EMPOWERING AUTONOMY: A NOVEL APPROACH TO THE RIGHT TO ACCESSIBLE ABORTION

EXPLORING REALITIES FROM THE PERSPECTIVE OF ABORTION SEEKERS IN CANADA AND ENGLAND AND WALES

by

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Abstract

Women's reproductive rights are consistently threatened globally. Timely access to safe and respectful abortion is unobtainable for many. This is a human rights violation. *Accessible* abortion is necessary for the exercise of autonomy and female flourishing. This thesis presents an updated understanding of accessible abortion as a human right based on the following rights well-established in international law: the right to life; the right to be free from cruel, inhuman or degrading treatment; the right to health and the right to equality and non-discrimination. Furthermore, this thesis will analyse the often-competing rights: freedom of religion and conscience, and the freedom of expression. From these rights emerge a 'constellation' of State obligations that form the international right to accessible abortion, including both international and regional obligations.

This thesis then considers the implementation of the right to accessible abortion in two jurisdictions with unique legal and policy frameworks on abortion: Canada and England and Wales. Whilst abortion was completely decriminalised in Canada by the Supreme Court in 1988, abortion remains a criminal offence in England and Wales by virtue of historic legislation. Instead, a lawful abortion in England and Wales is provided by way of a defence for the doctor who provides a termination in accordance with the Abortion Act 1967. Adopting a socio-legal and critical feminist methodology, this thesis focuses on the lived realities of abortion law. Examining policy, healthcare guidelines, and the experience of abortion care by real life women goes beyond mere statistics.

Ultimately, after establishing the existence of a robust international right to accessible abortion, this thesis sheds light on the domestic failure to fulfil women's right to accessible abortion in two jurisdictions often overlooked by the abortion conversation. It suggests necessary reform so that everyone with the capacity to become pregnant has access to safe and respectful abortion care.

Lay Summary

Reproductive rights are constantly under threat, with reproductive autonomy consistently neglected. This thesis brings together state obligations from well-established human rights to shape the right to accessible abortion. Subsequently, this thesis analyses the extent to which law and policy in Canada and England and Wales fulfils the right to accessible abortion. It utilises a socio-legal and feminist method to assess the real-life impact of abortion law and policy on women. Ultimately, the thesis argues for necessary reforms in both jurisdictions for the fulfilment of the right to accessible abortion.

Preface

This thesis is the original, unpublished, independent work of the author, Hannah Ellison.

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Chapter I: Introduction

Approximately 73 million abortions take place each year globally.[1] In 2021, there were 214,256 abortions in England and Wales.[2] For the same period in Canada, the total number of reported abortions was 87,595.[3] The demand for abortion is undeniable. In 2020, the World Health Organisation published a list of essential healthcare services – abortion is on this list.[4] Abortion is essential healthcare that individuals with capacity for pregnancy will always need. Furthermore, abortion is incredibly safe when performed in line with medical best practice.[5] However, when a pregnant person faces barriers to accessing abortion, its safety begins to decline.[6] Therefore, the fact that abortion must be accessible would appear self-evident.

However, access to abortion is dictated by a combination of domestic law and policy and presently, individuals do not have the ability to access abortion in a way that matches its demand.

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[1] Guttmacher Institute, "Unintended Pregnancy and Abortion Worldwide" (March 2022), online (Fact Sheet): <https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide>.

[2] Office for Health Improvement & Disparities, "Abortion statistics, England and Wales: 2021" (12 September 2023), online (National Statistics): <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021/abortion-statistics-england-and-wales-2021>. This is the latest data set for an entire year. Between January and June 2022, the total number of abortions was 123,219. This is higher than the total of abortions for these months the year prior: Office for Health Improvement & Disparities, "Abortion statistics for England and Wales: January to June 2022" (24 August 2023), online (National Statistics): <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-january-to-june-2022/abortion-statistics-for-england-and-wales-january-to-june-2022>.

[3] Canadian Institute for Health Information, "Induced Abortions Reported in Canada in 2021" (27 June 2023), online (Data Tables): <https://www.cihi.ca/sites/default/files/document/induced-abortions-reported-in-canada-2021-data-tables-en.xlsx>.

[4] World Health Organisation, *Maintaining essential health services: operational guidance for the COVID-19 context* (1 June 2020) at 29, online: <https://www.who.int/publications/i/item/WHO-2019-nCoV-essential_health_services-2020.2>.

[5] Margaret Brazier and Emma Cave, *Medicine, Patients and the Law*, 6th ed (Manchester: Manchester University Press, 2016) at 405.

[6] Royal College of Obstetricians and Gynaecologists, *Coronavirus infection and abortion care: Information for healthcare professionals*, (31 July 2020) 3rd ed at 8, online (Information for healthcare professionals): <https://www.rcog.org.uk/guidance/coronavirus-covid-19-pregnancy-and-women-s-health/coronavirus-covid-19-infection-and-abortion-care/>.

Additionally, abortion regulation is plagued by politics,[7] and centuries old sexism[8] such that the lived realities of contemporary women are ignored.

It is time we understand accessible abortion as a human right against which we can hold states accountable. Furthermore, understanding accessible abortion as a human right appreciates the importance of reproductive autonomy and self-determination to the lives of all women.

Methodology

Research Objectives

1. Argue for the existence of the right to accessible abortion.
2. Criticise the domestic failure to fulfil this right for equal enjoyment of all women through assessment of both domestic law and policy in England and Wales and Canada.
3. Interrogate law and policy makers' intentions, deconstruct any façade concealing attempts to fortify a gendered power hierarchy.
4. Suggest some necessary steps to be taken by Canada and England and Wales to fulfil the right to accessible abortion.

Socio-legal research

According to Lisa Webley, socio-legal research is 'the examination of how law, legal phenomena and/or phenomena affected by law and the legal system occur in the world, interact with each other

[7] Caroline Moreau et al, "Abortion regulation in Europe in the era of COVID-19: a spectrum of policy responses" (2020) 47 BMJ Sexual & Reproductive Health 1 at 2.
[8] Sally Sheldon, *Beyond Control: Medical Power and Abortion Law* (London: Pluto, 1997).

and impact upon those who are touched by them.'[9] It rejects the claim that law is autonomous,[10] and instead contends that law must be assessed in light of its context because it does not operate in a vacuum.[11]

Abortion law is no exception, it interacts with many other aspects of society such as policy, healthcare coverage and medical best practice guidelines. A meaningful assessment of abortion law must appreciate these interactions to understand the multitude of factors that determine the way law operates on a personal level. Therefore, in this thesis I examine how abortion regulation operates in the world, as well as how law and policy interact to affect women's lived realities. Furthermore, socio-legal theory is a pragmatic methodological choice that allows me to consider the wide variety of sources required to assess abortion in practice, for example, World Health Organisation best-practice guidelines and Canadian provincial healthcare plans.

Central to the field of socio-legal theory since its inception is its commitment to progressive politics, justice and equality.[12] Abortion is a highly politicised area of healthcare, with women's safety and reproductive rights so often being sacrificed in favour of political whim.[13] My research objectives include exposing this; I share the commitment to progressive politics, reproductive justice and gender equality. Therefore, using socio-legal methodology is a prudent choice conducive to my objective of recommending rights-focused reform of abortion law and policy.

[9] Lisa Webley, "The Why and How to of Conducting a Socio-Legal Empirical Research Project" in Naomi Creutzfeldt, Marc Mason and Kirsten McConnachie, ed, *Routledge Handbook of Socio-Legal Theory and Methods* (London: Routledge, 2019) 58 at 59.
[10] Reza Banakar and Max Travers, *Law and Social Theory*, 2nd ed (Oxford: Hart Publishing, 2013) at 91.
[11] Lynn Mather, "Law and Society" in Robert Goodin, ed, *The Oxford Handbook of Political Science* (Oxford: OUP, 2011) 289.
[12] *Ibid* at 291.
[13] Moreau et al, *supra* note 7 at 2.

Critical feminist theory

I will preface this section by making the same 'hefty disclaimer' as Vanessa Munro: a single unified feminist method does not exist.[14] Despite this, Munro identifies common feminist worldviews that often inform a feminist methodology. First is an assessment of the way in which law reinforces a gendered power hierarchy. I am assessing the ways domestic abortion laws and policy reinforce a gendered power hierarchy because the right to accessible abortion as I intend to frame it is shaped in part by state commitments to end a gendered power hierarchy.

Another aspect of feminist theory is its 'suspicion of abstraction';[15] assessing the law means it cannot be removed from its context. Feminist scepticism towards the abstraction of law is rooted in the law's historical failure to appreciate women's experiences. Clearly, a critical feminist approach is complimentary to a socio-legal analysis of the lived realities of abortion law and policy. Combining these methodologies will allow me to reveal the reality of widespread women's rights violations through domestic abortion law and policy.

However, there is the tendency to commit the offences feminist theory often charges other theorists with. Namely, standardising experience and neglecting intersectionality. Katherine Bartlett acknowledges that even the terms 'feminist' and 'women's experiences' can be accused of generalising the diverse experiences of women.[16] Ultimately, Bartlett concedes that these terms are useful so ought to be employed with caution.[17] Therefore, whilst adopting this terminology, I remain vigilant and critical of their connotations. In particular, I scrutinise the way law neglects the nuance of the multiplicity of 'women's experience'. I will not limit my analysis to the

[14] Vanessa Munro, "The master's tools? A feminist approach to legal and lay decision-making" in Dawn Watkins and Mandy Burton, ed, *Research Methods in Law* (London: Routledge, 2017) 194.
[15] *Ibid* at 197.
[16] Katharine T Bartlett, "Feminist Legal Methods" (1990) 103:4 Harvard Law Review 829 at 834.
[17] *Ibid.*

experiences of white cis-gendered women, instead I will appreciate intersectionality through analysing the abortion experience of minorities and underserved, including victims of domestic violence and some of Canada's Indigenous Peoples.

Comparative analysis

Finally, my thesis is informed by a comparative analysis of two jurisdictions: Canada, and England and Wales. These jurisdictions provide fertile ground for analysis given their unique methods of abortion regulation. Canada is one of only two countries to completely decriminalise abortion, and this was done by the judiciary. In England and Wales, abortion remains a criminal offence however has carved out a lawful abortion in statute by way of a defence for the individual who provides the abortion. Most obviously, considering these jurisdictions allows me to consider the value of criminal law in violating the right to accessible abortion. However, these jurisdictions are also politically, socially and culturally similar. Both jurisdictions purport to be committed to human rights.

Pierre Legrand condemns the way in which comparativism 'harbours many positivist variations.'[18] The positivist detachment of law from reality presents itself in comparative methodology by way of surface-level analysis between jurisdictions, an analysis that fails to appreciate the role of culture in law. On what some may view as the opposite side of the debate to culturalists, lie functional comparativists. Concerned with abortion law specifically, Rachel Rebouché criticizes current methodology for failing to appreciate the relationship between law and policy.[19] Current abortion comparativism oversimplifies the situation by relying on outdated constitutional decisions

[18] Pierre Legrand, "Jameses at Play: A Tractation on the Comparison of Laws" (2017) 65 American Journal of Comparative Law 1 at 4.
[19] Rachel Rebouché, "A Functionalist Approach to Comparative Abortion Law" in Rebecca J. Cook, Joanna N. Erdman & Bernard M. Dickens, ed, *Abortion Law in Transnational Perspective* (Philadelphia: Penn Press, 2014) 98 at 101.

from the US and Germany. Rather, Rebouché advocates for a functional approach. An assessment of how abortion law and policy functions in society avoids positivist abstraction, instead concentrating on a sociolegal appreciation of law in context. Rebouché explicitly acknowledges that comparativism may 'reveal shared doctrines, which can apply across borders', or it may indicate that abortion laws are 'too divergent, too local, too embedded in culture to harmonise.'[20] It is this explicit commitment to culture which leads me to disagree with the idea that culturalists and functionalists are opposing theories. Whilst Legrand has been critical of functionalism for only partially 'penetrating the façade of language,'[21] I do not think the positions of Legrand and Rebouché are irreconcilable. Both theorists are committed to legal realities experienced on a deeper level than black letter.

Taking heed of both Legrand and Rebouché, I will assess not merely legislative differences but also realities faced by pregnant people seeking abortion and providing abortion in these jurisdictions. I appreciate the operation of law as culturally significant by adopting the sociolegal position that law is not autonomous. My research remains vigilant to the fact that, whilst lessons towards reform can be gained from comparative law, it does not automatically follow that a uniform approach to abortion policy would successfully operate to achieve female flourishing in all jurisdictions. Ultimately, my suggestions for law reform necessary to fulfill the right to accessible abortion are not uniform across my case studies. My recommendations are tailored to improving the context-specific plights of abortion seekers in both jurisdictions.

[20] *Ibid.*
[21] Oliver Brand, "Conceptual Comparisons: Towards a Coherent Methodology of Comparative Legal Studies" (2007) 32:2 Brooklyn Journal of International Law 405 at 429.

Structure

My thesis will commence with a theoretical assessment of the competing theories of reproductive autonomy. This will allow me to conceptualise reproductive autonomy in a sense that underpins my analysis of the right to *accessible* abortion. Meaningful reproductive autonomy demands a right to *accessible* abortion, and not merely a right to abortion. Furthermore, it will highlight the importance of a human rights approach that does not shy away from imposing positive obligations upon states. In my third chapter I will pull together existing human rights obligations to argue for the existence of the right to accessible abortion. I will assess both regional systems of rights protections and the United Nations. I will argue that individuals have the right to access expedient and quality abortion care by virtue of the rights to life, dignity, health, and equality as well as the oft competing right freedom of expression.

My thesis turns to examine the extent to which Canada and England and Wales fulfil the right to accessible abortion. I will do this by examining the domestic laws and policies at play, and the lived realities of abortion care seekers in both jurisdictions. Therefore, chapter IV of my thesis provides a brief summary of the legal frameworks regulating abortion in both jurisdictions – including the Abortion Act 1967 in England and Wales, and the road to decriminalisation in the Supreme Court of Canada. In chapter V, I will analyse how abortion stigma violates the right to accessible abortion, and then consider the operation of stigma in England and Wales and Canada. This includes an assessment of the way the legal frameworks are both based on abortion stigma and continue to perpetuate it. In chapter VI of my thesis, I assess the practical experience of abortion in England and Wales, and the legal, social and political factors that shape it. This includes examining the cost and location of abortion services, specifically analysing the threat unnecessary travel requirements and costly services pose to women's rights.

A note on gendered terminology

Access to abortion is a challenge faced predominantly by women with a potent attachment to female inequality and women's rights. Therefore, I use the gendered pronouns she/her. This is also in the interests of academic clarity. However, it must be acknowledged that accessible abortion is the right of all individuals with the reproductive capacity to become pregnant – whether they identify as female or not.

Chapter II: Conceptualising Reproductive Autonomy

Introduction

The concept of autonomy is messy. Traditionally riddled with gendered ignorance, its value for theorising women's reproductive decision-making has historically been limited.[22] In light of these shortcomings, feminists challenged the lack of consideration afforded to women's lived reality of choice by reconceptualising autonomy with appreciation for the specific challenges women face in the *fulfilment* of their choices.[23]

In this chapter, I will firstly assess the prominent early understanding of reproductive autonomy conceptualised by John Robertson. After scrutinising its gendered failings, as well as its ignorance of inequality, I will consider more meaningful conceptualisations of reproductive autonomy. This includes the works of Erin Nelson and Catherine Mills. Understanding reproductive autonomy is central to an appreciation of women and their lived realities. We therefore must conceive of it in a way that can be mutually supportive to human rights. This chapter will clarify the value of arguing for a right specifically to *accessible* abortion, rather than just a right to abortion. *Accessible* abortion is a positive right, it demands action from states, and it has the potential to buttress female power and flourishing.

The Traditional Liberal Understanding

Perhaps the most influential[24] early conceptualisation of autonomy in reproductive decision making is that provided by John Robertson:

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[22] Rhonda Copelon, "Reproductive and Sexual Freedom in the 1980's" (1982) 2 Antioch LJ 47.
[23] *Ibid*.
[24] Erin Nelson, *Law, Policy and Reproductive Autonomy* (London: Bloomsbury, 2014) at 32.

> 'The core of reproductive autonomy is the freedom to bring or avoid bringing a child into the world.'[25]

Robertson's 'procreative liberty' concept reflects the traditional understanding that reproductive decisions belong to the private sphere.[26] In this sphere they are to be free from the interference of third parties – including governments.[27] In this view, reproductive decisions are grounded in negative liberties, or *freedoms*.[28] Robertson writes at a time when science was making huge advances in birth control, bestowing greater control upon women over their sexuality.[29] This new sexual and procreative freedom appreciated that women are not merely vessels for reproduction. The possibility of sex without reproduction challenged long-held stereotypes regarding the role of women in society, in particular the female vocation of motherhood.[30] Therefore, it provoked intense efforts to tightly regulate the new scientific advances allowing it,[31] in particular the new methods of safe abortion faced fierce global opposition.[32]

For Robertson then, the solution is to protect this sexual and reproductive freedom from state interference. The traditional 'procreative liberty' is rooted in John Stuart Mill's harm principle: 'without a showing of tangible harm to some legitimate interest, the moral views of one group in the community – even a dominant group – are not sufficient to restrict the reproductive rights of others.'[33] Thus, concerns over female sexuality or attempts to block female participation in society

[25] John A Robertson, "Procreative Liberty and the Control of Conception, Pregnancy and Childbirth" (1983) 69:3 Va L Rev 405 at 464.
[26] *Ibid.*
[27] *Ibid* at 412.
[28] *Ibid* at 405.
[29] Copelon, *supra* note 22.
[30] Robertson, *supra* note 25 at 408.
[31] *Ibid* at 407.
[32] Claudia Roesch, "A Contested Pill: Transnational Controversies over Medical Abortion in Germany, France, and the United States" (2022) 57:4 J Contemp History 895.
[33] Robertson, *supra* note 25 at 436.

do not justify an imposition in to the private 'procreative liberty' sphere. According to the traditional liberal understanding of reproductive autonomy, the state must merely 'stay out' of an individual's reproductive decisions.

However, this liberal understanding of a reproductive autonomy free of interference conflates personal with private. Whilst reproductive decisions are deeply personal, it does not automatically follow that they belong to a private sphere in which the state has no obligations. In fact, as feminist endeavours evolved, it was realised that *practical* reproductive control is a necessary condition for complete and equitable participation in society.[34] This evolution implicates the state, reproductive decision-making is of inevitable public importance: '[t]he personal is political.'[35] The 'hands-off' approach that the liberal concept of reproductive autonomy calls for is just not possible. Thus, we must harness the positive potential of inevitable state involvement; we must use law and policy to further the feminist endeavour rather than feebly trying to keep it out of a fictional private realm of reproduction.

Furthermore, the autonomous individual that liberal theory envisions is a 'caricature'.[36] Lorraine Code, offering a symbolic criticism of autonomy, finds the 'autonomous man' of liberalism to be 'self-sufficient, independent, and self-reliant, a self-realizing individual who directs his efforts towards maximising his personal gains.'[37] This understanding prioritises independence at the

[34] Sheldon, "The Decriminalisation of Abortion: An Argument for Modernisation" (2016) 36:2 Oxford J Legal Stud 334 at 357.
[35] Rebecca Campbell and Sharon M Wasco, "Feminist Approaches to Social Science: Epistemological and Methodological Tenets" (2000) 28:6 American Journal of Community Psychology 773 at 788.
[36] Catriona Mackenzie and Natalie Stoljar, "Introduction Autonomy Refigured" in Mackenzie and Stoljar, ed, *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self* (New York: OUP, 2000) 3 at 5.
[37] Lorraine Code, *What Can She Know? Feminist Theory and the Construction of Knowledge*, (Ithica: Cornell University Press, 1991) at 78.

expense of relational subjectivity and devalues relationships and notions of 'love, loyalty, friendship and care'[38] - values typically associated with femininity.[39]

Undeniably male, the liberal decision-maker ideal is also implausibly operating in the absence of any structural disadvantage or societal expectation. Rhonda Copelon criticises the negative right approach to autonomy since it 'perpetuates the myth that the ability to effectuate one's choices rests exclusively on the individual, rather than acknowledging that choices are facilitated, hindered or entirely frustrated by social conditions.'[40] Therefore, the liberal approach of state non-interference can only protect the reproductive autonomy of a select few in society.[41] It fails to appreciate the varying degrees of social injustice experienced within society.[42] Robertson's 'hands-off' reproductive freedom approach only works if the individual faces no structural disadvantage impediments to their decision-making. For example, an individual who has the freedom to decide they do not want children may be unable to actually realise this sine they cannot afford the travel expenses required for the safest abortion. Indeed, Robertson pays very little attention the social factors at play in reproductive decision making, and his assessment does not once feature the word 'inequality.' His acknowledgement of 'social conditions in determining women's childbearing choices' are limited to the role structural disadvantage plays as an impediment to the freedom *to* procreate, not the freedom *not to* procreate.

As this thesis will demonstrate, it is a fallacy to assume that all abortion seekers hold equal footing in access to reproductive healthcare services, an individual's reproductive decision-making does not take place in a vacuum devoid of all practical and social considerations. Overall, Robertson

[38] Mackenzie and Stoljar, *supra* note 36 at 9.
[39] *Ibid.*
[40] Rhonda Copelon, "Losing the Negative Right of Privacy: Building Sexual and Reproductive Freedom" (1990) 18:1 NYU Rev L & Soc Change 15 at 46.
[41] Tess Johnson, "Free to Decide: The Positive Moral Right to Reproductive Choice" (2021) 31:3 Kennedy Institute of Ethics Journal 303 at 306.
[42] Robertson, *supra* note 25.

not only ignores the public implications of a woman's reproductive decision-making, but he also fails to grasp that the realisation of these reproductive decisions is not automatic. A hands-off approach from the state would only be satisfactory if reproductive decisions were made in an ideal world with no structural inequality. The value of the negative approach to reproductive decision making is limited to an individual's moment of choice and not what comes next to make this choice a reality.

Exercisable Choice

We must conceptualise reproductive autonomy in a way that is more meaningful for the individual in need of an abortion.[43] After all, what good is the freedom to have reproductive autonomy if it is not exercisable?[44] Erin Nelson defines autonomy as

> "the prerogative of the individual to live her own life, in accordance with her own values and desires: to live by her own lights."[45]

This conception is clearly more meaningful for the individual; she has a right to *live* her life as she desires – not merely a freedom to decide *how* she wants to live, only to have that reality remain illicit. Instead, reproductive autonomy demands both respect for an individual's choices *and* the facilitation of such choices so that they are exercisable.[46] Thus, in any meaningful sense, reproductive autonomy is positive – it demands a 'hands-on' approach from the state. As I will demonstrate in chapter 2, this understanding of reproductive autonomy is clearly more compatible

[43] Emily Jackson, *Regulating Reproduction: Law, Technology and Autonomy* (Portland: Hart Publishing, 2001) at 7.
[44] Kristin Zeiler, "Reproductive autonomous choice – A cherished illusion? Reproductive autonomy examined in the context of preimplantation genetic diagnosis" (2004) 7 Medicine, Health Care and Philosophy 175 at 176.
[45] Nelson, *supra* note 24.
[46] Zeiler, *supra* note 44.

with the spectrum of State obligation that comes from the right to accessible abortion in the right to life; freedom from cruel, inhuman or degrading treatment; right to health and equality rights.

Conceptualising reproductive autonomy as the exercisability of choice, thereby placing obligations of facilitation on law and policy makers, has the potential to better appreciate the inequalities across society that impact the ability of an individual to 'live by her own lights'.[47] Where the traditional liberal approach can only promote the reproductive autonomy of the privileged, the exercisable choice model appreciates the varying degrees of economic and social disadvantage experienced by abortion seekers. Policy and law makers have an obligation to facilitate the achievement of reproductive desires for everyone, regardless of race, wealth or religion. All people with female physiology may need an abortion. It is important for States to be able to fulfil the right to accessible abortion of *all* women.

Supporting Female Power

Autonomy is intrinsically linked to power.[48] The exercise of self-governed choices is central to the production of subjectivity which, according to Michel Foucault, occurs by virtue of 'technologies of power'.[49] In his early work, Foucault's technologies of power concerned the power of institutions over individuals through discipline, surveillance and the normalisation of society expectations, and how this shaped an individual's idea of self.[50] However, Foucault's later works concerns the power within individuals, finding that the *practice* of this power plays a central role in the production of subjectivity.[51] The trajectory of Foucault's theory on power appears similar to

[47] Erin Nelson, "Autonomy, Equality, and Access to Sexual and Reproductive Health Care" (2017) 54:3 Alta L Rev 707 at 711.
[48] Johnson, *supra* note 41 at 309.
[49] Michel Foucault, "The Subject and Power" in Hubert L Dreyfus and Paul Rabinow, eds, *Michel Foucault Beyond Structuralism and Hermeneutics*, 1st ed (London: Routledge, 1982) 208.
[50] Michel Foucault, "Discipline and Punish: The Birth of the Prison" in Bruce Lawrence and Aisha Karim, eds, *On Violence*, (Duke University Press, 2007) 445.
[51] Foucault, *supra* note 49 at 212.

that of reproductive autonomy I have outlined thus far: from the non-interference of state power to the appreciation that the individual must be empowered to realise her choices. I would like to note here that, by 'empowerment' I do not mean the bestowal of power upon women by the few elevated members of society designated as powerful. Instead, I mean the facilitation of choice realisation through public policy which has the potential to facilitate the power women already possess to live by her own lights.

Foucault holds that power is not solely 'a renunciation of freedom',[52] rather it 'exists only when it is put into action.'[53] An individual's ability to self-determine is therefore shaped by the power exerted by governments on individuals *and* the actionable power inherent to individuals. Catherine Mills then utilises Foucault's later works on technologies of power as a springboard. Mills argues that, since reproductive autonomy is 'a project of self-making' that can only occur by virtue of actionable inherent power, it also 'requires enactment to gain meaning within the life contexts' of individuals.[54] The *practice* of liberty, and therefore the exercise of reproductive choice, is a positive right.[55] Thus, the provision of policy that makes reproductive choice exercisable, facilitates actionable female power. The right to accessible abortion integral to the right to life, health and equality therefore also facilitates actionable female power. As established in the previous chapter, the right demands the provision of a framework that makes abortion accessible, that makes reproductive choices actionable. The rights framework therefore demands the prioritisation of reproductive autonomy, subsequently supporting female flourishing.

Furthermore, conceptualising reproductive autonomy in terms of its relationship with power highlights the failures of a liberal 'hands-off' approach within the equality we see today. The

[52] *Ibid* at 220.
[53] *Ibid* at 219.
[54] Catherine Mills, "Reproductive Autonomy as Self-Making: Procreative Liberty and the Practice of Ethical Subjectivity" (2013) 38 Journal of Medicine and Philosophy 639.
[55] *Ibid.*

negative liberty approach is insufficient because, for those not already empowered to a certain degree by their privilege in society, inaction from policymakers denies these individuals the opportunity of empowerment through reproductive self-determination.[56] Advocating for a 'positive moral right to reproductive choice', Tess Johnson refers specifically to assisted reproductive technologies as 'technologies of power'. Johnson's adoption of Foucault's language in a very literal sense captures the importance of medical advancements to an individual's self-determination and the internal power this requires. Similarly, we can consider safe methods of abortion, such as a medical abortion through 'the abortion pill' and the telemedical provision of abortion care and follow up, to be important "technologies of power" that affirm the abortion seeker's power in self-government and self-definition.[57] All abortion seekers must have these opportunities to access such technologies of power.

Facilitating Female Flourishing

The positive conceptualisation of reproductive autonomy that choices must be exercisable, is also central to female 'flourishing'.[58] An individual's ability to self-define, to live by her own lights, is bolstered by Martha Nussbaum's Capability Approach.[59]

Nussbaum's theory is a universalist approach intertwined with human rights.[60] Nussbaum provides a list of ten capabilities essential to the flourishing of every individual,[61] that is a life worthy of the dignity all human beings possess.[62] Of particular significance for the accessible abortion right are two of Nussbaum's capabilities. Firstly,

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[56] Johnson, *supra* note 41.
[57] *Ibid* at 309.
[58] *Ibid* at 304.
[59] Martha Nussbaum, "Human Capabilities, Female Human Beings" in Martha Nussbaum and Jonathan Glover, eds, *Women, Culture, and Development: A Study of Human Capabilities* (Oxford: OUP, 1995) 61.
[60] *Ibid* at 63.
[61] Martha Nussbaum, "Human Rights and Human Capabilities" (2007) 20 Harv Hum Rts J 21 at 23.
[62] Martha Nussbaum, "Capabilities As Fundamental Entitlements: Sen and Social Justice" (2003) 9 Feminist Economics 33 at 40.

> "*Bodily Health*. Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter,"[63]

and secondly,

> "*Bodily Integrity*. Being able to move freely from place to place; to be secure against violent assault, including sexual assault and domestic violence; having opportunities for sexual satisfaction and for **choice in matters of reproduction**."[64]

The ten capabilities create the minimum standard of acceptable human life and social justice.[65] Therefore, the approach places obligations on states because the failure to guarantee such a standard of life to all individuals 'falls short of being a fully just society, whatever its level of opulence.'[66]

The Capabilities Approach is particularly appealing in its potential to buttress the familiar human rights model. Firstly, the approach affords no distinction between so-called 'first generation' civil and political rights, and 'second generation' social and economic rights.[67] Instead, the ten capabilities are non-hierarchical, they are all equally important to the flourishing of all individuals in areas of common core importance: 'a society that neglects one of them to promote the others has shortchanged its citizens, and there is a failure of justice in the shortchanging.'[68] Eroding the generational dichotomy removes the misconception that first generation rights are more important

[63] Nussbaum, *supra* note 59.
[64] *Ibid.*
[65] *Ibid.*
[66] Nussbaum, *supra* note 62 at 40.
[67] Rita Stephan, "Generations of Women's Human Rights" in Jodi O'Brien, ed, *Encyclopedia of Gender and Society* 2nd ed (SAGE Publications, 2009) 608.
[68] Nussbaum, *supra* note 62 at 40.

with greater impetus on states to implement them.[69] Since first generation rights are negative, the apparent possibility for immediate realisation means that by extension they are misunderstood as more important.[70] It has satisfied the international community that second generation rights, since they place positive obligations upon states for their implementation, may be progressively realised.[71] The lack of immediacy in their realisation has subsequently relegated them to a degree of inferiority.[72]

Instead of arbitrarily categorising rights, Nussbaum values the individual by highlighting the positive obligations inherent to all rights. At the core of Nussbaum's arguments is that the value of rights comes from an individual's ability to exercise it,[73] not in theoretically possessing it.[74] Nussbaum conceptualises rights as 'entitlements to capabilities [which] have material and social preconditions, and all require government action.'[75] It is the exercisability of rights, which must be facilitated by states, which in turn leads to flourishing.

The traditional hierarchy of rights has been undeniably gendered,[76] reflecting the field's preoccupation with the public sphere of life.[77] Therefore, the Capabilities Approach has significant value for women. Human rights has historically been concerned with liberties and ensuring the existence of a private sphere free from interference but offering little protection or regulation within the private realm.[78] This means that human rights, for a long time, failed to regulate a sphere

[69] Claire-Michelle Smyth, "Social and Economic Rights The struggle for equivalent protection" in Jean Quataert and Lora Wildenthal, eds, *The Routledge History of Human Rights* (London: Routledge, 2019) 141.
[70] *Ibid* at 143.
[71] *Ibid.*
[72] *Ibid.*
[73] Johnson, *supra* note 41 at 310.
[74] *Ibid.*
[75] Nussbaum, *supra* note 61 at 21.
[76] Charlotte Bunch, "Women's Rights as Human Rights: Toward a Re-Vision of Human Rights" (1990) 12:4 Hum Rts Q 486.
[77] Nussbaum, *supra* note 62 at 39.
[78] Bunch, *supra* note 76 at 488.

that women disproportionately occupy more than men, leaving them vulnerable to rights violations, violence and discrimination in a sphere neglected by the international community.[79] The Capabilities Approach affords equal consideration to both public and private matters. For example, in the 'bodily integrity' capability, Nussbaum explicitly addresses the violence experienced in the private sphere when she states individuals are to be secure against domestic violence.[80] By focusing on the actual abilities of all individuals, this approach is better equipped to address the lived experiences of women in all spheres of life.[81]

Nussbaum contends that it is in the specificity of her Capabilities Approach that its potential for feminism lies.[82] The explicit commitment that is present in the ten capabilities is a result of real appreciation of individual experience. This assessment of ability makes clear the socially erected impediments to female flourishing.[83] Furthermore, it becomes obvious that governments must take active steps to ensure women can flourish by removing the barriers constructed by society and facilitating their capabilities in a way that may require unequal treatment: 'the state needs to take action if traditionally marginalised groups are to achieve full equality.'[84] A hands-off approach is undeniably insufficient.

As a self-proclaimed universalist approach,[85] Nussbaum's argument faces strong criticism from liberal theory.[86] After the arguments I have made in this chapter, it may be surprising to learn that the critique charges Nussbaum with neglecting autonomy.[87] By providing a definite list of human capabilities central to all human life, Nussbaum arguably ignores an individual's right to

[79] *Ibid.*
[80] Nussbaum, *supra* note 62 at 37.
[81] *Ibid.*
[82] *Ibid* at 33.
[83] *Ibid.*
[84] *Ibid* at 39.
[85] Nussbaum, *supra* note 59 at 63.
[86] *Ibid* at 94.
[87] *Ibid* at 95.

autonomously decide for themselves what is central to their own life.[88] However, this argument overlooks the fact that the capabilities are just that, they are not explicit instructions on how every individual should act. Nussbaum carefully constructs the list with choice as the ultimate driving force.[89] The capabilities leave sufficient room for an individual to choose how they flourish. Instead of directing individual choices, capabilities direct government action to ensure all citizens have the same opportunities of choice – that all have equal opportunity to flourish. The ultimate choice rests with individuals: "A person with plenty of food can always choose to fast."[90] Similarly, an individual with access to abortion is still capable of choosing to carry a pregnancy to term, can still choose to have children. Preoccupied with an autonomous decision-maker caricature, the liberal criticism of the Capabilities Approach ignores significant nuance.

Combining a human rights understanding with the capabilities approach makes the importance of individual reproductive choice and autonomy undeniable. In the production of subjectivity, that is an individual's ability to live by her own lights, the Capabilities Approach appreciates that the individual is best placed to know how she will flourish. Yet concurrently, Nussbaum understands the importance of an individual's ability to actually exercise this self-determination by holding the capabilities as the benchmark all societies must provide for their citizens. The capabilities of bodily health and integrity demand reproductive choice, which we know includes whether or not to have a child, as included in this minimum standard of life. Therefore, governments must take positive action that allows for women to be capable of exercising their right to accessible abortion.

[88] *Ibid.*
[89] *Ibid.*
[90] *Ibid.*

Conclusion

The traditional liberal understanding of autonomy is of little meaning to the contemporary abortion seeker. This understanding of autonomy fails to appreciate the importance of exercisable choice for reproductive decision-making to be understood as truly autonomous. Since the exercise of self-governed reproductive choice is also intimately linked to power, the role of law and public policy in facilitating female power and exercising reproductive rights is emphasised. Reproductive self-determination demands abortion that is *accessible*. Accessible abortion necessitates the provision of a public framework that facilitates the exercisability of this right. Furthermore, the accessibility of abortion is integral to the achievement of bodily health and integrity, capabilities that are essential to the fundamental standard of living and therefore must be expedited by law and policy. The demand for a right to accessible abortion is clear; the next chapter will assess what the right to accessible abortion actually looks like and what it demands of states.

Chapter III: Accessible Abortion as a Human Right

Introduction

There is no express right to abortion enshrined in international law. Instead, we find its existence rooted in other explicitly protected rights, as well as the work of treaty bodies. This chapter will establish that accessible abortion is a human right by virtue of a 'constellation' of State obligations[91] stemming from the rights to life, health, equality and dignity (freedom from cruel, inhuman or degrading treatment). An individual's ability to access abortion is crucial for her enjoyment of these rights. Additionally, implementation of the right to accessible abortion is informed by state obligations under the, in practice, competing freedoms of religion and conscience and expression.

To establish a benchmark of assessment for the lived reality of abortion seekers in Canada and in England and Wales, the following rights arguments are grounded in instruments and institutions these countries have accepted the jurisdiction of. For a robust grounding of the right to accessible abortion, this chapter includes regional systems of rights protection, namely the European Convention on Human Rights and the Organisation of American States, as well as international rights bases from the United Nations.

The Right to Life

Article 6 of the International Covenant on Civil and Political Rights (ICCPR) enshrines that 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be

[91] Christina Zampas and Jaime M Gher, "Abortion as a Human Right – International and Regional Standards" (2008) 8:2 HRL Rev 249 at 255.

arbitrarily deprived of his life.'[92] It is 'the supreme right from which no derogation is permitted,'[93] it is interrelated with the enjoyment of all other rights and is not, according to the Human Rights Committee (HRC), to be 'interpreted narrowly'.[94] The right to life 'concerns the entitlement of individuals to be free from acts and omissions that are intended or may be expected to cause their unnatural or premature death, as well as to enjoy a life with dignity.'[95] The right to life is also well established in regional systems: Article 2 of the ECHR; Article 1 of the American Declaration of the Rights and Duties of Man; and Article 4 of the American Convention on Human Rights. The right to life's importance entitles it to a broad scope of interpretation.

The HRC has been explicit that abortion is implicated by the right to life. General Comment 36 states that domestic regulation of abortion 'must not result in violation of the right to life of a pregnant woman or girl, or her other rights under the Covenant.'[96] The Committee also emphasises that regulation 'must not, inter alia, jeopardize their lives, subject them to physical or mental pain or suffering that violates article 7 of the Covenant [freedom from cruel, inhuman or degrading treatment], discriminate against them or arbitrarily interfere with their privacy.'[97] Therefore, a state's abortion law and policy must not risk the lives of pregnant people, otherwise states violate the right to life.

[92] *International Covenant on Civil and Political Rights*, 19 December 1966, 999 UNTS 171 article 6 (entered into force 23 March 1976) [ICCPR].
[93] UNHRC, *General Comment No. 36*: *Article 6 (Right to Life)*, 124th Sess, adopted 8 October 2018, UN Doc CCPR/C/GC/36, online: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G19/261/15/PDF/G1926115.pdf?OpenElement>.
[94] *Ibid.*
[95] *Ibid* at para 3.
[96] *Ibid* at para 8.
[97] *Ibid.*

Pregnancy is dangerous

It is widely accepted that where pregnancy threatens the life of the pregnant person, the right to life means they are entitled to an accessible abortion.[98] This is confirmed by the HRC in General Comment 36 which concerned the right to life:

> 'States parties must provide safe, legal and effective access to abortion where the life and health of the pregnancy woman or girl is at risk, or where carrying a pregnancy to term would cause the pregnant woman or girl substantial pain or suffering, most notably where the pregnancy is the result of rape or incest or where the pregnancy is not viable.'[99]

However, all pregnancy is an enormous physical undertaking. It carries significant risks to the life of the pregnant person - childbirth even more so.[100] There are enormous lists of common, but by no means minor, complications associated with pregnancy;[101] '[t]he fact that women regularly choose to endure this and are often thrilled with the outcome shouldn't blind us to the fact that pregnancy is a risky endeavour.'[102] Statistically, abortion in accordance with medical best practice will always be safer than childbirth.[103]

Being forced to carry an *unwanted* pregnancy to term and birth an unwanted child drastically increases the threat to the pregnant person's life.[104] 'The Turnaway Study' was a ten-year study conducted in the USA where researchers compared the experiences of individuals who obtained

[98] Zampas and Gher, *supra* note 91 at 254.
[99] UNHRC, *supra* note 93 at para 8.
[100] Shari Motro, "The Price of Pleasure" (2010) 104:3 Nw U L Rev 917 at 923.
[101] Diana Greene Foster, *The Turnaway Study: Ten Years, a Thousand Women, and the Consequences of Having – or Being Denied – an Abortion* (New York: Scribner, 2021) at 124.
[102] *Ibid.*
[103] Jennifer S Hendricks, "Body and Soul: Equality, Pregnancy, and the Unitary Right to Abortion" (2010) 45:2 Harv CR-CLL Rev 329 at 343.
[104] Foster, *supra* note 101 at 122.

an abortion with individuals who were denied an abortion.[105] Both groups of interviewees reported side-effects of their experiences, however the degree of complication was incomparable.[106] Individuals who had an abortion reported bleeding, cramps and nausea, whereas those who were denied an abortion and gave birth reported serious complications such as preeclampsia, haemorrhage, pelvis fracture and serious bleeding requiring transfusion.[107] One participant who was denied an abortion, and gave birth to an unwanted child, died from an infection rarely fatal outside of pregnancy.[108] Having wanted a termination, this participant's death demonstrates the study's harrowing finding that 'the stresses of carrying an unwanted pregnancy to term and perhaps the lack of social support that made that pregnancy unwanted in the first place may substantially increase the risk of death for women who prefer an abortion.'[109] For example, an individual who wanted an abortion but is denied one are less likely to take prenatal medication.[110] The study did not have any deaths of participants related to abortions.

Furthermore, being forced to carry and birth an unwanted pregnancy is detrimental for mental health.[111] Individuals who are denied an abortion suffer significantly greater anxiety and lower self-esteem than those able to access a termination.[112] Contrary to the misinformation often spread by anti-abortion groups,[113] women who have abortions do not generally come to regret this decision.[114] These claims are unfounded. A 2020 study found 'no support for claims that abortion

[105] *Ibid.*
[106] *Ibid.*
[107] *Ibid* at 124.
[108] *Ibid* at 129
[109] *Ibid.*
[110] *Ibid* at 125.
[111] Hendricks, *supra* note 103 at 364.
[112] Antonia Biggs, "Women's Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion", online: (2017) 74:2 JAMA Psychiatry 169 <10.1001/jamapsychiatry.2016.3478>.
[113] Reva Siegel, "The Right's Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument" (2008) 57:6 Duke LJ 1641.
[114] Corrine Rocca et al, "Emotions and decision rightness over five years following an abortion: An examination of decision difficulty and abortion stigma", online: (2020) 248 Social Science & Medicine 112704 <https://doi.org/10.1016/j.socscimed.2019.112704>.

causes negative emotions or that women typically come to regret their abortions.'[115] Instead, at all points following termination, 'relief was the most commonly felt emotion.'[116] Individuals denied access to abortion undoubtedly experience 'substantial pain or suffering' – the threshold that the HRC purports to trigger State action to 'provide safe, legal and effective access to abortion'.

Law that allows abortion only under a limited circumstance are based on a misunderstanding that only an abnormal pregnancy is one that threatens a pregnant person's life. This is not true. Pregnancy always presents risks to an individual's life – an unwanted pregnancy exacerbates this. Being forced to carry an unwanted pregnancy will always cause the 'substantial pain and suffering' required for the right to accessible abortion.

The clandestine abortion

Furthermore, inaccessible abortion threatens the lives of pregnant people because it is well-established that laws restricting access to lawful abortions drives services 'underground'.[117] To avoid the unbearable suffering of unwanted pregnancy, women are forced to obtain clandestine abortions.[118] Clandestine abortions can be extremely dangerous; approximately 68,000 women die from unsafe abortions every year.[119] Although the actual figure is likely to be much higher due to underreporting.[120] Methods of unsafe abortion include ingesting toxins such as bleach, or inserting various household instruments into the cervix.[121]

[115] *Ibid* at 7.
[116] *Ibid.*
[117] Zampas and Gher, *supra* note 91 at 255.
[118] *Ibid.*
[119] Lisa Haddad and Nawal Nour, "Unsafe Abortion: Unnecessary Maternal Mortality" (2009) 2:2 Rev Obstet Gynecol 122.
[120] *Ibid.*
[121] *Ibid* at 123.

Thankfully, contemporary less-invasive methods of abortion using medication have eroded the dichotomy between safe lawful abortion, and unsafe clandestine abortion.[122] The non-profit organisation Women on Web remotely provides abortion medication safely to individuals in jurisdictions where abortion seekers face prosecution.[123] An unlawful abortion is no longer a death sentence. However, it is understood that abortion is safest when an individual has access to medical support for after-care or the rare event of complication.[124] Let me be clear, this does not mean that abortion must be carried out in a hospital by doctors. Instead, the right to life demands access to abortion that lawfully operates within a medical framework of support so that women are not forced to seek abortions of a lesser quality. Overall, since people with reproductive capacity will always need abortions, women will continue to be forced to terminate pregnancies at a standard that is not best practice where a lawful abortion is inaccessible, instead risking their lives.

Abortion delays increase risks

Inaccessible abortion also threatens the right to life because it subjects individuals to unnecessary delays accessing abortion care. Although abortion, when carried out in line with medical guidelines, is incredibly safe for the individual, risks do increase with gestation.[125] Therefore, when an individual cannot access timely abortion care, the risks to her life are increasing. Furthermore, for a person who has already decided they require an abortion, to be kept waiting is detrimental to her wellbeing, contributing to high levels of stress.[126] Law and policy that increases threats to an individual's physical and mental wellbeing disregards 'the entitlement of individuals...to enjoy a life with dignity' as the right to life provides.

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[122] Rebecca J Cook, "Stigmatized Meanings of Criminal Abortion Law" in Rebecca J Cook, Joanna N Erdman and Bernard M Dickens, eds, *Abortion Law in Transnational Perspective* (Philadelphia: Penn Press, 2014) 347 at 352.
[123] Rebecca Gomperts et al, "Using telemedicine for termination of pregnancy with mifepristone and misoprostol in settings where there is no access to safe services" (2008) 115:9 BJOG 1171.
[124] World Health Organisation, *Abortion care guideline* (Geneva: WHO, 2022) at 80.
[125] Royal College of Obstetricians and Gynaecologists, *supra* note 6.
[126] Julia Steinberg et al, "Psychosocial factors and pre-abortion psychological health: The significance of stigma" (2015) 150 Social Science & Medicine 67.

State obligations

The right to life can no longer be considered a negative right,[127] it is unhelpful for fulfilling the right to accessible abortion. In General Comment No 36, the Human Rights Committee confirmed the right to life operates on a spectrum of obligation: 'obligation of States parties to respect and ensure the right to life, to give effect to it through legislative and other measures, and to provide effective remedies and reparation to all victims of violations of the right to life.'[128] Since inaccessible abortion threatens the right to life, somewhere on this spectrum of obligation lies the positive provision of accessible abortion. Without this, the right to life cannot be enjoyed in its entirety by all individuals with the capacity for pregnancy.

Elaborating on the right to life's specific abortion-related state obligations, the HRC confirms that states should not regulate abortion using criminal sanctions since doing so "compels women and girls to resort to unsafe abortion."[129] Furthermore, states should actively "remove existing barriers to effective access by women and girls to safe and legal abortion" and should "prevent the stigmatization of women and girls who seek abortion.'[130]

Overall, states must fulfil their positive obligations under the right to life, namely the provision of accessible abortion, so that women are not subject to unwanted pregnancy or dangerous clandestine abortions or delayed care – all of which unnecessarily threaten a pregnant person's life.

[127] Ida Koch, "Dichotomies, Trichotomies or Waves of Duties?" (2005) 5:1 HRL Rev 81.
[128] UNHRC, *supra* note 93.
[129] *Ibid.*
[130] *Ibid.*

Freedom from Cruel, Inhuman or Degrading Treatment

The right to be free from cruel, inhuman or degrading treatment (CIDT) is well-established. On a global scale, this freedom is enshrined in article 7 of the ICCPR.[131] Regionally, article 3 of the ECHR prohibits 'inhuman or degrading treatment or punishment'[132] whilst article 5 of the American Convention on Human Rights protects the right to humane treatment, similarly prohibiting 'cruel, inhuman or degrading punishment or treatment.'[133] At its core, this is a right protecting an individual's inherent dignity and integrity (physical and mental).[134] This right goes beyond the right to life's protection of an individual's ability to live, instead dignity is concerned with *how* an individual lives – free from CIDT.[135] For an individual with the capacity to become pregnant, her dignity is dependent on her ability to control her reproductive choices.[136] Therefore, international human rights bodies have recognised that denying access to abortion can amount to CIDT. The result of long-fought battle by feminists to recognise the suffering unique to women as rights violations.[137]

European advancements

There is significant jurisprudence from the European Court of Human Rights (ECtHR) concerning the relationship between inaccessible abortion and CIDT. There are four cases worthy of attention. In 2007 the ECtHR heard *Tysiąc v Poland* which concerned a Polish woman denied an abortion

[131] ICCPR, *supra* note 92 article 7.
[132] *European Convention on Human Rights*, 4 November 1950, article 3 [ECHR].
[133] *American Convention on Human Rights*, 22 November 1969, article 5 [ACHR].
[134] UNHRC, *General Comment No. 20: Article 7 (Prohibition of Torture, or Other Cruel, Inhuman or Degrading Treatment or Punishment)*, 44th Sess, adopted 10 March 1992, UN Doc HRI/GEN/1/Rev.9, online: <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2FCCPR%2FGEC%2F6621&Lang=en>.
[135] Samantha Halliday, "Protecting human dignity: reframing the abortion debate to respect the dignity of choice and life" (2016) 13:4 Contemporary Issues in Law 287.
[136] Alyson Zureick, "(En)Gendering Suffering: Denial of Abortion as a Form of Cruel, Inhuman or Degrading Treatment" (2015) 38:1 Fordham Int'l J 99.
[137] *Ibid.*

despite the fact it may lead to her blindness.[138] Poland's abortion law permits termination where pregnancy threatens the individual's health however healthcare providers still refused. Unable to obtain an abortion, the applicant birthed the child and her eyesight deteriorated to the extent that she was disabled.[139] The ECtHR found a breach of the applicant's right to privacy, but not her Article 3 right – the Court dismissed the claim, apparently due to the facts being too far removed from the typical Article 3 case of an imprisoned male being tortured.[140] In 2010, the ECtHR declined to consider the Article 3 violation alleged by the applicants in *A, B, and C v Ireland*.[141] The domestic law on abortion in Ireland at the time was unclear, whilst abortion was strictly prohibited, its exception concerning 'real and substantial' risk lacked practical impact.[142] According to the Court, being forced to travel to England to secure an abortion did not reach the threshold of CIDT.

The attitude of the ECtHR shifted when it found an Article 3 violation in *R.R. v Poland* in 2011.[143] R.R. was repeatedly denied the prenatal genetic testing that would confirm a suspected foetal abnormality, which would entitle her to a lawful abortion in Poland.[144] The applicant was subject to an incredibly arduous and lengthy search for the testing to which she was legally entitled.[145] After receiving confirmation of the foetal abnormality ten weeks later, the applicant was refused an abortion. Doctors claimed her gestation was now too far along.[146] The ECtHR found that the needless delays R.R. was subjected to in trying to access services she was entitled to domestically constituted pain and suffering to the level required by Article 3.[147] Furthermore, the Court found

[138] *Tysiąc v Poland*, No 5410/03, [2007] ECHR 212, 45 EHRR 42.
[139] *Ibid* at para 18.
[140] The Court referred to its judgment in *İlhan v. Turkey*, No 22277/93, [2000] ECHR 35, (2002) 34 EHRR 36.
[141] *A, B, and C v Ireland*, No 25579/05, [2010] ECHR 2032, (2011) 53 EHRR 13.
[142] *Ibid* at para 253.
[143] *R.R. v Poland*, No 27617/04, [2011] ECHR 828, 53 EHRR 31.
[144] *Ibid.*
[145] *Ibid.*
[146] *Ibid* at para 33.
[147] *Ibid* at para 161.

the applicant, in a position of vulnerability,[148] was humiliated by the doctors' treatment.[149] In 2012, the ECtHR again found a violation of Article 3 in *P & S v Poland*.[150] The treatment of the applicants in this case is alarming. P was a 14-year-old girl, pregnant as a result of rape, who was repeatedly denied an abortion she was legally entitled to under Polish law. P and S (P's mother) were subsequently subject to disclosure of their personal information in the media; repeated harassment; police investigation; the temporary removal of P from S's custody and placement in a juvenile shelter.[151] The Ministry of Health intervened to secure P an abortion in a hospital 500 kilometres away from her home, however the details of this had again been published by the media.[152] The ECtHR, highlighting P's vulnerability as a minor and rape victim, found a violation of P's Article 3 right – that her treatment amounted to CIDT.[153]

Comparing the fact that the ECtHR found violations of Article 3 only where it was clear that the applicants had been denied access to treatment they were domestically entitled to, it is easy to conclude that the ECtHR is concerned with procedural matters - particularly since the Court has never found the substance of a domestic abortion law to be in violation of Article 3.[154] Alternatively, it can be argued that the trajectory of the Court's decisions was merely an attempt to strategically increase the stakes to influence Poland.[155] However, a closer examination of the factors that influenced the court reveals a real concern for reproductive autonomy and the pain and suffering caused when it is ignored.[156] For example, in *R.R.*, the ECtHR labours a discussion on a pregnant person's entitlement to make fully informed decisions, as well as the exacerbation of pain and suffering caused by the delay to her treatment - ultimately '[h]er concerns were not properly

[148] *Ibid* at para 159.
[149] *Ibid* at para 160.
[150] *P & S v Poland*, No 57375/08, [2012] ECHR 1853.
[151] *Ibid.*
[152] *Ibid* at para 41.
[153] *Ibid* at para 166.
[154] Zureick, *supra* note 136 at 113.
[155] *Ibid* at 123.
[156] *Ibid* at 124.

acknowledged and addressed'.[157] Similarly in *P & S*, 'the Court considers that no proper regard was had to the first applicant's vulnerability and young age and her own views and feelings.'[158] The development of the ECtHR's jurisprudence signals a growing appreciation for the relationship between reproductive autonomy and dignity. The ability of an individual to make actionable reproductive choices is intimately related to her ability to live with dignity.

Human Rights Committee

The HRC provided the first international decision that recognised that the pain and suffering of being denied abortion can amount to CIDT in *KL v Peru*.[159] The case concerned 17-year-old KL whose pregnancy was non-viable and carrying to term threatened her life, both physically and through prolonged mental suffering. However, whilst Peru allows abortion under a limited exception where the woman's life or health is threatened, KL was denied an abortion.[160] Peru's hospitals found KL's situation did not fall within the remit of the exception. Forced to continue her pregnancy to term, KL gave birth to a baby who died four days later. KL became severely depressed and required psychiatric treatment.[161] The case is particularly significant for focusing on KL's mental suffering as CIDT, it 'relates not only to physical pain but also to mental suffering.'[162] Furthermore, the Committee's CIDT finding was unrelated to KL's entitlement to a lawful abortion under domestic law – the HRC prioritised the individual's substantive experience. In 2011 the Committee found a violation of the prohibition of CIDT in *LMR v Argentina* where repeated denial of a lawful abortion amounted to humiliation, ultimately forcing LMR to obtain a

[157] *R.R.*, *supra* note 143 at para 159.
[158] *P & S*, *supra* note 150 at para 166.
[159] UNHRC, Communication No 1153/2003, *KL v Peru*, UN Doc CCPR/C/85/D/1153/2003, online: <https://www.escr-net.org/sites/default/files/caselaw/decision_0.pdf>.
[160] *Ibid.*
[161] *Ibid* at para 2.6.
[162] *Ibid* at para 6.3.

clandestine abortion.[163] The HRC paid particular attention to LMR's vulnerability as a minor with diminished mental capacity, who was pregnant as a result of rape.[164]

Overall, it is clear that there is no bright line rule on when denial of abortion amounts to CIDT, human rights bodies have been clear that each case is to be judged by its own merits. However, there are some identifiable principles which courts consider. Important is the frequent consideration of 'autonomy deficits', specifically where the applicant is a vulnerable individual.[165] For example, as in the cases of *P&R* and *LMR*, the bodies found that the vulnerability of the abortion seekers exacerbated their pain and suffering. Furthermore, where the individual is pregnant as a result of rape, this can also be considered an autonomy deficit that will make denial of their abortion more likely to constitute CIDT.[166] International human rights law seems coherent in its appreciation that denying an abortion to individuals with an autonomy deficit is particularly cruel.[167]

However, we must be cautious of identifying a group of individuals more 'deserving' of an abortion.[168] There are, of course, greater autonomy interests at play for any individual seeking an abortion than whether the individual is pregnant because of rape. Particularly since this reinforces the idea that individuals consenting to have sex for pleasure and not procreation should expect to experience the punishment of unwanted pregnancy.[169] Inaccessible abortion commandeers a woman's reproductive decision-making, her autonomy is ignored since she cannot make her own

[163] UNHRC, Communication No 1608/2007, *LMR v Argentina*, UN Doc CCPR/C/101/D/1608/2007, online: <https://www.escr-net.org/sites/default/files/Decision.pdf>.
[164] *Ibid* at para 9.2.
[165] Zureick, *supra* note 136 at 135.
[166] *Ibid.*
[167] *Ibid.*
[168] Lisa Kelly, "Reckoning with Narratives of Innocent Suffering in Transnational Abortion Litigation" in Rebecca J. Cook, Joanna N. Erdman & Bernard M. Dickens, ed, *Abortion Law in Transnational Perspective* (Philadelphia: Penn Press, 2014) 303 at 317.
[169] Drucilla Cornell, *The Imaginary Domain: Abortion, Pornography and Sexual Harassment* (New York: Routledge, 1995) at 81.

actionable and value-driven reproductive choices. Instead, she will be involuntarily subject to the significant and detrimental physical and mental health changes that accompany unwanted pregnancy. Therefore, a woman's dignity cannot be separated from her reproductive autonomy and abortion must be accessible for all if she is to not be subject to CIDT.

The Right to Health

The first acknowledgement of a right to health came in the Universal Declaration of Human Rights under which Article 25 holds that '[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care.'[170] However, the International Covenant on Economic, Social and Cultural Rights (ICESCR) enshrines what is widely considered the most influential articulation of the right to health,[171] and it is here that I will ground my argument for a right to accessible abortion by virtue of health. Article 12 stipulates that the States parties to the Covenant 'recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'[172] The existence of a universal right to health is certain, a right that Canada and the UK have committed to through treaty ratification.

The meaning of 'health'

The scope of the right to health is expansive.[173] The meaning of 'health' is internationally understood as more than just a state of physical wellbeing.[174] For example, the World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being

[170] *Universal Declaration of Human Rights*, UNGA, 3rd Sess, UN Doc A/810 (1948) GA Res 217A (III) article 25.
[171] Ronli Sifris, "Restrictive Regulation of Abortion and the Right to Health" (2010) 18 Med L Rev 185 at 191.
[172] *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 article 12. [ICESCR]
[173] Sifris, *supra* note 171 at 192.
[174] *Ibid.*

and not merely the absence of disease or infirmity.'[175] Human rights bodies have implemented a broad right to health –the HRC has used the WHO definition to read mental health into a State's domestic exception to unlawful abortion based on threats to the pregnant person's health.[176] There is a consensus that people have a right to physical and mental well-being that is also integral to the operation of other rights.

It may seem obvious to those with female reproductive capacity that their reproductive health ought to be a part of this universal right to health.[177] However, international law historically failed to consider experiences uniquely impactful upon women.[178] The inclusion of reproductive rights in international law is no exception. Therefore, reproductive healthcare's absence from Article 12 is unsurprising despite physiological differences dictating vastly different healthcare needs. Thankfully, the implementation of CEDAW demonstrates that international human rights appreciate women's experiences and that gender-sensitive measures of implementation may be required to ensure female flourishing, this includes in matters of healthcare.

In 2000, the Committee on Economic, Social and Cultural Rights (ComESCR) finally elaborated on the scope of the right to health. Paragraph 8 of its General Comment No14 stipulates that:

> "The right to health includes both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference...By contrast, the entitlements include the right to a

[175] *Constitution of the World Health Organisation*, 22 July 1946, 14 UNTS 185.
[176] *KL v Peru, supra* note 159.
[177] Sifris, *supra* note 171 at 193.
[178] Hilary Charlesworth, Christine Chinkin and Shelley Wright, "Feminist Approaches to International Law" (1991) 85:4 Am J Intl L 613.

> system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[179]

Therefore, the right to health now explicitly includes reproductive health, defined by the Committee as "the freedom to decide if and when to reproduce and the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate healthcare services."[180] Thus, the right to reproductive healthcare has *both* negative and positive obligations, it must be respected through non-interference, and fulfilled by facilitating the enjoyment of the highest attainable level of public health.

In 2016 the Committee published General Comment No22, devoted solely to the right to sexual and reproductive health under Article 12. The Committee felt that access to reproductive healthcare remained "seriously restricted."[181] The Comment provided arguably the most detailed articulation of the right to reproductive health to date:

> 'The freedoms include the right to make free and responsible decisions and choices, free of violence, coercion and discrimination, regarding matters concerning one's body and sexual and reproductive health. The entitlements include unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health.'[182]

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[179] UNComESCR, *General Comment No.14: Article 12 (Right to the highest attainable standard of health)*, 22nd Sess, adopted 11 August 2000, UN Doc E/C.12/2000/4, online: <https://digitallibrary.un.org/record/425041?ln=en> at para 8.
[180] *Ibid* at para 12.
[181] UNComESCR, *General Comment No.22: Article 12 (Right to sexual and reproductive health)*, adopted 2nd May 2016, UN Doc E/C.12/GC/22, online: <https://digitallibrary.un.org/record/832961?ln=en> at para 2.
[182] *Ibid*, at para 5.

This articulation makes hugely significant advances for the position of reproductive health in international law. The Committee advocates the importance of autonomous choice, bodily integrity, accessibility and equal opportunity of the enjoyment of the right to health in matters of reproduction. The application of this demands the accessibility of abortion. Moreover, in the midst of a global pandemic, the WHO classified abortion as essential healthcare service in 2020.[183] Subsequently, it is undeniable that accessible abortion is crucial to the reproductive healthcare right.

Overall, as a matter of essential reproductive healthcare, an individual must have a right to abortion by virtue of her Article 12 'right to make free and responsible decisions...regarding matters concerning one's body'. This abortion must then be accessible by virtue of her entitlements to 'unhindered access' and a 'system of health protection' which must operate to ensure the 'enjoyment of the right for all.' Accessible abortion is reproductive healthcare under the definitions agreed upon in international human rights law.

Implementation obligations

It is important to make clear that the right is not a right to be healthy, this would lead to the absurdity that States violate the rights of their citizens whenever an individual was ill.[184] Instead, when it comes to the implementation of the right to health, the ComESCR confirmed that state obligation are threefold.[185] In order to respect the right to health, states must 'refrain from interfering directly or indirectly with the enjoyment of health.'[186] To protect the right, states must 'take measures that prevent third parties from interfering with the right.'[187] Lastly, to fulfil the

[183] World Health Organisation, *supra* note 4.
[184] Joseph Raz, "Human Rights in the Emerging World Order" (2010) 1:1 Transnational Legal Theory 31 at 45.
[185] *General Comment No.14*, *supra* note 179 at para 33.
[186] *Ibid.*
[187] *Ibid.*

right, states must 'adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.'[188] As a matter of health then, the implementation of the right to accessible abortion is no exception. States must respect it through non-interference, protect it from the interference of others, and fulfil it by taking the necessary measures to render abortion accessible.

In General Comment No22 the Committee categorises the 'interrelated and essential elements' of 'comprehensive' reproductive health care.[189] Firstly 'availability', under which the Committee expressly demands the availability of essential medication for abortion and post-abortion care.[190] Secondly, 'accessibility' which includes physical accessibility, affordability and information.[191] The third essential element of reproductive care is its 'acceptability' which demands care be respectful and sensitive to cultural differences and diversity of individuals.[192] Lastly, reproductive healthcare must be of 'good quality, meaning that they are evidence-based and scientifically and medically appropriate and up-to-date.'[193] Therefore, States are under an obligation to ensure methods of abortion are available, that they are affordable and physically accessible, that care is provided in a culturally sensitive manner and of good quality. The right to health demands states provide abortion care in a manner consistent with medical best practice and not, as is so often the case, driven by political ulterior motives[194] or historic female stereotypes and control.[195]

[188] *Ibid.*
[189] *General Comment No.22*, *supra* note 181 at para 11.
[190] *Ibid* at para 12.
[191] *Ibid* at para 15.
[192] *Ibid* at para 20.
[193] *Ibid* at para 21.
[194] Moreau et al, *supra* note 13 at 2.
[195] Sheldon, *supra* note 8 at 17.

So, what is best practice? According to the WHO,[196] and professional medical bodies,[197] best practice in abortion care calls for an individual being able to choose which method of abortion is best for her. This is important because the methods of abortion vary significantly, with particular impact on the individual.[198] For example, a surgical abortion is the most invasive method of terminating a pregnancy, of which there are several kinds. The gestation of the individual determines which type of surgical abortion is safest and most medically appropriate for the individual; it also determines its painfulness and efficacy. A medical abortion involves the medication mifepristone and misoprostol, commonly referred to collectively as 'the abortion pill'. Mifepristone is to be taken orally, followed 24-48 hours later by misoprostol which safely induces a miscarriage. Misoprostol may be administered vaginally, buccally, or sublingually - the method of administering misoprostol varies depending on the gestation.[199] An individual may prefer a surgical abortion since the procedure is relatively quick and generally less painful due to the routine offering of pain management.[200] Further, an individual may find comfort in the immediate relief that termination was successful since the WHO requires the provider to confirm surgical abortion completeness.[201] On the other hand, an individual may prefer a medical abortion since it can be carried out in the comfort of the home, offering privacy and convenience, whilst another with a fear of blood may not be comfortable with a medical abortion.[202] An abortion seeker may choose one method of abortion over another for many reasons, all equally valid. Therefore, states are under an obligation to facilitate a framework that gives abortion seekers these important choices. Furthermore, since the availability of methods are dictated in part by gestation, abortion

[196] WHO, *supra* note 124.
[197] National Institute for Health and Care Excellence, "Abortion Care" (September 2019), online (NICE guideline): <https://www.nice.org.uk/guidance/ng140/resources/abortion-care-pdf-66141773098693>.
[198] Jordan Parsons and Elizabeth Chloe Romanis, *Early Medical Abortion, Equality of Access, and the Telemedical Imperative* (New York: OUP, 2021) at 3.
[199] WHO, *supra* note 124 at 68.
[200] Parsons and Romanis, *supra* note 198.
[201] *Ibid.*
[202] Kathryn LaRoche and Angel Foster, "'It gives you autonomy over your own choices': A qualitative study of Canadian abortion patients' experiences with mifepristone and misoprostol" (2020) 102 Contraception 61 at 63.

care remains time sensitive. The framework must operate efficiently so that an individual's choice is respected, and she is not forced into a method of care that she does not believe to be most appropriate for her because she faced delays in accessing services.

In General Comment No22, the Committee goes even further to provide the 'core obligations' for states. Of particular value is the obligation '[t]o repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information.'[203] Thus, a state that fails to address barriers to accessing reproductive healthcare, and therefore abortion, fails to implement the right to health, a fact made explicit by the Committee in its "examples of violations":

> "Violations of the obligation to respect occur when the State, through laws, policies or actions, undermines the right to sexual and reproductive health. Such violations include State interference with an individual's freedom to control his or her own body and ability to make free, informed and responsible decisions in this regard. They also occur when the State removes or suspends laws and policies that are necessary for the enjoyment of the right to sexual and reproductive health."[204]

Importantly, in particular for my later assessment of the reality in Canada – where there are no laws specific to abortion,

> "[v]iolations through acts of omission include the failure to take appropriate steps towards the full realization of everyone's right to sexual and reproductive health and the failure to enact and enforce relevant laws. Failure to ensure formal and substantive equality in the

[203] *General Comment No.22*, *supra* note 181 at para 49(a).
[204] *Ibid* at para 56.

> enjoyment of the right to sexual and reproductive health constitutes a violation of this right. The elimination of de jure as well as de facto discrimination is required for the equal enjoyment of the right to sexual and reproductive health."[205]

Overall, abortion is essential reproductive healthcare. Therefore, by virtue of the right to health, there is an obligation upon states to provide equal access to abortion. The ComESCR, particularly so in its General Comment No22, has provided ample guidance on how states can fulfil their obligations with regard the right to reproductive health and therefore, the right to accessible abortion. These obligations include providing access to available abortion care of high quality that is in line with medical best practice. Therefore, the right to health demands both abortion access and abortion choice.

Equality and Non-Discrimination

Article 2 of the ICCPR holds States must guarantee the rights within the Covenant to all people, 'without discrimination of any kind.'[206] Article 26 of the same Covenant states that '[a]ll persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as...sex.'[207] Article 3 of the ICESCR holds that 'States Parties to the present Covenant undertake to ensure the equal right of men and women to the enjoyment of all economic, social and cultural rights set forth in the present Covenant,'[208] which includes the right to health discussed above. Equality is therefore well-established as a human right, and as a precondition for the enjoyment of other rights. However, it

[205] *Ibid* at para 55.
[206] ICCPR, *supra* note 92 article 2.
[207] *Ibid* article 26.
[208] ICESCR supra note 172 article 3.

is the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) that made significant progress in the fight for sex equality.[209]

CEDAW marked a momentous move away from anti-discrimination provisions in international human rights law that had thus far applied equally to men and women.[210] Instead, CEDAW focuses on the experiences of sex discrimination that are unique to women.[211] Article 1 of the Convention defines discrimination 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 rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.'[212] The Convention appreciates that meaningful change requires an approach focused on women.

CEDAW's focus is the *active elimination* of the discrimination women experience.[213] Article 2 holds that 'States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women.'[214] Article 2 then proceeds by providing a list of positive actions States must 'undertake', for example taking the necessary legal and non-legal methods for the 'practical realisation' of the principle of equality of men and women.[215] At the very heart of CEDAW is transformative equality.[216] Whilst formal equality is essential to the implementation of CEDAW, it is not

[209] *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981). [CEDAW].
[210] Simone Cusack and Lisa Pusey, "CEDAW and the Rights to Non-Discrimination and Equality" (2013) 14:1 Melbourne J Int'l L 1.
[211] *Ibid* at 5.
[212] CEDAW, *supra* note 209 article 1.
[213] Rebecca J Cook and Susannah Howard, "Accommodating Women's Differences under the Women's Anti-Discrimination Convention" (2007) 56:4 Emory LJ 1039 at 1043.
[214] CEDAW, *supra* note 209 article 2.
[215] *Ibid.*
[216] Cusack and Pusey, *supra* note 210 at 11.

sufficient. Transformation demands both de jure and de facto equality.[217] For this, the CEDAW Committee makes clear that States must confront,

> 'the underlying causes of discrimination against women, and of their inequality...The lives of women must be considered in a contextual way, and measures adopted towards a real transformation of opportunities, institutions and systems to that they are no longer grounded in historically determined male paradigms of power and life patterns.'[218]

There can therefore be no doubt that States must take positive action to transform female opportunity so that female equality is no longer determined by a historically incorrect inferiority to men. 'Respecting' equality in its traditional, non-interference, understanding would not be transformative. Simone Cusack and Lisa Pusey identify 'two distinct but related categories of obligations' stemming from CEDAW's transformative equality.[219] The first 'concerns the transformation of institutions, systems and structures that cause or perpetuate discrimination and inequality.' This is necessary since, as the Committee makes clear, a State that merely guarantees identical treatment of men and women on paper is insufficient because the 'biological, socially and culturally constructed differences between women and men...may require non-identical treatment' for transformation of women's lived disadvantage.[220] Secondly, states must transform 'harmful norms, prejudices and stereotypes.'[221] These stereotypes inform discriminatory law and policy, and are in turn perpetuated such that they are seemingly validated; they limit female

[217] UN ComEDAW, General Recommendation No. 25: Article 4 (on article 4, paragraph 1 of the Convention: temporary special measures), 30th Sess, adopted 18 August 2004, online: <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2FCEDAW%2FGEC%2F3733&Lang=en>.
[218] *Ibid* at para 10.
[219] Cusack and Pusey, *supra* note 210 at 11.
[220] General Recommendation No.25, *supra* note 217 at para 8.
[221] Cusack and Pusey, *supra* note 210 at 11.

opportunity.[222] I will now consider each category in turn to establish how it demands accessible abortion.

Biological realities and self-determination

Firstly, women's right to equality and non-discrimination demands accessible abortion because the propensity for pregnancy is one that rests with women alone. There must be transformation of law and policy, and medical infrastructure, to facilitate accessible abortion so that women are not disadvantaged by the biological reality that only individuals with female reproductive capabilities may get pregnant.

In 2017, the Working Group on the issue of discrimination against women in law and practice held that '[t]he right of a woman or girl to make autonomous decisions about her own body and reproductive functions is at the very core of her fundamental right to equality and privacy.'[223] Reproductive self-determination is central to equality. According to Rebecca Cook and Susannah Howard, 'non-discrimination serves the ethic of justice that requires that the same interests are treated equally without discrimination.'[224] If we take reproductive self-determination as the interest shared by both men and women, states must treat this interest so that it is equally achievable by men and women. But, as Catharine MacKinnon points out, '[m]en, as a group, are not comparably disempowered by their reproductive capacities. Nobody forces them to impregnate women. They are not generally required by society to spend their lives caring for children to the comparative preclusion of other life pursuits.'[225] It is undeniable that women have a unique, special

[222] General Recommendation No.25, *supra* note 217.
[223] UN Working Group on the issue of discrimination against women in law and in practice, *Women's Autonomy, Equality and Reproductive Health in International Human Rights: Between Recognition, Backlash and Regressive Trends*, 2017, (Working group clarifying its position on termination of pregnancy), online: <https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/WomensAutonomyEqualityReproductiveHealth.pdf>.
[224] Cook and Howard, *supra* note 213 at 1040.
[225] Catharine A MacKinnon, "Reflections on Sex Equality under Law" (1991) 100:5 Yale LJ 1281 at 1313.

interest in achieving reproductive self-determination. Here lies the distinguishing factor that demands the non-identical treatment to secure the transformative equality that CEDAW demands. Furthermore, in its 2022 annual report, the Working Group identified inaccessible abortion care as one of the 'major human rights barriers to girls' and young women's activism.'[226] In order to not be disadvantaged by biology, states must transform law and policy to ensure accessible abortion, thereby bestowing full reproductive self-determination upon women so that they can participate in society, and be autonomous individuals in control of their bodies, to the same extent as men. CEDAW demands women have access to abortion care so that the lived realities of women are transformed to have de facto equality of opportunity.

Gendered stereotypes

Secondly, equality and non-discrimination rights demand accessible abortion because law, policy and practice that renders abortion inaccessible perpetuates discriminatory gendered stereotypes.[227] Article 5(a) of CEDAW enshrines the obligation upon states to transform these discriminatory stereotypes:

> 'States Parties shall take all appropriate measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or superiority of either of the sexes or on stereotyped roles for men and women.'[228]

[226] UN Working Group on discrimination against women and girls, *Girls' and young women's activism* UNGAOR, 50th Sess, UN Doc A/HRC/50/25 (2022) at para 31.
[227] Rebecca J Cook, "International Protection of Women's Reproductive Rights" (1992) 24:2 NYU J Int'l L & Pol 645.
[228] CEDAW, *supra* note 209 article 5(a).

Evidently, States are under an obligation to take active steps to eradicate discriminatory gender stereotypes. This requires the modification of law, policy and practice that is based off of, and/or perpetuates, harmful stereotypes to achieve de facto equality. Abortion law, policy and practice is one of these areas for modification since it is so often based on the stereotyped roles for women – often ensuring their continuity in society.[229] According to Cook and Howard, stereotypes 'generalise 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.'[230] This is because an individual cannot present herself as she chooses – rather she is seen by society in accordance with attributes already ascribed to her group.[231] The stereotype is therefore discriminatory when its application renders the group inferior in some way to the extent that benefits are denied on the basis of belonging to the group.[232]

One stereotype that plays a huge role in abortion regulation is the idea that motherhood is the inevitable female vocation; women are supposed to be mothers.[233] When a woman is able to control sex, specifically its procreative element, she challenges the traditional role ascribed to her – that she will be a mother.[234] Therefore, when abortion is inaccessible, this control is removed. A woman's propensity for reproductive self-determination is removed. Instead, the idea that motherhood is her biological 'destiny' is perpetuated.[235] Thus, she is rendered less autonomous than men whose reproductive self-determination and bodily control is not limited by law and policy that renders procreative choice inaccessible. Hence, those with female reproductive capacity are restricted from full societal participation in a way that men are not. Instead, she is inferior to

[229] Reva Siegel, "The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions" (2007) 2007: 3 U Ill L Rev 991 at 994.
[230] Cook and Howard, supra note 213 at 1043.
[231] Sophia R Moreau, "The Wrongs of Unequal Treatment" (2004) 54:3 UTLJ 291 at 299.
[232] *Ibid.*
[233] Cook, *supra* note 227 at 683.
[234] *Ibid.*
[235] Sheldon, *supra* note 8 at 42.

the man who is not ascribed the same reproductive expectations. A State that does not take all appropriate steps to eradicate this violates equality and non-discrimination rights.

Of particular significance are the discriminatory stereotypes perpetuated by the criminalisation of abortion. Whilst a full assessment of criminal law theory is beyond the scope of this thesis, to assess it perpetuation of stereotypes, a brief consideration of why acts are criminalised is beneficial. Firstly, Mill's hugely influential harm principle holds that 'the only purpose for which power can be rightfully exercised over nay member of a civilised community, against his will, is to prevent harm to others.'[236] Secondly, legal moralism calls for the criminalisation of conduct that society deems morally wrong.[237] The degree of wrongfulness ascribed to particular acts is then reflected in sentencing and what society deems the appropriate degree of punishment.[238] Therefore, the criminalisation of abortion constructs the abortion seeker as 'deviant', an individual who has the potential to harm society and subsequently ought to be punished.[239] The generalisation that abortion seekers are so dangerous in their rejection of motherhood, so morally antagonistic that they must be controlled by criminal law, is a stereotype that informs restrictive abortion policy. Thus, an individual is discriminated against since she can no longer make free and informed reproductive decisions in a policy framework that supports her autonomy.

In 2016, the HRC made timid advancements in holding states accountable for discrimination in abortion law and policy when it provided its decision in *Mellet v Ireland*.[240] The case concerned Ireland's almost-total ban on abortion through criminalisation. Mellet was 21-weeks pregnant when she was informed that the foetus she was carrying had a condition that meant it would die in

[236] John Stuart Mill, *On Liberty* (first published 1859: CUP, 2011) at 22.
[237] Lindsay Farmer, "Criminal Law as an Institution, Rethinking Theoretical Approaches to Criminalisation" in R A Duff et al, ed, *Criminalization: The Political Morality of the Criminal Law* (New York: OUP, 2014) 80 at 82.
[238] Cook, *supra* note 227 at 348.
[239] *Ibid* at 349.
[240] UNHRC, Communication No 2324/2013, *Mellet v Ireland*, UN Doc CCPR/C/116/D/2324/2013, online: < https://juris.ohchr.org/casedetails/2152/en-US>.

utero or immediately after birth.[241] Her healthcare professionals advised her that termination was not possible in Ireland, leaving her with two options: (1) travel to another jurisdiction for an abortion; or (2) carry the pregnancy to term knowing the foetus would likely die in utero after which she would be provided medical care.[242] Mellet travelled to Liverpool, England to obtain a lawful abortion, incurring significant costs to do so.[243] The Committee held that Mellet's treatment in Ireland and necessary travel violated her Article 26 equal protection right under the ICCPR.[244] However, the Committee restricted its consideration of equal protection in terms of other similarly situated pregnant people; according to the HRC, other individuals pregnant with a non-viable foetus would have access to the abortion care that Mellet had to incur significant costs to obtain.[245]

The real value of this case lies in the individual opinion provided by HRC member Sarah Cleveland, who used the opportunity to elaborate on State obligations concerning discriminatory gender stereotypes.[246] Cleveland considers how Mellet 'contends that Ireland's criminalisation of abortion stereotyped her as a reproductive instrument and thus subjected her to discrimination.'[247] The criminalisation of abortion perpetuated the idea that motherhood is the primary role of women.[248] Cleveland confirms that a law that fails to appreciate the biological differences of men and women, that subsequently disadvantages women, is discrimination that fails to 'achieve the "effective and equal empowerment of women".'[249] Additionally, although often evoked by States, 'tradition, history and culture' is an inadequate justification for this discrimination.[250] Cleveland's opinion was confirmed in 2021 when the Working Group on discrimination against women and

[241] *Ibid* at 2.
[242] *Ibid.*
[243] *Ibid* at 17 para 7.10.
[244] *Ibid* at 18 para 8.
[245] *Ibid* at 17 para 7.11.
[246] *Ibid* at Annexe II.
[247] *Ibid* at Annexe II para 4.
[248] *Ibid.*
[249] *Ibid* at Annexe II para 7.
[250] *Ibid* at Annexe II para 15.

girls published its report titled 'Women's and girls' sexual and reproductive health rights in crisis.' It found that discriminatory law, policy and practice violated sexual and reproductive health rights.[251] At the centre of these discriminatory laws and policies were those denying or delaying safe abortion care.[252]

Overall, abortion law and policy that renders the essential healthcare service inaccessible is based off of discriminatory stereotypes and continues to perpetuate them. Subsequently, individual female autonomy is limited, the abortion seeker is denoted as inferior, and she is denied reproductive self-determination. Not only must States take all active measures to eradicate this, States must also transform law and policy so that women are not disadvantaged by biology or their socially determined differences to men. Instead, women's lived realities must be transformed to facilitate female opportunity – targeted approaches to discrimination are necessary for de facto non-discrimination.

This targeted approach must appreciate the intersectional dimensions of discrimination women face,[253] particularly in relation to accessing abortion care. States must recognise that an individual may encounter discrimination on the basis of various and overlapping identities – including race, indigeneity, disability and poverty.[254] CEDAW has been criticised as, at times, "inattentive to women's intersectional disadvantage."[255] However, it does pay limited yet specific attention to the plight of rural women: States "shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women... the

[251] Working Group on discrimination against women and girls, *Women's and girls' sexual and reproductive health rights in crisis*, UNGAOR, 47th Sess, A/HRC/47/38 (2021).
[252] *Ibid.*
[253] Meghan Campbell, "CEDAW and Women's Intersecting Identities: A Pioneering Approach to Intersectional Discrimination" (February 2016), online (Working Paper): <https://globalnaps.org/wp-content/uploads/2018/08/cedaw-and-women-s-intersecting-identities-a-pioneering-approach-to-intersectional-discrimination.pdf>.
[254] *Ibid.*
[255] *Ibid* at 5.

right (b)To have access to adequate health care facilities, including information, counselling and services in family planning".[256] Therefore, it is important to note that States are under an explicit obligation to ensure the accessibility of healthcare for rural women. Transformative approaches to abortion law and policy must ensure that *all* individuals with the capacity to become pregnant have timely access to safe and quality abortion care.

Regional Rights Systems

There is rich jurisprudence from regional human rights systems in their protection of reproductive rights. For example, I have considered the significant jurisprudence of the ECtHR regarding CIDT. Regional systems' protection of human rights is arguably more powerful given its 'potential to act as a conduit in making global human rights local',[257] as well as having greater success in the implementation of rights.[258] The potential of both the Inter-American and European systems to push the boundaries of reproductive rights protection, impacting women's lives, therefore deserves consideration.

The Inter-American System

The Organisation of American States (OAS) has several mechanisms for the protection of rights. There are three main instruments: the 1948 American Declaration of the Rights and Duties of Man; the 1948 Charter of the OAS; and the 1978 American Convention on Human Rights. The Charter established the system's two main institutions designed to protect and promote rights: the Inter-American Commission on Human Rights and the Inter-American Court of Human Rights. Canada became a full member of the OAS in 1990 after signing the Charter, thereby accepting its

[256] CEDAW, *supra* note 209 article 14 (b).
[257] Başak Çalı, "Regional Protection"in chapter 20 in Daniel Moeckli, Sangeeta Shah and Sandesh Sivakumaran, ed, *International Human Rights Law*, 3rd ed (Oxford: OUP, 2018) 411.
[258] *Ibid.*

obligation to implement the rights within the Charter and Declaration. Further, it recognised the authority of the Inter-American Commission, who may make recommendations to states, hear individual complaints and conduct thematic and country-specific investigations. However, Canada has not ratified the Convention, nor has it accepted the jurisdiction of the Court. Therefore, Canada is only under the jurisdiction of the Commission in terms of the rights included in the Declaration which, although not technically a treaty, is understood as binding and justiciable on all OAS member states.[259] Therefore, Canada is obliged to carry out the Commission's recommendations in good faith; assessing the jurisprudence of the OAS remains valuable.

The American Convention is the only major human rights treaty that purports to demand protection of unborn 'life'.[260] As a result of religious influence on drafters, Article 4.1 demands States protect the right to life 'by law and, in general, from the moment of conception.'[261] Whilst this may initially appear damning to the accessible abortion right, an assessment of the Inter-American jurisprudence indicates this is not the case.

The first time the system was required to consider abortion and its relationship to Article 4 was in 1981 in *Baby Boy v USA*.[262] Firstly a note on jurisdiction. As is the case with Canada, the USA is also not a party to the Convention so could only be assessed for its obligations under the American Declaration. Despite this, the Commission provided clear guidance on the right to life. Following the landmark *Roe v Wade* judgment, the Commission was called on to consider the refusal to convict an abortion provider in the USA in terms of 'Baby Boy's' right to life.[263] The Commission

[259] Bernard Duhaime, "Canada and the inter-American human rights system: Time to become a full player" (2012) 67:3 Int'l J 639 at 642.
[260] Patricia Palacios Zuloaga, "Pushing Past the Tipping Point: Can the Inter-American System Accommodate Abortion Rights?" (2021) 21 HRLJ 899 at 914.
[261] *Ibid* at 911.
[262] *White and Potter ('Baby Boy') v the USA*, Case 2141, Inter-Am Comm'n HR, Report No 23/81, OEA/Ser.L/V/II.54, doc. 9 rev. 1 (1981).
[263] *Ibid.*

found that the right to life, in both the Declaration and Convention, was never intended to render abortion unavailable.[264] Instead, the main reason for including foetal protection was to prioritise state participation in the system as the inclusion of the phrase 'in general' catered for both States where abortion is lawful and those where it is not.[265] The *Baby Boy* decision, that abortion was never intended to be rendered inaccessible, remains the key principle of abortion in the Inter-American system.

An interesting trajectory in the system's stance on reproductive autonomy is evident in cases concerning assisted reproduction and forced sterilisation. The Inter-American Court reaffirmed the principles from *Baby Boy* in *Artavia Murillo et al v Costa Rica*.[266] The Supreme Court of Costa Rica had imposed a domestic ban on in-vitro fertilisation, holding that it 'clearly jeopardizes the life and dignity of the human being.'[267] The Inter-American Court once again found that, due to the presence of the term 'general', the Article 4.1 protection of foetal 'life' was never absolute.[268] The Court held that inaccessible reproductive healthcare infringed privacy and integrity rights – both physical and mental. This interpretation has been criticised as 'trivialising' foetal life, prioritising other interests in a manner 'incompatible with the object and purpose of the Convention, which is to protect the right to life, not mandate violations thereof.'[269] Ligia De Jesus charges the Court with the 'relativization of right to life versus the absolute character given to autonomy [which] may eventually undermine the Court's understanding of the right to life in general.'[270] This criticism resents the judgment's potential for abortion access. De Jesus fails to

[264] *Ibid* at para 30.
[265] *Ibid.*
[266] *Artavia Murillo et al v Costa Rica,* Preliminary Objections, Merits, Reparations and Costs, Inter-Am Ct HR, (ser C) No 257 (18 November 2012).
[267] *Ibid* at para 74.
[268] *Ibid* at para 264.
[269] Ligia M De Jesus, "The Inter-American Court of Human Rights' Judgment in Artavia Murillo v Costa Rica and Its Implications for the Creation of Abortion Rights in the Inter-American System of Human Rights" (2014) 16:2 Or Rev Int'l L 225 at 231.
[270] *Ibid* at 232.

consider the suffering experienced by the individual denied reproductive autonomy by necessary medical technology being inaccessible.[271]

In 2016, the Inter-American Court decided in a case of forced sterilisation, *I.V. v Bolivia*.[272] The Court conducted a sophisticated and progressive assessment of the gender stereotypes at play in the delivery of reproductive healthcare.[273] The Court identifies some of the stereotypes ascribed to women most detrimental to their accessibility of reproductive healthcare. Firstly, "women are seen as vulnerable beings, incapable of taking reliable or consistent decisions,"[274] subsequently women are denied information to facilitate full and informed consent. Secondly, "women are considered impulsive and indecisive and in need of the guidance of a more stable person with better judgment, usually a protective man."[275] The Court then developed its understanding of autonomy – moving away from privacy (an understanding similar to Robertson), the Court appreciated the role of autonomy as dignity.[276] The Court understands that, at the core of dignity is self-determination and choice[277] – therefore, autonomy prohibits States from "[converting individuals] into a means for purposes unrelated to their choices about their own life, body and full development of their personality."[278] This includes the use of women's bodies as vessels of reproduction.[279] The Court considers the harm and suffering of individuals to make significant advancements of reproductive autonomy and reproductive rights. The availability of reproductive healthcare is mandated by the right to dignity – and this does not come secondary to an apparent protection of 'foetal life'.

[271] *Artavia Murillo*, *supra* note 266 at para 146.
[272] *I.V. v Boliva*, Preliminary Objections, Merits, Reparations and Costs, Inter-Am Ct HR, (ser C) No 329 (30 November 2016).
[273] *Ibid* at para 187.
[274] *Ibid.*
[275] *Ibid.*
[276] *Ibid* at para 235.
[277] *Ibid* at para 150.
[278] *Ibid* at para 165.
[279] ibid at para 150.

The Inter-American bodies of rights implementation have a long history of avoiding the term 'abortion' in their judgments,[280] most likely a result of the demands of ensuring the participation of deeply religious States.[281] However, this has not prevented the protection of individuals in the most desperate situations. In 2010 the Commission issued precautionary measures in the case of '*Amelia*',[282] a pregnant Nicaraguan woman denied cancer treatment due to the implication it would have on the foetus. The Commission held the State should 'adopt the measures necessary to ensure that the beneficiary has access to the medical treatment she needs to treat her metastatic cancer.'[283] Although not strictly about abortion, the Commission makes clear that priorities lie with the pregnant person – not a foetus. Similarly, in *B v El Salvador* in 2013 both the Court and Commission promoted the achievement of life and rights of the pregnant person through 'all necessary and effective measures' regardless of its effect on the foetus.[284] In the 2015 case of *Mainumby*,[285] the Commission requested the State protect the life of a 10-year-old Peruvian girl raped and denied an abortion when it was deemed pregnancy did not pose a risk to her life.[286] The Commission was fairly obvious in calling for an abortion as a demand of health, albeit without using the word: the State should "guarantee that she has access to medical treatment that is appropriate to her situation and that is recommended by specialists - in light of the technical guidelines of the World Health Organisation and other similar sources applicable in the field of the reproductive health of girls and adolescents – and in which all available options are ensured."[287] Both of the human rights institutions in the Inter-American system are keen to ensure the availability of abortion in at least some situations.

[280] Zuloaga, *supra* note 260 at 919.
[281] *Ibid.*
[282] *'Amelia', Nicaragua*, Case MC 43/10, Inter-Am Comm'n HR, Precautionary Measures (2010).
[283] *Ibid.*
[284] *Matter of B v El Salvador*, Provisional Measures, Order of the Court, Inter-Am Ct HR (ser E) (29 May 2013).
[285] *'Mainumby', Paraguay*, Case MC 178/15, Inter-Am Comm'n HR, Precautionary Measures (2015).
[286] *Ibid.*
[287] *Ibid* at para 23 (translation by Zuloaga, *supra* note 260 at 919).

So, what about the individual simply not wanting children? The OAS jurisprudence on reproductive rights is driven by a potent appreciation of the harm and suffering caused by unwanted pregnancy. As Patricia Zuloaga emphasises in the context of the right to life, "pregnancy and childbirth can be physically and emotionally difficult even if reproduction is very much wanted and all pregnancies carry a heightened risk of death."[288] The Inter-American System jurisprudence is promising though since it uses this suffering to inform its discrimination-aware approach to reproductive autonomy which has developed to be understood as dignity. Dignity that demands access to all reproductive healthcare to facilitate the self-determination of individual choice.

Balancing Competing Rights: The Freedom of Thought, Conscience and Religion

Article 18 of the ICCPR articulates "the right to freedom of thought, conscience and religion"[289] which includes freedom of an individual "to manifest his religion or belief in worship, observance, practice and teaching."[290] Almost identical provisions are found in Article 9 of the ECHR[291] and Article 12 of the American Convention on Human Rights.[292] Common to all of these articulations of the freedom of conscience and religion is the fact that the freedom has two main aspects, each enjoying different levels of protection. First is the freedom of conscience and religion that is integral to an individual's *forum internum*.[293] This freedom is the absolute protection of an individual's autonomous thought and decision-making,[294] this freedom cannot be interfered with

[288] Zuloaga, *supra* note 260 at 923.
[289] ICCPR, *supra* note 92 article 18.
[290] *Ibid* at article 18 para 2.
[291] ECHR, *supra* note 132 article 9.
[292] ACHR, *supra* note 133 article 12. Although the American Convention does not contain explicit protection of freedom of 'thought'.
[293] Tarunabh Khaitan and Jane Calderwood Norton, "The right to freedom of religion and the right against religious discrimination: Theoretical distinctions" (2019) 17:4 Int'l J Constitutional L 1125 at 1130.
[294] *Ibid.*

by the State.[295] The second limb is the freedom to manifest this belief. This is the performative aspect of the freedom – the *forum externum*.[296] This protects practices such as prayer, rituals and "non-coercive attempts to persuade, sometimes called 'missionary work'."[297] Given its potential to impact others,[298] this aspect of the freedom is not absolute and may be lawfully limited where such limitations are "prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others."[299] An individual's freedom to think and believe is absolute – when it has the potential to impact others it is afforded a lesser degree of protection.

The freedom of conscience and religion engages the right to accessible abortion because an individual's belief system may mean that they disagree with abortion. The manifestation of this belief then has the potential to impede accessible abortion. The UN Special Rapporteur on freedom of religion or belief has acknowledged the increased use of religion globally to encourage laws and policies that discriminate against women.[300] The UN Working Group on Discrimination Against Women and Girls identifies this as a "organised and well-funded global political backlash against gender equality" by religious fundamentalists and their political allies.[301] It is therefore appreciated internationally that religion and beliefs are widely used to justify women's rights violations.[302] However, the freedom to manifest thought, conscience and religion does not provide for the violation of the rights of others – including non-discrimination and reproductive rights.

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[295] Special Rapporteur on freedom of religion or belief, Ahmed Shaheed, *Interim report on Freedom of Thought*, UNGAOR, 76th Sess, UN Doc A/76/380 (2021) at para 27.
[296] Khaitan and Norton, *supra* note 293 at 1131.
[297] Special Rapporteur on freedom of religion or belief, Heiner Bielefeldt, *Interim Report on Elimination of all forms of religious intolerance*, UNGAOR, 67th Sess, UN Doc A/67/303 (2012) at para 26.
[298] *Grimmark v Sweden*, No 43726/17, [2020] ECHR 238 at para 23
[299] ICCPR, *supra* note 92 article 18 para 3.
[300] Special Rapporteur on freedom of religion or belief, Ahmed Shaheed, *Report on Gender-based violence and discrimination in the name of religion or belief*, UNGAOR, 43rd Sess, UN Doc A/HRC/43/48 (2020).
[301] UN Working Group, *supra* note 251 at 47.
[302] UNHRC, *General Comment No. 28: Article 3 (The Equality of Rights Between Men and Women)*, 68th Sess, adopted 29 March 2000, UN Doc CCPR/C/21/Rev.1/Add.10, online: <https://www.refworld.org/pdfid/45139c9b4.pdf>.

Where rights compete, states must conduct a balancing act between competing interests – not to protect one rights at the total expense of another.[303]

One matter of complexity for states is conscientious objection to abortion. A healthcare professional does have a protected right to manifest their beliefs and conscience – however this is not an absolute right. Where this freedom to manifest threatens the rights of others – states must consider limiting the freedom. Where a healthcare professional's manifestation of beliefs takes the form of refusal to provide abortion care, this conscientious objection has the potential to render abortion inaccessible, subsequently there are competing rights. Conscientious objection is particularly dangerous for rural communities where one healthcare facility serves a large area.[304] Therefore, the UN HRC has urged states to remove barriers to safe and legal abortion including "barriers caused as a result of conscientious objection by individual medical providers."[305] So how should states do this in a way that respects both the freedom of conscience and the right to accessible abortion?

The Columbian Constitutional Court has been praised for its holistic approach to the protection of rights at stake in matters of conscientious objection to abortion,[306] and has been hailed as a model for jurisdictions worldwide.[307] Through four key decisions, the Columbian Constitutional Court provided principles on rights balancing. The principles, *inter alia*, restrict who can conscientiously object to physicians directly related to abortion provision and require conscientious objection to

[303] Francesca Negro et al,"Conscientious objection to abortion: how to strike a legal and ethical balance between conflicting rights?" online: (2022) 93:4 Acta Biomed <10.23750/abm.v93i4.13477>.

[304] Special Rapporteur on freedom of religion or belief, *supra* note 300 at para 44.
[305] UNHRC, *supra* note 93 at para 8.
[306] International Planned Parenthood Federation, "IMAP Statement on conscientious objection: refusal of care and professional conduct of reproductive health services in the context of legal restrictions" (December 2016), online (Statement): <https://www.ippf.org/sites/default/files/2017-01/IMAP%20Statement%20on%20conscientious%20objection.pdf>.
[307] Luisa Cabal, Monica Arango Olaya and Valentina Montoya Robledo, "Striking a Balance: Conscientious Objection and Reproductive Health Care from the Colombian Perspective" (2014) 16:2 Health & Hum Rts 73.

be in writing with the religious individual's religious conviction.[308] These measures are designed to prevent widespread and institutional conscientious objection which can wipe out reproductive care for large numbers of individuals, and ensure the system is not abused.[309] Furthermore, the principles ensure conscientious objection does not render abortion inaccessible by imposing obligations of referral on the objecting physician and imposing an obligation on government to ensure an adequate supply of abortion providers.[310] These progressive principles successfully implement the recommendation from the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, that conscientious objection be well-defined and well-regulated.[311] Furthermore, the Columbian Constitutional Court demonstrates a fair balancing of rights because conscientious objection is not forbidden completely, instead it is regulated in a way that mitigates its potential to violate the right to accessible abortion.

Recent developments have also been made in the ECtHR. The applicant in the 2021 case *Grimmark v Sweden* claimed a violation of her Article 9 right to religion.[312] The applicant was informed she was no longer welcome at the hospital where she was training in midwifery after she said she could not assist in carrying out abortions due to her religious faith and conscience.[313] The Court accepted that "the applicant's refusal to assist in abortions due to her religious faither and conscience constitutes such a manifestation of her religion which was protected under Article 9."[314] However, whilst there was an interference, the Court found this interference to be necessary.[315] The ECtHR held that since Sweden provides nationwide abortion care, it was obliged to "organise its health

[308] *Ibid* at 78.
[309] *Ibid.*
[310] *Ibid.*
[311] Anand Grover, *Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UNGAOR, 66th Sess, UN Doc A/66/254 (2011) at 20.
[312] *Grimmark v Sweden, supra* note 298.
[313] *Ibid.*
[314] *Ibid* at para 25.
[315] *Ibid* at para 26.

system in a way to ensure that the effective exercise of freedom of conscience of health professionals in the professional context does not prevent the provision of such services."[316] The Court recognised an infringement, but that it was justified as the manifestation of expression in this case threatened the provision of abortion care. The Court seems to have created an obligation upon states that purport to provide nationwide abortion care, an obligation to ensure conscientious objection does not threated accessible abortion. Similarly, the Inter-American Commission on Human Rights is explicit that states must balance rights here: "while healthcare professionals demand respect for their right to conscience, they must also show equal respect for their patients' rights to conscience"[317] – that is their decisional autonomy. The Inter-American Commission is explicit that this balancing is performed by referrals; an objecting healthcare professional must refer the patient to another who can provide the required services because states must not obstruct accessible reproductive healthcare.[318]

Another contentious issue is where anti-abortion protest or demonstration has religious motivations. I will look at anti-abortion protests in greater detail below in terms of the freedom of expression. For now, it suffices to reiterate that the practice of religion is granted less protection that autonomous held personal beliefs. A protest will not be prioritised merely because it has religious aspects. Jurisprudence from the European Commission on Human Rights confirms this. In *Van Schijndel, Van Der Heyden and Leenman v The Netherlands* the applicants alleged a breach of their freedom of religion when they were charged with breach of the peace after praying in the corridors of an abortion clinic, the claim was declared inadmissible.[319] Similarly in *Van Den Dungen v The Netherlands* the Commission declared a claim that alleged a violation of article 9

[316] *Ibid.*
[317] Inter-Am Comm'n HR, "Access to Information on Reproductive Health from a Human Rights Perspective" (22 November 2011) para 94, online (OEA/Ser.L/V/II): <https://www.oas.org/en/iachr/docs/annual/2012/women_access_information.pdf>
[318] *Ibid* at para 95.
[319] *Van Schijndel, Van Der Heyden and Leenman v The Netherlands*, No 30936/96, ECHR (Commission Decision 10 September 1997).

inadmissible.[320] The applicant had received an injunction preventing him from going within 250 metres of an abortion clinic he had been demonstrating at.[321] The applicant had displayed images of Christ and referred to abortion as murder to the extent that treatment had to be delayed for some individuals.[322] The manifestation of religion here had delayed treatment – causing abortion risks to increase and obstruct the highest attainable standard of health. The Commission found that article 9 "primarily protects the sphere of personal beliefs and religious creeds...and acts which are intimately linked."[323] The Commission held that article 9 "does not cover each act which is motivated or influenced by a religion or belief."[324] Not all manifestations of religion or conscience are protected, they must always be balanced against the rights of others, including accessible abortion.

Overall, freedom of thought, conscience and religion is a very important right that is taken seriously by rights bodies globally. However, when it has the potential to impact others and their rights enjoyment, it is no longer absolute and may be lawfully limited. Therefore, there is a necessary balancing act between rights that shapes state obligations when fulfilling the right to accessible abortion.

Balancing Competing Rights: The Freedom of Expression

The value of free expression to democratic society is not to be underestimated.[325] The right to freedom of expression is well established in international law and is supported by a wealth of 'soft

[320] *Van Den Dungen v The Netherlands*, No 22838/93, ECHR (Commission Decision 22 February 1993).
[321] *Ibid.*
[322] *Ibid.*
[323] *Ibid* at para 1.
[324] *Ibid.*
[325] Michael O'Flaherty, "International Covenant on Civil and Political Rights: Interpreting freedom of expression and information standards for the present and the future" in Tarlach McGonagle and Yvonne Donders, ed, *The United Nations and Freedom of Expression and Information*, (Cambridge: CUP, 2015) 55 at 56.

law.'[326] It can be considered a "multiplier" for all other rights,[327] meaning that the enjoyment of all rights is enabled by the ability to express ideas freely.[328] For example, expression of ideas is closely linked to the manifestation of religious beliefs and conscience. Article 19 Paragraph 2 of the ICCPR states that "[e]veryone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice."[329] However, this right is not absolute. Paragraph 3 of Article 19 delineates when expression may be restricted: "(a) For respect of the rights or reputations of others; (b) For the protection of national security or of public order, or of public health or morals."[330]

The HRC has confirmed that the scope of the right is very broad: "every communicable type of subjective idea and opinion is embraced."[331] The protection of free speech was strengthened by General Comment No34 which established a demanding benchmark for restrictions of expression: "when a state party invokes a legitimate ground for restriction of freedom of expression, it must demonstrate in specific and individualized fashion the precise nature of the threat and the necessity and proportionality of the specific action taken, in particular by establishing a direct and immediate connection between the expression and the threat." [332]Freedom of expression through "any medium" is also protected regionally in the OAS by Article 4 of the American Declaration, and Article 13 of the American Convention. In the European system, Article 10 Paragraph 1 of the ECHR provides a broad articulation of the freedom of expression, whilst Paragraph 2 stipulates

[326] *Ibid* at 58.
[327] *Ibid* at 59.
[328] Ibid.
[329] ICCPR, *supra* note 92 article 19 para 2.
[330] *Ibid* at para 3.
[331] UNHRC, Communication no 359/1989, *Ballantyne et al v Canada*, UN Doc CCPR/C/47/D/359/1989, online: <https://juris.ohchr.org/casedetails/345/en-US>.
[332] UNHRC, *General Comment No 34: Article 19 (Freedoms of opinion and expression)*, 102nd Sess, adopted 12 September 2011, UN Doc CCPR/C/GC/34, online: <https://www2.ohchr.org/english/bodies/hrc/docs/gc34.pdf> at para 35.

the conditions for its lawful restriction which include restriction necessary for "the protection of the reputation or rights of others."[333] Consistent across these global articulations of the freedom of expression is the demand for a delicate balancing act between freedom of expression and the enjoyment of other rights.

Not exempt from this balancing act is the right to accessible abortion. For women to enjoy the right to accessible abortion, there are situations in which it must be balanced effectively with another's freedom of expression. For example, where anti-abortion protest interferes with delivery of abortion care. Therefore, respect for freedom of expression shapes a State's positive obligations under the right to accessible abortion. Demonstrating this is the ECtHR's tumultuous jurisprudence concerning the competing right to freedom of anti-abortion expression, with the personal rights of abortion providers. In 2011, the ECtHR provided judgment in *Hoffer and Annen v Germany*.[334] The case concerned the criminal conviction in Germany of anti-abortion protestors who had written a pamphlet calling an abortion provider a "killing specialist for unborn children," and had likened the abortion to the Holocaust, "Then: Holocaust; Today: Babycaust."[335] In a departure from its usual stringent protection of free expression, the ECtHR found that there had been no violation of the applicants' Article 10 right. Whilst appreciating opinions expressed on matters of public interest deserve 'a special degree of protection,'[336] the ECtHR found the State's interference with the applicants' freedom of expression was necessary in a democratic society.[337] With particular reference to Germany's history, the Court found the Holocaust reference to be a "very serious violation of the physician's personality rights."[338] The ECtHR has long protected expression which "offends, shocks and disturbs"[339] which has caused academics to criticise this

[333] ECHR, *supra* note 132 article 10 para 2.
[334] *Hoffer and Annen v Germany*, Nos 397/07 and 2322/07, [2011] ECHR 46, 58 EHRR 40.
[335] *Ibid* at para 8.
[336] *Ibid* at para 44.
[337] *Ibid* at para 43.
[338] *Ibid* at para 49.
[339] *Handyside v The United Kingdom*, No 5493/72, [1976] ECHR 5, 1 EHRR 737.

decision as "questionable."[340] The case calls into question the existence of a special status for anti-abortion expression – is it protected to a lesser degree? Although there is greater reason to believe it is the Holocaust that possesses special status (including guidance from the Council of Europe[341]), the question remains since the Court did not consider a previous case in which expression calling someone a "closet Nazi" was protected.[342]

However, in 2015 the ECtHR decided that there had been an Article 10 violation when the applicant, again Annen, was ordered by Germany domestic courts to stop disseminating anti-abortion leaflets at clinics and publishing the personal information of abortion providers on a website called "www.babycaust.de".[343] Rather perplexingly, despite references to Auschwitz in the pamphlet, the Court observed "the applicant did not – at least not explicitly – equate abortion with the Holocaust."[344] On this occasion, the Court prioritised the applicant's freedom of expression over the rights of the abortion providers. What is absent is consideration of abortion seekers, and how this free expression impacts their rights. Interestingly, two dissenting judges did not agree that a public interest threshold had been reached by protecting this expression.[345] These judges considered the impact of the applicant's expression on an abortion seeker: 'if the first result found when "googling" the clinic was the "babycaust" website, an average potential patient might prefer to avoid it.'[346] Furthermore, the dissent found the domestic injunctions achieved a fair balance of competing rights since the applicant was only forbidden from disseminating doctors' personal information on his website, and forbidden from disseminating leaflets within the vicinity

[340] Ronan O'Fathaigh, "Anti-Abortion Protest and Freedom of Expression in Europe", online: (2011) 17:2 Colum J Eur L 47 at 49.
[341] Council of Europe, "Guide on Article 10 of the European Convention on Human Rights" (31 August 2022), online: <https://www.echr.coe.int/documents/d/echr/guide_art_10_eng>.
[342] *Scharsach v Austria*, No 39394/98 , [2003] ECHR 596, (2005) 40 EHRR 22.
[343] *Annen v Germany*, No 3690/10, [2015] ECHR 1043.
[344] *Ibid* at para 63.
[345] *Ibid* at Joint dissenting opinion of Judges Yudkivska and Jäderblom.
[346] *Ibid.*

of the clinics concerned.[347] The applicant remained able to express his opinions – just in a way that did not infringe the rights of another. It seems the disregard for the abortion seeker in this case allowed the ECtHR to conclude the State's violation of Article 10 was unjustified.

In 2018, the ECtHR faced Annen once again. This time, following an undeniable equation of abortion providers with concentration camp commanders, the Court found the State's interference with Annen's freedom of expression to be justified.[348] The State had ordered a civil injunction and ordered Annen to pay damages – there was no violation of his Article 10 right. The Court found the ferocity with which Annen expressed his opinion was capable of inciting hatred and aggression, with no factual value.[349] Germany had successfully balanced the applicant's freedom of expression with the abortion provider's right to respect for private life. The civil injunction and damages ordered was a proportionate and justified infringement of Annen's freedom of expression.

Thus far, case law is limited to a balancing of rights of anti-abortion activists and abortion providers. Should Annen choose to target abortion seekers, the opportunity may arise to balance an anti-abortion protestor's freedom of expression with the right of abortion seekers to access quality abortion care. Of course, we should not be quick to limit expression simply because we do not like what is being expressed – such restriction should be exceptional.[350] Nobody has the right to restrict the expression of information simply because they do not want to hear it. However, where an individual's freedom of expression poses a barrier to the highest level of abortion care, causes delays in accessing care, or renders abortion completely inaccessible – the expression must be justifiably and necessarily restricted. This does not mean anti-abortion expression must be

[347] *Ibid.*
[348] *Annen v Germany (No 5),* No 70693/11, [2018] ECHR 734.
[349] *Ibid* at para 35.
[350] Richard Moon, "Commissioned Paper: Freedom of Expression" September 2022, online (Background Paper for the Public Order Emergency Commission): <https://publicorderemergencycommission.ca/files/documents/Policy-Papers/Freedom-of-Expression-Moon.pdf>.

prohibited altogether. After all, international rights systems have articulated the apparent public interest of anti-abortion rhetoric. However, anti-abortion expression must be restricted in a manner that is proportionate – so that women may still enjoy the right to accessible abortion.

Conclusion

To summarise, the right to accessible abortion is shaped as follows. Firstly, the right to life demands women must not be subject to unwanted pregnancy and childbirth, or dangerous clandestine abortion, or delayed care. All of these scenarios threaten a pregnant person's life. Secondly, the right to be free from CIDT means dignity cannot be separated from reproductive autonomy – abortion must be accessible for women if they are not to be subject to CIDT. Per the developing jurisprudence in the Inter-American system of rights, unwanted pregnancy causes pain and suffering tantamount to CIDT; dignity means possessing the power to put reproductive self-determination into action. Thirdly, the right to health demands both abortion access and choice. Abortion is essential reproductive healthcare that must be accessible so that a woman's right to the highest attainable standard of health can be fulfilled. Fourthly, the right to equality and non-discrimination means that women need accessible abortion so that they are not disadvantaged by their biological reproductive capacity to a degree greater than men. Furthermore, the policy that provides this must not be informed by, nor perpetuate, discriminatory stereotypes. Fifthly, the freedom of thought, conscience and religion demands states balance an individual's manifestation of belief with accessible abortion. This includes the close regulation, not complete prohibition, of conscientious objection so that it does not render abortion inaccessible. Lastly, the right to freedom of expression requires states to balance expression with women's right to accessible abortion. Where an individual's freedom of expression impedes another's access to quality and timely abortion care – the expression must be proportionately restricted so that both rights can be reasonably respected and fulfilled.

Important and influential jurisprudence has evolved within regional systems which solidifies the prioritisation of reproductive autonomy. International human rights appreciate the importance of a woman's capability to self-determine her childbearing potential in accordance with her own desires, it is time domestic law does too.

Chapter IV: The Domestic Abortion Laws

England and Wales

Criminal Offences

Abortion remains a criminal offence by virtue of two statutes in England and Wales. Firstly, section 58 of the Offences against the Person Act 1861 (OAPA 1861) states a person is 'liable to be kept in penal servitude for life' when, with intent to procure a miscarriage, she attempts to unlawfully procure a miscarriage. The Act is explicit that this can be committed by the pregnant person herself or by another person who attempts to procure a miscarriage of a person who may not actually be pregnant. Section 59 OAPA 1861 also makes it a criminal offence to 'unlawfully supply or procure any poison of other noxious thing, or any instrument' with the knowledge that it is to be unlawfully used with intent to procure a miscarriage. Secondly, section 1 of the Infant Life (Preservation) Act 1929 sets out the offence of child destruction, committed when a person does a 'wilful act' that causes a child that is 'capable of being born alive' to die before it is born. 'Capable of being born alive' is now understood to mean a foetus at 24 weeks' gestation.[351] Therefore, the key distinction between the offences lies in the gestational stage at which the offence can be committed.

Prior to 1967, the possibility of an abortion not constituting a s58 procurement of miscarriage was established in *R v Bourne*[352] in 1939. A doctor was acquitted of procuring a miscarriage after performing an abortion on a fourteen-year-old who was pregnant as a result of gang rape. Macnaghten J interpreted the use of the word 'unlawful' in s.58 as meaning that, logically, there

[351] Human Fertilisation and Embryology Act 1990, s 37.
[352] *R v Bourne* [1939] 1 KB 687.

must be the possibility for a lawful procurement of a miscarriage.[353] It is unlikely that this interpretation was Parliament's intention. However, McNaghten J's interpretation relied on the fact the defendant was a qualified doctor.[354]

> 'if the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother.'[355]

The idea of a lawful abortion was created: a doctor must have decided in good faith that the abortion would save the life of the pregnant person. However, lawful abortion was inaccessible for most – it was too expensive, and many could not find a doctor willing to perform it.[356] Only individuals with sufficient financial means had access to safe abortion.[357] Abortion that was accessible for most was the clandestine abortion, and it was dangerous.[358] An individual attempting to self-induce an abortion employed a variety of methods including the consumption of herbal concoctions, to the use of an enema syringe to douche the cervix with a blend of hot soapy water and various household disinfectants.[359] Those visiting a 'backstreet' abortionist could expect a variety of instruments to be inserted into the uterus, including bicycle spokes, knitting needles and goose quills.[360] Official statistics suggest that between 35 and 40 people died each year resulting from an unsafe abortion.[361] However, unofficial sources find this number to be exceptionally

[353] *Ibid*, at 691.
[354] *Ibid*, at 694.
[355] *Ibid.*
[356]Parsons and Romanis, *supra* note 198 at 15.
[357] Sheldon, *supra* note 8 at 17.
[358] Albert Davis, "2,665 Cases of Abortion: A Clinical Survey" (1950) 2: 4671 BMJ 123.
[359] *Ibid*, at 124.
[360] Malcom Potts, Peter Diggory & John Peel, *Abortion*, (London: CUP, 1977) at 261.
[361] Sheldon, *supra* note 8 at 20.

higher at over 200 deaths per year.[362] Individuals were risking life imprisonment to obtain life threatening procedures, and it was prevalent.

The Abortion Act 1967

The Abortion Act 1967 (hereafter referred to as the Abortion Act) does not provide a right to abortion. Creating a right to abortion was never the intention of Parliament.[363] Rather, the government sought to 'manag[e] the social problem of abortion and bringing under control a situation of widespread illegality and de facto female resistance to the law.'[364] The Abortion Act provides circumstances in which a doctor can lawfully perform an abortion without criminal repercussion. Section 1(1) states that a registered medical practitioner shall not be guilty of an offence if they terminate a pregnancy after two registered medical practitioners form the good faith opinion:

(a) That the pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the woman[365] or any existing children of her family; or
(b) That the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or
(c) That the continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or
(d) That there is a substantial risk that if the child were born it would suffer from physical or mental abnormalities as to be serious handicapped.

[362] Bernard M Dickens, *Abortion and the Law* (London: MacGibbon & Kee, 1966) at 113.
[363] Fran Amery, *Beyond pro-life and pro-choice: The changing politics of abortion in Britain* (Bristol: Bristol University Press, 2020) at 39.
[364] Sheldon, *supra* note 8 at 17.
[365] The Act uses the gendered term 'woman' however it must apply to all with female reproductive organs, whether or not they identify as a woman.

Today, almost all abortions in England and Wales are provided under s.1(1)(a) because abortion will always be statistically less risky than childbirth.[366] Therefore, it is true that every pregnancy less than 24 weeks' gestation can be lawfully terminated.[367] However, as this thesis will make clear, the Abortion Act does not create abortion on demand – there remain significant barriers to accessing this essential care. While it is uncommon for individuals to face prosecution for unlawful abortion in England and Wales today,[368] criminal proceedings against women are still a reality.[369] Lack of prosecution is poor justification for the continued criminalisation of essential reproductive healthcare and women's rights.

Canada

Pre-decriminalisation

Abortion was fully decriminalised in Canada in 1988 following the Supreme Court ruling in *R v Morgentaler*.[370] Prior to this, s.251(1) of the Criminal Code made it an indictable offence for any person with intent 'to procure the miscarriage of a female person.' Subsection (2) created the parallel indictable offence for any pregnant woman 'to procure her own miscarriage.' Subsection (4) then stated that these offences 'do not apply' to a qualified medical practitioner or pregnant person if, before the termination, 'the therapeutic abortion committee for that accredited or approved hospital', by majority and following a committee meeting in which the person's case was reviewed, has '(c) by certificate in writing stated that in its opinion the continuation of the

[366] Brazier and Cave, *supra* note 5 at 405.
[367] Elizabeth Chloe Romanis, "Abortion access and the benefits and limitations of abortion-permissive legal frameworks: Lessons from the United Kingdom" (2023) 32:3 Cambridge Quarterly of Healthcare Ethics 378 at 382.
[368] Brazier and Cave, *supra* note 5.
[369] Sally Sheldon and Jonathan Lord, "Care not criminalisation: reform of British abortion law is long overdue" (2023) 49:8 J Med Ethics 523.
[370] *R v Morgentaler*, [1988] 1 SCR 30, 37 CCC (3d) 449 [*Morgentaler* cited to SCR].

pregnancy of such female person would or would be likely to endanger her health, and (d) has caused a copy of that certificate to be given to the qualified medical practitioner.' This burdensome process for accessing an abortion did not operate equitably across Canada.[371] Section 251(4) required an accredited or approved hospital, approval granted by a provincial health minister who was under no obligation to grant any such accreditation.[372] Furthermore, subsection (4) affords great deference to physicians, there was no standard by which a particular pregnant person could expect to be granted an abortion, the section even failed to define 'health'. The Report on the Committee on the Operation of the Abortion Law published in 1977 found that '[i]n terms of all civilian hospitals (1,348) in Canada in 1976, 20.1 per cent had established a therapeutic abortion committee.'[373] This was obviously insufficient for the provision of essential abortion healthcare.

Decriminalisation in the Supreme Court

The Appellants in *Morgentaler* were all qualified medical practitioners who had opened clinics and provided abortions to pregnant people who had not acquired certificate from a therapeutic abortion committee.[374] At the Supreme Court, the matter was whether s.251 infringed the rights protected under the Canadian Charter of Rights and Freedoms or the Canadian Bill of Rights.[375] The Court found that section 7 of the Charter, that 'everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice,' was unjustifiable infringed by s251.[376] Dickson CJ and Lamer J held that s.251

[371] *Ibid,* at 65.
[372] *Ibid,* at 66.
[373] Canada, Privy Council, *Report of the Committee on the Operation of the Abortion Law* (Ottawa: Minister of Supply and Services, 1977) at 28.
[374] *Morgentaler, supra* note 370 at 31.
[375] *Ibid.*
[376] *Ibid,* at 79.

> 'clearly interferes with a woman's physical and bodily integrity. Forcing 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 an infringement of security of the person.'[377]

Furthermore, the principles of fundamental justice are found in 'the basic tenets' of the Canadian legal system, one of which is that 'when Parliament creates a defence to a criminal charge, the defence should not be illusory or so difficult to attain as to be practically illusory.'[378] Dickson CJ and Lamer J found the operation of therapeutic abortion committees in providing abortion access to be so illusory.[379]

In her judgment, Wilson J approached section 7 of the Charter slightly differently, in a broader manner than the other Supreme Court Justices. Wilson J focused on the liberty aspect of s.7 – holding that it 'guaranteed to every individual a degree of personal autonomy over important decisions intimately affecting his or her private life.'[380] Wilson J held that this includes the decision to terminate a pregnancy:

> 'It is not just a medical decision; it is a profound social and ethical one as well. Section 251 of the Criminal Code takes a personal and private decision away from the woman and gives it to a committee which bases its decision on "criteria entirely unrelated to [the pregnant woman's] own priorities and aspirations".'[381]

[377] *Ibid,* at 32.
[378] *Ibid,* at 33.
[379] *Ibid.*
[380] *Ibid,* at 36.
[381] *Ibid,* at 37.

Therefore, Wilson J found that, under s.7 of the Charter, Canadians have a right to personal autonomy over deciding whether to have an abortion. Appreciating that this decision cannot be made by anyone other than the pregnant person, Wilson J's judgment was momentous for abortion in Canada. It did not, however, speak to the necessary corollary that this individual then be able to *access* abortion to make her decision actionable. After all, international human rights have become comfortable with the notion that autonomy in any meaningful sense requires the ability to have actionable choices by imposing positive obligations upon states (capabilities).

Decriminalisation of abortion in Canada was momentous – it is currently one of only two jurisdictions in the world to completely decriminalise abortion.[382] Furthermore, that a Supreme Court Justice articulated a right to reproductive autonomy so explicitly was critical to the development of women's rights in Canada. However, whilst the system pre-Morgentaler was recognised for not operating fairly – the current system can also be criticised for this. Access to services remains elusive for many, with abortion stigma still rife.

[382] Jonathan Herring, Emily Jackson and Sally Sheldon, "Would decriminalisation mean deregulation?" in Sally Sheldon and Kaye Wellings, eds, *Decriminalising Abortion in the UK What Would it Mean?*, (Bristol: Policy Press, 2020) 57.

Chapter V: Abortion Stigma

Introduction

Despite the fact that abortion is a routine aspect of reproductive healthcare, abortion stigma remains highly prevalent. Anuradha Kumar and others term this the 'prevalence paradox: the social construction of deviance despite the high incidence of abortion.'[383] The prevalence of abortion stigma can have a significant impact on an individual's abortion experience,[384] including accessing abortion and consequences for women's health. When abortion law or policy, or lack thereof, perpetuates this stigma, there is the potential for rights violations. This chapter will examine the experience and implications of abortion stigma in Canada and England and Wales, to consider the extent to which they fulfil women's rights.

The most widely used definition of stigma is that provided by Erving Goffman as a 'deeply disturbing' attribute "that makes [a person] different from others...and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak."[385] Developing this, Kumar and others define abortion stigma as 'a negative attribute ascribed to women who seek to terminate a pregnancy that marks them, internally or externally, as inferior to ideals of womanhood.'[386] They identify the ideals of womanhood transgressed by the abortion seeker to be threefold: 'female sexuality solely for procreation; the inevitability of motherhood and instinctual nurturance of the vulnerable.' The chapter will be asking to what extent the law in England and

[383] Anuradha Kumar, Leila Hessini and Ellen Mitchell, "Conceptualising abortion stigma" (2009) 11 Culture, Health & Sexuality 625 at 629.
[384] *Ibid.*
[385] Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity* (London: Simon & Schuster 1963).
[386] Kumar et al, *supra* note 383 at 628.

Wales perpetuates this notion of stigma. Thereafter it will ask the extent to which abortion seekers in Canada, in the absence of abortion law, experience abortion stigma?

Abortion stigma violates the right to accessible abortion

Abortion stigma has a direct impact on an individual's timely access to quality abortion care. Firstly, perceived abortion stigma refers to an individual's fear of how others will view her when they find out she has had or plans to have an abortion.[387] She fears she will be viewed in terms of her apparent rejection of the ideals of womanhood. The abortion seeker fears the opinions of society, abortion providers, and even those she is closest to – her support system.[388] This has the practical implication of potentially causing an individual to delay accessing a termination, despite the fact she has already decided an abortion is right for her. Also, she may not seek any necessary post-abortion care.[389] Thus, stigma has the potential to cause risky personal healthcare decisions; although abortion is extremely safe, its associated risks do increase with gestation. Therefore, the perpetuation of perceived abortion stigma is a violation of the right to accessible and quality abortion care.

Secondly, internalised abortion stigma can have detrimental consequences for the individual. Internalised abortion stigma is when an individual's sense of self is impacted by her rejection of what society deems the ideals of womanhood; she "incorporates devaluing social norms, beliefs and attitudes related to abortion into her self-image, creating a sense of shame, guilt or other negative feelings."[390] Studies indicate that, as a coping mechanism for this, abortion seekers feel

[387] Kristen Schellenberg et al, "Social Stigma and Disclosure about Induced Abortion: Results from an Exploratory Study" 6:1 (2011) Global Public Health 111 at 113.
[388] Edna Astbury-Ward, Odette Parry and Ros Carnwell, "Stigma, Abortion, and Disclosure – Findings from a Qualitative Study" (2012) 9 J Sex Med 3137 at 3141.
[389] Cook, *supra* note 122 at 355.
[390] Franz Hanschmidt et al, "Abortion Stigma: A Systematic Review" (2016) 48:4 Perspect Sex Reprod Health 169.

the need to keep their abortion experiences secret from society and their friends and family.[391] Being exceptionalised for needing routine reproductive healthcare can lead to feelings of inferiority and loneliness. Thus, individuals seeking abortions and those who have already undergone the procedure are isolated.[392]

Abortion's status as a 'well-kept secret' harms women.[393] Research has identified the negative emotions caused by internalised stigma as a risk factor for mental health.[394] The isolation and feelings of necessary secrecy strips the individual of her support system.[395] Although it is not medically necessary, there is evidence suggesting some women desire post-abortion support. Therefore, when a woman has internalized feelings of shame so that she keeps her abortion secret, she is denied the opportunity to access care she feels she needs. Albeit in assessment of other stigmatised groups, studies indicate a 'loss of social support is associated with increases in symptoms of depression and anxiety.'[396] Therefore, as medicine has made clear, it is not abortion that causes psychological illness. Instead, it is the operation of abortion stigma that is detrimental to women's mental health. Stigma is an impediment to 'the enjoyment of the highest attainable standard of physical and mental health' as the right to health entitles.

The quiet suffering stigma causes may amount to cruel, inhuman or degrading treatment (CIDT). Given its detrimental impact on an individual's mental health, the secrecy that shrouds abortion is clearly contrary to an individual's right to dignity and integrity. The internalised feelings of shame, and the perceived feelings of disappointment and inferiority, ought to be considered cruel. Because stigma can have the practical implication of causing an individual to delay termination – a course

[391] *Ibid.*
[392] *Ibid.*
[393] Nicky Priaulx, "The Social Life of Abortion Law: on Personal and Political Pedagogy" (2017) 25:1 Med L Rev 73.
[394] Astbury-Ward et al, *supra* note 388 at 3142.
[395] *Ibid.*
[396] Hanschmidt et al, *supra* note 390 at 170.

of action she had already decided was best for her – abortion stigma operates in opposition to reproductive autonomy. As the ECtHR has come to appreciate, the pain and suffering that an individual experiences when reproductive autonomy is ignored is a uniquely female suffering that is a violation of her rights.[397] Therefore, the consequences of abortion stigma render it capable of violating a woman's right to be free from CIDT.

As long as stigma continues to relegate abortion conversation to the shadows, women of reproductive capacity remain in fear. Should an individual ever need an abortion, will she be able to confide in anyone, or will she fear the reactions of even those closest to her? Suffering in silence prevents the enjoyment of the right to accessible abortion by inciting risky personal health choices and mental health detriment. With this in mind, I will now consider the role of abortion stigma in abortion law and regulation in England and Wales, and Canada.

Stigma and criminalisation - the situation in England and Wales

The criminal offences

The criminalisation of abortion has an intimate relationship with abortion stigma: it is both grounded in, and perpetuates, stigma.[398] As addressed in chapter 2, regulation of abortion through the criminal law presents the abortion seeker as unscrupulous to the extent that she is a danger to society, and who ought to be punished.[399] The criminal regulation of abortion in England and Wales is no exception. Firstly, the offences themselves are outdated and riddled with problematic language. The Offences Against the Person Act 1861 (OAPA 1861) criminalises the 'procurer of

[397] Zurieck, *supra* note 136.
[398] Melissa Graham et al, ""That's a woman's body, that's a woman's choice": The influence of policy on women's reproductive choices", online: (2022) 90 Women's Studies International Forum 102559 <https://doi.org/10.1016/j.wsif.2021.102559>.
[399] Cook, *supra* note 122 at 348.

a miscarriage', whilst the Infant Life Preservation Act 1929 criminalises the 'child destructor'. It is surely unlikely that an abortion provider, who has chosen to provide the service, would be comfortable calling themselves a destructor. The language contained in these offences does not represent the views of abortion providers or seekers, nor does it reflect the reality of abortion today. The legislation is out of date. Whilst both statutes repeatedly refer to the foetus as a 'child', the more recent statute (within the last one hundred years at least) criminalises the destruction of 'the life of a child capable of being born alive...before it has an existence independent of its mother'.

The criminal law's conflation of gestation with motherhood is erroneous and stigmatising. Firstly, it is grammatically incorrect to refer to a pregnant person as a mother when referring to her present pregnancy and not to any pre-existing children.[400] Secondly, equating gestation with motherhood is scientifically incorrect.[401] There are two main competing conceptualisations of gestation. The first is the 'foetal container model'[402] which contends pregnancy involves 'two distinct entities within one body'.[403] The second is the 'parthood model' which holds that the foetus is *part* of the pregnant person by virtue of a 'functional integration', it is not a separate entity.[404] The parthood model is a new introduction in to legal discourse which had thus far been satisfied with the scientifically unsound foetal container model.[405] The parthood model is based on medical fact that a foetus is physiologically and biologically 'integrated, and interdependent with' the pregnant person.[406] Any idea that the foetus is a separate entity capable of being mothered is a social construct.[407] Further, contemporary healthcare providers recognise that it is important to refer to a pregnant person experiencing an unwanted pregnancy as a 'mother' and the foetus as a 'baby,'

[400] The Oxford dictionary defines 'mother' as 'The female parent of a human being; a woman in relation to a child or children to whom she has given birth'. A pregnant person cannot, by definition, be a mother of a foetus.
[401] Zaina Mahmoud and Elizabeth Chloe Romanis, "On Gestation and Motherhood" (2022) 31 Med L Rev 109.
[402] *Ibid.*
[403] Halliday, *supra* note 135.
[404] Mahmoud and Romanis, *supra* note 401 at 111.
[405] *Ibid.*
[406] Elselijn Kingma, "Were You a Part of Your Mother?" (2019) 128:511 Mind 609 at 626.
[407] Mahmoud and Romanis, *supra* note 401 at 111.

instead modern medicine prioritises autonomy and respects choice.[408] Generally, a pregnant person seeking an abortion does not identify as a mother to a baby.[409] Instead, she is a pregnant individual in need of reproductive healthcare.

Conflating gestation with motherhood reflects the Roman Law principle operating in English family law today: *mater semper certa est*, the mother is always certain.[410] In English law, the individual who gestates a foetus is the legal mother of the child upon its birth, subsequently bearing the legal rights and responsibilities of a mother.[411] However, its application to unwanted pregnancy is misguided – the principle should not be used to implicate pregnant people with obligations of motherhood. Doing so rejects the autonomous individual's ability to self-determine their reproductive choices, instead it perpetuates stigmatising and discriminatory stereotypes.

According to legal moralism, the state criminalises conduct that society deems morally wrong.[412] Lawmakers then denote the degree of wrongfulness with the appropriate degree of punishment.[413] In England and Wales the s.58 OAPA 1861 offence, procurement of a miscarriage, carries a maximum sentence of life imprisonment.[414] This is the most severe punishment for abortion in Europe.[415] Clearly, the criminal law ascribes an egregious level of 'wrongfulness' to abortion – the notoriety of the perpetrator is reflected in its extreme punishment, designed to remove the immoral threat from society.

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[408] Lachlan de Crespigny, Frank Chervenak, Laurence McCullough, "Mothers and babies, pregnant women and fetuses" (2005) 106:12 BJOG 1235.
[409] *Ibid.*
[410] Rita D'Alton-Harrison, "Mater Semper Incertus Est: Who's your mummy?" (2014) 22:3 Med L Rev 357.
[411] Mahmoud and Romanis, *supra* note 401 at 110.
[412] Farmer, *supra* note 237 at 82.
[413] Cook, *supra* note 122.
[414] S.58 Offences Against the Person Act 1861 stipulates anybody found guilty is 'liable to be kept in penal servitude for life'.
[415] Sally Sheldon, "British Abortion Law: Speaking from the Past to Govern the Future" (2016) 79 Mod L Rev 283 at 286.

On 12th June 2023, the sentencing of a woman found guilty of a s.58 OAPA 1861 procurement of a miscarriage sparked outrage across the United Kingdom.[416] Carla Foster was sentenced to 28 months' imprisonment after she self-administered mifepristone and misoprostol at 32-34 weeks' gestation during the height of the Covid-19 pandemic.[417] In his sentencing remarks, Mr Justice Pepperall demonstrated that abortion stigma perpetuated by this Victorian-era statute is very much alive today. Firstly, he made sweeping claims about the feelings and decision-making process of abortion seekers: 'In my judgment, the vast majority of women and girls seeking an abortion only do so after the most anxious consideration. It is often a very difficult decision and it is always intensely personal and painful.'[418] The immediate question is what qualitative data Justice Pepperall is basing these claims upon. For many abortion seekers, the decision is not 'a very difficult' one – instead it is what they consider to be their only option.[419] Although the decision is personal, it is not 'always painful'.[420] Pepperall J's remark presents the abortion seeker as an individual who is deeply troubled by her predicament, an exaggeration that is grounded in the ideals of womanhood – in particular the inevitability of motherhood. Furthermore, Pepperall J considered the 'harm' in the present case, concluding that it was 'very high in that the drugs were effective in causing [Foster] to miscarry.'[421] It is astounding that Pepperall J prioritised a foetus over the interests of Foster's three children at home who he acknowledged 'would suffer' from her imprisonment.[422] Since Foster was sentenced to prison regardless of this, it would be illogical to

[416] Tobi Thomas, *Outrage at jail sentence for woman who took abortion pills later than UK limit* (June 2023), online: The Guardian <https://www.theguardian.com/world/2023/jun/12/woman-in-uk-jailed-for-28-months-over-taking-abortion-pills-after-legal-time-limit>.
[417] *R v Foster*, Sentencing Remarks (Crown Court Stoke on Trent, 12 June 2023), <https://www.judiciary.uk/judgments/r-v-foster/>.
[418] *Ibid* at para 11.
[419] Elizabeth Janiak and Alisa B Goldberg, "Eliminating the phrase 'elective abortion': why language matters" (2016) 93 Contraception 89.
[420] Graham et al, *supra* note 398.
[421] *R v Foster*, supra note 417 at para 16.
[422] *Ibid* at para 21.

conclude that Pepperall J is concerned with anything other than punishment of Foster. It is challenging to glean any public interest in the jailing of Foster.[423]

Thankfully, on 18th July 2023 Carla Foster's sentence was quashed in the Court of Appeal. Dame Victoria Sharp, President of the King's Bench Division, remarked the case 'calls for compassion not punishment.'[424] Although she held the custodial threshold had been passed due to the length of gestation, Dame Victoria held 'no useful purpose is achieved by detaining Ms Foster in custody.' Subsequently, Foster's sentence was reduced to a 14-month suspended sentence and could return home to her children.[425] Despite this, the treatment Carla Foster endured demonstrates the hostility of the current abortion law regime towards those who terminate pregnancies. Indeed, abortion stigma is so rife that individuals who suffer spontaneous miscarriage have been subject to suspicion and a cruel police investigation.[426] Worryingly, data suggests that the number of women subject to investigation under these historic offences is increasing, with 52 women investigated in England and Wales since 2015.[427] Such treatment is indicative of a stigma that denotes abortion seekers as, per Goffman's understanding, 'bad or dangerous.'[428] Women who were pregnant but do not have a child are immediately thrust into criminal suspicion without real consideration of what is just.

The criminalisation of abortion in England and Wales serves no purpose other than to perpetuate stigma and punish women for choosing to live their life contrary to the stereotypical 'ideals of womanhood'. Britain's first statutory prohibition of abortion, The Ellenborough Act of 1803, was

[423] Sheldon and Lord, *supra* note 369 at 524.
[424] *R v Carla Foster* (Sentencing Appeal, Court of Appeal Criminal Division) 17 July 2023, <https://www.judiciary.uk/judgments/r-v-carla-foster/> . At the time of writing, only a summary of the Court of Appeal decision was available.
[425] *Ibid.*
[426] Sheldon and Lord, *supra* note 369.
[427] *Ibid.*
[428] Goffman, *supra* note 385.

intended to prevent injury to the abortion seeker.[429] Today, when abortion in England and Wales is incredibly safe thanks to significant medical advancements,[430] this justification is obsolete. The harm principle has been subverted; criminalisation now operates to protect society's morals from the apparently deviant abortion seeker.[431] It seeks to punish those who have sex for a purpose other than procreation, 'condemn[ing] unmarried women seeking to disguise illicit sex causing pregnancy, and married women denying husbands their children.'[432] The criminal law, 'the most formidable and authoritarian of state powers,'[433] validates the myth that those who can procreate, ought to do so.

The Abortion Act 1967 grounds for abortion

The Abortion Act 1967 (hereafter referred to as the Abortion Act) continues the law's relationship with abortion stigma. In particular, it perpetuates motherhood as the norm for women. Section 1 of the Act is set up to only allow an individual to reject her current pregnancy, justifying its termination under one of the four grounds for a lawful abortion. The abortion seeker cannot reject her biological destiny of motherhood,[434] she is not entitled to seek an abortion on the grounds that she does not see children in her vision of a happy life. It was apparently unfathomable to 1960s law makers that a woman may simply not want children. The idea that a woman be able to choose whether to have children barely featured in Parliamentary debates.[435] Instead, law makers chose to continue 'defin[ing] women in terms of their reproductive capacity.'[436] The result is that an

[429] Preamble, Ellenborough Act 1803 (43 Geo 3 c 58).
[430]Sheldon, *supra* note 34 at 344.
[431] Cook, *supra* note 122 at 351.
[432] *Ibid.*
[433] Lula Mecinska, Carolyne James & Kate Mukungu, "Criminalization of Women Accessing Abortion and Enforced Mobility within the European Union and the United Kingdom" (2020) 30:5 Women & Criminal Justice 391 at 394.
[434] Sheldon, *supra* note 8 at 42.
[435] Fran Amery, "Solving the 'Woman Problem' in British Abortion Politics: A Contextualised Account" (2015) 17 BJPIR 551 at 555.
[436] Isabelle Engeli, "The Challenges of Abortion and Assisted Reproductive Technologies Policies in Europe" (2009) 7 Comparative European Politics 56 at 58.

individual seeking an abortion must convince two doctors that her situation falls under one of the grounds for abortion that society deems acceptable.

The lawful grounds for abortion themselves perpetuate the inevitability of motherhood. For example, the individual is entitled to an abortion if continuing the pregnancy would risk the physical or mental health of 'any existing children of her family'.[437] This ground suggests that a woman is worthy of an abortion if it will enable her to be a better mother to the children she already has.[438] This individual is not rejecting motherhood so may have a lawful abortion. Absent from the grounds of justifiable abortion is choosing to prioritise other life pursuits outside of the home, such as career. Excluding this as an acceptable reason for termination encourages the notion that motherhood is 'the natural feminine vocation.'[439] The woman who does not prioritise motherhood above all else, of either existing children or those she is destined to have in the future, is not worthy of abortion. 1960s law makers envisioned an abortion seeker as a vulnerable victim of her circumstances who would otherwise be forced to seek a dangerous clandestine abortion but for the Abortion Act. The woman who rejects the inevitability of motherhood does not comply with this vision. Instead, she is a 'promiscuous deviant' who engaged in sexual activity not for the purpose of procreation who must now deal with the consequences of her actions.

Thankfully, since scientific advances in abortion care mean that it will always carry less risk than childbirth, an abortion can statistically always be provided under s.1(1)(a) of the Abortion Act. Indeed, most abortions in England and Wales are carried out under this ground.[440] The operation of s.1(1)(a) of the Abortion Act suggests that healthcare professionals appreciate unwanted

[437] Abortion Act 1967 S.1(1)(a).
[438] Sheldon, *supra* note 8 at 43.
[439] Engeli, *supra* note 436 at 64.
[440] Office for Health Improvement & Disparities, "Abortion Statistics for England and Wales: January to June 2022" (24 August 2023), online (National Statistics): <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-january-to-june-2022/abortion-statistics-for-england-and-wales-january-to-june-2022>.

pregnancy always threatens the life and livelihood of an individual. Termination of unwanted pregnancy is always a life-saving procedure – the accessibility of which is necessary for the implementation of the right to life.

However, it is important to dispel the argument that 'the Abortion Act simply contains a harmless legal fiction because in practice doctors usually just give their approval for decisions that have already been taken.'[441] That the Abortion Act delineates 'acceptable' grounds for abortion at all is incredibly harmful. Overall, criminalisation suggests all abortion is immoral and the Abortion Act provides for abortion that society will *tolerate*. The abortion seeker must 'present her circumstances in the worst possible light'[442] if her rejection of the ideals of womanhood is to be tolerated.

Decision-making under the Abortion Act 1967

The Abortion Act appoints doctors as the 'gatekeepers' of abortion,[443] thereby suggesting that women are incapable of making their own reproductive decisions. Section 1(1) of the Abortion Act stipulates that for an abortion to be lawful, it must be decided by 'two registered medical practitioners' that the individual's circumstances comply with one of the lawful grounds.[444] Therefore, the decision of whether to have an abortion or bring a child into the world does not belong to women, instead it rests in the good faith opinions of two medical practitioners. The law constructs abortion seekers as 'incapable of judging the circumstances in which they should become mothers.'[445] Thereby perpetuating the stigma that women who do not conform to the ideals

[441] Jackson, *supra* note 43 at 81.
[442] *Ibid.*
[443] Sally Sheldon, "The Medical Framework and Early Medical Abortion in the U.K.: How Can a State Control Swallowing?" in Rebecca J Cook, Joanna N Erdman and Bernard M Dickens, ed, *Abortion Law in Transnational Perspective* (Philadelphia: Penn Press, 2014) 189 at 195.
[444] Note the exception in S.1(4) that states the opinion of one medical practitioner will suffice if the situation is urgent.
[445] Siân M Beynon-Jones, "Expecting Motherhood? Stratifying Reproduction in 21st-century Scottish Abortion Practice" (2013) 47:3 Sociology 509 at 510.

of womanhood must be protected from their own decisions. This uncomfortable power dynamic between doctor and patient is a relic of the 1960s.[446] Law makers placed female reproductive decision-making in the hands of a respected and predominantly male profession.[447] Through the Abortion Act, Parliament created the illusion of choice for women whilst maintaining the ability to control the incidence of abortion by men. There may have been a degree of consideration for the safety of women since, at the time, abortion demanded a skilled surgical professional.[448] However, today this paternalism is what Sally Sheldon calls 'an unacceptable anachronism.'[449] In a 2018 study involving doctors who provide abortions, most participants recognised the paramount importance of the abortion seeker as the decision-maker: "who is the best judge about the need of the woman? The woman herself or me? I think it's the woman."[450] The study highlights how inappropriate it is that the law on abortion continues to imply 'doctor-knows-best'.

The two-doctor approval rule has practical implications for the delivery of service. Both the Royal College of Obstetricians and Gynaecologists and the British Medical Association have expressed concern over its potential to create unnecessary obstacles to timely abortion care.[451] This is of particular concern for women in remote locations where a clinic may not have two doctors available to provide their signatures. Given the time-sensitive nature of safest abortion care, any delay is cause for concern.

Thankfully, its full detrimental potential has been mitigated for most women due to a liberal interpretation of the Abortion Act by healthcare professionals. Practical guidance for healthcare

[446] Parsons and Romanis, *supra* note 198 at 20.
[447] Sheldon, *supra* note 8 at 44.
[448] Parsons and Romanis, *supra* note 198 at 18.
[449] Sheldon, *supra* note 415 at 291.
[450] Ellie Lee, Sally Sheldon and Jan Macvarish, "The 1967 Abortion Act fifty years on: Abortion, medical authority and the law revisited" (2018) 212 Social Science & Medicine 26 at 29.
[451] Science and Technology Committee, *Scientific Developments Relating to the Abortion Act 1967* (HC 2006-07, 12-I) para 88 and British Medical Association, "The law and ethics of abortion" (26 April 2023) 9, online: <https://www.bma.org.uk/advice-and-support/ethics/abortion/the-law-and-ethics-of-abortion>.

professionals provides that the secondary approval can be done remotely and without observation of the patient – approval may be given on the basis of another professional's assessment.[452] The Abortion Act's requirement of two-doctor approval is evidentially 'entirely bureaucratic.'[453] Shamefully, the Parliamentary Science and Technology Committee listed 'appeas[ing] the pro-life lobby' as a possible justification for retaining the statutory two-doctor requirement. Since healthcare professionals have criticised this rule as a barrier to access and quality abortion care,[454] this rule amounts to 'political ideology masquerading as scientific fact.'[455] There is no legitimate justification for the retention of the two-doctor approval requirement.

The development of medical ethics, in conjunction with advancements in abortion care, render the gatekeeping of reproductive care unjustified today. Its sole purpose continues to be the perpetuation of stigma that marks abortion seekers as unable to make their own decisions, and increase the authoritarian control over female bodies and sexuality.

Abortion exceptionalism

Abortion exceptionalism is, according to Erica Millar, 'the singling out of abortion from other areas of medicine on the grounds that it is special, different, or more complex or risky than is empirically justified'.[456] The exceptional treatment of abortion instead reflects its 'highly politicised and stigmatized status'.[457] Abortion exceptionalism is 'stigma-in-action.'[458]

[452] Department of Health and Social Care, "Guidance in Relation to the Requirements of the Abortion Act 1967" (May 2014) at para 21, online (Guidance for doctors) : <https://www.gov.uk/government/publications/guidance-for-doctors-on-compliance-with-the-abortion-act>.
[453] Sheldon, *supra* note 34 at 345.
[454] Lee, Sheldon and Macvarish, *supra* note 450 at 30.
[455] Sheldon, *supra* note 34 at 336.
[456] Erica Millar, "Abortion stigma, abortion exceptionalism, and medical curricula", online: (2023) Health Sociology Review <10.1080/14461242.2023.2184272>.
[457] Carole Joffe and Rosalyn Schroeder, "COVID-19, health care, and abortion exceptionalism in the United States" (2021) 53:1 Perspect Sex Reprod Health 5.
[458] Millar, *supra* note 456 at 3.

Exceptionalising abortion sets the abortion seeker apart from other patients, she is presented to society as 'less desirable' and in need of stricter regulation. Elizabeth Chloe Romanis and Jordan Parsons define abortion exceptionalism as the 'additional control that the law exerts over the bodies of pregnant people.'[459] For example, abortion is the only routine medical procedure in England and Wales that requires the approval of two doctors before it can be performed.[460]

We can see how the law in England and Wales exceptionalises abortion to exert control when we compare the Abortion Act with the general laws of medical consent. In the leading case *Re T (Adult: Refusal of Treatment)* Lord Donaldson finds that the law affords capacitous adults with 'an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of treatments being offered.'[461] Further, '[t]his right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.'[462] Although Lord Donaldson notes a possible exceptional where 'the choice may lead to the death of a viable foetus', this was merely obiter. In *Montgomery v Lanarkshire Health Board* Lady Hale asserted '[g]one are the days when it was thought that, on becoming pregnant, a woman lost, not only her capacity, but also her right to act as a genuinely autonomous human being.'[463]

The Abortion Act does away with the 'absolute right to choose' by requiring abortion seekers to instead satisfy two doctors that she fulfils a statutory criterion. In complete opposition to Lord Donaldson's judgment, the Abortion Act limits the abortion seeker's right to choose where she is rejecting the inevitability of motherhood and 'transgressing the ideals of womanhood'.

[459] Parsons and Romanis, *supra* note 198 at xxiv.
[460] Elizabeth Chloe Romanis, Alexandra Mullock and Jordan A Parsons, "The Excessive Regulation of Early Abortion Medication in the UK: The Case for Reform" (2021) 30 Med L Rev 4.
[461] *Re T (Adult: Refusal of Treatment)* [1992] EWCA Civ 18, [1992] 3 WLR 782 (CA) at 786.
[462] *Ibid.*
[463] *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] 2 WLR 768 at 800.

Reproductive decisions are in fact 'limited to decisions which others might regard as sensible.' Contrary to Lady Hale, the Abortion Act inhibits the autonomous decision-making capacity of pregnant people.[464] Therefore, we must arrive at the uncomfortable conclusion that a pregnant individual's capacity is lost only when they express a desire to no longer be pregnant. The law is enabling control over the bodies of pregnant people by limiting their reproductive autonomy when they want to use this autonomy to not have children.

CEDAW violations

Abortion laws in England and Wales frames the abortion seeker as criminal, whose rejection of the ideals of womanhood is so deviant that she ought to be exceptionally regulated, subsequently rejecting her decision-making capacity. This stigma violates the right to accessible abortion under CEDAW. In particular, a state's obligation to end the perpetuation of discriminatory stereotypes through legal reform. Thus, abortion must be decriminalised, and the Abortion Act substantially reformed to eradicate abortion exceptionalism and the idea that motherhood is a woman's biological destiny.

Furthermore, contrary to the CEDAW Committee's direction, the law in England and Wales continues to be 'grounded in historically determined male paradigms of power and life patterns.'[465] It perpetuates an abortion stigma that is intimately related to the disempowerment of women. According to Franz Hanschmidt and others, 'stigma can be viewed as an exercise of power of a dominant group over members of a less powerful group, who are considered different, negatively stereotyped, discriminated against and marginalized within society.' The abortion law in England and Wales exerts a power over women since it is premised upon the antiquated assumption that

[464] Romanis, Mullock and Parons, *supra* note 460.
[465] General Recommendation No.25, *supra* note 217.

expects women to 'subordinate all of their own interests, including their health, to the interests of their families.'[466] The law continues to perpetuate this stigma, prioritising a woman's reproductive potential above all other interests that make her an individual capable of flourishing – she is disempowered, and her worth reduced to incubation. When the Abortion Act was constructed to establish male doctors as the gatekeepers of women's health, it validated the idea that women are incapable of making their own decisions – and that their life choices should be dictated by men. Today, the medical profession remains predominantly male,[467] and women remain legally unentitled to an abortion on the grounds that it is their self-determined choice.

Summary

Abortion stigma violates the right to accessible abortion – England and Wales are under a positive obligation to reform the law and practice that perpetuates this stigma if it is to fulfil women's rights. Firstly, abortion must be decriminalised through repeal of anachronistic legislation that creates the offences of child destruction and procurement of a miscarriage. The decriminalisation of reproductive health services has been called for by multiple international human rights bodies.[468] Decriminalising would reduce the stigma that motherhood is a woman's biological destiny. This endeavour would be supported by significant reform or repeal of the Abortion Act which saw the removal of the lawful grounds for abortion. These criteria support the categorisation of tolerable and intolerable termination. Instead, from the instant an individual decides she needs an abortion for any reason, this choice should be respected and actionable. Furthermore, the exceptional requirement that two doctors approve the termination must be removed to end the

[466] Cook and Howard, *supra* note 213 at 1076.
[467] Frédéric Michas, "Registered doctors in the United Kingdom in 2021, by gender and specialty" (20 September 2022), online (statistics): <https://www.statista.com/statistics/698260/registered-doctors-united-kingdom-uk-by-gender-and-specialty/>.
[468] General Comment No.22, *supra* note 181.

undermining of female reproductive autonomy that suggests women are incapable of deciding for themselves that abortion is right for them.

Stigma in the absence of criminalisation - the situation in Canada

Canada does not impose any legal restrictions on abortion. However, this does not mean that women in Canada do not experience abortion stigma. Whilst it does not have the legitimation of legislation, abortion is still a highly stigmatized and exceptionalised aspect of healthcare.[469] Although not depicted as an individual whose rejection of womanhood marks her as criminally deviant, abortion seekers in Canada are still subject to a stigma that renders them inferior. Abortion is still an extremely common and routine procedure that remains shrouded in secrecy and judgment. This is a result of both the social and political climate surrounding abortion.[470] Since the decriminalisation of abortion in 1988, there have been numerous attempts to pass anti-choice legislation.[471] These attempts include the recriminalisation of abortion except where a doctor believes it necessary to preserve the woman's health,[472] and the proposal of a Parliamentary committee to reassess when a foetus becomes human in 2012.[473] Overall, since *Morgentaler* there have been almost fifty private members' bills or motions that include anti-abortion measures.[474] Politically, abortion remains a highly contentious issue in Canada, the repeated threats to a woman's reproductive autonomy fuels the stigma that she is abnormal and requires greater regulation.

[469] Madeleine Ennis et al, "Experience of stigma and harassment among respondents to the 2019 Canadian abortion provider survey", online: (2023) 124 Contraception 110083 <https://doi.org/10.1016/j.contraception.2023.110083>.
[470] Rachael Elizabeth Grace Johnstone, 'The Politics of Abortion in Canada After Morgentaler: Women's Rights as Citizenship Rights' (DPhil Thesis, Queen's University 2012).
[471] *Ibid.*
[472] Bill C-43, *An Act Respecting Abortion*, 2nd Sess, 34th Parl, 1990.
[473] House of Commons Journals, 41st Parl, 1st Sess, No 153 (26 September 2012) Private Members' Business M-312.
[474] Paul Saurette and Kelly Gordon, "Arguing Abortion: The New Anti-Abortion Discourse in Canada" (2013) 46:1 Can J Political Science 157 at 158.

Crisis Pregnancy Centres

Crisis Pregnancy Centres (CPCs) are 'non-profit organizations that present themselves as unbiased medical clinics or counselling centres for pregnant people.'[475] However, they are often religiously affiliated organisations, with anti-choice ulterior motives and no medical expertise.[476] CPCs' primary objective is to dissuade an individual from having an abortion by virtue of stigmatising judgmental services.[477]

CPCs adopt scare tactics, including graphic imagery[478] and falsely claiming adverse medical consequences of abortion such as breast cancer and post-abortion syndrome (PAS).[479] Although there is no medical evidence to support its existence, PAS is routinely appropriated by anti-choice organisations. It is ideology masquerading as protection. Alarmingly, comparing studies conducted in 2016 and 2020 indicates an increase in the number of CPCs making false claims about the negative psychological impact of abortion.[480] The notion of PAS perpetuates the idea that women who reject their biological destiny of motherhood only come to regret it, fuelling the misconception that women must be protected from their own flawed decision-making. It suggests a woman is incapable of knowing what is best for herself and that she must be guided by others. In fact, this is contrary to the experiences of individuals who do not regret their abortion.[481]

[475] Joyce Arthur et al, "Examining the Websites of Anti-Choice "Crisis Pregnancy Centres" (8 March 2023) 12, online (study): <https://www.arcc-cdac.ca/media/crisis-pregnancy-centres/cpc-website-review-2023.pdf>.
[476] *Ibid.*
[477] *Ibid.*
[478] Kathryn J LaRoche and Angel M Foster, "Toll free but not judgment free: evaluating postabortion support services in Ontario" (2015) 92 Contraception 469.
[479] Arthur et al, *supra* note 475.
[480] *Ibid.*
[481] La Roche and Foster, *supra* note 478 at 473.

When it comes to the provision of post-abortion services, CPCs' primary objective turns to shame and guilt.[482] Studies have found that post-abortion, CPCs offer 'counselling' to individuals should they want support. However, this 'counselling' is riddled with 'shaming and stigmatizing language and medically inaccurate information.'[483] CPCs are not concerned with the individual before them, their sole concern is the use of propaganda to advance their anti-choice agenda.[484] Studies indicate that CPCs operate on the assumption that all abortion is 'a traumatic birth loss' that will cause 'postabortion stress,' regardless of the feelings and experiences of the individual before them.[485]

CPCs operate on dangerous generalisations of abortion experience; they 'mislead and manipulate' women.[486] In fact, since 2016 CPCs have become increasingly vague about their religious and ideological stances.[487] Simultaneously, there has been an increase in CPCs providing ultrasounds and screenings for sexually transmitted diseases.[488] Thus, CPCs are increasingly presenting themselves in a way that supposedly validates their legitimacy, whilst concealing their true intentions. However, CPCs are unregulated in Canada – they do not have to adhere to medical standards.[489] Joyce Arthur, Executive Director of Abortion Rights Coalition of Canada, notes "abortion is the only medical service in Canada that has a system of fake medical clinics intended to divert people from the care they need via disinformation, ideological persuasion, and unlicensed medical services".[490] Therefore, CPCs are an example of dangerous and stigmatising abortion exceptionalism in action in Canada.

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[482] Kathryn J LaRoche and Angel M Foster, ""I kind of feel like sometimes I am shoving it under the carpet": Documenting women's experiences with post-abortion support in Ontario" (2017) 2 FACETS 754.
[483] LaRoche and Foster, *supra* note 478.
[484] Arthur et al, *supra* note 475.
[485] LaRoche and Foster, *supra* note 478 at 472.
[486] Abortion Rights Coalition of Canada, *Study finds "Crisis Pregnancy Centres" mislead and manipulate* (March 2023), online: ARCC <https://www.arcc-cdac.ca/study-cpcs-mar8-2023/>.
[487] *Ibid.* Olivia Jensen from BCHA believes this to be result of the Liberal Party stating their intention to prevent anti-choice groups from being registered as charities in 2021.
[488] Arthur et al, *supra* note 475.
[489] Abortion Rights Coalition of Canada, *supra* note 486.
[490] *Ibid.*

CPCs are perpetuating the discriminatory stereotype that women who seek abortions are unable to make their own reproductive decisions and that women who have abortions ought to feel ashamed of their rejection of motherhood. Since CPCs are unregulated, Canada is not fulfilling its obligation to end the perpetuation of discrimination against women. Furthermore, CPCs are disseminating dangerous medical misinformation without repercussion. Canada is facilitating the violation of an individual's right to reproductive health, which demands an individual be able to make 'free, informed and responsible decisions'[491] regarding her body. An individual cannot do this when her decision-making process is hijacked by medically unsound anti-choice propaganda. By failing to regulate the actions of CPCs, Canada is violating the right to health and diminishing reproductive autonomy.

CPCs are preventing women's enjoyment of the right to accessible abortion. Therefore, for Canada to fulfil the right to accessible abortion, they must regulate CPCs. However, the individuals who operate CPCs are entitled to freedom of expression. Thus, a balancing act of competing rights must be executed. Whilst opinions on abortion have been afforded special protection as contributing to discourse in the public interest, freedom of expression may be lawfully restricted to respect the rights of others. Respecting the right to access timely and quality abortion care means restricting the widespread and dangerous expression of false information and stigma perpetuated by CPCs.

A proportionate response from Canada does not demand the closure of all CPCs. However, it does necessitate regulation that prevents CPCs from disseminating false medical information and discriminatory quasi-counselling services which violate the right to accessible abortion. As ICCPR's General Comment No34 demands, we can prove the "direct and immediate connection

[491] *General Comment No.22*, *supra* note 181 at para 56.

between the expression [of CPCs] and the threat" to women's right to accessible abortion.[492] Furthermore, regulating CPCs in this way would not infringe their right to manifest their religious or conscientious beliefs. Reconciling rights demands recognition that freedom of religion does not entitle anyone to act however they wish provided it is religious or a demonstration of their beliefs. Regulation of such conduct is necessary to balance it with the demands of accessible abortion. The stigmatising 'care' provided by CPCs violates the right to accessible abortion – it can cause an abortion seeker to delay seeking treatment and amount to cruel and degrading treatment, thereby increasing risks to her physical and mental health.

Stigma in Indigenous communities

Abortion stigma has a special and complicated presence within Indigenous communities. Prior to settler arrival, and during the process of colonisation, Indigenous communities such as Nehiyawak "held teachings of what medicines to use to induce abortion and birth control."[493] In a 2023 study by Renée Monchalin and others "exploring access barriers to abortion services among Indigenous Peoples in Canada,"[494] one Indigenous participant explained that traditional methods of reproductive control indicate that "Indigenous culture suggests a tradition of honoring pregnant people's self-determination of their own bodies."[495] For these communities, abortion is respected self-determination. Unfortunately, the same individual (participant 009) speaks to a culture of secrecy and denial that is now present in the community.[496] This participant attributed the denial of Indigenous abortion history to "colonial Christian Catholic, settler ideologies."[497] Erica Violet

[492] *General Comment No 34*, *supra* note 332 at para 35.
[493] Erica Violet Lee and Tasha Spillett, "Indigenous women on the Prairies deserve reproductive freedom" (25 November 2017), online (News article): <https://www.cbc.ca/news/indigenous/opinion-indigenous-women-reproductive-freedom-1.4418787>.
[494] Renée Monchalin et al, "A qualitative study exploring access barriers to abortion services among Indigenous Peoples in Canada", online: (2023) 124 Contraception 110056 <https://doi.org/10.1016/j.contraception.2023.110056>.
[495] *Ibid* at 3.
[496] *Ibid.*
[497] *Ibid.*

Lee and Tasha Spillett argues that the Indigenous women who possessed the traditional knowledge of abortion and birth control methods were, and continue to be, "considered great threats to the Canadian project of replacing Indigenous governance structures with men who claim to speak for us."[498] These Indigenous communities understood bodily self-determination as reproductive control. The idea that this be plagued by abortion stigma, that such self-determination is wrong, seems to have been transplanted into communities during the process of colonisation.[499] The brutal imposition of religion "disrupted the intergenerational transfer of reproductive practices."[500] Unfortunately the 2023 study revealed abortion stigma, including the expectation of motherhood, from both within Indigenous communities and wider society to be a barrier to accessible abortion today.[501]

Abortion stigma violates the right to accessible abortion. Indigenous individuals experience this stigma from both within their community and society. The intersecting identities of Indigenous women are directly impacting their abortion experience: Indigenous individuals' right to accessible abortion is violated and the stigma's propensity for impeding access to care is uniquely compounded. According to the Committee on Economic, Social and Cultural rights, the right to health demands the provision of reproductive healthcare that is "respectful of the culture of individuals, minorities, peoples and communities."[502] The Committee then specifies that this cultural respect "cannot be used to justify the refusal to provide tailored facilities, goods, information and services to specific groups."[503] Therefore, to fulfil its positive obligations to ensure the right to accessible abortion, Canada must provide a tailored response to eradicate the

[498] Lee and Spillett, *supra* note 493.
[499] Karen Stote, "Decolonizing Feminism: From Reproductive Abuse to Reproductive Justice" (2017) 38:1 Atlantis 110.
[500] Monchalin et al, *supra* note 494 at 3.
[501] Ibid.
[502] *General Comment No.22*, *supra* note 181 at para 20.
[503] *Ibid.*

abortion stigma experienced by its Indigenous population, cultural differences cannot justify a failure to do so.

Practically, the participants in Monchalin's 2023 study expressed a desire for abortion doulas.[504] Abortion doulas are trained to provide "continuous patient support, which ranges from emotional support to providing accurate medical information when addressing patient concerns."[505] Abortion doulas offer care that enhances autonomy and is instrumental in decreasing the shame and stigma encountered during the abortion experience.[506] Indigenous abortion doulas are particularly beneficial for Indigenous abortion experiencers, "they have been found to identify and counter medical racism in hospital and clinical settings, while encompassing cultural teachings and spiritual connections."[507] Indigenous abortion doulas are uniquely qualified to understand the stigma felt within Indigenous communities. Canada must support the Indigenous endeavour to reclaim their history and traditional knowledge that was forced underground by settlers, including abortion and birth control traditions.[508] Canada should work to implement abortion care that is culturally sensitive and Indigenous led to reduce stigma, thereby fulfilling the right to accessible abortion for all who may need it - this includes supporting the proliferation of Indigenous abortion doulas.

Summary

Even in the absence of abortion legislation, Canada is still under a positive obligation to end the perpetuation of abortion stigma across the country. The absence of regulation of CPCs must change. Although it requires a careful balancing of rights, Canada must regulate CPCs in a way

[504] Monchalin et al, *supra* note 494.
[505] Shannon Lee, "Hold my Hand: How Abortion Doulas Improve Abortion Care", online: (2022) 8 Voices in Bioethics at 3 <https://doi.org/10.52214/vib.v8i.9027>.
[506] *Ibid.*
[507] Monchalin et al, *supra* note 494.
[508] *Ibid.*

that prevents nationwide dissemination of abortion stigma and dangerous misinformation which is violating women's right to accessible abortion. Furthermore, Canada must understand the significance of abortion stigma within its Indigenous communities and appreciate its troubling history. This includes providing access to Indigenous led care that can reduce the stigma within communities and regain ancestral knowledge that understood abortion as a method of self-determination – not a perverse violation of female norms.

Conclusion

Abortion stigma violates the right to accessible abortion. In particular, the right to health demands a comprehensive system of reproductive healthcare that, inter alia, is available and acceptable.[509] A system that stigmatises an abortion seeker to the extent that she delays accessing care is not one premised on the highest attainable standard. In fact, a delay may force an individual into a method of abortion she does not desire – further violating the right to health because abortion best practice calls for respect and facilitation of choice of method. Therefore, States must provide a system that does not deliver care based on stigmatising discriminatory expectations of those with the female capacity to procreate, nor may it perpetuate them.

In England and Wales, abortion law and policy therefore violate the right to accessible abortion; the criminalisation of essential reproductive healthcare such as abortion perpetuates very harmful stigma. Furthermore, the Abortion Act 1967 can only be described as abortion-tolerant at best. It is not abortion supportive. Despite the fact that there is no law on abortion in Canada, abortion stigma is still present, and its perpetuation continues to be facilitated by Governmental indifference and inaction. The detrimental potential of abortion stigma transcends jurisdictions.

[509] *General Comment No.22*, *supra* note 181.

Under the right to accessible abortion then, both jurisdictions are under positive obligations to eliminate abortion stigma given its dangerous and discriminatory potential that renders it in contravention to the right. The reform proposed in this chapter would reduce abortion stigma that isolates women to suffer both the physical and mental health consequences of inaccessible abortion in silence. The positive obligations on states would help to bring abortion out of the shadows and into an understanding that it is healthcare that provides actionable reproductive choices. Law and policy that makes reproductive choice actionable without fear facilitates the exercise of female power in the production of self that is not informed by stigma.

Chapter VI: Abortion Location and Cost

Introduction

This chapter will assess the experience of abortion in England and Wales and Canada, as well as the legal, social, and political factors that shape this experience. This analysis demonstrates that the right to accessible abortion requires policy that prioritises medical best-practice and the experiences of women trying to physically access abortion care.

England and Wales

The criminalisation of abortion means that the Abortion Act 1967 provides strict stipulations on how abortion care must take place for it to be lawful. These stipulations may have had justification in the 1960s,[510] however the present analysis will demonstrate that they now function contrary to contemporary best practice of abortion. The following section will assess the abortion experience in England and Wales in terms of both the provider and location of termination.

Who provides abortion care?

Abortion charities play a tremendous role in the delivery of abortion care in England and Wales.[511] Following the Abortion Act in 1967, the NHS lacked the resources to cope with the increase in demand for lawful abortions, and was not provided with any extra funding.[512] The situation remained dangerous for most women. With hospitals unable to afford the provision of abortion

[510] Parsons and Romanis, *supra* note 198 at 18.
[511] Sally Sheldon et al, *The Abortion Act of 1967: a biography of a UK law*, (Cambridge: CUP, 2023) at 116.
[512] *Ibid.*

and doctors still refusing,[513] safe lawful abortion belonged to a 'thriving private sector.'[514] Abortion was off limits to anyone who could not afford it. This does bring into question what Parliament had envisioned with the Abortion Act. Without providing the means for the Act's successful operation, Parliament seems to have been prioritising the reproductive health of only affluent members of society. It appears that the accessibility of abortion has been an afterthought from the beginning.

Responding to demand, charities such as the British Pregnancy Advisory Service (BPAS, formerly Birmingham PAS) expanded their services to offer lawful and safe abortion at affordable cost for all who needed it.[515] In 1976, Marie Stopes International (operating today as just MSI) joined the fight for low-cost accessible abortion.[516] However, the regional discrepancies of abortion access under the NHS became 'entrenched.'[517] This changed in the 1980s when, seeking greater economic efficiency in the health sector, agency agreements were introduced.[518] These are agreements whereby the NHS contracts out abortion services to charitable providers. Having been trialled in Birmingham, where conscientious objection by NHS doctors was exceptionally high, it became apparent that the abortion care delivered by charities was superior, safer and cheaper than that provided by the NHS.[519]

These arrangements spread across the nation. Today, almost all abortions are funded by the NHS (99%). In 2021, 21% of abortions were performed in hospitals and 77% provided by independent

[513] *Ibid.*
[514] Sheldon, *supra* note 8 at 17.
[515] Sheldon, *supra* note 511 at 116.
[516] *Ibid.*
[517] *Ibid.*
[518] *Ibid*, at 117.
[519] *Ibid.*

sector clinics under NHS contract.[520] Therefore, abortion care in England and Wales is free to anyone entitled to NHS treatment.

This arrangement for the delivery of abortion services has been criticised as a mode of exceptionalism,[521] suggesting that abortion is abnormal healthcare that deserves different management.[522]

However, the care provided by these charities is uniquely abortion-seeker focused and ultimately encourages a stigma-free experience. For example, the MSI website contains a wealth of non-judgmental support, including a video in which a doctor instructs individuals how to safely take abortion pills.[523] In stark contrast to Canada's CPCs, MSI only features information supported by medical evidence, has no religious affiliation, and never gives unsolicited quasi-counselling. BPAS is explicit that their 'ambition' is '[a] future where every woman can exercise reproductive autonomy and is empowered to make her own decisions about pregnancy.'[524] The level of focused care that the charities provide is such that abortion seekers do not experience the full extent of abortion stigma, particularly that which the law perpetuates.[525] In fact, many abortion seekers in England and Wales are unaware of abortion's criminal status.[526] The actions of abortion charities is therefore integral to mitigating the stigmatising potential of the law, and promoting a judgment-free abortion experience.

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[520] Office for Health Improvement and Disparities, *supra* note 2.
[521] Nathan Emmerich, "We should not take abortion services for granted", online: (2023) 18:1 Clinical Ethics 1 <https://doi.org/10.1177/147775092211407>.
[522] *Ibid.*
[523] "Medical & Surgical Abortion Services" (2020), online: *MSI UK Reproductive Choices* <https://www.msichoices.org.uk/abortion-services/>.
[524] "What BPAS stands for: our ambition, purpose and values", online: *British Pregnancy Advisory Service* <https://www.bpas.org/about-our-charity/history/what-we-stand-for/>.
[525] Romanis, *supra* note 367 at 383.
[526] *Ibid.*

Furthermore, abortion seekers can directly access pro-choice providers who have chosen to specialise in the delivery of abortion care. This limits the occurrence of conscientious objection. Under the Abortion Act 1967, conscientious objection is permitted under section 4: 'no person shall be under a duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorised by this Act to which he has a conscientious objection.'[527] The law's protection of the possibility of conscientious objection is exceptionalising, Sally Sheldon argues that it 'permits the unethical abandonment of professional obligations to patients for reasons of non-verifiable personal beliefs, undermining best practices grounded in scientific evidence and secular medical ethics.'[528] Lady Hale appreciated the harmful potential of conscientious objection in the Supreme Court when she held a 'necessary corollary' of the duty of care owed by doctors to patients required an objector to refer the case to another who would not object.[529] After all, the revered status society has bestowed upon doctors means their opinion can have substantial significance for an individual's medical decisions.[530] Further, where an abortion seeker is unaware of all of her options, for example where English is not her first language or she is a minor, the refusal of one provider has the potential to appear a definite refusal that leaves her believing her only option is unwanted pregnancy.[531]

The protection of conscientious objection in the Abortion Act 1967 demonstrates a prioritisation of doctors' freedom to manifest their religion or belief system. However, this freedom is not absolute. Interestingly, there are similarities to be drawn between England and Wales and Sweden. The European Court of Human Rights held that, because Sweden provided nationwide abortion care, it was obligated to disallow the exercise of conscientious objection to threaten the delivery

[527] Abortion Act 1967 S.4.
[528] Sheldon, *supra* note 511 at 186.
[529] *Greater Glasgow Health Board v Doogan and Another* [2014] UKSC 68, [2015] 2 WLR 126.
[530] Arianne Shahvisi, "Conscientious objection: a morally insupportable misuse of authority", online: (2018) 13:2 Clinic Ethics 82 at 84 <https://doi.org/10.1177/1477750917749945>.
[531] Jackson, *supra* note 43 at 86.

of accessible abortion care.[532] Similarly England and Wales purports to provide nationwide abortion care, therefore the government must be under this obligation to disallow conscientious objection to threaten accessible abortion. Thankfully, abortions by explicitly pro-choice providers allows women to bypass the possibility of conscientious objection. Being able to bypass being told by another that her autonomous reproductive choice is wrong ultimately leads to better care and improves access. However, to adequately reconcile the freedom to manifest conscience with the right to accessible abortion, conscientious objection, in particular a doctor's personal religious beliefs, must have a limited and closely regulated place in today's delivery of healthcare.[533] Contemporary medical ethics replaced paternalism with a respect for patient autonomy.[534]

The NHS agency agreements caused the expansion of abortion clinics across the nation which regrettably provided convenient locations for pro-life protest.[535] Prominent groups such as 'Good Counsel Network' and 'Helpers of God's Precious Infants' have consistently harassed individuals outside of clinics with cruel methods.[536] For example, hosting prayer vigils and displaying large graphic images of dismembered foetuses.[537] These groups profess to be 'saving' women,[538] a highly problematic notion that suggests women rejecting motherhood must be rescued from their own decision-making. The effect on women is significant psychological distress.[539] Encouraged by the influential anti-choice movement in USA,[540] there has been a recent increase in pro-life demonstrations outside of UK abortion clinics.[541] Following a long campaign by BPAS,[542]

[532] *Grimmark v Sweden*, *supra* note 298.
[533] Julian Savulescu, "Conscientious objection in medicine" (2006) 332 BMJ 294.
[534] Ibid at 295.
[535] Sheldon, *supra* note 511 at 120.
[536] *Ibid*, at 121.
[537] *Ibid.*
[538] Pam Lowe and Sarah-Jane Page, "'On the wet side of the womb': The construction of 'mothers' in anti-abortion activism in England and Wales" (2019) 26:2 EJWS 165.
[539] *Dulgheriu v London Borough of Ealing* [2019] EWCA Civ 1490, [2020] WLR 609.
[540] Katharine Stewart, "'If we can do it, you can do it': US anti-abortion groups ramp up activities in UK" (2 April 2023), online (News article) : <https://www.theguardian.com/world/2023/apr/02/us-anti-abortion-groups-uk-far-right>.
[541] Sheldon, *supra* note 511 at 123.
[542] British Pregnancy Advisory Service, "Back Off", online: <https://bpasprd.wpengine.com/campaigns/backoff/>.

Parliament finally stepped in and, on 2 May 2023, the Public Order Act 2023 became law. Section 9 of the Public Order Act 2023 establishes 'safe access zones': 'an area which is within a boundary which is 150 meters from any part of an abortion clinic.' Section 9 makes it a criminal offence to intend to influence, obstruct or harass any person within these zones.

This is a meaningful attempt to eliminate the experience of abortion stigma suffered by women – inflicted by a very vocal minority.[543] The creation of safe access zones demonstrates an appreciation for women's rights. An individual who has decided in-person abortion care is best for them, who is then subject to the pain and suffering of harassment when enacting this decision, is being subjected to cruel, inhuman and degrading treatment. Treatment that obstructs the practice of reproductive autonomy is cruel, it is an impediment to dignity.[544] Further, the new efforts to support women protects the right to health as it eliminates the obstacle protestors pose to mental and physical wellbeing,[545] it eliminates a potential delay in treatment and a cause for psychological distress.

The creation of safe access zones demonstrates a fulfilment of the State requirement to reconcile competing rights: the freedom of expression of anti-abortion demonstrators and the right to access safe and timely abortion care. In 2022, the United Kingdom Supreme Court addressed the relationship between safe access zones and the freedom of expression in *Reference by the Attorney General for Northern Ireland – Abortion Services (Safe Access Zones) (Northern Ireland) Bill*.[546] The Supreme Court unanimously held the creation of safe access zones to be compatible with the right to freedom of expression under the European Convention.[547] In a departure from the

[543] Lowe and Page, *supra* note 538.
[544] Zureick, *supra* note 136.
[545] KL v Peru, *supra* note 159.
[546] *Reference by the Attorney General for Northern Ireland – Abortion Services (Safe Access Zones) (Northern Ireland) Bill*, [2022] UKSC 32, [2022] 2 WLR 33.
[547] *Ibid.*

jurisprudence from the European Court of Human Rights which has thus far been limited to consideration of the personality rights of abortion providers, the Supreme Court prioritised the rights of abortion seekers. Delivering the judgment, Lord Reed considered the physical and psychological suffering an individual visiting an abortion provider may be experiencing as well as the unique exacerbation of this suffering for certain groups such as minors and victims of sexual offences.[548] The Court found that safe access zones are intended to "ensure that women seeking a safe termination of pregnancy have unimpeded access to clinics where such treatment is provided, and are not driven to less safe procedures by shaming behaviour, intrusions upon their privacy, or other means of undermining their autonomy," – the creation of safe access zones "is a rational response to a serious public health issue."[549]

Although the Court's decision was made in the context of Northern Ireland, the legislative creation of safe access zones in both Northern Ireland and England and Wales are almost identical. Both make it a criminal offence to harass people in safe access zones, a summary criminal offence which is punishable by a fine. Therefore, the Court's proportionality assessment is relevant also to Section 9 of the Public Order Act 2023. In neither jurisdiction is the right to freedom of expression being forbidden altogether, the location in which an individual can exercise the freedom is merely being limited. The Supreme Court appreciated this distinction in its conclusion that a fair balance of rights had been struck.[550]

Overall, the creation of safe access zones in England and Wales clearly support the "reasonable expectation" of abortion seekers to be able to access care "without having their autonomy challenged and diminished, whether by attempts by protestors to persuade them to change their minds, or by protesters praying for the souls of foetuses with the intention or effect of provoking

[548] *Ibid* at para 98.
[549] *Ibid* at para 118.
[550] *Ibid* at para 127.

feelings of guilt, or by other means calculated to undermine their resolve."[551] Furthermore, in accordance with jurisprudence from the European Court of Human Rights, the new legislation confirms that the freedom to manifest religion does not guarantee a right to behave in any way in the public sphere simply because it is religious in nature or motivated by belief. Section 9 of the Public Order Act 2023 is a positive prioritisation of women's lived abortion experience as required by the right to accessible quality abortion care.

Abortion care is provided free of charge by pro-choice charities for the vast majority of England and Wales which facilitates high-quality, autonomy centred care – when it can be physically *accessed*.

Where do abortions take place?

The Abortion Act 1967 stipulates the location an abortion must take place for it to be lawful. Until recently, section 1(3) required termination be carried out in an NHS hospital or 'a place approved for the purposes of this section by the Secretary of State.' The legislation therefore bestows upon the Secretary of State for Health and Social Care in England, and the Minister for Health and Social Services in Wales, the exclusive power to determine where an abortion may lawfully take place. Except in an emergency, an abortion can only take place in a location deemed suitable by government ministers without the threat of prosecution.

However, the development of the medical abortion to require the administration of just two pills taken 24-48 hours apart meant that safe abortion care did not necessitate treatment in a hospital.[552] Indeed, the requirement for travel to an approved location only stood to impede access.[553] The law

[551] *Ibid* at para 126.
[552] Romanis, Mullock and Parsons, *supra* note 460.
[553] Jordan Parsons, "2017-19 governmental decisions to allow home use of misoprostol for early medical abortion in the UK" (2020) 124:7 Health Policy 679.

required an abortion seeker to travel to an approved location to be prescribed the medication and administer the first pill (mifepristone), and then return 24 hours later to administer the second pill (misoprostol). This was unnecessarily laborious; having to travel to administer misoprostol often resulted in the individual experiencing a miscarriage on her journey home.[554] This would be especially distressing for individuals using public transport; who had travelled alone;[555] or those who wished to be discrete – perhaps due to perceived stigma or an abusive situation at home.[556]

In 2018, health ministers in both England[557] and Wales[558] granted approval orders making it lawful for a person having a medical abortion to self-administer misoprostol at home. Having been introduced in 1991, change to the delivery of a medical abortion was long overdue. These orders maintained the requirement of travel for the prescribing of the medication and the supervision of mifepristone administration, the individual must then be 'ordinarily resident' at the location she self-administers misoprostol. Whilst this was a huge advancement for the experience of medical abortion, the approval orders merely cut the requirement of travel in half.[559]

The travel requirement remained a large barrier to accessible abortion.[560] The law created regional inequality of access between those able to visit a provider and those who could not. For example,

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[554] *Ibid.*
[555] *Ibid.*
[556] Mary Ann Castle et al, "Listening and learning from women about mifepristone" (1995) 5:3 Women's Health Issues 130 at 135.
[557] Department of Health and Social Care, "The Abortion Act 1967 – Approval of a Class of Places" (27 December 2018), online (Approval Order): <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/768059/Approval_of_home_use_for_the_second_stage_of_early_medical_abortion.pdf>.
[558] Wales Health and Social Services, "The Abortion Act 1967 (Approval of Place for Treatment for the Termination of Pregnancy) (Wales)" (20 June 2018), online (Approval Order): <https://gov.wales/sites/default/files/publications/2019-07/the-abortion-act-1967-approval-of-place-for-treatment-for-the-termination-of-pregnancy-wales-2018-2018-no-56.pdf>.
[559] Elizabeth Chloe Romanis and Jordan Parsons, "COVID-19 and abortion care: why we need remote access to reproductive health services" (21 March 2020), online (blog): *BMJ Sexual and Reproductive Health Blog* <https://blogs.bmj.com/bmjsrh/2020/03/21/covid-19-abortion/>.
[560] Jonathan Lord et al, "Early medical abortion: best practice now lawful in Scotland and Wales but not available to women in England" (2018) 44:3 BMJ Sexual & Reproductive Health 155 at 156.

access was difficult for those living in rural areas since abortion clinics are clustered in cities.[561] The nearest provider for an abortion seeker may be over 100 miles away,[562] which necessitates lengthy and possibly costly travel arrangements.[563] Meanwhile, having an abortion provider nearby did not mean abortion automatically became accessible. One abortion seeker's nearest clinic may serve a large geographical area, subsequently it is unable to cope with demand.[564] In a study conducted by Abigail Aiken and others,[565] exploring the barriers to access on individual abortion seekers, one participant said 'I am currently between 7-8 weeks pregnant and want a medical termination however all abortion services in the UK are heavily backed up and cannot offer me an appointment for over three weeks. I've called every service provider in my area and also gone through my GP.' The woman continues, 'I can't endure the mental anxiety of staying pregnant for another three weeks and then having a surgical procedure.'[566] It is important to remember that best medical practice, and therefore the right to health, demands respect for an individual's choice regarding *method* of abortion. Furthermore, once an individual has decided she needs a medical abortion – to force her into a procedure contrary to her autonomous decision by virtue of procedural inequality is CIDT. The delivery of abortion care must ensure an individual's abortion choice is both respected and actionable.

The unavoidable travel requirement made abortion inaccessible for those in rural areas and for those who could not afford it. It is inexcusable that it took a global pandemic to force a change to this standard of care.

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[561] *Ibid.*
[562] Abigail Aiken et al, "Barriers to accessing abortion services and perspective on using mifepristone and misoprostol at home in Great Britain" (2018) 97 Contraception 177 at 180.
[563] *Ibid.*
[564] Parsons and Romanis, *supra* note 198 at 43.
[565] Aiken et al, *supra* note 562.
[566] Ibid, at 179.

At-home abortions and the "telemedical imperative"[567]

On 23rd March 2020, the Covid-19 Pandemic forced then Prime Minister Boris Johnson to instruct the nation to 'stay-at-home'.[568] Despite this, abortion seekers remained subject to a travel requirement to access care. Charities including BPAS urged the Government to implement telemedical early medical abortion (TEMA) as a matter of safe and equitable access to essential healthcare in the midst of a global public health crisis.[569] TEMA involves the remote prescription of mifepristone and misoprostol which is then self-administered by the individual at home.[570] In fact, TEMA has long been understood as a safe and expeditious method of termination; in 2015 the WHO recommended the use of TEMA where the individual has a 'source of accurate information and access to a healthcare provider should they need or want it any stage of the process.'[571] The WHO confirmed its recommendation in 2019: 'self-management and self-assessment approaches can be empowering and also represent a way of optimizing available health workforce resources and sharing of tasks.'[572] Furthermore, the WHO has confirmed that TEMA may be someone's 'only feasible option' whilst it may be another's 'active choice;' it is *not* a 'last resort'.[573] TEMA improves accessibility and provides another abortion care option, thereby facilitating meaningful choice for an individual to safely self-manage their reproductive decisions – a fact long appreciated by professionals.

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[567] Parsons and Romanis, *supra* note 198.
[568] "Coronavirus: 'You must stay at home', Boris Johnson orders" (23 March 2020), online (News article): <https://www.bbc.com/news/av/uk-52012581>.
[569] British Pregnancy Advisory Service, "Healthcare professionals call on Boris Johnson to intervene to protect women's health - reckless failure to listen to scientific advice is putting vulnerable women at severe risk" (25 March 2020), online: <https://www.bpas.org/about-our-charity/press-office/press-releases/healthcare-professionals-call-on-boris-johnson-to-intervene-to-protect-women-s-health-reckless-failure-to-listen-to-scientific-advice-is-putting-vulnerable-women-at-severe-risk/>.
[570] Parsons and Romanis, *supra* note 198 at 15.
[571] World Health Organisation, *Health worker roles in providing safe abortion care and post-abortion contraception* (Geneva: WHO, 2015) at 41.
[572] World Health Organisation, *Consolidated Guideline on Self-Care Interventions for Health* (Geneva: WHO, 2019) at 67.
[573] WHO, *supra* note 124 at 98.

The pandemic forced the Government to acknowledge this and implement TEMA, although this was temporary and not without political farce. An order approving the home-use of mifepristone and misoprostol following remote consultation and prescription via videolink, telephone or other electronic means on 23rd March 2020 but it was retracted the same day. In a second U-turn, the approval order was reinstated on 30th March 2020, the Welsh Government granted the same approval the following day. At one week, this delay may at first appear minor. However, this was a week filled with uncertainty and inaccessibility for the abortion seeker. Further, given the time-sensitive nature of abortion care, this may have been the week that an individual's gestation crossed the threshold of lawful abortion. The Government's actions were frivolous with little regard to individual experience. The Abortion Act 1967 made this possible, it facilitated a state of anxious uncertainty for all sexually active individuals with the capacity to reproduce – not knowing which methods of abortion would remain available to them should they need it.

The crucial difference between the retracted order and its replacement was the inclusion of a sunset clause in the latter: 'this approval expires on the day on which the temporary provisions of the Coronavirus Act 2020 expire, or the end of the period of 2 years beginning with the day on which it is made, whichever is earlier.'[574] TEMA proved to be successful; since its implementation abortions have taken place at earlier gestations. In 2019, prior to TEMA, just over 80% of abortions took place at gestations earlier than 10 weeks'.[575] In 2021, this number rose to 89%.[576] To reiterate, the earlier an abortion is carried out the safer it is. Furthermore, a 2021 study found that TEMA was not an inferior method of abortion care, and that 'the evidence is compelling that no-test

[574] Department of Health and Social Care, "The Abortion Act 1967 – Approval of a Class of Places" (30 March 2020), online (Approval Order): <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876740/30032020_The_Abortion_Act_1967_-_Approval_of_a_Class_of_Places.pdf>.
[575] Department of Health and Social Care, "Abortion Statistics, England and Wales: 2019" (11 June 2020), online (National Statistics): <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2019>.
[576] Office for Health Improvement and Disparities, *supra* note 2.

telemedicine should become routine in the provision of abortion care.'[577] Therefore, by eradicating the need for travel, TEMA improves both safety and accessibility of abortion care. The evidence made this indisputable.

Satisfied with TEMA's successful operation, the Welsh Minister for Health and Social Services announced on 24th February 2022 that these measures would become permanent in Wales.[578] However, on 21st March 2022, the Department of Health and Social Care in England announced TEMA would remain lawful only until 29th August 2022, at which point in-person services must resume.[579] This was contrary to all evidence available that had proved at-home abortions were safe and effective. It demonstrated that, when it comes to abortion, 'politics often trumps evidence.'[580] The Abortion Act 1967 location requirement would continue to necessitate travel and continue to impede access to abortion. This was a non-sensical step backwards for autonomy and women's reproductive rights.

However, once again in a U-turn fashion, the House of Commons voted in favour of making TEMA permanent.[581] The vote was in response to an amendment to the Health and Care Bill made by peer Baroness Sugg in the House of Lords. Therefore, TEMA continues to operate on a permanent basis in England and Wales by virtue of section 178 of the Health and Care Act 2022. It implements the following provisions into the Abortion Act:

[577] ARA Aiken et al, "Effectiveness, safety and acceptability of no-test medical abortion (termination of pregnancy) provided via telemedicine: a national cohort study" (2021) 128:9 BJOG 1464 at 1472.
[578] Gov.Wales, "Written Statement: Arrangements for Early Medical Abortion at Home" (24 February 2022), online (Approval Order): <https://gov.wales/written-statement-arrangements-early-medical-abortion-home>.
[579] Department of Health and Social Care, "The Abortion Act 1967 – Approval of a Class of Places" (21 March 2022), online (Approval Order): <https://www.gov.uk/government/publications/extension-of-temporary-approval-of-home-use-for-both-stages-of-early-medical-abortion>.
[580] Moreau et al, *supra* note 7 at 2.
[581] HC Deb 30 March 2022, vol 711, cols 898-900.

> Section 1(3C): If the usual place of residence of the registered medical practitioner terminating the pregnancy is in England or Wales, the medicine may be prescribed from that place by the registered medical practitioner.
>
> Section 1(3D): If the pregnant woman's usual place of residence is in England or Wales and she has had a consultation (in person, by telephone or by electronic means) with a registered medical practitioner, registered nurse or registered midwife about the termination of the pregnancy, the medicine may be self-administered by the pregnant woman at that place.

Ultimately, TEMA is now lawful and is operating without an end date – this is a good thing. However, its tumultuous legislative journey is difficult to ignore. When we consider that TEMA has a well-established footing in modern medicine and has immense potential for reproductive autonomy, it is challenging to justify any unreasonable delay in its implementation.

Vulnerable abortion seekers

Aiken's study found 18.2% of its participants said 'threat of violence or controlling circumstances' was a reason they felt unable to access lawful abortion in Britain; 11.5% specified 'fear or experience of intimate partner violence and control.'[582] For these individuals, the barrier that strict regulation on abortion location created was compounded: one participant said 'I'm in a controlling relationship, he watches my every move, I'm so scared he will find out, I believe he's trying to trap me and will hurt me. I can't breathe. If he finds out, he wouldn't let me go ahead, then I will be trapped forever. I cannot live my life like this.'[583] Before the implementation of TEMA, the law

[582] Aiken et al, *supra* note 562 at 180.
[583] *Ibid*, at 181.

forced these individuals to travel to obtain abortion from an approved location. The law failed to respect the reproductive autonomy of these abortion seekers since they did not have actionable abortion choices –their only option to travel for care was not safe for them.

Therefore, the approval of TEMA and at-home abortion is incredibly valuable for victims of domestic abuse or intimate partner violence because of its propensity for private and discrete self-management of abortion. However, it is not a perfect solution. The Health and Care Act 2022 stipulates EMA obtained telemedically can be self-administered in the individual's 'usual place of residence.' Thus, where a pregnant person does not feel safe in their 'usual place of residence,' the law prevents her taking two pills in an environment in which she feels safe, without risking criminality. This is detrimental to a victim of domestic abuse who risks violence to comply with the law.

Not only is the location requirement dangerous in this situation, but it is also a rights violation. Firstly, the right to life means abortion law and policy must not risk the lives of pregnant people. Secondly, the law is subjecting a victim of domestic violence to criminality if she self-manages her EMA in a location that is not her residence. Her alternative is to administer the medication in a dangerous environment or have to travel what may be a significant and costly distance, for a method of termination she was forced into by her situation and the law. This is contrary to best practice which demands respect for an abortion seeker's autonomous choice of method, and it may amount to cruel, inhuman or degrading treatment.

Consequently, section 1(3D) of the Health and Care Act 2022 ought to be reformed to allow an individual to self-administer an EMA in a place that she feels safe. Provided she has access to support or aftercare should she desire it, there should be no requirement that the termination take place in her 'usual place of residence.'

Abortion politicisation

The haphazard expansion of the Abortion Act 1967's location of abortion provision demonstrates the lack of importance lawmakers in England and Wales afford to the lived realities of abortion seekers. Despite two years of medical evidence that TEMA was effective, the Government remained steadfast in its intention to end the lawfulness of TEMA. Ending TEMA would have forced abortion seekers back to unnecessary abortion travel and reinforce the detrimental potential of the Abortion Act's location requirement. To put an end to the delivery of evidently safe and effective abortion care is putting an end to 'the highest attainable standard of care'. The right to health demands a system of comprehensive reproductive care that is physically accessible, evidence-based, and up to date.[584] Reinforcing a location requirement established by 1960s legislation, before the possibility of an at-home medical abortion had been conceived, would have been a step backwards.

For abortion services to remain up to date, it required both Houses of Parliament, and lobbying from the providers of abortion care,[585] to do what one minister had the power to do from the moment evidence indicated the safety of TEMA. The Abortion Act dangerously placed the fate of reproductive rights in the hands of one minister. The Health and Care Act 2022 does not revoke the Secretary of State's power to approve locations of lawful abortion. In fact, the newly inserted section 1(3A)(b) states the power is 'not limited by subsections (3C) and (3D).' As Adelyn Wilson notes, the relationship between these provisions is unclear and it is uncertain how a court might

[584] *General Comment No.22, supra* note 181.
[585] inews, "Home abortions: Fury from women's groups as Government winds down temporary law allowing 'pills by post'" (24 February 2022), online (News article): <https://inews.co.uk/news/home-abortions-pills-by-post-procedures-covid-pandemic-government-scraps-temporary-law-1481478>.

interpret this provision if faced with an approval that seemed to interfere with the now statutorily ensured TEMA.[586]

The politicisation of abortion did not end with TEMA's new statutory footing. Despite the Health and Care Act, Members of Parliament (MPs) have used the recent and very public case of Carla Foster to launch new attacks at TEMA.[587] For example, in June of this year, Conservative MP Sir Edward Leigh asserted '[s]urely the solution, given that it is difficult to determine gestation without an in-person appointment, is to return to the system of in-person appointments, so that women can receive safe, legal abortions if they wish.'[588] In the same debate, Conservative MP Sir Desmond Swayne asked '[t]his tragedy would not have occurred had there been a requirement for a face-to-face consultation and clinical administration of the drugs, would it?'[589] Most abhorrently, Conservative MP Nick Fletcher first makes scientifically inaccurate assertions:[590] 'after 6 weeks old, those babies are fully formed and it is just a case of them growing, as we continue to do when we are outside the womb.'[591] He proceeds to make sweeping claims that studies suggest to be an incorrect depiction of the abortion experience: 'I am sure no woman goes to an abortion clinic and has an abortion and does not hate that experience. I am sure it is something that no woman ever wants to do.'[592] He concludes his attack with one final shot at women: '[m]aybe, if they had used contraception or had looked at things in a different way, these babies would not have happened.'[593] This perpetuates the discriminatory stereotype that abortion seekers are promiscuous deviants who

[586] Adelyn L M Wilson, "The Health and Care Act 2022: inserting telemedicine into the Abortion Act 1967" (2023) 31 Med L Rev 158 at 165.
[587] HC Deb 15 June 2023, vol 734.
[588] Ibid, col 438.
[589] Ibid, col 440.
[590] NHS "You and your baby at 12 weeks pregnant" (12 October 2021), online (Patient advice webpage): <https://www.nhs.uk/pregnancy/week-by-week/1-to-12/12-weeks/>.
[591] Hansard, *supra* note 587 at 441.
[592] *Ibid.*
[593] *Ibid.*

ought to deal with the consequences of their own actions or are victims who are unable to make their own reproductive decisions.

The offensive, ill-informed and medically incorrect assertions made in just one Parliamentary debate demonstrate the hostility of lawmakers towards reproductive rights. The UK Government is yet to explain its 2022 quiet withdrawal of commitments to reproductive rights from an official 'statement on freedom of religion or belief and gender equality.'[594] The original text, which had already been signed by more than twenty countries, held that the UK was committed to repealing laws and practices that threatened women and girls' 'sexual and reproductive health and rights, bodily autonomy.' The provision was amended to protect 'women and girls' full and equal enjoyment of human rights.'[595] It is no coincidence that the organisation of the international ministerial conference on freedom of religion or belief, held in London, had heavy involvement from MP Fiona Bruce – co-chair of the all-party Parliamentary pro-life group.[596] This seems to be a political move operating under the guise of balancing competing rights, the Government can act under the guise of implementing freedom of religion or belief. However, the Government has simply removed any commitments to reproductive rights. Canada has not signed the new version, and will not do so without explanation as to the modification.[597]

[594] Foreign, Commonwealth and Development Office, "Statement on freedom of religion or belief and gender equality" (7 July 2022), online (Policy paper): < https://www.gov.uk/government/publications/freedom-of-religion-or-belief-and-gender-equality-statement-at-the-international-ministerial-conference-2022/statement-on-freedom-of-religion-or-belief-and-gender-equality#:~:text=We%20affirm%20that%20the%20right,believe%20and%20practise%20their%20beliefs>.
[595] *Ibid.*
[596] The Guardian, "UK under international pressure over deletion of abortion commitments" (22 July 2022), online (News article): <https://www.theguardian.com/global-development/2022/jul/22/european-countries-pressurise-uk-over-removal-of-abortion-commitments-liz-truss>.
[597] *Ibid.*

Implementing the right to accessible abortion in England and Wales

The provision of abortion in England and Wales is regulated by antiquated legislation and stigmatising policy that is contrary to best practice today. Women's rights, experiences, and scientific evidence can merely be described as afterthoughts in the delivery of reproductive healthcare. This approach to abortion care violates the right to accessible abortion. Therefore, we must now ask what positive action England and Wales must take to implement women's right to accessible abortion?

The right to accessible abortion mandates a framework of reproductive healthcare that is evidence-based and scientifically and medically appropriate and up-to-date.[598] Abortion law and regulation in England and Wales can only, at best, be considered minimally informed by medical evidence. To change this, England and Wales must decriminalise abortion since this would demand the Abortion Act 1967 be either 'radically revised or repealed in its entirety'[599] because the role of the Abortion Act as providing a defence to crime would be obsolete. Repealing the Abortion Act would remove the anachronistic hurdles on abortion location that stood in the way of immediate implementation of TEMA as soon as evidence indicated its safe potential to improve access. [600] Indeed, when the Government in England and Wales implemented and then withdrew the approval of TEMA, and when it announced TEMA was to end on 29th August, it was removing law 'necessary for the enjoyment of the right to sexual and reproductive health' – an 'example of a violation' of the right to health as elicited by the Committee on Economic, Social and Cultural Rights. Abortion was one political wrong move from being returned to inaccessible. TEMA continues to make abortion safer and more accessible; in 2022 (January to June), almost 90% of

[598] *General Comment No.14*, *supra* note 179.
[599] Herring, Jackson and Sheldon, *supra* note 382.
[600] Elizabeth Chloe Romanis et al, "COVID-19 and reproductive justice in Great Britain and the United States: ensuring access to abortion care during a global pandemic", online: (2020) 7:1 Journal of Law and Biosciences <https://doi.org/10.1093/jlb/lsaa027> at 7.

abortions were carried out before 10 weeks' gestation.[601] It is alarming that this improved safety for women needing an abortion was almost sacrificed to political ideology – enable by criminal legislation.

Decriminalisation does not mean deregulation, it means scientific regulation by medical professionals.[602] Abortion's criminal regulation is exceptional but it does not mean all other healthcare is provided in a 'legal vacuum.'[603] Instead, healthcare has multiple arms of strict regulation which function to promote best practice, including general criminal and civil law protections.[604] The NHS and abortion clinics are regulated by the Care Quality Commission in England, and the Care and Social Services Inspectorate in Wales. Doctors are regulated by the General Medical Council, whose objectives include protecting, promoting and maintaining the health and safety of the public, as well as maintaining public confidence in the profession and proper standards.[605] Furthermore, abortion providers must adhere to guidance provided by professional bodies such as the RCOG.[606] Since EMA is the most common method of abortion used in England and Wales, it is important to establish that mifepristone and misoprostol would, following decriminalisation, continue to be closely regulated. The Human Medicines Regulations 2012 contains specific provision for medications deemed 'prescription only.' This includes making it a criminal offence to supply prescription drugs if the supplier is inadequately qualified or unregistered.[607] The GMC's requirement that doctors must not prescribe medicine without 'adequate knowledge of the patient's health, and are satisfied that the drugs or treatment serve the

[601] National Statistics, *supra* note 440.
[602] Herring, Jackson and Sheldon, *supra* note 382.
[603] *Ibid* at 58.
[604] *Ibid.*
[605] Medical Act 1983, S.1.
[606] Herring, Jackson and Sheldon, *supra* note 382 at 61.
[607] Human Medicines Regulations 2012, Regulation 214.

patient's needs'[608] would continue to operate. Collectively these measures constitute a framework of abortion care regulation that is not stigmatising and continues the safe delivery of care. Abortion care would not be so vulnerable to the opinions of political actors, but scientifically regulated by medical professionals.

This an efficient infrastructure for the delivery of the highest attainable standard of health. It is time for it to be applied to the delivery of abortion care.

Canada

The abortion experience varies significantly across Canada. Factors such as the location and cost of abortion are stipulated by provincial health care insurance plans.

Canada's healthcare system

Following decriminalisation, abortion in Canada operates in the healthcare sphere. By virtue of S.92 of the Constitution Act 1867, delivery of healthcare in Canada is under provincial and territorial authority and is therefore regulated by the Canada Health Act 1985.[609] The Health Act provides the criteria all provincial and territorial healthcare policies must satisfy to receive a full cash contribution from the federal government.[610] This federal and provincial cost sharing agreement forms medicare, Canada's system of universal healthcare. Section 3 of the Health Act states that medicare is intended 'to protect, promote and restore the physical and mental well-being

[608] GMC "Good practice in prescribing and managing medicines and devices" (5 April 2021), online (Practitioner guidance): <https://www.gmc-uk.org/-/media/documents/prescribing-guidance-updated-english-20210405_pdf-85260533.pdf>.
[609] *Canada Health Act*, RSC 1985, c 6.
[610] *Ibid* at S.4.

of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.'[611]

The Canada Health Act requires provincial and territorial healthcare insurance plans to be (1) publicly administered; (2) comprehensive in its coverage; (3) universal; (4) portable across Canadian territories; and (5) accessible. When it comes to 'comprehensive', according to Section 2 of the Act, the plans must cover 'medically necessary' hospital services and 'medically required' physician services. Unfortunately, the Canada Health Act does not provide a national benefit package stipulating specific services that must be covered. This is a decision to be made at the discretion of provincial and territorial governments. Therefore, coverage of services not specified in the Health Act as medically necessary varies between jurisdictions.[612]

Abortion is always medically required; inaccessible abortion threatens both physical and psychological health.[613] The necessity of abortion care has been confirmed in Canada by all colleges of physicians and surgeons.[614] Therefore, abortion must be covered by medicare – a fact the Federal Government has repeatedly made clear since 1995.[615] To satisfy the demands of accessibility, s.12(1)(a) of the Canada Health Act requires provinces to provide the required services 'on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons.'[616] Therefore, the Canada Health Act requires provinces to provide abortion care that is accessible to everyone as part of its universal healthcare system. When a province fails to do so, the Canada Health Act enables the Federal government to reduce or withhold its cash contribution

[611] *Ibid* at s 3.
[612] Howard A Palley, "Canadian Abortion Policy: National Policy and the Impact of Federalism and Political Implementation on Access to Services" (2006) 36:4 Publius 565.
[613] *General Comment No.22, supra* note 181.
[614] Palley, *supra* note 612 at 567.
[615] *Ibid* at 678.
[616] Canada Health Act, *supra* note 609 at s (1)(a).

to the province.[617] Despite this, accessible abortion remains elusive for many across Canada by virtue of geography and Canada's constitutional healthcare arrangements.

Canada's costly abortion geography

As the second largest country in the world, Canada's population distribution is expansive, people are dispersed across a large geographic area. This poses a difficulty for the provision of abortion on a scale unparalleled by almost all other countries.[618] The distribution of abortion care providers in Canada fails to align with its population distribution which has caused a distinct inequity of abortion access between individuals living in rural and urban regions.[619] Prior to the approval of 'the abortion pill' in Canada in 2017, almost 90% of all abortions were provided in metropolitan areas, and most within 150km of Canada's border with USA.[620] This is problematic since it is estimated that fewer than 60% of reproductive age females lived in these areas.[621] Thus, in the period between decriminalisation in 1988 and 2017, abortion seekers were forced to travel significant distances to access surgical abortion care which resulted in substantial out-of-pocket costs. This included both the travel arrangements and other expenses such as childcare or loss of income due to time off work.[622] Canada's geography mandates substantial travel to access in-person abortion care. This is an ongoing barrier to equitable abortion access across Canada.

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[617] *Ibid* at s 15.
[618] Brooke Ronald Johnson Jr, Louise Keogh and Wendy V Norman, "What would be the likely impact of decriminalisation on the incidence, timing, provision and safety of abortion?" in Sally Sheldon and Kaye Wellings, eds, *Decriminalising Abortion in the UK What Would it Mean?* (Poole: Policy Press, 2020) 99 at 112.
[619] Dorothy Shaw and Wendy V Norman, "When there are no abortion laws: A case study of Canada" (2020) 62:1 Best Practice & Research Clinical Obstetrics & Gynaecology 49 at 54.
[620] Johnson et al, *supra* note 618 at 112.
[621] *Ibid.*
[622] Christabelle Sethna and Marion Doull, "Spatial disparities and travel to freestanding abortion clinics in Canada" (2013) 38 Women's Studies International Forum 52 at 56.

EMA has the potential to alleviate the barrier Canada's disparate geography presented to accessible abortion.[623] However, Canada was exceptionally slow in its approval of mifepristone and misoprostol for abortion. Initially, one might think the lack of abortion law would make Canada the ideal location for mifepristone EMA, however this is not true. In Canada, it is usual practice for pharmaceutical companies to initiate the drug approval process.[624] So, when the federal government was urged to invite drug companies to apply for mifepristone testing, governments deferred to protocol and refused.[625] By deferring to usual practice, the government was able to appear neutral; '[b]y declining to invite the drug company to test in Canada, the government did not appear to seek increased abortion access; by following established Health Canada practice, it did not appear to prevent access.'[626] The government had attempted to appease all sides of the abortion debate to the detriment of women. The lack of abortion legislation did not make Canada immune from powerful abortion politicisation that seem to override consideration of best-practice and female experience. Canada's geography poses a huge barrier to abortion access, yet politics stood in the way of a solution that could alleviate this for decades.

An application for approval of mifepristone was made to Health Canada by pharmaceutical company Linepharma in 2011.[627] The 'abortion pill', which is branded collectively in Canada as mifegymiso, was eventually approved in 2015.[628] However, its approval was subject to strict and medically unnecessary conditions on its use.[629] Health Canada required particular 'risk management activities'[630] which included physician-only dispensing and mandatory pre-

[623] Sarah B Munro et al, "Advancing Reproductive Health through Policy-Engaged Research in Abortion Care" (2022) 40:5 Semin Reprod Med 268 at 270.
[624] Patricia Campbell, "Making sense of the abortion pill: a sociotechnical analysis of RU486 in Canada" (2018) 27:2 Health Social Review 121 at 125.
[625] *Ibid* at 130.
[626] *Ibid.*
[627] *Ibid* at 122.
[628] *Ibid* at 121.
[629] Shaw and Norman, supra note 619 at 54.
[630] Canada, Health Canada, *Regulatory Decision Summary for Mifegymiso*, (Ottawa: Health Canada, 2015).

prescription training.[631] This exceptional over-regulation stood to actively discourage the provision of safe EMA. Thankfully, these conditions of use were removed by Health Canada within the first year of mifegymiso's availability following the election of a liberal government committed to reproductive rights.[632] Health Canada permitted mifegymiso to be dispensed directly 'to patients by a pharmacist or a prescribing health professional' that could then be administered as directed in a health facility or at home.[633] Therefore, Canada's lack of abortion legislation did enable quick and medically informed removal of unnecessary impediments to access.

Furthermore, following mifegymiso approval, the implementation of TEMA didn't face the legislative barriers that it did in England and Wales. Instead, the delivery of abortion care has the opportunity to develop at the same rate as best-practice.[634] During the Covid-19 Pandemic, the Society of Obstetricians and Gynaecologists of Canada adopted the position that EMA "can safely be provided by telemedicine or virtual visits."[635] In theory, Canada was able to embrace TEMA as a safe solution to the geographical barriers facing abortion access where an individual wished to self-manage her abortion.[636] However, it is important to remember that the delivery of healthcare in Canada is a matter for provinces. Therefore, federal action can only go so far in the achievement of equitable abortion access across Canada.

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[631] *Ibid.*
[632] Munro et al, *supra* note 623 at 272.
[633] "Health Canada updates prescribing and dispensing information for Mifegymiso" (7 November 2017), online: <https://recalls-rappels.canada.ca/en/alert-recall/health-canada-updates-prescribing-and-dispensing-information-mifegymiso>.
[634] Munro et al, *supra* note 623.
[635] Society of Obstetricians and Gynaecologists of Canada, "Induced Abortion: Updated Guidance during Pandemics and Periods of Social Disruption" (6 May 2020), online: <https://sogc.org/common/Uploaded%20files/Induced%20Abortion%20-%20Pandemic%20Guidance%20-%20FINAL.PDF>.
[636] Munro et al, *supra* note 623 at 274.

Health care insurance plans

Despite, the approval of mifegymiso and removal of restrictions on its use, provincial health care insurance plans continue to dictate the provision of abortion care. These plans provide specific conditions of coverage for the cost of abortion which can include specifying the location or method of abortion. I will now analyse the impacts of two provincial health care plans that are particularly detrimental to abortion seekers, namely the plans of New Brunswick and Prince Edward Island.

New Brunswick

The abortion policy in New Brunswick is troubling. Medicare covers surgical abortions but only when provided in hospital up to 16 weeks' gestation.[637] This is a result of outdated Regulation 84-20, the provincial government's amendment to their 'Medical Services Payment Act' in the year following abortion decriminalisation.[638] The Regulation required abortion be carried out in a registered hospital and only with written approval from two doctors that the procedure was medically necessary.[639] Whilst this Regulation has been significantly amended, the location requirement remains. There are only three hospitals in the province providing surgical abortion care.[640] Therefore, accessing a covered surgical abortion may require costly and time-consuming travel arrangements. Furthermore, the climate in New Brunswick can make travel unsafe and extremely difficult during the winter.[641]

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[637] *General Regulation – Medical Services Payment Act*, NB Reg 20/84, sch 2.
[638] Rachael Johnstone, "Explaining Abortion Policy Developments in New Brunswick and Prince Edward Island" (2018) 52:3 Journal of Canadian Studies 765 at 772.
[639] *Ibid.*
[640] *Ibid* at 775.
[641] Jacques Poitras, "Federal health ministers says NB abortion access can be 'difficult,' but it quiet on what Ottawa will do next" (28 February 2023), online (News article): <https://www.cbc.ca/news/canada/new-brunswick/abortion-nb-access-difficult-1.6761777>.

There is one clinic providing abortions in New Brunswick, Clinic 554 in Fredericton.[642] Having an abortion here will cost the individual between $700-$850(CAD) out-of-pocket.[643] This renders an out-of-hospital abortion completely inaccessible for a New Brunswick abortion seeker who cannot afford the care or the cost of travel to a different province. Joanna Erdman finds that '[a]s compared to hospitals, clinics are widely held to offer more supportive and higher quality care'.[644] Therefore, abortion care that is widely considered most supportive is not accessible by all who may require it given uneven distribution of providers and financial barriers. The highest attainable standard of health is off limits to anyone without the financial means to cover the costs. New Brunswick's failure to cover the cost of clinic abortions has been repeatedly criticised for obstructing accessible abortion, to the extent that the federal government withheld $140,216 of its transfer to the province in 2021, with Prime Minister Trudeau committing to ensuring Clinic 554 be subsidised.[645] However, in the two years since, no progress has been made to cover the cost of abortions as Clinic 554. This is despite the fact the province is increasingly allowing surgeries to be performed in private clinics outside hospitals and billed to Medicare to tackle high wait times.[646] The reluctance to do the same for abortion care can only be described as exceptionalism.

Medicare in New Brunswick will also cover the cost of mifegymiso up to 9 weeks' gestation. This is promising because it can be prescribed by any doctor or nurse practitioner and then dispensed at an individual's local pharmacy.[647] However, it is important to remember that reproductive autonomy demands meaningful choices – including the ability to decide on a course of termination

[642] Clarissa Hurley, "T.A." in Shannon Stettner, ed, *Without Apology: Writings on Abortion in Canada* (Edmonton: AU Press, 2016) 83 at 88.
[643] "Reproductive Health", online (Clinic 554 Website): <http://www.clinic554.ca/reproductivehealth.html>.
[644] Joanna Erdman, "In the Back Alleys of Health Care: Abortion, Equality and Community in Canada" (2007) 56:1 Emory LJ 1093 at 1095.
[645] "Trudeau says Ottawa withholding health-care transfers to N.B. over abortion access" (27 July 2021), online (News article): <https://atlantic.ctvnews.ca/trudeau-says-ottawa-withholding-health-care-transfers-to-n-b-over-abortion-access-1.5524840>.
[646] Poitras, *supra* note 641.
[647] Jacques Poitras, "Rising use of abortion pill shifting the landscape, expert says" (31 May 2023), online (News article): <https://www.cbc.ca/news/canada/new-brunswick/abortion-pill-expert-1.6859533>.

best for an individual.[648] Medical best-practice also calls for choice of abortion method.[649] An individual needs to have actionable options from which she can choose the most appropriate for herself. Furthermore, EMA may not be the most appropriate method of termination for an individual, for example if she has learning difficulties and is unable to self-manage abortion medication dispensed by her local pharmacy. Perhaps an abortion seeker lacks a safe environment in which she can self-manage her abortion, or she may have a phobia of blood. Therefore, the sparse distribution of insured abortion providers, and the failure to cover clinics, means that accessible abortion that respects choices remains unattainable for many women in New Brunswick.

Prince Edward Island (PEI)

PEI's health care insurance plan covers both surgical and medical abortion when accessed through Sexual Health, Options & Reproductive Services (SHORS) at Prince County Hospital.[650] However, the provision of medical abortion is subject to exceptional overregulation that subjects abortion seekers to an unnecessarily laborious process.[651] *Health PEI* details that an individual requiring a medical abortion must attend three appointments. The first appointment involves bloodwork and an ultrasound in order to progress with the medical abortion; the second appointment is where the individual takes mifepristone and is given misoprostol to take at home; at the third appointment a week to two weeks later, the individual has either an ultrasound or pelvic exam to confirm the abortion was successful.[652] These requirements are excessive, in particular Health Canada explicitly removed the requirement for pre-abortion ultrasound in 2019.[653] PEI is

[648] Nelson, *supra* note 24.
[649] WHO, *supra* note 124.
[650] Prince Edward Island, "Sexual Health, Options & Reproductive Services (SHORS)" (22 June 2023), online: <https://www.princeedwardisland.ca/en/information/health-pei/sexual-health-options-reproductive-services-shors>.
[651] Prince Edward Island, "Medical Abortion" (22 June 2023), online: <https://www.princeedwardisland.ca/en/information/health-pei/medical-abortion>.
[652] *Ibid.*
[653] Government of Canada, "Health Canada approves updates to Mifegymiso prescribing information: Ultrasound no longer mandatory" (28 October 2019), online: <https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/fact-sheets/mifegymiso.html>.

forcing unnecessary and potentially costly travel that presents a barrier to timely care. Any delay to abortion only increases its associated risks.

Historically, PEI's abortion politics have been overtly moralistic, informed by religion and the notion that life begins at conception.[654] PEI has long feared abortion's potential to challenge patriarchal power dynamics.[655] Fears of the implication abortion can have on the moral status of female sexuality has fuelled denial of women's reproductive autonomy. [656] In fact, PEI only reintroduced abortion services in the province in 2016, prior to this abortion had not been available in the PEI since 1982.[657] Prior to 2016, an abortion seeker could only access care out-of-province in Nova Scotia with PEI physician referral, or in New Brunswick without referral. Whilst the cost of the abortion would be covered by medicare, the cost of travel would not. An abortion was unattainable for anyone who could not afford substantial travel. This policy attitude is stigmatizing – it tolerates abortion provided they do not take place within PEI. Subsequently issuing a 'smug' value judgment on abortion;[658] this policy suggests individuals who require abortion ought to be ashamed that they were so 'cavalier about their fertility' and are responsible to deal with the consequences of their own actions.[659] This stigmatising trepidation to provide abortion seems to remain potent in today's PEI abortion policy. The provincial government continues to require exceptional treatment contrary to best-practice. These unnecessary hoops abortion seekers are forced to jump unnecessarily impede timely abortion care. Given the fact that any delay to abortion care increases its associated risks, PEI's policy stands to unjustifiably increase women's risks when accessing essential reproductive care.

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[654] Joanna Erdman, "The Law of Stigma, Travel, and the Abortion-Free Island" (2016) 33:1 Colum J Gender & L 29.
[655] *Ibid.*
[656] Johnstone, *supra* note 638 at 768.
[657] Donalee Moulton, "PEI to finally offer abortions on the island" (2016) 188:9 CMAJ E171.
[658] Shannon Stettner, "Without Apology: An Introduction" in Shannon Stettner, ed, *Without Apology : Writings on Abortion in Canada* (Edmonton: AU Press, 2016) 3.
[659] *Ibid.*

Overall, the political landscapes in both provinces have resulted in a scarcity of accessible abortion services.[660] In the absence of legislation, provincial healthcare arrangements have continued to dictate the delivery of abortion care and has been subject to political whim and a desire to limit the occurrence of norm-challenging abortion. This has resulted in unnecessarily exceptionalised treatment of abortion, perpetuating the experience of abortion stigma and requiring abortion be provided at a standard that is sub-best practice.

Indigenous access

The experiences of Indigenous women and girls, as well as Two-Spirit Peoples, in obtaining abortion care is disappointingly under researched.[661] Ongoing colonialism has caused significant disparities in social determinants and outcomes of health for Indigenous peoples – such as housing, transportation and discrimination.[662] This means that the existing barriers to reproductive healthcare are exacerbated for Indigenous individuals, including Indigenous abortion seekers.[663] The distribution of providers mandating substantial travel in particular from rural areas is disproportionately detrimental for Indigenous peoples because 60% of Canada's Indigenous population live in rural areas;[664] a 2013 study found that 'First Nations and Metis were almost three times more likely to report travelling over 100km to access a clinic as compared with white women.'[665] A 2023 Indigenous-led qualitative study confirms that the cost and location of abortion care in Canada remains a serious barrier to Indigenous abortion access that results in delayed care.[666] Furthermore, there is a concern that mandatory travel results in a loss of privacy due to the

[660] Johnstone, *supra* note 638.
[661] Erin Nelson, *supra* note 47.
[662] Stote, *supra* note 499.
[663] Renée Monchalin, "Novel Coronavirus, Access to Abortion Services, and Bridging Western and Indigenous Knowledges in a Postpandemic World" (2020) 31:1 Women's Health Issues 5 at 6.
[664] Monchalin et al, *supra* note 494 at 3.
[665] Sethna and Doull, *supra* note 622 at 60.
[666] Monchalin et al, *supra* note 494.

nature of tight-knit communities living on reserve.[667] Overall, Indigenous abortion seekers face increased cost and geographical barriers to timely abortion services, thus obstructing their ability to access the highest standard of care.[668]

The right to accessible abortion belongs to all individuals with the capacity to become pregnant – this includes Canada's Indigenous population. However, current policy in Canada seems determined to make the situation worse. In Saskatchewan, the defunding of public transport has resulted in bus services to rural communities being forced to end which has made in-person abortion care inaccessible for many,[669] and the right to choose the method of abortion care ignored. Ensuring transport that services rural Indigenous communities must be prioritised as a matter of reproductive rights, health and choice. Canada must enact focused policy that recognises and combats the ongoing impact of colonialism on reproductive healthcare.

"Access Zones" in Canada

Several provinces have passed legislation creating access zones around abortion providers across Canada. The first of its kind in Canada came from British Columbia when it passed the Access to Abortion Services Act 1996. In response to the shooting of an abortion provider,[670] the Access to Abortion Services Act 1996 automatically provides access zones to the homes and offices of abortion providers whilst facilitating that abortion care providers must apply for a zone.[671] There are only three clinics in British Columbia that are currently protected.[672] Within these access zones,

[667] "Decolonize Abortion Care: Reproductive Justice for Indigenous Communities" (2020), online: *Abortion Rights Coalition of Canada* <https://www.actioncanadashr.org/sites/default/files/2020-06/2020_Abortion_Caravan_Decolonize_Abortion_Care_0.pdf>.
[668] Monchalin et al, *supra* note 494.
[669] Lee and Spillett, *supra* note 493
[670] Abortion Rights Coalition of Canada, "Safe Access Zone Laws and Court Injunctions in Canada" (22 August 2022) online: <https://www.arcc-cdac.ca/media/2020/06/Bubble-Zones-Court-Injunctions-in-Canada.pdf>.
[671] *Ibid.*
[672] *Ibid.*

the Access to Abortion Services Act 1996 makes it a criminal offence to do any of the following 'restricted activities':

a) engage in sidewalk interference;
b) protest;
c) beset;
d) physically interfere with or attempt to interfere with a service provider, a doctor who provides abortion services or a patient;
e) intimidate or attempt to intimidate a service provider, a doctor who provides abortion services or a patient.[673]

For a first conviction, an individual doing one of these restricted activities in an access zone could face a fine not exceeding $5000 (CAD), up to six-month imprisonment, or both.[674] For a subsequent conviction, the fine increases to less than $10000 (CAD), up to one year in prison, or both.[675] In 2008, the British Columbia Court of Appeal upheld this legislation after it was challenged as unconstitutional.[676] The Court held that the legislation was a reasonable restriction on the freedom of expression rights because the legislation's "objective of equal access to abortion services, enhanced privacy and dignity for women making use of the services and improved climate and security for service providers" was sufficiently important to justify the restriction.[677] It is noteworthy that this decision was made even though the Access to Abortion Services Act 1996 makes expression an offence potentially punishable by a prison sentence, this is a somewhat harsh punishment. However, the Court considered a 1994 case from Ontario which held the freedom of expression "does not include a right to have one's message listened to."[678] Protesting at abortion

[673] Access to Abortion Services Act 1996, RSBC 1996, c 1, s 2(1)(a)-(e)
[674] *Ibid* at s 14(3).
[675] *Ibid* at s 14(4).
[676] *R v Spratt; R. v Watson*, 2008 BCCA 340, [2009] 1 WWR 72.
[677] *Ibid* at para 71.
[678] *Ontario (Attorney-General) v Dieleman*, (1994) 117 DLR (4th) 449, 49 ACWS (3d) 1059.

clinics forces those seeking care to listen to the anti-choice agenda – making the suffering inflicted by the anti-abortion protestors unavoidable. The British Columbia Court of Appeal justifiably prioritised the accessibility of abortion over the freedom of expression in designated areas of public space. The decision demonstrates the fulfilment of an obligation states are under in the provision of accessible abortion.

Since British Columbia's legislative creation of access zones withstood judicial creativity, other provinces have followed suit. In 2016, Newfoundland and Labrador passed its own Access to Abortion Services Act which is almost identical to British Columbia's. Today, access zones legislation that creates criminal offences also exists in Quebec, Ontario, Alberta and Nova Scotia.[679] This is a positive expansion of laws that prioritise the rights of abortion seekers over the freedom of expression of a vocal minority in a proportionate manner.

Implementing the right to accessible abortion in Canada

Scientifically informed best practice abortion care must be covered by medicare. Firstly, this means full coverage of both surgical and medical abortions, provided in hospitals *and* clinics. In 2021 (Canada's most recent official dataset) only 36.8% of all abortions in Canada were medical – 63.2% were surgical.[680] This is troubling because a recent study found that only 31% of Canadian women would choose a surgical abortion (24% were unsure).[681] For 2021 in England and Wales, medical abortions accounted for 87% of all abortions.[682] During this period both jurisdictions lawfully allowed telemedical EMA. However, the different statistics may demonstrate the grip provincial politics in Canada have on an individual's decision making. The same recent study also

[679] Abortion Rights Coalition of Canada, *supra* note 670.
[680] Data Tables, *supra* note 3.
[681] Ipsos, "More than 8 in 10 Canadian women strongly advocate for availability and access to the two abortion options in Canada and autonomy of choice" (24 May 2023), online: <https://www.ipsos.com/sites/default/files/ct/news/documents/2023-05/Abortion%20Survey_Factum.pdf>.
[682] Office for Health Improvement and Disparities, *supra* note 2.

found that 80% of Canadian women agree 'that they want to be able to choose between the abortion options';[683] 82% 'believe that Canadians should have the same access to both methods';[684] and 80% agree that 'a medication abortion would make early-stage pregnancy termination accessible for all.'[685] Whilst this last claim may be somewhat over-optimistic, the fact remains that women understand the importance of choice that international human rights protects. Provincial health care must cover all methods of abortion in order to respect and facilitate autonomous choice as is necessary for the highest attainable level of care.[686]

Secondly, the exceptional and scientifically uninformed overregulation of abortion must cease. For example, there should be no mandatory travel requirement for accessing EMA nor a compulsory ultrasound for abortion care to be covered by medicare. These are measures that were removed by the federal government. Furthermore, other jurisdictions, as well as charitable providers such as Women on Web,[687] show that EMA can be safely and effectively provided telemedically without these requirements that only stand to obstruct equitable access. TEMA also has the potential to be hugely beneficial for Indigenous abortion seekers living on reserve, and those abortion seekers forced to travel the longest distances to obtain essential care. To harness the full potential of EMA, to implement the highest attainable standard of health, there is no place for historic political ideology in the delivery of essential reproductive healthcare today. These changes can increase accessibility and therefore be effective implementation of human rights.

Where a province fails to implement these changes, the Federal government must step in. The Federal government can withhold its cash contributions to a province when its health care insurance plan does not ensure accessibility of necessary services. Although reluctant to use this

[683] Ipsos, *supra* note 681.
[684] *Ibid.*
[685] *Ibid.*
[686] WHO, *supra* note 124.
[687] Women on Web, "Abortion Pill Access by Mail", online: <https://www.womenonweb.org/en/>.

power in the past, it is time to hold provinces accountable for their neglect of reproductive rights. Whilst the Federal government did exercise its power in relation to New Brunswick, with the PM announcing his commitment to ensuring clinic abortions were covered, there has been no change in the two years since.[688] The action taken, including the actual cash amount withheld from New Brunswick, was inconsequential. Erin Nelson calls for 'focused policy attention and cooperation between federal and regional governments.'[689] More collaborative action must be taken to implement the right to accessible abortion and ameliorate the unequal distribution of accessible care across Canada.

Conclusion

For the implementation of the right to accessible abortion, science and women's experience must be the driving force in regulation – not secondary to political whim or reproductive control. Although exceptional, we see a respect for women's reproductive autonomy and medicine in the charitable delivery of abortion care in England and Wales. The safe, non-judgmental care provided is a level of care required by human rights. The problem for physically accessing this care lies in politics, a problem Canada also suffers from. When the accessibility of care is not prioritised, inequality emerges in costly travel requirements and significant detriment to society's most vulnerable and marginalised: victims of domestic abuse/intimate partner violence, and Indigenous Peoples. This is a violation of the right to accessible abortion.

There must be equal provision of abortion methods in accordance with best practice, which facilitate and support meaningful reproductive decision-making. Both jurisdictions purport to have universal healthcare – but free abortion choice seems more attainable across England and Wales

[688] News article, *supra* note 645.
[689] Nelson, *supra* note 47 at 726.

than it does in Canada. An abortion seeker in England and Wales can obtain a clinic abortion, or an at-home abortion, or a surgical abortion free of charge. Meaningful reproductive choice is not so readily available across Canada. There is a chasm between abortion 'law in books' and 'law in practice' which demonstrates the multitude of actors that influence the accessibility of abortion. For example, the full detrimental potential the Abortion Act 1967 has for delivery of care is mitigated by the operation of healthcare professional. Conversely, decriminalisation in Canada did not ensure accessible abortion care that is free of charge and emancipated from the strictures of political whim.

Chapter VII: Conclusion

Meaningful reproductive autonomy and self-determination demand *accessible* abortion which requires positive action from the State. In chapter III of this thesis, I set out the right to accessible abortion. I assessed well-established human rights norms and jurisprudence and provided the ways in which they shape the right to accessible abortion and correlative state obligations. My arguments can be summarised as follows: the right to life requires that an individual is not subject to unwanted pregnancy, clandestine abortion, or abortion delays. The right to be free from cruel, inhuman or degrading treatment requires that an individual not be subject to the pain and suffering caused by unwanted pregnancy. Additionally, dignity requires actionable reproductive autonomy. The right to health requires both abortion access and abortion choice of termination method is in line with best practice. Equality and non-discrimination require that abortion be accessible so that women are not disadvantaged by their physiological differences to men. It also means abortion law and policy cannot perpetuate discriminatory stereotypes. States are also under an obligation to balance competing rights, namely freedom of thought, conscience and religion, and freedom of expression with the demands of the right to accessible abortion outlined above.

The thesis then turned to consider the domestic realities of abortion access in England and Wales and Canada. In chapter V, I assessed the operation of abortion stigma in these jurisdictions as a violation of the right to accessible abortion. This chapter revealed the importance of decriminalising abortion. The criminal law in England and Wales characterises abortion as immoral and dangerous to society. Painfully recent case law highlights the detrimental stigmatising impacts of abortion criminalisation that England and Wales continue to allow. However, this chapter demonstrated that whilst decriminalisation is necessary, it is not a panacea for the eradication of stigma which continues to impede abortion access across Canada. In chapter V I

proposed reform that was necessary for Canada and England and Wales to fulfil their obligation to eradicate abortion stigma and fulfil the right to accessible abortion. This included the decriminalisation of abortion in England and Wales, and the regulation of Crisis Pregnancy Centers in Canada as well as focused policy on Indigenous abortion access that appreciates key cultural differences.

In chapter VI, I considered practical and material impediments to abortion access such as the location and cost of abortion care. My analysis found that, to fulfil the obligations under the right to accessible abortion, states must regulate abortion in a way that is informed by modern medicine and women's experiences. Abortion law and policy must not force the delivery of abortion care to be sub-contemporary best practice. This chapter provided insight into the value of safe access zones – a successful and proportional balancing of competing rights as well as the harm caused by abortion politicisation. In the same chapter I proposed dramatic reform of the Abortion Act 1967, eradicating outdated requirements on the delivery of care. For Canada to fulfil its obligations under the right to accessible abortion, both medical and surgical abortion in both hospital and clinic settings must be covered by medicare across all provinces. Where this does not happen, the Federal government must exercise its powers to condemn the failure to respect reproductive autonomy and fulfil women's rights.

Accessible abortion is a human right which imposes obligations upon Canada and England and Wales that they fail to fulfil. Abortion accessibility for all who may need it must be a priority in any state claiming to be a proponent of human rights so that women can flourish in society.

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