entitled to the benefit of the law, and thus it constitutes a denial of their right to equal protection.

States are, therefore, obligated to clarify the conditions that satisfy the particular legal grounds so they are clear to both the provider and the women seeking services. Conditions should not be listed as exhaustive, but only suggestive of reasons sufficiently prejudicial as to justify abortions on a particular ground.

- The preservation of life: Clarification might be useful to provide examples of when it would be appropriate to save life or to address life-endangering illness.
- Physical health reasons: Clarification might address pregnant women who have malaria or who are HIV positive.
- Mental health: Clarification might be necessary for mental health reactions to pregnancy and to prospective delivery and capacity for parenting.¹⁶⁴
- The rape indication: Clarification might be necessary to ensure effective and timely access to services to which women are legally entitled. Forensic verification of rape should not be required as a precondition to prompt care, and any occasional deliberate deception should be adequately addressed under laws against filing false reports and perjury.¹⁶⁵

In addition to clarification of legal grounds for abortion, states are also obligated to clarify that adolescents should be treated according to their evolving capacity. The Convention on the Rights of the Child,¹⁶⁶ which defines a child as a person less than eighteen years of age,¹⁶⁷ requires that they

¹⁶³ *Convention, supra* note 10, art. 2(c) (requiring states parties to “establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination”). Additionally, Article 15(1) requires states parties to “accord to women, in civil matters, a legal capacity identical to that of men.” *Id.* art. 15(1).

¹⁶⁴ Rebecca J. Cook et al., *Legal Abortion for Mental Health Indications*, 95 INT’L J. OF GYNECOLOGY & OBSTETRICS 185, 185–86 (2006).

¹⁶⁵ COOK, DICKENS & FATHALLA, *supra* note 42.

¹⁶⁶ Convention on the Rights of the Child, Nov. 20, 1989, art. 5, 1577 U.N.T.S. 44, art. 14(2).

¹⁶⁷ *Id.* art. 1.

are treated according to their individual capacity to make decisions¹⁶⁸ and not according to some arbitrary chronological age.

The World Health Organization has offered valuable guidance for delivery of lawful abortion services.¹⁶⁹ Liberalization of abortion enables specialist professional associations to develop practice guidelines that set a standard of care that all members of the profession should follow.¹⁷⁰ Guidelines, whether established internationally or domestically, serve to meet the mandate of states under the Convention by enacting protocols to ensure a uniform minimum standard for care related to women's conditions and circumstances.

The development and application of such guidelines are important in clarifying terms and conditions of lawful services for institutions that provide abortion services, those seeking services, and all women at risk of needing services. By the application of clear guidelines in health service institutions and the training of health care providers in their use, standards for the delivery of legal services are less apt to be arbitrary and unfair. Lack of transparency in legal delivery of abortion care is symptomatic of governmental failure to address health care that only women need, as required by Article 12 of the Convention.¹⁷¹

B. Expropriating Women's Bodies

It is conventional in modern law and Kantian ethics not to treat human beings as property.¹⁷² Nevertheless, the value of considering people as possessing a property-like interest in their own bodies is that their bodies cannot then be commodified by others without consent. Men's interests in development of their families, tribes or clans, and communities have caused them to assert control over women's reproduction.¹⁷³ Accordingly, societies

¹⁶⁸ *Id.* art 14(1); *see also* Bernard M. Dickens & Rebecca J. Cook, *Adolescents and Consent to Treatment*, 89 INT'L J. OF GYNECOLOGY & OBSTETRICS 179, 179–84 (2005).

¹⁶⁹ *See* WORLD HEALTH ORG., SAFE ABORTION: TECHNICAL AND POLICY GUIDANCE FOR HEALTH SYSTEMS (2003), http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf.

¹⁷⁰ *See generally* ROYAL COLL. OF OBSTETRICIANS & GYNECOLOGISTS, THE CARE OF WOMEN REQUESTING INDUCED ABORTION: EVIDENCE-BASED CLINICAL NUMBER GUIDELINE 10 (2004), http://www.rcog.org.uk/resources/Public/pdf/induced_abortionfull.pdf; Victoria Jane Davis, *Induced Abortion Guidelines*, 28 J. OBSTETRICS & GYNECOLOGY CAN. 1014 (2006).

¹⁷¹ *Convention, supra* note 10, art. 12.

¹⁷² *See generally* IMMANUEL KANT, FOUNDATIONS OF THE METAPHYSICS OF MORALS (Lewis White Beck trans., Univ. of Chi. Press 1950) (1785); IMMANUEL KANT, *Doctrine of Virtue*, in THE METAPHYSICS OF MORALS 139 (Mary Gregor trans., Cambridge Univ. Press 1996) (1785).

¹⁷³ *See* MOLLMANN, DECISIONS DENIED, *supra* note 87.

dominated by men have asserted and exercised interests analogous to proprietary interests in the chastity of their daughters, sisters, and wives as an attribute of family honor and have insisted, in modern times, on seeking injunctions and employing coercive legal means to restrain abortions.

The use of legal and other force to compel women's involuntary continuation of pregnancy is a form of legally supported coercion analogous to violence against women. Coercion to continue unwanted pregnancy has been analogized to rape in that it compels women, against their will, to serve through their bodies the interests of those able to exercise force against them and power over them.¹⁷⁴ Like rape, the exercise of this control both reflects and reinforces attitudes that minimize women's agency. While the act of rape reduces women to sexual objects, forced pregnancy reduces women to their reproductive capacity. Both deny women the ability to make their own decisions regarding the use of their bodies; both practices instrumentalize women's bodies to further the objectives of others.

The General Recommendation on violence against women of the Committee on the Elimination of Discrimination Against Women Committee provides,

Traditional attitudes by which women are regarded as subordinate to men or as having stereotyped roles perpetuate widespread practices involving violence or coercion Such prejudices and practices may justify gender-based violence as a form of protection or control of women. The effect of such violence on the physical and mental integrity of women is to deprive them of the equal enjoyment, exercise and knowledge of human rights and fundamental freedoms. . . . [T]hese forms of gender-based violence help to maintain women in subordinate roles and contribute to their low level of political participation and to their lower level of education, skills and work opportunities.¹⁷⁵

It further provides that "States parties should ensure that measures are taken to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe procedures such as illegal abortion because of lack of appropriate services in regard to fertility control."¹⁷⁶

¹⁷⁴ Ellen Willis, *Abortion: Is a Woman a Person?*, in POWERS OF DESIRE: THE POLITICS OF SEXUALITY 460, 473 (Ann Snitow et al. eds., 1983).

¹⁷⁵ *General Recommendation No. 19*, *supra* note 13, ¶ 11.

¹⁷⁶ *Id.* ¶ 24(m).

1. *Forced Pregnancy*

Justifications for restricting access to abortion in order to coerce women to continue unwanted pregnancies often overlap and evolve in response to changing sociopolitical contexts. Nineteenth-century German law prohibiting abortion has been characterized as reflective of nationalist population growth strategies and as reinforcing Victorian gender roles situating women strictly within the home as wives and mothers.¹⁷⁷ The abortion policy of Nazi Germany was strongly characterized by the goal of racial purification. Women who would give birth to children that met state-defined standards of racial purity and mental fitness were prohibited from accessing abortions, while women whose children would not meet these requirements were subject to coerced abortion and sterilization.¹⁷⁸ The wishes of pregnant women themselves were legally irrelevant because abortion, both compelled and prohibited, was a function of state policy to promote the births of children favored by the state.¹⁷⁹

Fetal protection is the most frequently used modern justification for restricting access to abortion. This objective is often articulated as a religious obligation. The Catholic Church has expressed its position that abortion is equivalent to murder by blocking progressive abortion policies at both the international and domestic level.¹⁸⁰ Laws permitting abortion under certain circumstances, but which lack sufficient guidelines and transparency, have allowed officials to abuse their authority by denying abortion services in accordance with their own religious beliefs. For example, in Mexico, an adolescent rape victim was denied abortion to which she was legally entitled because of the hospital's commitment to religious ideology.¹⁸¹ Preventing women from accessing abortion because it conflicts with Church doctrine denies women's freedom of conscience to exercise control over their bodies in accordance with their own values. When the state introduces conscription of

¹⁷⁷ D.A. Jeremy Telman, *Abortion and Women's Legal Personhood in Germany: A Contribution to the Feminist Theory of the State*, 24 N.Y.U. REV. L. & SOC. CHANGE 91, 97 (1998).

¹⁷⁸ *Id.* at 107–11.

¹⁷⁹ U.N. War Crimes Comm'n, *Trial of Ulrich Greifelt and Others*, 8 LAW REPORTS OF TRIALS OF WAR CRIMINALS I (1949).

¹⁸⁰ Rishona Fleishman, Comment, *The Battle Against Reproductive Rights: The Impact of the Catholic Church on Abortion Law in Both International and Domestic Arenas*, 14 EMORY INT'L L. REV. 277, 279–83 (2000).

¹⁸¹ Friendly Settlement, Paulina del Carmen Ramirez Jacinto, Petition 161-02, Inter-Am. C.H.R. (Mar. 9, 2007) (Mex.), <http://www.cidh.oas.org/annualrep/2007eng/Mexico16102eng.htm>; see also MOLLMAN, SECOND ASSAULT, *supra* note 87, at 17.

men to military service and sacrifice, it frequently accommodates conscientious objection of religious pacifists,¹⁸² such as by requiring their engagement only in noncombat roles. However, when women are conscripted to be mothers, there is no accommodation of their conscientious objection because they become punishable as criminals.

The inhumanity to which the imposition of fetal-protective policies can run was recently illustrated when the U.N. Human Rights Committee condemned Peru for its responsibility in denying an adolescent girl, K.L., access to an abortion to which she was legally entitled.¹⁸³ She was forced to carry her pregnancy to term, to deliver, and then breast feed a newborn baby. A prenatal test had established that the fetus was anencephalic and, if born alive, would be nonviable. The newborn died within four days of birth. The Committee found that the treatment forced upon this young girl constituted a violation of her rights under the International Covenant on Civil and Political Rights to be free from inhuman and degrading treatment (Article 7), to private life (Article 17), to such measures of protection as are required by her status as a minor (Article 24), and to her right to an effective remedy for violations of those rights (Article 2).

The complainant in the K.L. case also alleged violation of her right to sexual nondiscrimination in accessing services because her special needs as a pregnant woman were ignored through the State's inability to prevent a violation of her right to access lawful health services and the arbitrary conduct of some of the health personnel.¹⁸⁴ In addition, she alleged sex discrimination in the exercise of her rights and denial of equal protection of the law. She was denied a lawful therapeutic abortion due to social prejudices and failure of the health authorities to address the special situations of women with life and health-threatening pregnancies that prevented her from exercising her Covenant rights equally with men.¹⁸⁵ Finally, she alleged discrimination in accessing the courts because of prejudices of health and judicial officials, resulting in lack of appropriate means to enforce her rights to obtain a legal abortion.¹⁸⁶

¹⁸² Emily N. Marcus, *Conscientious Objection as an Emerging Human Right*, 38 VA. J. INT'L L. 507, 539 (1998).

¹⁸³ U.N. Human Rights Comm., *Huamán v. Peru*, U.N. Doc. CCPR/C/85/D/1153/2003 (Nov. 22, 2005).

¹⁸⁴ *Id.* ¶ 3.2 (a).

¹⁸⁵ *Id.* ¶¶ 3.2 (b), 3.8.

¹⁸⁶ *Id.* ¶ 3.2 (c).

The Human Rights Committee held the claims of sex discrimination under Article 3 and denial of equal protection of the law under Article 26 inadmissible.¹⁸⁷ The Committee said that the claims “have not been properly substantiated, since the data submitted by the author is not sufficient to establish an instance of the type of discrimination covered by the articles mentioned.”¹⁸⁸ This rejection is problematic. While the Peruvian law allowing therapeutic abortion is not discriminatory on its face, it is discriminatory in its effect. It places a disproportionate burden on pregnant women seeking therapeutic services in ways that are not imposed on men seeking therapeutic services. Peru has not operationalized the therapeutic indication for abortion; that is, it has taken no steps to enable women to exercise their rights to ensure their access to lawful health services.¹⁸⁹ Moreover, the director of the public hospital interfered with K.L.’s decision to seek lawful health services by misstating the law in order to deny her access to such services.¹⁹⁰

The Committee’s rejection of discrimination and denial of equal protection claims is also problematic in view of the Committee’s General Comment on Equality Between Men and Women, including the Comment’s general substantiation of reproductive equality.¹⁹¹ The Comment requires member states to ensure that men and women enjoy Covenant rights equally¹⁹² and to remove all obstacles to the equal enjoyment of those rights.¹⁹³

The Committee’s denial of the sexual equality arguments raises a larger question of what the claimant should have shown in order to address errors of omission in the submitted evidence, such as proving neglect of women’s pregnancy-related health needs. Should the claimant have tried to show that the hospital director denied all women pregnancy-related health services? Given the difficulties of proving a negative, it might be more promising for a claim of indirect discrimination to concentrate on the disproportionate impact of conservative abortion laws on pregnant women seeking lawful life- or health-preserving hospital services, as compared to laws regulating men’s access to such necessary services.

¹⁸⁷ *Id.* ¶ 5.3.

¹⁸⁸ *Id.* ¶ 5.3.

¹⁸⁹ *Id.* ¶ 3.1.

¹⁹⁰ *Id.* ¶ 2.3.

¹⁹¹ *See, e.g.*, HRC, *supra* note 66, ¶¶ 5, 10–12, 15, 20, 24.

¹⁹² *Id.* ¶¶ 2, 4, 6, 31.

¹⁹³ *Id.* ¶¶ 3, 5, 18.

Restricting access to abortion in order to promote the birth of a fetus subordinates the pregnant woman's health and liberty interests to this objective. For example, where legislation bans all abortions, as in Nicaragua,¹⁹⁴ or where it prohibits particular abortion procedures without allowing exceptions for women's health, as in the United States,¹⁹⁵ legislators are implicitly asserting that "fetal life is more valuable than women's health."¹⁹⁶ In contrast, no comparable limitations have been placed on men in the interest of promoting the births or in sustaining the lives of their offspring. Case law and legislation in several states have affirmed men's ability to withdraw consent to the use of embryos that have been fertilized with their semen in assisted reproductive procedures. One court held that as a matter of public policy, "forced procreation is not an area amenable to judicial enforcement."¹⁹⁷ Courts have thus far found it far easier to affirm men's liberty to decide not to become a parent even though "forcing" procreation on a man in such circumstances involves allowing his genetic material to be used in a manner to which he had previously consented without any additional medical procedures or physical labor, whereas forcing procreation on a woman involves considerable demand on her physical and emotional resources both during pregnancy and childrearing.

While the law may compel women to furnish the resources of their bodies to their children before birth, if the survival of children following birth depends on blood or bone marrow donation that their fathers may provide, it is improbable that the fathers will be legally compelled to provide donations or that they will even be tested for compatibility as donors.¹⁹⁸ The protection the law gives to preservation of the bodily integrity and autonomy of fathers following births is not equaled in protection with the physical integrity and

¹⁹⁴ The Nicaraguan National Assembly repealed Article 165, allowing for therapeutic abortion, on October 26, 2006 through the enactment of Law No. 603, which entered into force November 17, 2006, *La Gaceta*, (official gazette) No. 224 (Nov. 17, 2006); see Jill Replogle, *Nicaragua Tightens Up Abortion Laws*, 369 *LANCET* 15 (2007).

¹⁹⁵ Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201.

¹⁹⁶ *Hope Clinic v. Ryan*, 195 F.3d 857, 881 (7th Cir. 1999), *vacated*, *Christensen v. Doyle*, 530 U.S. 1271 (2000).

¹⁹⁷ *A.Z. v. B.Z.*, 725 N.E. 2d 1051, 1058 (Mass. 2000); see also *Evans v. U.K.*, 6339/05 Eur. Ct. H.R. (2006) (affirmed by the Grand Chamber on April 10, 2007); cf. CA 2401/95 *Nachmani v. Nachmani* [1996] *IsrSC* 50(4) 661 (permitting a woman to implant fertilized embryos despite her former husband's desire to prevent the process because the woman lacked any alternative to achieving genetic parenthood).

¹⁹⁸ See *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 91 (Allegheny County Ct. Com. Pl. 1978); see also Katherine A. Taylor, *Compelling Pregnancy at Death's Door*, 7 *COLUM. J. GENDER & L.* 85, 125 (1997) (discussing this case as a contrast to laws that prohibit incompetent pregnant women or their proxies from removing life-sustaining medical support where there is a chance that the fetus may be born alive).

autonomy of pregnant women before birth, although the hazards of blood and bone marrow donation are trivial compared to the hazards of gestation and childbirth. Furthermore, compelling women to continue their pregnancies in the interests of fetal life elevates the rights of the fetus above those of existing children who have no comparable claim on the bodily resources of their parents.¹⁹⁹ This inconsistency undermines the assertion of a governmental interest in promoting life; there is no rational basis upon which obligations to unborn children should be greater than towards one's living children. The fact that the provision of bodily resources can only be compelled in the interest of a fetus by necessity means that it will only be the resources of women's bodies that are at issue.

Imposing the physical burdens of procreation on women reflects the stereotype of "selfless motherhood" whereby normal women are expected to subordinate all of their own interests, including their health, to the interests of their families.²⁰⁰ Those who fail to adhere to this norm are perceived not only as flawed, but as threatening to societies that depend on women to serve as self-sacrificing caregivers. The coercive force of the state is therefore required not to protect the unborn, but to ensure that women behave in accordance with the prevailing patriarchal social model. Pregnant women are particularly vulnerable because they quite literally embody the subordination of self-interest for the benefit of another.²⁰¹ As such, pregnant women have been targeted not only in the context of debates surrounding abortion, but through the criminalization of their behavior during pregnancies they intend to carry to term,²⁰² as well as through the limitation of their rights to refuse consent to invasive medical procedures deemed beneficial to the fetus.²⁰³ Siegel argues that

¹⁹⁹ Taylor, *supra* note 198, at 122.

²⁰⁰ Erin Nelson, *Reconceiving Pregnancy: Expressive Choice and Legal Reasoning*, 49 MCGILL L.J. 593, 622–27 (2004).

²⁰¹ CAROL GILLIGAN, *IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT* 132 (1982).

²⁰² April Cherry, *Maternal-Fetal Conflicts, the Social Construction of Maternal Deviance, and Some Thoughts About Love and Justice*, 8 TEX. J. WOMEN & L. 245, 252–55 (1999); see also Melanie Randall, *Pregnant Embodiment and Women's Autonomy Rights in Law: An Analysis of the Language and Politics of Winnipeg Child and Family Services v. D.F.G.*, 62 SASK. L. REV. 515, 516 (1999).

²⁰³ See Cherry, *supra* note 202, at 251; Taylor, *supra* note 198, at 90; Nelson, *supra* note 200, at 598–601. As Nelson and Cherry illustrate, such targeting occurs particularly towards those women who stray most from the norms of idealized motherhood, including norms of class and race. Cherry, *supra* note 202, at 252–57; Nelson, *supra* note 200, at 623–24.

some strategies of fetal-protection impose the costs of protecting unborn life solely on women, while others distribute them across the community as a whole; some strategies control and punish women in their capacities as mothers, while others empower and assist women in their efforts to bear and rear healthy children.²⁰⁴

The concept of equality requires that women should be no more advantaged or disadvantaged in the sphere of reproduction than men. This means that where physiological differences exist, they should be accommodated rather than used to construct and reinforce gender stereotypes. The accommodation of men and women's differences in the context of reproduction, from a perspective of transformative equality, would require that states engage in a variety of activities that seek to discredit the stereotypical norms surrounding pregnancy and motherhood²⁰⁵ and to promote meaningful decision making regarding reproduction. This would require access to information regarding reproductive choices, as well as ongoing access to the necessary resources—health and otherwise—that becoming the parent of a healthy child entails.

Transformative equality in the context of reproduction requires the substantive goal of both healthy parents and healthy children.²⁰⁶ The development of policies from this starting point would not permit reliance on stereotypical, unequal gender roles for parents because these stereotypes impose burdens and privileges that are based on the irrelevant physical characteristic of sex, rather than on individual needs and capacities. The Committee on the Elimination of Discrimination Against Women states:

There is general agreement that where there are freely available appropriate measures for the voluntary regulation of fertility, the health, development and well-being of all members of the family improves. Moreover, such services improve the general quality of life and health of the population, and the voluntary regulation of population growth helps preserve the environment and achieve sustainable economic and social development.²⁰⁷

Making the regulation of one's fertility free and voluntary requires the elimination of gender stereotypes as these limit the choices one has available according to a prescribed set of gender norms. To the extent that restrictive

²⁰⁴ Siegel, *supra* note 46, at 346.

²⁰⁵ Nelson, *supra* note 200, at 627.

²⁰⁶ Sandra Fredman suggests this when she states that “[s]ubstantive equality requires a deep-seated commitment to the value of children and parenting.” Fredman, *supra* note 27, at 118.

²⁰⁷ *General Recommendation No. 21*, *supra* note 14, ¶ 23.

abortion laws rely on gender norms to restrict women's liberty, they necessarily result in discrimination against women. The goal of transformative equality promoted under the Convention requires states to implement policies that empower women to bear healthy children and empower both women and men to rear them in the best conditions possible. States cannot rely on conceptualizations of women that reflect and reinforce gender inequality to restrict access to abortion.

2. *Punishing Women*

The punishment of women by due process of criminal law for unlawful abortion is but one variant of the many ways in which the state seeks to curtail women's ability to structure their reproductive and sexual lives according to their own needs and priorities. Noted examples of imprisoning women for unlawful abortion exist in countries as diverse as Chile²⁰⁸ and Nepal.²⁰⁹

Criminal punishment is only part of a spectrum of punishments applied to women for what is perceived as indulgence in nonprocreative sex. Denial of legal access to safe abortion directs many women to treatments that are not only unsafe, but also undignified. The description of a "back-alley" abortion is not invariably a euphemism for unlawful or unsafe abortion, but it is a depressing measure of the costs of women's pursuit of autonomy and freedom of conscience. Under oppressive laws, women who put protection of their dependent children or their future prospects before compliance with legal restrictions, or who have no means of access to services to which they would be entitled on payments they cannot make, are compelled to bear extraordinary sacrifices. They must be prepared to risk or surrender their security, dignity, and peace of mind to obtain services.

Where laws permit abortion, women may still face humiliation and de facto punishment. The staff who serve women in public health facilities are often disrespectful and patronizing.²¹⁰ Attending private clinics may require women to face harassment, including gruesome depictions of mutilated fetuses.

²⁰⁸ Lidia Casas-Becerra, *Women Prosecuted and Imprisoned for Abortion in Chile*, 5 REPROD. HEALTH MATTERS 29, 30 (1997); CTR. FOR REPROD. LAW & POLICY AND OPEN FORUM ON REPROD. HEALTH & RIGHTS, *WOMEN BEHIND BARS: CHILE'S ABORTION LAWS—A HUMAN RIGHTS ANALYSIS* 5 (1998).

²⁰⁹ Geeta Ramaseshan, *Women Imprisoned for Abortion in Nepal: Report of a Forum Asia Fact-Finding Mission*, 5 REPROD. HEALTH MATTERS 133, 134 (1997); CTR. FOR REPROD. LAW & POLICY AND FORUM FOR WOMEN, LAW AND DEV., *ABORTION IN NEPAL: WOMEN IMPRISONED* 11 (2002).

²¹⁰ Cynthia Steele & Susana Chiarotti, *With Everything Exposed: Cruelty in Post-Abortion Care in Rosario, Argentina*, 12 REPROD. HEALTH MATTERS 39, 40 (Supp. 2004).

Medical evidence establishes that abortions are most safely performed in specialized clinics for the procedure, but such clinics may be isolated from general hospitals and may become targets for hostile picketing.²¹¹ These protesters attempt to shame and humiliate women and can create psychological trauma bordering on violence.

Laws are enacted to characterize or depict abortions at every stage of gestation by reference only to those undertaken out of medical necessity late in pregnancy.²¹² This is sometimes described as “autilising abortion.”²¹³ Judge Posner of the United States Seventh Circuit Court of Appeals has characterized the aim of legislation banning partial-birth abortions as “dramatiz[ing] the ugliness of abortion.”²¹⁴ Judge Posner has also opined that some abortion legislation is “concerned with making a statement in an ongoing war for public opinion The statement is that fetal life is more valuable than women’s health.”²¹⁵

Punitive care can also be common. One such practice is the denial of anesthesia to women undergoing invasive procedures as a means of “teach[ing] them a lesson” not to risk unplanned pregnancy in the future.²¹⁶ Another practice recorded in several countries is conditioning abortion on the woman’s sterilization.²¹⁷ Although this paternalistic practice seeks to protect women

²¹¹ See *Schenck v. Pro-Choice Network of W. N.Y.*, 519 U.S. 357, 362 (1997) (describing protestors’ hostile actions toward an abortion clinic); *R. v. Lewis*, [1996] 139 D.L.R. (4th) 480, 513–14 (Can.) (describing the effect of hostile protestors on service providers and patients).

²¹² *Stenberg v. Carhart*, 530 U.S. 914 (2000) (holding that Kansas statute, which criminalized performance of partial-birth abortions, was unconstitutional); *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005) (holding that the federal Partial-Birth Abortion Ban Act of 2003, which banned partial-birth abortions except to save the life of the mother, was unconstitutional because it did not contain an exception for the health of the mother), *rev’d*, 127 S. Ct. 1610 (2007).

²¹³ JANET HADLEY, *ABORTION: BETWEEN FREEDOM AND NECESSITY* 193 (1996) (citing LYNDALL RYAN ET AL., *WE WOMEN DECIDE: WOMEN’S EXPERIENCES OF SEEKING ABORTION IN QUEENSLAND, SOUTH AUSTRALIA AND TASMANIA 1985–1992* (1994)). For an overview of strategies invoked by antiabortion campaigners intended to “awfulise” abortion, see *id.* at 146–51.

²¹⁴ *Hope Clinic v. Ryan*, 195 F.3d 857, 879 (7th Cir. 1999) (Posner, J., dissenting).

²¹⁵ *Id.* at 880–81.

²¹⁶ NW. TERRITORIES, *ABORTION SERVS. REVIEW COMM., REPORT OF THE ABORTION SERVICES REVIEW COMMITTEE* (1992); *Afterword to NO CHOICE: CANADIAN WOMEN TELL THEIR STORIES OF ILLEGAL ABORTION* 154 (Childbirth by Choice Trust ed., 1998).

²¹⁷ See, e.g., Manisha Gupte, Sunita Bandewar & Hemlata Pisal, *Abortion Needs of Women in India: A Case Study of Rural Maharashtra*, 5 REPROD. HEALTH MATTERS 77, 82 (1997) (discussing pressure sometimes put on women to become sterilized following abortion); 1 ELIZABETH KATHLEEN LANE, *COMM. ON THE WORKING OF THE ABORTION ACT, REPORT OF THE COMMITTEE ON THE WORKING OF THE ABORTION ACT* 96, ¶ 299 (1974).

from future abortions, it revokes the autonomy and dignity provided by modern informed consent laws.

Men who conscientiously defy their communities in commitment to goals they consider best to serve their families and their own future ambitions are rarely stripped of their dignity and denied autonomy by the criminal law, unless they pursue these goals by violence or depredations against others' lives or property. Men may become eccentrics, mavericks, or even countercultural heroes, but they are not humiliated in the ways that women are when they seek the modest goals of creating families, opportunities, and private lives of their choice, which other women enjoy by the grace of good fortune.

Carol Smart has contrasted the immunity provided to sexually deviant men with the criminal sanctions and indignities suffered by similarly situated women. She explains that “[i]n criminal law, women’s bodies are constructed as a site for unlawful practices. Women are a problem because their bodies invite unlawful behavior, or because their bodies escape the formal constraints that law attempts to impose on them.”²¹⁸ She further explains:

Men’s bodies are simply not constructed as problematic in this way. They may be violent—but it is their actions that are problematic, not their bodies. Indeed the law has only rarely turned its attention to the reproductive capacities of men (as opposed to focusing on and punishing the results of this behaviour).²¹⁹

Punitive reactions to women’s sexuality offer women’s critics the certainty of satisfaction because a woman who has an abortion may be punished and will be socially condemned, and if she continues her pregnancy outside marriage, she will be punished socially through stigmatization.

Member states to the Convention agree “[t]o repeal all national penal provisions which discriminate against women”²²⁰ and to “take . . . all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality

²¹⁸ CAROL SMART, *LAW, CRIME AND SEXUALITY: ESSAYS IN FEMINISM* 224 (1995); see also *S v. Jordan* 2002 (6) SA 642 (CC) at 668 (S. Afr.) (Sachs, J., dissenting) (characterizing a law that criminalized prostitutes but not their clients as discriminatory because it reinforced a “difference in social stigma [that] tracks a pattern of applying different standards to the sexuality of men and women The inference is that the primary cause of the problem is not the man who creates the demand but the woman who responds to it: she is fallen, he is at best virile, at worst weak.”).

²¹⁹ SMART, *supra* note 218, at 225.

²²⁰ *Convention, supra* note 10, art. 2(g).

with men.”²²¹ In order to comply with the Convention, states must remedy penal provisions that imprison women for seeking medical treatment related to female health issues.

3. *Stigmatizing Women and Their Health Needs*

Few countries have decriminalized abortion. Countries that have liberalized their abortion law, sometimes to the point of permitting abortion de facto on request, do so by creating exceptions from criminal punishment, not affirming human rights. The effect is to keep abortion under the shadow of criminal stigma, fostering a culture of silence that inhibits women's agency and promotes harassment of providers.²²² The consequence has been that governments whose laws have created exceptions may be reluctant to make the legal accommodation of abortion transparent,²²³ leaving it to the medical and related professions to express conditions and techniques for abortion in medical terms rather than legal terms. Furthermore, few gynecologists whose careers are devoted to the safe termination of pregnancies describe themselves as abortionists. The term remains an epithet, invoking the stigma of unlawful practice, medical misconduct, quackery, and human butchery.

This stigma is pervasive in all levels of medical education. Some national medical associations permit medical students to refuse to study procedures to which they conscientiously object, even though the same techniques are required for practices to which there is no conscientious objection, such as removal of a dead fetus from a woman's body. Medical students studying reproductive health care do not speak of taking abortion lessons, and continuing medical education courses that include improving safe abortion skills have only recently advertised themselves as such. Sometimes, carefully worded brochures imply that the courses focus on inducing labor and childbirth.

In the countries where abortion is legal, practitioners escape the stigma of outlaw abortionists. Similarly, while women who seek abortions may still be considered misguided and sacrilegious, they avoid the disgrace associated with criminality.

²²¹ *Id.* art. 3.

²²² Arthur Okwemba, *Clinics Close over Abortion*, DAILY NATION (Nairobi), June 3, 2004, at 23.

²²³ *See supra* Part II.A.3.

Criminal law is a powerful tool through which stigma is produced and reproduced. When states legalize abortion procedures by providing exemptions from criminal prohibitions, they stigmatize abortion; when states, threaten criminal sanctions for abortion providers, they stigmatize the practitioners; and when states mandate various punishments, including imprisonment, for undergoing abortion, they stigmatize abortion seekers.²²⁴ Stigma can deter people from seeking care, leading to their premature death,²²⁵ and it enables discrimination against those involved in the treatment of stigmatized conditions as well as those suffering from such conditions.²²⁶

Regulating abortion under the criminal law stigmatizes abortion patients and service providers by labeling them deviants. The use of the criminal law in this context encourages the linking of a particular condition—unwanted pregnancy—to a negative value that enables discrimination against all those with that condition.²²⁷ Antidiscrimination law has the potential to protect against the discrimination of those with stigmatized conditions, including people with disabilities, HIV/AIDS, or epilepsy.²²⁸ Member states to the Convention are obligated to “take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs, and practices that constitute discrimination against women.”²²⁹ Where laws, customs, or practices discriminate through the imposition of stigma on women because of their particular conditions, states need to be held accountable for reforming such laws and practices.

C. *Reducing Women’s Moral Agency*

Although governments increasingly permit exceptions to their criminal prohibition of abortion, their retention of abortion within the criminal law framework fundamentally denies women’s moral agency. The origin of traditional crime is sin, which by definition is immoral. Societies do not accommodate the moral agency of criminals since criminal law condemns the immorality of their crimes. The failure to approach access to safe abortion services from the perspective of women confirms that, in this regard, women

²²⁴ See *supra* Part II.B.2.

²²⁵ Gerald T. Kusch et al., *Stigma and Global Health: Developing a Research Agenda*, 367 LANCET 525, 525 (2006).

²²⁶ ERVING GOFFMAN, *STIGMA: NOTES ON THE MANAGEMENT OF SPOILED IDENTITY* 5 (1963).

²²⁷ See Scott Burris, *Disease Stigma in U.S. Public Health Law*, 30 J.L. MED. & ETHICS 179, 183 (2002) (linking the criminalization of an act with stigma).

²²⁸ Scott Burris, *Stigma and the Law*, 367 LANCET 529 (Feb. 11, 2006).

²²⁹ *Convention*, *supra* note 10, art. 2(f).

have no right of moral agency. The inherent immorality of abortion justifies health care providers' rights of conscientious objection within the exceptions to criminal prohibition granted by liberalizing law. This pattern is an assertion of moral superiority over women who seek services, suggesting that, even when women propose to act within the law, they risk compromising service providers' moral status. The further assertion that the moral status of the embryo or fetus weighs in decision making suggests that women's own moral stature is diminished in proportion.

1. Third Party Authorization Requirements

Even when criminal prohibitions were relaxed by exceptions, they were initially liberalized only for preservation of women's lives and health. As discussed above, such exceptions diminish women's moral agency by reducing their options. In effect, women may bear the child, irreparably harm themselves, or die trying. However, the choice is not the woman's to make. Physicians assess the danger facing the woman and often require specialists to confirm the necessity of the procedure. This process can be problematic when physicians hold religious beliefs that may influence their decision making. For instance, physicians in Peru²³⁰ and Mexico²³¹ who were also acting as directors of the respective public hospitals, denied access to women for services that they were legally entitled to obtain.

Laws and the underlying social expectations requiring nonmedical third parties to authorize abortion procedures further diminish women's autonomy and moral agency. Some laws require women to receive their husband's approval, unmarried women or minors to receive parental consent, and widows to receive authorization by a male family member or community member. Women's compromised autonomy reflects not only their subordinate status in their marriages, families, and societies, but also their economic dependency because women do not control means to pay for the services for which they are legally eligible. Further, where women have to travel to access services, they may not be able to travel alone or may require permission, in part for their protection and in part to contain their perceived tendencies to waywardness.

Social infantilization of women is rooted in the presumption of a male dominated world in which adult imagery is exclusively masculine. Women who assert their autonomy are forsaking the feminine character of motherhood

²³⁰ U.N. Human Rights Comm., *supra* note 183.

²³¹ Friendly Settlement, *supra* note 181.

with which nature had endowed them and assuming an unnatural, masculine role.²³² Even in more modern societies that have largely shed these restrictive gender stereotypes, there remain influential secular and religious institutions that resist women's decision-making authority, including over the choice to abort. A common reaction to the liberalization of abortion laws is the attempt by the putative father to limit the pregnant woman's autonomy in choosing to terminate the pregnancy. In particular, husbands, partners, and ex-partners often resort to litigation before courts.²³³ Putative fathers have not prevailed before national²³⁴ or regional courts,²³⁵ but the tendency to subordinate women's agency in the abortion context remains strong.

Lawsuits to prevent lawful abortions have consistently been resolved in favor of the woman's right to privacy, but they might equally and strongly be decided on the basis of women's equality with men as autonomous decision makers over their own bodies. Where spousal or partner authorization policies are discriminatory on their face, they offend equal protection principles. Even where such requirements are ostensibly gender neutral, they disproportionately burden women because it is primarily women who seek reproductive health services. The General Recommendation on Women and Health, therefore, obligates states to remove such restrictive barriers in accessing services.²³⁶

²³² See ROSALIND POLLACK PETCHESKY, *ABORTION AND WOMAN'S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM* 271 (1990) (criticizing the view that women are privileged to be able to be defined by traditional feminine roles).

²³³ *Advocate Achyut Prasad Kharel v. His Majesty's Government of Nepal* (Ministry of Law, Justice and Parliamentary Affairs, Ministry of Health, Ministry of Women, Children and Social Welfare, Office of Prime Minister and Cabinet, Parliament Secretariat), Writ no. 3352 of 2061 B.S, filed on January 5, 2005, Supreme Court of Nepal (cited in PURNA SHRESTHA, *ENSURING REASONABLE ACCESS TO ABORTION SERVICES IN NEPAL* 26 (2006) (L.L.M. thesis, University of Toronto, Faculty of Law)).

²³⁴ See, e.g., *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 69 (1976); *Tremblay v. Daigle*, [1989] 2 S.C.R. 530 (Can.); *A v. B*, [1981] IsrSC 35(3) 57; *Attorney-General (QLD) ex rel. Kerr v. T* (1983) 46 A.L.R. 275 (Austl.); *C. v. S.*, (1987) 2 W.L.R. 1108 (Court of Appeal, Eng.); Judgment of Oct. 31, 1980, Conseil d'Etat, D.S. Jur. 19,732 (Council of State of France, 1980); Judgment of Mar. 31, 1988, Gazz. Ufficiale, 1 serie speciale, Apr. 13, 1988, n.15; *Giur. Cost. e Civ.* 2110 (Constitutional Court of Italy, 1988); Judgment of Feb. 15, 1978, Dec. No. 157/77, 3 Yugoslav Law 65 (Constitutional Court of Yugoslavia, 1979); *Kelly v. Kelly*, (1997) S.C. 285 (Court of Session, Scotland).

²³⁵ See, e.g., *Paton v. United Kingdom*, 3 E.H.R.R. 408 (1980) (Eur. Comm'n H.R.) (rejecting a father's attempt to prevent an abortion); *H. v. Norway*, 73 Eur. Comm'n H.R. Dec. & Rep. 155 (1992) (same) *Boso v. Italy*, 7 Eur. Ct. H.R. 451 (2002) (same).

²³⁶ *General Recommendation No. 24*, *supra* note 15, ¶ 14.

2. Abuse of Conscientious Objection

Human rights law seeks to protect both the freedom of religion and the right to conscience.²³⁷ However, efforts to use the right of conscience to deny women necessary care have emerged, usually in periods after legal liberalization of abortion. Conventionally, legal and ethical requirements accommodate conscientious objection through a duty to refer patients to reasonably accessible nonobjecting providers. Typically, physicians may not conscientiously object when a woman's life or health is in danger.²³⁸

Some practitioners go further, insisting that referral itself constitutes participation in abortion and violates their rights of conscience. The purpose of the emerging organized invocation of conscience by physicians, nurses, pharmacists, health care institutions, and insurers is to leave access to abortion services unavailable.²³⁹ Indeed, the Committee is acutely aware of the discriminatory impact that conscientious objection continues to have on the delivery of health services. As a result, the Committee's General Recommendation on Women and Health calls on states "to ensure that women are referred to alternative health providers."²⁴⁰

Fundamentally, conscientious objectors claim that their conscience is superior to that of women requesting abortion services. National courts²⁴¹ and national guidelines²⁴² clarify that medical practitioners have a professional

²³⁷ Dickens, *supra* note 74, at 337; Ngwena, *supra* note 74, at 5.

²³⁸ Dickens, *supra* note 74, at 348; Ngwena, *supra* note 74, at 8.

²³⁹ See generally Claire A. Smearman, *Drawing the Line: The Legal, Ethical and Public Policy Implications of Refusal Clauses for Pharmacists*, 48 ARIZ. L. REV. 469 (2006) (examining the purposes and effects of conscientious objection in the context of emergency contraception).

²⁴⁰ *General Recommendation No. 24*, *supra* note 15, ¶ 11.

²⁴¹ See, e.g., Sentencia C-355/06, Corte Constitucional (May 10, 2006) (Colum.).

[N]o doubt there are people who, from what are said to be religious reasons, object to the operation being performed at all, in any circumstances [A] person who holds such an opinion ought not to be a doctor practising [sic] in that branch of medicine, for, if a case arose where the life of the woman could be saved by performing the operation and the doctor refused to perform it because of some religious opinion, and the woman died, he would be in grave peril of being brought before this court on a charge of manslaughter by negligence. He would have no better defence [sic] than would a person who, again for some religious reason, refused to call in a doctor to attend [to] his child, where a doctor could have been called in and the life of the child saved. If the father, for a so-called religious reason, refused to call in a doctor, he also would be answerable to the criminal law for the death of his child.

R v. Bourne, (1938) 3 All E.R. 615, 618–19.

²⁴² See, e.g., U.K. DEP'T OF HEALTH, BEST PRACTICE GUIDANCE FOR DOCTORS AND OTHER HEALTH PROFESSIONALS ON THE PROVISION OF ADVICE AND TREATMENT TO YOUNG PEOPLE UNDER 16 ON

duty of care to refer women to doctors who will provide the necessary services. The European Court of Human Rights rejected an appeal by French pharmacists of their conviction under the consumer code when they refused to sell contraceptive pills.²⁴³ The court explained that the right to freedom of religious belief does not always guarantee the right to behave in public in a manner governed by that belief. The court noted that as long as the sale of contraceptives is available only through pharmacies, the pharmacists cannot exercise their right of religious freedom in a way that imposes their religious beliefs on others. The court was respectful of their religious beliefs, but explained that “they can manifest those beliefs in many ways outside the professional sphere.”²⁴⁴

The claim of conscientious objection is a fundamental challenge to health care professionalism. The modern version of the Hippocratic Oath, the World Medical Association’s Declaration of Geneva, requires physicians to pledge that “[t]he health of my patient will be my first consideration.”²⁴⁵ This dedication to self-sacrifice embodies the commitment of the historically reputable medical profession. Some doctors enter their profession, however, out of a religiously inspired commitment to assist others. By pursuing their own path toward spiritual virtue and salvation, these physicians place their own interests above their patients’ health interests, rendering them in conflict with their basic duty. Physicians holding such beliefs should resolve this conflict by practicing medicine in ways that do not require clinical care of patients.²⁴⁶ If they propose clinical care by inducing patients’ dependency, they should, in advance, declare the medically indicated services that they

CONTRACEPTION, SEXUAL AND REPRODUCTIVE HEALTH 3–4 (2004), <http://www.dh.gov.uk/assetRoot/04/08/69/14/04086914.pdf> (requiring physicians to refer patients and to prominently advertise their willingness to do so).

²⁴³ Pichon and Sajous v. France, App. No. 49853/99, Eur. Ct. H.R. (2001).

²⁴⁴ *Id.*

²⁴⁵ WORLD MED. ASS’N, DECLARATION OF GENEVA (2006), <http://www.wma.net/e/policy/c8.htm>.

²⁴⁶ *See R v. Bourne*, (1938) 3 All E.R. at 618–19. The implications of continuing to provide clinical care to patients while reserving the right to refuse to perform abortions on religious grounds was recognized as early as 1938 by Justice McNaghten in *R v. Bourne*, (1938) 3 All E.R. at 618–19:

[N]o doubt there are people who, from what appear to be religious reasons, object to the operation being performed at all, in any circumstances. That is not the law On the contrary, *a person who holds such an opinion ought not to be a doctor practising in that branch of medicine*, for, if a case arose where the life of the woman could be saved by performing the operation and the doctor refused to perform it because of some religious opinion, and the woman died, he would be in grave peril of being brought before this court on a charge of man-slaughter by negligence.

Id. (emphasis added).

refuse to undertake so that prospective patients can seek care, or those forms of care in particular, through other practitioners.

The International Federation of Gynecology and Obstetrics's Ethical Guidelines on Conscientious Objection also addressed the scope and limits of conscientious objection.²⁴⁷ According to the Guidelines, conscientious objection should apply only to the performance of actual treatments and not to related services. Importantly, objection attaches only to individuals, not institutions. Moreover, the Guidelines impose on doctors a duty to refer and require that objectors provide timely notice to existing and prospective patients. Conscientious objectors typically refuse to participate in contraceptive care and prescription, sterilization, and abortion. Contraception and sterilization are available to both sexes but remain primarily the woman's responsibility. Thus, practitioners generally conscientiously object to performing services that meet women's health needs. The contrast is obvious: physicians have not objected to prescribing erectile dysfunction medicine for men, and pharmacists have not refused to fill these prescriptions, although the consequence of such treatments may be unplanned pregnancies resulting in women's request for abortions that such practitioners object to provide.

3. *Diminishing the Personhood of Women*

Opposition to abortion claims a long history, but perceptions of what constitutes abortion have evolved rapidly in modern times. The historical perception was that pregnancy began at quickening (when the woman first felt the movement of the fetus), which usually occurs near the end of their first trimester of gestation. With knowledge of human reproduction evolving in the later nineteenth century, the Catholic Church revised its definition in 1869. Under this edict, the Church believed that human life began at conception.²⁴⁸ However, increasing knowledge of reproductive biology suggests that fertilization occurs before conception, which is medically recognized as implantation of a fertilized ovum in the uterine wall—in other words the beginning of pregnancy.²⁴⁹ Instead, the Church now considers fertilization to

²⁴⁷ FIGO Committee for the Ethical Aspects of Human Reprod. & Women's Health, *Ethical Guidelines on Conscientious Objection*, 92 INT'L J. GYNECOLOGY & OBSTETRICS 333, 333–34 (2006).

²⁴⁸ JOHN KENYON MASON, *MEDICO-LEGAL ASPECTS OF REPRODUCTION AND PARENTHOOD* 109 (2d ed. 1998).

²⁴⁹ INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO) COMMITTEE FOR THE STUDY OF ETHICAL ASPECTS OF HUMAN REPRODUCTION AND WOMEN'S HEALTH, *ETHICAL ISSUES IN OBSTETRICS AND GYNECOLOGY* 58 (2006), <http://www.figo.org/docs/Ethics%20Guidelines.pdf>.

be the beginning of protected human life.²⁵⁰ A further development has been the recognition of not just the fact of fertilization, but also the theoretical possibility of fertilization after a woman has ovulated but before the egg and the sperm have joined.²⁵¹ Accordingly, the definition of personhood has receded from quickening, conception, and fertilization to the mere chance of a sperm encountering the ovum in a woman's body or petri dish.

Related technical developments have coincided to personify early human life forms. At one end of the spectrum is the development of optic fiber technology and ultrasound, which have made the fetus in utero visible. Another development is in utero fetal surgery, which has made the fetus tangible. The other end of the spectrum is in vitro fertilization, which provides microscopic visualization of how sperm penetrates the outer lining of the ovum, leading to syngamy. Each of these developments signifies an enormous advance in reproductive technology, but each has a cost. Opponents of the technologies have paid attention to identification of minor fetal abnormalities, such as cleft palates that may lead to abortion and the discarding of embryos that fail to meet standards of "normality" according to preimplantation genetic diagnosis.

The personification of fetuses, and even embryos, necessarily detracts from the personhood of the women in whose bodies they exist.²⁵² Traditional legal systems and modern human rights tribunals²⁵³ reject the recognition of fetuses and embryos as persons. However, some constitutions recognize personhood at conception.²⁵⁴ For example, the Supreme Court of Argentina prohibited the use of emergency contraception in 2002 by providing full legal protection to the fertilized egg before implantation, basing its reasoning on religious doctrines expressed in the national constitution that state that life begins at conception.²⁵⁵ Opponents of abortion invoke generic provisions recognizing a "right to life" without regarding women's needs.²⁵⁶ In Germany, the

²⁵⁰ Daniel P. Sulmasy, *Emergency Contraception for Women Who Have Been Raped: Must Catholics Test for Ovulation, or Is Testing for Pregnancy Morally Sufficient?*, 16 KENNEDY INST. ETHICS J. 305, 307 (2006).

²⁵¹ *Id.*

²⁵² Cherry, *supra* note 202, at 247–48.

²⁵³ *See, e.g.*, *Vo v. France*, App. No. 53924/00, 8/VII/04, Eur. Ct. H.R. (2004).

²⁵⁴ *See, e.g.*, CONST. ARG. Art. 75 ¶ 25; IR. CONST., 1937, amend. 8; CONST. (1987), Art. II § 12 (Phil.).

²⁵⁵ *Portal de Belen – Asociación sin Fines de Lucro c/ Ministerio de Salud y Accion Social de la Nación s/ amparo*, 5 Mar. 2002, Recurso de Amparo, p. 709. XXXVI (Supreme Court of Argentina) (cited in Fiorella Melzi, *The Supreme Court of Argentina: Ruling Against Women's Equality*, 4 J.L. & EQUALITY 261, 263–64 (2005)).

²⁵⁶ *Christian Lawyers Ass'n v. Minister of Health* 1998 (4) SA 1113 (High Court of South Africa, Transvaal Provincial Division) at 1117 (S. Afr.).

Constitutional Court held that the right to life requires the state to protect the fetus from being aborted.²⁵⁷ However, this holding created a legal inconsistency by affording the fetus rights against its mother, despite the fact that neither civil nor criminal law recognizes the fetus's rights with respect to injuries caused by third persons.²⁵⁸ This decision only reinforced the perspective that reproduction and the well-being of children are the exclusive responsibility of women.

The Colombian Constitutional Court, in declaring the criminal prohibition of all abortions unconstitutional, recognized the constitutional value of life, including fetal life. However, the Court distinguished between the value of life and the claimed legal right to life. The legal right to life was ruled to be limited to a born human being, while the constitutional value of life can be protected before a fetus is born. The Court explained that the state can protect prenatal life, but it may do so only in a way that is compatible with the rights of women: "A woman's right to dignity prohibits her treatment as a mere instrument for reproduction. Her consent is essential to the fundamental life changing decision of giving birth to another person."²⁵⁹

The concept of one person contained within the body of another raises the possibility that the interests of one will conflict with the interests of the other. Benign medical practice focuses on the synergy of interests between mother and child so that the well-being of one contributes to the well-being of the other.²⁶⁰ A "maternal-fetal conflict" arises when pregnant women require medication or treatment, such as chemotherapy, that may harm embryonic or fetal life.²⁶¹ Unfortunately, this characterization risks generating a simplistic and polarizing perception that "feminists" favor mothers over fetuses and that "pro-life" supporters favor fetuses over mothers. These conflicting perceptions may be resolved differently in individual cases. However, the attribution of

²⁵⁷ Bundesverfassungsgericht [BVerfG] [Federal Constitutional Court] Feb. 25, 1975, 39 Entscheidungen des Bundesverfassungsgerichts [BVerfGE] 1 (F.R.G.), translated in John D. Gorby & Robert E. Jonas, *West German Abortion Decision: A Contrast to Roe v. Wade*, 9 J. MARSHALL J. PRAC. & PROC. 551 (1976).

²⁵⁸ See Telman, *supra* note 177, at 128–29 (describing the elements of the German Federal Constitutional Court's holding).

²⁵⁹ Sentencia C-355/06, Corte Constitucional (May 10, 2006) (Colum.). For an analysis of the Colombian Constitution's treatment of fetuses as people prior to this 2006 decision, see Martha I. Morgan, *Emancipatory Equality: Gender Jurisprudence Under the Colombian Constitution*, in THE GENDER OF CONSTITUTIONAL JURISPRUDENCE 75, 95 (Beverly Baines & Ruth Rubio-Marin eds., 2005).

²⁶⁰ See Patricia A. King, *Helping Women Helping Children: Drug Policy and Future Generations*, 69 MILBANK Q. 595, 604–05 (1991) (analyzing treatments of the mother-fetus relationship).

²⁶¹ A similar conflict may arise when a woman refuses treatment necessary to save the life of her unborn baby. See, e.g., *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457, 460 (Ga. 1981).

rights or interests to unborn human life²⁶² diminishes the claims to autonomy of women who are pregnant or may become pregnant, in contrast to claims of those who cannot become pregnant. A woman who prioritizes her own interests over those of the child she bears or is liable to bear is stigmatized as selfish, self-indulgent, callous, or ignorant regarding the harm that her actions pose to the unborn child. Such women are considered less worthy individuals than those who are either willing or compelled to subordinate their own interests to those of the children they are expected to bear.

The fetal rights discourse ignores the particularity of women's biological needs and sociocultural situations in making life-changing decisions. It shows a profound lack of understanding of women's gendered experiences and the systematic disadvantage women face. Fegan and Rebouche explain that the "moral argument . . . is constructed in pseudo-religious terms of 'preserving foetal life' without any recognition that the denial of women's agency is as much a moral issue, with implications that merit more thorough examination."²⁶³

According to the Convention, this discourse attempts to expunge women's fundamental rights. Transformative equality requires states parties to the Convention to ensure that women "are no longer grounded in historically determined male paradigms of power and life patterns,"²⁶⁴ including a serious lack of respect for women's moral agency that is based upon "the idea of the inferiority of [women and their] . . . stereotyped roles."²⁶⁵

CONCLUSION

Accommodating differences in the abortion context requires states to move beyond the myopic focus on the legality of the actual procedure to understand how the health care system neglects women, how antiabortion laws expropriate women's bodies and lives through forced childbearing and childrearing, and how they diminish women's moral agency. States are required not only to accommodate women's biological differences, but also to redress the dignity-denying treatment to which women are continually subjected in their various

²⁶² For an analysis of the factors relevant to determining when to attribute rights to unborn fetuses, see BONNIE STEINBOCK, *LIFE BEFORE BIRTH: THE MORAL AND LEGAL STATUS OF EMBRYOS AND FETUSES* 9–41 (1992).

²⁶³ Fegan & Rebouche, *supra* note 52, at 245.

²⁶⁴ *General Recommendation No. 25*, *supra* note 16, ¶ 10.

²⁶⁵ *Convention*, *supra* note 10, art. 5(a).

pathways to abortion. Transformative equality, as applied through the Women's Anti-Discrimination Convention, means that states can no longer require that women's reproductive capacities are considered more essential than their other attributes. It requires that states advance the health care system and address sociocultural norms to ensure that all women have equal and dignified access to services that respond to their particular health needs and that respect their moral agency.

